

# Walsall Healthcare NHS Trust

# Manor Hospital










## Quality Report

Moat Road  
Walsall,  
West Midlands,  
WS2 9PS  
Tel: (01922) 721172  
Website: [www.walsallhospitals.nhs.uk](http://www.walsallhospitals.nhs.uk)

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

### Ratings

<b>Overall rating for this hospital</b>	<b>Requires improvement</b>	
Urgent and emergency services	<b>Requires improvement</b>	
Medical care (including older people's care)	<b>Good</b>	
Surgery	<b>Requires improvement</b>	
Critical care	<b>Requires improvement</b>	
Maternity and gynaecology	<b>Inadequate</b>	
Services for children and young people	<b>Good</b>	
End of life care	<b>Good</b>	
Outpatients and diagnostic imaging	<b>Good</b>	

# 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 people. Acute hospital services are provided from one site, Manor Hospital, which has 550 acute beds. There is a separate midwifery led birthing unit and a specialist palliative care centre in the community.

The trust is currently in special measures, as we wanted to ensure services found to be providing inadequate care at the trust did not continue to do so. The trust went into special measures in February 2016 following our announced comprehensive inspection on 8 to 10 September 2015. We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

Following the 2015 inspection, we rated this trust as 'inadequate'. We made judgements about 11 services across the trust as well as making judgements about the five key questions we ask. 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'.

After the inspection period ended, the Care Quality Commission served the trust with a Section 29a Warning Notice, Health and Social Care Act 2008 which wholly related to concerns within maternity services.

The Section 29a Warning Notice set out the points of concern and timescales to address this. The trust responded to this with a detailed plan for remedial action. We have received weekly maternity information from the trust which has showed significant improvements relating to all concerns outlined in the Section 29a Warning Notice.

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 unannounced visits to eight hospital services to include; emergency department, medical services, surgery services, critical care services, maternity services, children and young people services, end of life services and outpatients and diagnostic services. The inspection team included CQC inspectors and clinical experts.

We held focus groups with a range of staff in the hospital and community 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.

We have rated this hospital as requires improvement. We made judgements about eight services across the hospital 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.

At this inspection, we saw some significant improvements in ratings for all acute services at Manor Hospital with the exception of maternity and gynaecology services.

In our previous inspection, we rated urgent and emergency services as inadequate however, we saw improvements had been made throughout this service and this was rated as requires improvement.

In our previous inspection, we rated medical care, surgery, critical care, services for children, young people end of life care, outpatients and diagnostic imaging as requires improvement.

In this inspection, we saw all of these services apart from critical care, had significantly improved and we rated them all as good. Critical care remains as requires improvement.

We rated Walsall Manor Hospital as requires improvement overall.

# Summary of findings

## **Our key findings as follows:**

- The trust did not meet its target compliance rate of 90% for mandatory training.
- Compliance rates within adult and children's safeguarding training was low.
- Areas we identified during our last inspection (2015) such as staffing levels and training continued to remain a concern. However, we saw that the trust was being proactive in trying to address these.
- Staff inconsistently completed trust documentation in patient records. We observed inconsistencies throughout the records with staff initials, signatures, and job roles. Not all entries were legible.
- Staff were not always managing deteriorating patients appropriately.
- Many guidelines remained out-of-date following our last inspection.
- Serious incident action plans were not always monitored or completed.
- The senior leadership team in maternity was in its infancy and there had been little oversight of governance and incidents at a senior level.
- The ED dementia lead nurse had contributed to significant staff awareness and understanding of the needs of patients living with dementia.
- Staff were knowledgeable about consent and mental capacity. Consent for treatment was obtained appropriately and in line with legislation and guidance.
- Multi-Disciplinary Team (MDT) working was effective.

## **We saw several areas of outstanding practice including:**

### **Urgent and Emergency Services**

- Staff and patients' relatives all told us the ED dementia lead nurse was making significant improvements for patients living with dementia.
- Staff told us about a seriously ill patient who had arrived into 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.

### **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.

### **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.

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

## **Importantly, the trust must:**

### **Maternity and Gynaecology**

- Ensure all staff have completed the required level of safeguarding training.
- Ensure the governance of the service is improved.

# Summary of findings

- Ensure risks are explained when consenting women for procedures.
- Ensure the service uses an acuity tool to evidence safe staffing.
- Ensure the service promotes a no blame culture.
- Ensure that action plans are monitored and managed for serious incidents.
- Ensure that lessons are disseminated effectively to enable staffing learning from serious incidents, and incidents.
- Ensure staff follow best practice national guidance.

## **Urgent and Emergency Services**

- The trust must take action to improve ED staff's compliance with mandatory training.

## **Critical care**

- The trust must ensure that plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.
- The trust must ensure any staff working within the outreach team are competent to do so.

## **Medical care**

- The provider must ensure mandatory training is up-to-date including safeguarding training at the required level.
- The provider must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced staff to keep patients safe.

## **Surgery**

- The service must ensure that all professional staff working with children have safeguarding level 3 training.
- The service must ensure that all staff are up to date with safeguarding adults.
- The service must ensure that patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.
- The service must ensure that all shifts have the correct skill for wards to run safely.
- The service must ensure that all staff are up-to-date with mandatory training.

## **Children and young people**

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

## **End of life care**

- Ensure attendance for mandatory training is improved.
- To undertake required safeguarding training as required for their individual role.
- All staff are trained and competent when administering medications via syringe driver.
- All staff must complete end of life documentation where appropriate.

## **Outpatients & diagnostic imaging**

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

## **In addition the trust should:**

### **Maternity and Gynaecology**

# Summary of findings

- Staff are compliant with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- There is a consultant obstetrician as the designated guideline development lead.
- Staff read and sign newly launched guidelines in a timely manner.
- Staff opinion is sought when developing the service.
- Complaint information is displayed appropriately.
- There are chaperone signs in outpatient areas.
- There are available appointments for women to access the clinic for vaginal birth after caesarean.
- Women do not have long waits to be discharged from the fetal assessment unit.
- Women are informed and involved in the planning of their care.
- Women are supported during their stay.
- Pain relief is given as prescribed or when requested.
- Documentation is completed and audited.
- Handovers follow a Situation Background Assessment Review (SBAR).
- The service had an alternative plan in place based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP).
- Student midwives are not practising unsupervised.
- There is a robust data collection system.
- The stillbirth rate is reviewed and an action plan developed.
- The dashboard data is reviewed and action plans are monitored and reviewed.
- Breast milk fridge is locked.
- Women are offered breast feeding support.
- Scans are uploaded to the electronic database.
- All cardiotocography machines have the correct time.
- Staff know their role in a major incident.
- Staff complete major incident training in line with the trust target.
- VTE risk assessments are completed.
- Prescription charts are fully completed.
- Women's antenatal handheld records are fully completed.
- All the areas of the electronic computer system are completed.
- Medical records are stored safely.
- Invasive treatments to babies are performed in a private environment respecting privacy and dignity of the baby.
- Environmental audit results are monitored and actions to improve.
- All areas are visibly clean.
- Audits of surgical infections are performed.
- An audit programme is developed and presented to the service.
- Low harm incidents are reviewed in a timely manner.
- Gynaecology staff complete the adult resuscitation training.

## Urgent and Emergency Services

- Ensure its nominated ED triage nurse is clearly identifiable to ambulance staff.
- Risk assess and re-evaluate its use of a cubicle as an ED review room.
- Reassess its policy for the use of review rooms in ED, ensure all staff are aware of, and adhere to the process.
  - Take action to ensure no confidential conversations between doctors, patients or their representatives take place in the ED review rooms, if there is a chance they could be overheard by other patients or visitors.

# Summary of findings

- Raise awareness of its chaplaincy service amongst its ED staff and ensure patients and relatives who may benefit from it are made aware of it.
- Ensure ED is able to offer written information to patients in languages other than English.
- Review its decision-making process around using RAT cubicles in ED to accommodate patients in time of increased demand, rather than ring fencing the cubicles to allow the RAT team to contribute to ED patient flow.
- Continue to improve its staff appraisal completion rates.

## Critical care

- Review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.
- Provide follow up clinics to patients after discharge from the critical care unit in line with Core Standards for Intensive Care.
- Consider how to effectively identify and manage all infectious patients in the critical care wards given the lack of appropriate isolation facilities.
- Essential equipment is procured and used with relevant patients; and staff are fully trained and competent to use this equipment, for example, capnographs.
- All risks to the service are included on the risk register.
- Deprivation of Liberty Safeguards are applied in all cases where these are required; for example restricting patients movements by use of bed rails.

## Medical care

- Medication trolleys are adequate for medications stored.
- Computers are password protected to protect against unauthorised access and that these are not left unlocked.
- Patients have access to call bells at all times and that all call bells can be heard by staff and used to signify an emergency.
- Review the nursing documentation to ensure it is fit for purpose and that risks, such as falls are regularly reassessed and recorded.
- Staff on wards have sufficient knowledge to care safely for neutropenic patients, including knowledge of neutropenic sepsis.
- Ensure that patient's nutritional needs are assessed and reviewed in accordance with current guidance.
- All staff are up-to-date with their appraisals.
- Sufficient staff trained in administering medication via a peripherally inserted central catheter line.
- Medical records are kept secure and that information contained within is kept safe.
- Fire exit on ward 29 is alarmed to alert staff if a patient leaves the ward.

## Surgery

- Cleaning rota responsibilities are completed and documented on all wards.
- Razors and COSHH items are stored appropriately, securely and in places where people who use services are not able to access.
- That it is easy to see what contents should be available in the paediatric difficult intubation trolley in the surgical recovery area.
- Intravenous fluids and other fluid items, such as nutritional drinks, are stored in a locked place and are not accessible to the public on ward 10.
- Fridge and room temperature checks' monthly audits are carried out and recorded consistently across all wards.
- Controlled drug checks' monthly audits are carried out and recorded consistently across all wards.
- Streamlining their processes for patient records. There are a number of different formats and systems for one patient record, which can cause confusion and has a potential risk of staff not having all relevant information when treating patients.
- Continue with improvements in performance of patient outcomes.

# Summary of findings

- Continue with improvements in performance of referral to treatment times and patient flow through the hospital.
- Continue with improvements in managing deteriorating patients.
- Continue with improvement plans for IT software to ensure full compliance with the Accessible Information Standards.
- Continue to do all it can to resolve the issues with recruitment to improve staff morale.
- Consider reviewing the developmental opportunities available for junior physiotherapists.

## **Children and Young People's Services**

- Review the system for recording safeguarding training and assure themselves that clinical staff in children's services complete safeguarding children training to level 3.
- The trust should review and update local clinical guidelines for children's services and ensure they are based on national guidance and best practice.
- Introduce a systematic approach to assessing and monitoring children's nutritional and hydration risks.
- Review the environment within the fracture clinic and make improvements to meet the needs of children using the service.
- Implement systems and processes to identify those with a learning disability and ensure adjustments are made to cater for their special needs.
- Improve the timeliness of provision of medicines for children to take home.

## **End of life care**

- Look for ways to improve privacy on the wards/department when breaking bad news or consoling bereaved families.
- Ensure staff including porters are clear on who is responsible for cleaning trolleys when

transferring patients from one department to another.

- Look for ways to support the porters with equipment such as trolleys that are not always suitable to use but have no other option but to use.

## **Outpatient and diagnostic imaging**

- There is a robust system in place for monitoring clinic running times to ensure they are running to time on a consistent basis, and take action where this is not the case

**Professor Edward Baker**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement



### Rating

### Why have we given this rating?

We rated this service as requires improvement because:

- We found instances of unsatisfactory infection prevention and control practice.
- Medicines management was not satisfactory in some areas of the department.
- We saw some patients accommodated in a potentially unsafe environment.
- ED was not achieving target times for assessment, treatment, or admitting, transferring or discharging patients.
- ED was not achieving the trust's targets for its staff to complete mandatory training, or to have appraisals.

However:

- Staff demonstrated a positive culture of incident reporting and audits, and of learning from incidents, audit results, complaints and concerns.
- Many improvements had been made since our inspection in September 2015, including: increased staff numbers and skill mix; equipment storage and availability in the resuscitation area; dedicated, and separate paediatric waiting and treatment areas.
- Staff considered patients' basic care a priority. Scheduled rounds took place ensuring patients were comfortable and had food and drinks where appropriate.
- Care and treatment was delivered in line with national guidelines and evidenced best practice.
- Internal and external multidisciplinary working was embedded and effective, and was constantly reviewed and improved.
- Feedback from people who use the service, their families, and carers was positive about the way staff treated people. People said staff cared about them.
- The dementia lead nurse had contributed to significant staff awareness and understanding of the needs of patients living with dementia.



# Summary of findings

- Staff spoke very positively about the department's managers, and told us they were supportive, approachable and 'a part of the ED family'. Staff and managers were proud of the progress they had made but aware the department needed to improve further, and were keen to help it do so.

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

Good



We rated this service as good because:

- Senior managers were being proactive in solving difficulties with nursing recruitment.
- Staff had undertaken projects to look at areas for improvement and to determine what actions were needed to drive improvement forward.
- Staff were aware of how to report incidents and were encouraged to do so. Senior staff shared learning in unit and divisional meetings.
- We saw some good infection control techniques such as hand washing and personal protective equipment (PPE). Staff put measures into place to manage an infection outbreak on some wards.
- The hospital participated in clinical audits and monitored its compliance against the National Institute for Health and Care Excellence (NICE) guidelines.
- The trust participated in the nurse preceptorship programme; this gave newly qualified nurses the opportunity to be supported by a mentor whilst developing their nursing skills.
- We saw evidence of good multidisciplinary team working where staff worked together to safely discharge patients or to plan patients' care.
- We saw that staff adhered to the Mental Capacity Act, 2005 and that they applied Deprivation of Liberty Safeguards (DoLS) when a patient met the criteria.
- Most patients were happy with the care they received; they felt staff were kind and helpful and that staff treated them with dignity and respect.
- Staff respected patient confidentiality by closing curtains and knocking on doors.

# Summary of findings

- The trust had recently increased its ambulatory care service opening hours so that it was open from 8am to 8pm from Monday to Sunday. This meant that the hospital was able to close an overflow ward.
- There was a frail elderly service operating between 8am and 8pm Monday to Friday and from 8 am to 4pm at weekends. The service completed holistic assessments, treatment, support, referrals, and signposted patients to other services. This service helped to prevent unnecessary hospital admissions, with many patients being discharged the same day.
- We saw that the trust responded to complaints and kept patients or their relatives updated when timescales for responding were not met. Complaints were discussed at both ward and divisional meetings.
- The average length of stay for medical elective patients was better than the England average.
- Between October 2016 and March 2017, the trust performed better than the England average for referral to treatment times.
- Most staff felt their managers were visible, approachable, and supportive.

However:

- The trust did not meet its target compliance rate of 90% for mandatory training. Compliance rates within adult and children's safeguarding training was low.
- The trust was unable to meet NICE guidelines on staffing levels for stroke patients. The trust used clinical support workers to compensate for registered nursing gaps. We saw that many wards were regularly short staffed, staff told us this affected the time they spent with patients, completion of documentation and put pressure on existing staff.
- Medication trolleys were not always adequate for medicines stored, which meant there was a potential risk of medication errors.
- Staff did not always complete daily cleaning documentation to show they had completed daily cleaning tasks.

# Summary of findings

- We found that nursing documentation did not contain a section for staff to review a patient's risk of falls.
- Neutropenic patients did not have access to a dedicated area or ward for initial management. This meant that out-of-hours' nurses who may not have oncology knowledge were caring for neutropenic patients.
- Nurses did not always assess patients' nutritional risks effectively. We saw that staff were not always completing malnutrition universal screening tools (MUST).
- Only 80% of staff had received an appraisal; this did not meet the trusts target compliance rate of 90%.
- We saw that there was not always someone trained on the acute medical unit to administer intravenous antibiotics through a peripherally inserted central catheter line.
- Some patients told us that medical professionals did not always keep them up to date in relation to their care and treatment.
- 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 impacted on the time patients needed to wait.
- Areas we identified during our last inspection (2015) such as staffing levels and training continued to remain a concern. However, we saw that the trust was being proactive in trying to address these.

## Surgery

### Requires improvement



We rated this service as requires improvement because:

- Staff were not always managing deteriorating patients appropriately. Significant improvements were needed to ensure deteriorating patients were identified, escalated and reviewed by a doctor in a timely manner.
- There were significant issues with the hip fracture pathway, which was evident in poor audit results and data on patient outcomes.

# Summary of findings

- Staffing was an issue and skill mix was not always correct. There was high vacancy, turnover, sickness absence and agency rates, and a low fill rate at night. The service filled these gaps with agency and clinical support workers.
- Staff inconsistently completed trust documentation in patient records. We observed inconsistencies throughout the records with staff initials, signatures and job roles. Not all entries were legible.
- Safeguarding adults and children staff training compliance rates were low. Not all staff were trained to level 3 in safeguarding children, which is a requirement of the Intercollegiate document (2014).
- Mandatory training was not up to date, which saw none of the mandatory training modules achieving the trust's completion target of 90%.
- A lack of storage in theatres and on some wards meant items were not always stored appropriately. Intravenous fluids and nutritional drinks were not always protected from tampering and people who used services had access to razors and harmful chemicals.
- The service was still not meeting referral to treatment times and patient outcomes. Improvements had been made but there was still more to be done.
- The service was not fully compliant with the Accessible Information Standards.
- Staff morale was low in areas due to staffing levels and limited developmental opportunities for junior physiotherapists.

However:

- There was a good incident reporting culture. Staff understood the need to raise concerns and report incidents, and were supported when they did.
- Concerns and incidents were investigated appropriately, and lessons were learned, shared and acted upon. Improvements were made to the quality of care as a result of complaints and concerns.

# Summary of findings

- The service routinely monitored and collected data to ensure safety and effectiveness. There was involvement in relevant local and national audits.
- Quality and safety was monitored and used to identify where improvement was needed, and actions were taken as a result, working together with external stakeholders.
- The application of the World Health Organisation (WHO) checklist and five steps to safer surgery was appropriate and effective.
- Staff were active and engaged with local safeguarding procedures, and involved relevant organisations.
- Medicines were stored securely and appropriately.
- Staff were knowledgeable about consent and mental capacity. Consent and treatment was obtained appropriately and in line with legislation and guidance.
- There were robust governance processes in place and risk registers reflected risks across the division.
- The service took into account the needs of individual people. Processes were in place to remove barriers for those who found it hard to use or access services.
- The service planned and delivered people's care and treatment in line with current evidence-based guidance, standards and best practice.
- There were good processes in place to ensure discharge arrangements were safe, which included relevant specialist teams and took account of people's individual needs and circumstances.
- Multi-disciplinary teams were coordinated and collaborative to ensure good assessment, planning and delivery of people's care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively.

# Summary of findings

- Managers identified the learning needs of staff and supported them to deliver effective care and treatment through appraisals. Training was accessible to meet those learning needs.
- Staff treated people with dignity, respect and kindness involving people in their care and with making decisions.
- People's confidentiality, privacy and dignity was maintained and staff responded compassionately when people needed their help.
- Feedback from people who used the service was positive.
- The service had a clinically lead model with a clear vision and strategy that was focused on quality and patient safety.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- The service was transparent, collaborative and open with all relevant stakeholders about performance.

## Critical care

### Requires improvement



We rated this service as requires improvement because:

- The CCU environment was not fit for purpose; the high dependency unit (HDU) and intensive care unit (ICU) were located on separate wards, which were a few minutes' walking distance from each other. There were ICU overspill beds in an adjoining unused surgical recovery room. This area was an empty room into which patient beds and equipment were wheeled. If the door was shut, this area would not be visible to the main ICU.
- We saw there was only one isolation room for the whole of CCU; this was located on ICU. This was not sufficient to manage infection prevention and control when more than one patient presented with an infectious illness or a patient had compromised immunity.
- Limited space between beds on HDU meant staff had a limited area to treat a patient in an emergency situation.

# Summary of findings

- We saw there were not enough capnography machines (to measure ventilated patients' carbon dioxide levels). This had consistently been raised as a risk during clinical governance meetings for almost a year, however was not actioned until after our inspection.
- Mandatory training levels were below trust target for the majority of modules including safeguarding.
- The outreach staff did not maintain competencies and skills relating to critical care, and were isolated from the main CCU team.
- There were no follow up clinics for patients discharged from CCU as required under the Core Standards for Intensive Care Units.
- We saw that the CCU had mixed sex breaches due to delayed discharges. Bed occupancy was consistently high.
- Deprivation of Liberty Safeguards (DoLS) were not applied for when using bed rails to prevent patients leaving or falling out of their bed.
- There was a lack of suitable facilities to accommodate visiting relatives, friends and carers.
- Not all risks were recorded and managed under the CCU risk register, despite being discussed at clinical governance meetings.

However:

- Staff were aware of how to report incidents, had a good understanding of the duty of candour, and provided evidence of learning from incidents.
- No never events had been recorded for the reporting period April 2016 to March 2017.
- Mortality and Morbidity meetings were multidisciplinary and conducted monthly; the chair emailed presentations to any required person who had not attended.
- In the main we observed infection prevention and control to be effective. Staff adhered to hand hygiene guidance during the inspection; this was supported by audit results.

# Summary of findings

- Records were well maintained; legible, securely held and accessible to all relevant staff. Appropriate risk assessments were included within a single patient documentation booklet.
- Staff had a clear understanding of safeguarding adults and children; and how to raise a concern. This was despite staff training being below the trust target.
- Data shared with the Intensive Care National Audit and Research Centre (ICNARC) demonstrated the critical care unit were performing either within expected levels, or better than expected levels as compared to similar sized units.
- We saw the unit was run in a multidisciplinary way; including input from pharmacists, physiotherapists, pain management nurses and specialist nurses for organ donation.
- All staff during the inspection were caring and compassionate towards patients in their care. We saw staff worked hard to provide a respectful environment for patients.
- The unit did not transfer any patients to a different hospital for non-clinical reasons.
- The unit had provision for patients with additional needs, for example patients with learning disabilities and bariatric patients.
- Staff reported local leadership were supportive and worked well to ensure substantive staff could carry out their duties.
- The critical care unit had a risk register assigned to it which addressed a range of risks; which were regularly reviewed.
- Substantive staff reported a rise in morale and a positive culture since the start of the new build critical care unit. Staff told us that they had some input into the planning of the unit.

## Maternity and gynaecology

### Inadequate



We rated maternity and gynaecology services as 'Inadequate'. The majority of concerns related to maternity services, because:

- Serious incident action plans were not always monitored or completed.
- There was poor evidence of learning from maternity incidents.



# Summary of findings

- Low harm incidents in maternity were not always categorised correctly or reviewed in a timely manner.
- Most staff we spoke with across maternity services could not explain duty of candour and were unable to tell us in detail about the process involved.
- Prescription charts were not fully completed.
- Medical and maternity records were not kept securely in all areas and were not easy to navigate through.
- Staff had not completed safeguarding training in accordance with the trust's target.
- Midwifery staffing was not at the agreed level and with high rates of vacancy and sickness staff were under constant pressure.
- Maternity staff did not always complete the venous thromboembolism risk assessment.
- Maternity staff we spoke with knew a major incident plan existed but nobody could be specific and explain their role within the major incident plan.
- Staff did not always plan care and treatment that was in line with current evidence-based guidance, standards and best practice.
- Audits and plans to improve maternity services were limited.
- Most women we spoke with following birth felt that their pain control had not been well managed.
- There was out-of-date information displayed or in folders for staff to refer to.
- There were many guidelines that remained out-of-date following our last inspection.
- Medical staff within maternity did not always explain the risks to women before a procedure.
- The milk fridges were not locked which meant breast milk could be tampered with.
- Instrumental births and caesarean section rates continued to be higher than the national average.
- Staff did not have the right qualifications, skills, knowledge and experience to do all aspects of the care they provided to women who used maternity services.

# Summary of findings

- Handovers were not always focused and in an effective environment.
- Women did not have access to the midwifery led unit due to staffing issues.
- Staff morale across maternity was low due to high levels of stress and work overload. Staff did not feel respected and valued.
- The maternity dashboard showed several risks that had continued to be evident without improvement.
- Due to the challenges facing the maternity service the senior team was focused on managing the daily strains it faced with little innovation evident.
- Women did not always receive compassionate care. Maternity service staff were trying to provide a caring and compassionate service in challenging circumstances.
- The trust performed worse than other trusts for two out of 19 questions in the CQC Maternity survey 2015.
- There was no consistency of how maternity meetings were held and minutes recorded.
- The senior leadership team was in its infancy and there had been little strategic oversight of governance and incidents at a senior level.
- Maternity staff did not feel involved with the decisions made about the service at a senior level.

## However:

- Medicines were stored in locked cupboards, and disposed of safely.
- Adult resuscitation equipment was checked daily in all areas.
- Maternity and Gynaecology staff completed early warnings scores.
- Gynaecology documentation was good.
- Medical staffing on the delivery suite was in line with RCOG Safer Childbirth recommendations.
- Multi-disciplinary team (MDT) working was in the maternity and gynaecology service.
- **Women on the gynaecology ward we spoke with told us that they had received pain relief when requested in a timely manner.**

# Summary of findings

- Areas we visited were mostly visibly clean.
- Hand hygiene audits carried out in January 2017 and February 2017 showed 100% compliance with recommended practice in all areas of the service.
- Fluid balance charts we observed were used and correctly calculated and up-to-date.
- Community midwives had good engagement with each other in the primary care setting.
- Gynaecology nurses had an understanding of the MCA, and could explain the process to us.
- There was an active maternity services liaison committee (MSLC), which meant that service user views were considered.
- Management was visible and approachable.

## Services for children and young people

Good



We rated this service as good because:

- Systems were in place to ensure there were adequate numbers of suitably trained and qualified staff to provide safe and effective care.
- There was good clinical leadership and staff felt well supported by their managers and the senior leadership team.
- Processes were in place to identify when a patient's condition deteriorated and escalation to medical staff resulted in a prompt response.
- There was a positive approach to incident reporting and the review of incidents to identify learning, was improving.
- The trust participated in national audits and assessed their adherence to national guidance and best practice through a range of clinical audits. We saw an improving picture of performance in relation to these.
- Collaboration with other agencies and providers of care had improved the safety, responsiveness and effectiveness of care for specific groups of patients; in particular those with mental health needs.
- Staff were kind and caring in their approach and there was good emotional support for children and their parents.

# Summary of findings

- Governance processes had been strengthened and improved. Staff demonstrated a commitment to providing quality care and an enthusiasm for further improvement. However:
- The environment within the fracture clinic was unsuitable for children and the trust did not provide any separate waiting area for children in this department.
- Although the individual needs of some specific groups of patients were recognised and addressed, systems and processes were not in place to identify those with a learning disability and ensure adjustments were made to cater for their special needs.
- Delays to discharge sometimes occurred due to a delay in the provision of medicines to take home.
- A significant number of local clinical guidelines required review.

## End of life care

Good



We rated this service as good because:

- Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for end of life care.
- The trust reported no serious incidents (SIs) for end of life care that met the reporting criteria set by NHS England between April 2016 and March 2017.
- There had been no end of life care incident, which required duty of candour (DoC) investigation in the palliative, and end of life care service.
- The service monitored patient outcomes through national and local audits; these were fed back to the board and end of life dashboard along with the trust's quality report.
- Multi-Disciplinary Team (MDT) working was effective within the end of life care service. The team worked as a one integrated team across the acute and community sites.
- DNACPR forms were filed out correctly in front of patient records so that staff could locate them quickly. Since the last inspection 2015, the trust has improved significantly around the DNACPR documentation.

# Summary of findings

- Staff cared for patients in a compassionate, dignified, and respectful manner.
- We saw in one of the viewing rooms at the mortuary that there were facilities for washing the body for religious and cultural reasons. We saw this as an understanding and respect for patients' cultural and religious needs.
- The chaplain service offered spiritual support to patients 24-hours a day, seven days a week.
- Patient discharge, including moving patients between acute and community care settings, followed patient-centred care best practice.
- The SPCT worked closely with commissioners and other providers to ensure patients' needs were met.
- The ensured patients who required end of life and palliative care were seen promptly and were identified in a timely way, that deceased bodies were cared for, and that religious and spiritual beliefs were respected and dignified.
- The professional lead chaired a multi-professional group. Membership included the acute and community , palliative care team, and representation from the clinical commissioning group (CCG) as well as the director of nursing.
- The service leaders had a clear direction of the service. Their aim was for an effective integrated service to ensure patients were provided with quality end of life care.
- Staff of all levels felt supported from the end of life and palliative care team.
- We saw the trust's five-year strategy plan for 2017-2022 called, "Becoming your partners for first-class integrated care".

However:

- We spoke with the hospital porters around incidents and learning from incidents, they told us they did not have access to a computer or IT access. The porters told us they received no feedback or actions in relation to incidents.
- Ward staff knowledge and awareness of when to use individualised care plans when caring for end of life patients varied from ward to ward.

# Summary of findings

- Porters we spoke with during our unannounced visit on 6 July 2017 informed us that they were never informed if a patient had an infection, especially when transporting patients from one department to another.
- The trust set out a target of 90% for completion of safeguarding training; as at 31 March 2017 nursing staff for end of life care services failed to meet training targets.
- There was a low completion rate for major incident training at Walsall Hospital. As at 31 March 2017, only 56 out of 188 eligible staff (30%) had completed this training.
- The trust had the amber care bundle on some wards as part of a phased roll out programme from the . This was being introduced in the last inspection in 2015 but this had still not been fully embedded throughout the wards.
- We saw nutritional assessments were being carried out, but was not always documented as part of the individualised care plan.
- Documented evidence of completed advance care plans (ACP) was only noted in 63 patients and these were predominantly within the community setting, only five patients in the acute setting had an ACP in place.
- Combined results across both sites (community and acute) demonstrated that the use of the individualised end of life care plan was 20% (45 patients in acute setting).
- Registered nurses on the wards had received training to enable them to safely administer medications through the T34s McKinley infusion pumps; however this was not consistent, some staff were not trained or did not know which syringe drivers were being used.
- Porters we spoke with said they had not received any specific end of life training; they told us that newly appointed staff learnt from and shadowed porters that were more senior.
- Ward staff told us that it was difficult at times to support relatives during an emotional time, as there were no specific rooms to speak with relatives in private.

# Summary of findings

- The trust did not have any dedicated beds for end of life care patients, they were cared for on general wards throughout the hospital.
- The route that people had to walk to the mortuary for the general office was long and poorly signposted.

## Outpatients and diagnostic imaging

Good



We rated this service as good because:

- Staff reported incidents in a timely manner and we found evidence of learning from incidents. We found the radiology department met the requirements of Ionising Radiation (Medical Exposure) Regulations 2000. We found good infection control and waste management systems in place. Staff had a robust system in place to manage medication and the distribution of prescriptions.
- We found evidence based policies and procedures across all departments. Staff worked in facilities that promoted the effective treatment of patients. We found good evidence of multidisciplinary working across outpatients and imaging service. All registered nurses and doctors asked understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010. However, three unregistered staff did not understand the legislation.
- All staff provided compassionate, supportive, and understanding care to patients. Staff encouraged patients to ask questions and be involved in the decision made about their care. Patient feedback about the service was positive. However, the latest Friends and Family Test results showed a lower than national average positive response.
- The trust was not meeting the national standard for the 18-week referral pathway. The fracture clinic environment was not easily accessible for patients who required a wheel chair or crutches to mobilise. Staff within outpatients had not undertaken any dementia awareness training. However, outpatients and imaging had received a low number of complaints.
- Staff had a positive attitude and we found an ethos of team working across the departments.

## Summary of findings

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Staff felt included within the team and that they could and did make a difference. We found good engagement with the public in the form of health promotion. However, we found meetings often lacked structure and detail, and did not routinely discuss feedback from complaints and incidents.

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# Manor Hospital

## Detailed findings

### **Services we looked at**

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

# Detailed findings

## Contents

Detailed findings from this inspection	Page
Background to Manor Hospital	26
Our inspection team	26
How we carried out this inspection	27
Facts and data about Manor Hospital	27
Our ratings for this hospital	28
Findings by main service	30
Action we have told the provider to take	215

## Background to Manor Hospital

The health of people in the Walsall area is generally worse than the England average. 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 worse than the England average. Walsall has higher obesity levels than the England Average, lower male and female life expectancy than England average and significantly higher infant mortality rates than the England average (<http://fingertips.phe.org.uk/profile/health-profiles>). For life expectancy and causes of death, Walsall has 6 out of 10 indicators worse than the England average. The trust provides acute hospital services from one main site, Manor Hospital. 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 improvements had been made since our last inspection.

The trust board had six executive directors plus the Chief Executive Officer and nine Non-Executive Directors, including the Chair. The Chief Executive Officer had been in post since May 2011. The Chair was appointed in April 2016.

When we inspected the trust, the chair of the board had been in post for one year, 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 human resources director had only been in post for a few weeks.

## 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. Twenty-seven specialist advisors also assisted us throughout the inspection.

# Detailed findings

## 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 to share what they knew about the trust with us. These organisations included NHS Improvement, Health Education England, Walsall Healthwatch, and 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 with 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.

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.

## Facts and data about Manor Hospital

Walsall Healthcare NHS Trust has one acute location, the Manor Hospital and also provides community health services for people living in Walsall and its surrounding areas. The trust serves a population of approximately 270,000 people.

The trust had an annual turnover of £239.4m and in 2014/15 saw a deficit of £12.9m. The organisation would have a deficit of £22m in 2016/2017, which was much higher than the original planned deficit of £6.2m, (which was therefore in excess of the control total agreed with NHSI).

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 270,000.

There are 550 acute beds at the trust. The trust had 33,017 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 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 surgical inpatient beds and 16 day-case beds. There are 27 beds on the emergency trauma and orthopaedics ward (ward 9), 14 beds on the

# Detailed findings

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 6 assessment chairs and the day case unit has eight beds.

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).

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 2107. The most common reasons for emergency admission to children's services were respiratory infections and viral infections.

## Our ratings for this hospital

Our ratings for this hospital are:





	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
<b>Overall</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# Detailed findings

## Notes

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

# Urgent and emergency services

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Walsall Healthcare NHS Trust's emergency department (ED) is a purpose-built facility situated within Manor Hospital. It has a four-bay resuscitation area, 23 treatment cubicles, a separate waiting room for children with three treatment rooms, and two triage rooms. An urgent care centre, run by a separate healthcare provider, is located on the same site, and shares an entrance and reception area with ED.

From April 2016 to March 2017, patients made 73,957 attendances at Walsall Manor Hospital's ED. Of these, 31,202 arrived by ambulance, and 14,913, or 20%, were aged 16 or under.

The ED is a trauma unit and is part of the West Midlands Trauma Network. The nearest major trauma centres for adults are Royal Stoke University Hospital and the Queen Elizabeth Hospital in Birmingham, and Birmingham Children's Hospital for paediatric trauma.

We visited ED as part of our announced comprehensive inspection from 20-22 June 2017. We spoke with 29 patients and their relatives, friends or carers, and 52 staff across a range of roles. We tracked patients' experience through their treatment at the ED, checked the quality of records, and observed staff practice.

## Summary of findings

During the last inspection in September 2015, we rated ED inadequate for safe, effective, responsive and well led and we rated caring as requires improvement. This made the service inadequate overall.

This was because;

- Not all staff used the reporting system. Patients' records were often not properly completed. Regular comfort checks for patients were not always carried out. Staffing levels were insufficient, particularly paediatric nurses.
- The plans ED implemented to improve practice were not always successful. Patients did not always receive effective pain relief and did not always receive food and drink.
- Some patients had to share a single cubicle with another patient and patients and visitors could see people's private information on the large tracker screen. Some senior staff did not wear name badges so people did not know who they were.
- The ED saw many more patients than it was built for and the space was cramped. Fewer people left without being seen than is the case in other hospitals. It was the department's policy to keep patients waiting in an ambulance rather than on trolleys in the ED.

# Urgent and emergency services

- The hospital did not have a strategic plan for how the ED would grow and improve in the future. Risks such as the lack of space, lack of children's nurses and giving patients pain relief were not being dealt with quickly.

Following this inspection we saw significant improvements across the service, however there was still more to be done and we rated this service as requires improvement overall, because:

- We found instances of unsatisfactory infection prevention and control practice.
- Medicines management was not satisfactory in some areas of the department.
- We saw some patients accommodated in a potentially unsafe environment.
- ED was not achieving target times for assessment, treatment, and admitting, transferring or discharging patients.
- ED was not achieving the trust's targets for its staff to complete mandatory training, or to have appraisals.

However:

- Many improvements had been made since our inspection in September 2015, when the service was rated inadequate and was a significant and contributory factor in placing the trust in special measures. Improvements we saw during this inspection included: increased staff numbers and skill mix; equipment storage and availability in the resuscitation area; and dedicated, separate paediatric waiting and treatment areas.
- Staff demonstrated a positive culture of incident reporting and audits, and of learning from incidents, audit results, complaints and concerns.
- Staff considered patients' basic care a priority. Scheduled rounds took place ensuring patients were comfortable and had food and drinks where appropriate.
- Care and treatment was delivered in line with national guidelines and evidenced best practice.

- Internal and external multidisciplinary working was embedded and effective, and was constantly reviewed and improved.
- Feedback from people who use the service, their families, and carers was positive about the way staff treated people. People said staff cared about them.
- The dementia lead nurse had contributed to significant staff awareness and understanding of the needs of patients living with dementia.
- Staff spoke very positively about the department's managers, and told us they were supportive, approachable and 'a part of the ED family'. Staff and managers were proud of the progress they had made but aware the department needed to improve further, and were keen to help it do so.

# Urgent and emergency services

## Are urgent and emergency services safe?

Requires improvement 

We rated safe as requires improvement because:

- The department was not achieving the trust's target on infection prevention and control audits.
- We saw patients were sometimes accommodated inappropriately, in a cubicle designated as a review room.
- We found disorganised and unsafe storage of some medicines in the resuscitation area.
- ED was not meeting the target for completion of mandatory training in all but one subject.
- Completion rates for safeguarding adults at risk were poor among medical staff.
- ED was not meeting the Royal College of Emergency Medicine's standard for treating patients within an hour of their arrival.
- ED was performing worse than the England average for assessment of patients arriving by emergency ambulance.

However:

- Staff knew how to report incidents and were able to give examples of the types of incident they had reported, or would report.
- Incident reports were seen as an opportunity to improve safety, and feedback was given in a range of different ways to ensure all staff were made aware of learning.
- The layout of equipment in the resuscitation area had been improved to ensure everything staff needed to treat seriously ill or injured patients was readily available in each cubicle.
- Paediatric patients had waiting and treatment areas that were physically separated from the adults' areas.
- Resuscitation and sepsis trolleys were available at strategic sites throughout the department. Equipment in the trolleys was laid out in a standardised, organised fashion. Trolleys were checked regularly.
- Other than in some parts of the resuscitation area, medicines were stored safely and securely, in temperature-controlled environments.
- Patients' notes were complete, legible, and well-structured.

- Systems were in place to recognise and escalate seriously unwell patients quickly.

ED had increased its staff numbers across all clinical grades since our inspection in September 2015. Staff told us the quality of patient care and their own morale had improved because of this.

### Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. From April 2016 to March 2017, the trust's urgent and emergency care services reported no incidents which were classified as never events.
- From April 2016 to March 2017, ED reported two serious incidents (SIs) which met the reporting criteria set by NHS England. One SI was a diagnostic incident and the other related to sub-optimal care of a deteriorating patient.
- Between October 2016 and April 2017 ED staff reported 157 incidents. Ninety-eight of these, representing 62%, were graded as 'no harm' or 'low harm', which evidenced a culture of reporting near miss incidents. Fifty-four incidents were graded as 'minor harm'.
- Four of the incidents reported by staff were graded as 'moderate harm', and one as 'major harm'. All these involved delays to or errors in diagnosis or treatment. We saw details of the actions resulting from investigation of these incidents. They included: training for nurses and doctors in ED; adding an ED consultant to a working group; reviews of care pathways and policies; one to one discussions with staff involved; documentation audits; and emails to all staff with reminders of specific policies. Details of the learning was also included in the hospital's 'lessons learnt' bulletins.
- We saw minutes of ED team meetings, during which staff were made aware of and discussed learning from incidents that had been investigated. Staff told us they were also made aware of learning from incidents by email, through the department communication book, at handover and, where appropriate, through attending root cause analyses. We were shown examples of emails giving details of incidents shortly after they had occurred, with headline changes to improve safety, pending full investigations or root cause analyses.



# Urgent and emergency services

- Nurses we spoke with were all aware of the trust's electronic incident reporting system and knew how to use it. They told us they discussed incidents with senior members of staff and took advice on immediate actions, then completed reports.
- Nurses and doctors told us they received feedback on clinical incidents, which was delivered in a blame-free manner aimed at improving the service they provided to patients.
- Consultants from ED took part in the hospital's mortality and morbidity meetings, to share learning from ED and improve services for ED's patients based on lessons learnt from other departments.
- The duty of candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong. All grades of clinical staff we spoke with demonstrated a good understanding of duty of candour, when it should be applied and the process for doing so.
- We were told about a serious incident, which had triggered duty of candour. Staff we spoke with were aware of the incident and how it triggered the duty, and of how the trust had communicated with the patient's family and kept them informed about the subsequent investigation. We saw letters sent to patients included an individualised apology.

## Cleanliness, infection control and hygiene

- We were shown the department's infection control and cleanliness audit results from November 2016 to March 2017. The trust's target on these audits was a score of 85%. ED had achieved this with a score of 88% in November 2016, but had not achieved it in subsequent months. The worst performance was 74%, recorded in February 2017. Areas where the department had been marked down included damage to walls, completion of cleaning registers, availability of hand cleansing gel, cleanliness of equipment and labelling of sharps bins. Each non-compliant item identified had actions recorded to rectify the issue. During our inspection, we saw many of these had been completed.
- In the 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 to the attention of staff, who immediately cleaned both pieces of equipment.
- IPC audits from November 2016 to March 2017 reported that ED staff were compliant with the trust's 'arms bare below the elbow', hand washing and personal protective equipment policies.
- We were shown the environment audit carried out in ED on two days in February 2017. The department had scored only 43% against a trust target of 85%. We were also shown the department's action plan to address non-compliant areas, which detailed 24 actions. Of those, 23 had either been completed by 31 March 2017 or had been reassessed and deemed to require no action. One item, regarding cleanliness of computer keyboards, was due for completion by 31 May 2017 but had not been recorded as complete.

## Environment and equipment

- The department had two areas used as 'review rooms', where patients could be accommodated whilst waiting for test results, admission to a ward or discharge home. One room, with two cubicles separated by curtains, was normally used for female patients and a large cubicle in the main department for male patients. The cubicle for male patients accommodated up to four people. Access to the two patients at the rear of the cubicle was restricted and staff may have been impeded if either of them needed urgent treatment. Managers told us the review rooms were only used for clinically stable patients, and showed us their criteria document for its use, however we were not reassured the arrangement was appropriate. A manager told us multiple patients should only be accommodated in the review rooms if there were no cubicles free, however on one occasion we saw three patients in the male review room while four nearby cubicles were empty. The criteria document for the review rooms made no mention of this rule.
- Staff told us, and we saw, the layout of equipment and consumable stores in the resuscitation area had been changed following our previous inspection. During our previous inspection, consumables were stored in one place, serving all four cubicles in the area. However, each cubicle now had its own set of storage lockers, which meant equipment and consumables were readily available, and staff no longer had to go to and from the old central storage area when they needed something. The lockers in each cubicle were laid out the same, so staff knew where equipment could be found regardless

# Urgent and emergency services

of which cubicle they were working in. Staff told us this change was an improvement and meant they spent less time moving around the department and could focus on their patient.

- In our previous report, published in January 2016, we told the trust it should consider redesigning the seating arrangement in ED general waiting area to provide some personal space between the seats. We saw this had been done, and seats in the waiting area allowed more space per user.
- The department had a separate waiting area for paediatric patients, which could not be accessed from the general waiting area without staff unlocking the door. This met the recommendations of the Royal College of Paediatrics and Child Health's Standards for Children and Young People in Emergency Care Settings.
- ED had resuscitation trolleys located throughout the department. We checked three trolleys and found they contained all the equipment and medicines needed to provide advanced life support. We checked 28 items of equipment at random, which were in intact sterile packaging and in date. Check sheets evidenced regular, daily checks of each trolley.
- ED also had sepsis trolleys in its resuscitation and majors areas. The trolleys were clearly marked, and contained equipment and medicines for each stage of assessment and treatment of suspected sepsis. This included equipment for administering oxygen, taking blood samples, administering intravenous antibiotics and fluid and taking observations. The equipment was housed in drawers, in the order it should be used.
- If patients had to spend extended periods of time in ED waiting for ward space, following a decision to admit, staff were able to obtain hospital beds so the patients could be transferred from their trolleys. This provided a safer and more comfortable wait for the patients. On one day, we saw nine patients had been in ED overnight, waiting to be admitted. All of them had been transferred to hospital beds.

## Medicines

- Medicines were stored safely behind locked doors or in restricted areas, which were only accessible to appropriate staff. Staff monitored temperatures in treatment rooms and medicine storage rooms daily. We saw records, which evidenced temperatures in these

rooms, were maintained within the recommended storage temperature for medicines. All the staff we spoke with knew the process to follow if a refrigerator temperature was found to be outside its safe range.

- We saw staff maintained records of controlled drugs (CDs) (medicines that require extra checks and special storage arrangements because of their potential for misuse) accurately in proper CD ledgers, in line with trust policy and national best practice guidelines.
- Staff told us they reported incidents about medicines on the trust's electronic incident reporting system. Managers discussed feedback and any learning with the members of staff involved, and the wider team if appropriate. Staff also discussed any medicine incidents at the department's weekly safety huddles.
- Pressures on resources meant that the pharmacy team was not able to provide a comprehensive pharmacy service to ED. Stock supplies of medicines were checked and ordered by pharmacy, however there was no further service available. The chief pharmacist recognised the benefits of having a pharmacist based in ED to support the service and improve medicine optimisation for patients on admission. However, due to a lack of resources they were unable to provide this high level of pharmacy service.
- We saw disorganised and unsafe medicine storage in the main resuscitation area's medicine cupboard. It was locked and secure. However, it was overfull and not suitable for the amount of medicines that were being stored. We saw one basket full of a mixture of different antibiotic vials without their original packaging. We raised this with a senior nurse at the time it was discovered and they arranged for the situation to be rectified and made safe immediately.
- Nurses raised concerns that they were unable to give some medicines in triage because the patient group directions to allow them to do so had expired and not been updated. This had affected the department because nurses had to find a doctor to prescribe these medicines, which led to increased patient discharge times. They felt that the increased presence of a pharmacist would have been supportive and positive to collaborative team working.
- We looked at the medicines refrigerator temperature check sheets in the resuscitation area. We saw checks recorded on all but two days from April to July 2017.
- We saw patients' allergies clearly documents on medicine prescribing forms.

# Urgent and emergency services

## Records

- We looked at 22 sets of patient records, to assess their quality and completeness. Ten of the records related to paediatric patients and the remaining 12 to adults. We saw they all included records of the patient's triage category, appropriate observations, and medical or paediatric early warning scores. All had a pain score recorded and where the patient had indicated they were experiencing pain, pain relieving medicine had been offered and administered when accepted.
- Staff completed comfort charts and skin assessments for all patients in the department. However, staff told us they would prefer to use ED-specific charts, as those they had were designed for longer-term use when patients were admitted.
- We looked at a set of notes for a patient who had triggered the sepsis pathway. Sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition, caused by an infection. We saw they had been identified as at risk of sepsis within 25 minutes of their arrival in the department, and had had a blood sample taken and been given antibiotics within 15 minutes after that. This met the recommendations of the National Institute for Health and Care Excellence guideline NG51: Sepsis: recognition, diagnosis and early management. However, while all elements of the treatment pathway had been carried out, we saw the record was incomplete and had not been signed by the clinician. We raised this with the nurse in charge who told us they would bring it to the doctor's attention.
- We were given blank copies of ED's adult and paediatric record booklets. The adult booklet was comprehensive and structured, without being complicated or unwieldy. It included sections for patients' personal, family and property details; reminders of clinical standards relating to times for assessments; medicine prescription and administration; clinical and nursing notes; investigations and results; care plans and treatment; pressure ulcer assessments; and comfort charts. The paediatric booklet was clearly marked as such, and printed on a different colour paper to differentiate it from the adult one. In addition to most of the items in the adult booklet, the paediatric one included paediatric early warning score (PEWS) charts for different age groups; a flow chart for escalation based on PEWS; and a handover document, including a risk

assessment for the transfer, from ED to one of the hospital's paediatric units. Like the adult booklet, the paediatric one was comprehensive, without being complicated.

## Safeguarding

- The trust had a target for 90% of its eligible staff to complete safeguarding training. We saw records evidencing 100% of nursing staff had completed safeguarding adults training by the end of June 2017, but only 33% of consultants and 14% of other doctors had done so. The trust had recently introduced new safeguarding adults courses for nurses and doctors, and staff who needed to complete these were scheduled to undertake them before the end of the financial year. This was important to ensure that all staff had safeguarding training to enable them to identify and act on the needs of vulnerable patients who were admitted to the department.
- By the end of June 2017, 65% of medical staff and 79% of nursing staff who were eligible to undertake safeguarding children level 2 training had done so. One member of medical staff was eligible to undertake safeguarding children level 3 but had not done so; and 83% of eligible nursing staff had completed this training.
- Nursing staff told us they completed internal safeguarding reports and contacted the local authority's children's service by telephone if they had any concerns about a vulnerable child. Nurses we spoke with knew how to contact the trust's safeguarding leads, and told us they had feedback on safeguarding referrals they made.
- We saw ED's record cards included prompts for staff to consider safeguarding issues when treating patients. We looked at 10 records of paediatric patients and saw the safeguarding prompts had been completed on all of them. We also saw safeguarding prompts were part of a checklist on the risk assessment document used before any child was transferred from ED to one of the hospital's paediatric units.

## Mandatory training

- Medical and nursing staff in ED received mandatory training on conflict resolution, equality and diversity, fire safety, infection control, information governance and patient handling. The trust's target for mandatory

# Urgent and emergency services

training completion was 90%. Apart from patient handling for nursing staff, which stood at 90%, at the end of March 2017 ED was not meeting the trust's target for any mandatory training courses.

- Completion rates for mandatory training courses, apart from patient handling for nursing staff, were: 57% for conflict resolution; 65% for equality and diversity; 67% for fire safety; and 31% for information governance. We were not given data on completion rates for infection control training.
- We were given the department's training plan, however only a small proportion of staff were booked in for mandatory courses they needed to complete.
- Sepsis awareness did not form part of the trust's mandatory training programme for medical or nursing staff.

## Assessing and responding to patient risk

- On arrival by ambulance, patients were triaged either by the rapid assessment and triage (RAT) team or by a nominated nurse in ED. However, some ambulance staff we spoke with told us when RAT was not operating, it was not always easy to identify the nominated triage nurse, and they were often left waiting in the department corridor for extended periods of time before their patient was triaged.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. From February 2016 to January 2017, the trust did not meet the standard for nine out of 12 months. Performance against this standard generally became worse over the 12 months, particularly from August 2016 to February 2017. In February 2017 the median time to treatment was 86 minutes compared to the England average of 57 minutes.
- In every month from March 2016 to February 2017, the average time from arrival by ambulance to initial assessment was worse than the England average. In January 2017, the average time to initial assessment after arrival by ambulance was 11 minutes, compared to the England average of seven minutes.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2016 to March 2017, the trust reported 249 black breaches. From November 2016 to April 2016, there was an average of 10 black breaches per week compared to an average of one black breach per week from April to October 2016.
- From 7am to 11.30pm, a nurse from the urgent care centre (UCC) streamed patients who self-presented at ED. The nurse then directed patients to the UCC or to ED triage as appropriate. Outside these hours, the ED triage nurse assessed all self-presenting patients. We observed nurses triaging four patients. The process was structured and thorough, and each patient was allocated an appropriate triage category, and offered pain relief if appropriate.
- Apart from those who were directed to the UCC, the triage nurse assessed all paediatric patients before they were sent into the paediatric area.
- Medical and nursing staff we spoke with demonstrated a good understanding of sepsis, including recognising the signs a patient may be suffering sepsis, an awareness of the severity of the condition and the need for rapid treatment. They told us and we saw evidence that they used the a nationally-recognised early warning score and 'sepsis six' checklist to assess when patients were at risk of sepsis.
- When the UCC nurse was not on duty in ED reception, receptionists followed a protocol to refer some patients for urgent triage. For example, any child under one year old, anyone complaining of chest pains or anyone who was undergoing chemotherapy treatment for cancer.
- Children attending ED were assessed using a version of a nationally recognised paediatric early warning score (PEWS), to give an early indication of any child who may be at risk of serious illness. The version used in ED had been adapted from that used in other paediatric areas in the hospital, to allow for the acute nature of patients in the department. A senior paediatric nurse had provided training for all nurses in ED on how to assess patients with PEWS, using scenarios.
- We saw adult patients were assessed and reassessed using national early warning scores (NEWS), to give an early indication of any patient who may be at risk of serious illness
- ED operated a 'rapid assessment and treatment' (RAT) process from 10am until 8pm, depending on need, Monday to Friday. During its operating hours, four cubicles were allocated to the RAT team, which consisted of a consultant, a band 6 nurse, and a care support worker.

# Urgent and emergency services

- However, when the department became busy and all the cubicles were full, the cubicles allocated to RAT were used to accommodate majors patients. This meant RAT could not operate and prevented the team from assisting with flow through the department to discharge.
- When an ambulance was bringing in a seriously ill or injured child and had called ahead to alert the department, the paediatric nurse attended the resuscitation area to join the team waiting to receive the patient. During this process, the general triage nurse triaged any paediatric patients who arrived in reception. All of the triage nurses had completed either European Paediatric Life Support or emergency care of the sick child training.
- We were shown a risk assessment document, which was completed before any patient under the age of 16 was transferred from ED to the paediatric assessment unit or ward. The document included a checklist of items to be completed or marked 'not applicable' prior to transfer, and a simple, easy-to-follow flowchart to establish what clinical level of escort the patient needed, and what equipment should accompany them.

## Nursing staffing

- The department calculated its nurse staffing needs using the Royal College of Emergency Medicine guidelines and the West Midlands quality standards.
- The department had vacancies for 1.6 whole time equivalent (WTE) band 7 nurses, 0.3 WTE band 6 nurses, eight WTE band five nurses and 2.4 WTE care support workers (CSWs). Their establishment had increased to 91 whole time equivalent nurses and CSWs from 67 WTE at the time of our inspection in September 2015.
- The department was funded for 6.2 WTE band 7, 27 WTE band 6 and 33 WTE band 5 nurses, and 24.5 WTE CSWs.
- Staff told us, and we saw records confirming the department had recruited 15 additional CSWs since our previous inspection, bringing numbers up from seven to 22 WTE, leaving 2.5 WTE outstanding to recruit. This meant comfort rounds, looking after patients' basic needs such as drinks and food, took place more frequently.
- Staff also told us, and we saw records showing the department had been funded to upskill a number of its

nurses from band 5 to band 6. Of four nurses who had left ED to work at other trusts for career advancement before this change, three of them had now returned to the department.

- A minimum of one paediatric-trained nurse was scheduled to be on duty in ED 24 hours a day, seven days a week. This complied with the Royal College of Paediatrics and Child Health's Standards for Children and Young People in Emergency Care Settings guidelines. However, we saw staffing records, which showed from January to April 2017 there had been no paediatric nurse on duty on 33 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, and if necessary support was obtained from the hospital's paediatric assessment unit or ward.
- The paediatric-trained nurses wore different uniforms, which were designed to be less intimidating for children, than nurses in the main department.
- CSWs, who rotated in from the adults' area on a shift-by-shift basis, supported paediatric-trained nurses.
- From December 2016 to May 2017, 946 registered nurse shifts in ED were covered by agency staff and 455 by bank staff. For the same period, 32 CSW shifts in ED were covered by agency staff and 98 by bank staff. We asked the trust to provide these figures as a percentage of the total number of shifts; however, they were not able to do so.
- We were shown the induction folder for new and temporary staff. We saw it was comprehensive, and included sufficient information to ensure new and temporary staff were able to work safely.
- The trust's target for sickness absence was 3.39%. From November 2016 to April 2017, sickness levels for ED nursing staff averaged 5.1%.
- Nursing handovers took place at each shift change, at 7.30am and 7.30pm every day. We attended three handovers and saw the nurse in charge discussing every patient in the department with all of the oncoming shift of staff, using a nationally-recognised mnemonic, 'SBAR' (situation, background, assessment and recommendation) to detail their history and treatment. The nurse in charge used a structured handover sheet to ensure no important information about patients was missed. The handover was conducted in an unhurried fashion, with time for staff to ask questions about patients if they needed to. It took place in a private room, away from the treatment and waiting areas. The



# Urgent and emergency services

nurse in charge also shared any safety messages or other important information during handover. Following this, the oncoming staff carried out a 'walk around' of the ED cubicles, with the nurse in charge.

## Medical staffing

- In 2015 we saw there were considerably more middle career doctors (22%) in the department than the England average (13%) and fewer registrars (27%) than the England average (39%). The percentage of junior doctors was higher (32%) than the England average (24%). This meant the ED medical skill mix two years ago had been weighted further toward fewer specialists and reliant on middle career and junior doctors.
- At this inspection we saw a significant improvement in medical cover in ED. Medical cover was provided by five substantive consultants, five NHS locum consultants, 10 middle-grade doctors, six advanced clinical practitioners, and 10 junior doctors. This met staffing guidance published by the Royal College of Emergency Medicine.
- Nurses told us the introduction of advanced care practitioners had improved patient flow by providing support for the department's doctors.
- Middle-grade doctors, advanced clinical practitioners and junior doctors were on duty in the department 24 hours a day, seven days a week.
- The department saw fewer than 16,000 children per year, which fell below the number at which the Royal College of Paediatrics and Child Health's Standards for Children and Young People in Emergency Care Settings guidelines stated it required a paediatric consultant. The hospital's paediatric department provided paediatric consultant support when it was required.
- Medical staff and the nurse in charge carried out board rounds of the department every day, at 10am, 1pm, 4pm, 7pm, and 10pm. During this process, every patient in the department was discussed to ensure they were receiving appropriate care and treatment and plans were in place to either admit or discharge them.
- Between March and May 2017, locums covered 645 junior doctor shifts, 1,953 middle grade doctor shifts, and 679 consultant shifts in ED. We asked the trust for these as a proportion of all shifts during that period however, they did not supply the information.

- Consultants worked 8am to midnight Monday to Friday, and 10am to 1pm on weekends. Outside those hours, consultants were available on call if needed in the department.
- From November 2016 to April 2017, sickness levels among medical staff averaged 4.1%, which was worse than the trust's target of 3.39%.

## Major incident awareness and training

- As required by the Civil Contingencies Act 2004, the trust had business continuity plans for ED. Staff we spoke with were aware of the plan, which involved the department decanting to one of two nearby sites, one a clinic and the other a ward, in the event it became unsafe to use.
- Staff we spoke with demonstrated 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.
- Security staff could be called to ED either by telephone, or by staff activating one of a number of alarm call points located throughout the department. Staff told us security were always quick to respond to calls from the department, and tended to base themselves there during evenings and nights unless they were required elsewhere in the hospital.
- We were shown the department's major incident and decontamination equipment. It was securely and tidily stored, in a large locker, which staff were able to access.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- Treatment in the emergency department (ED) was based on national guidelines and evidenced best practice.
- The department had a positive culture of auditing the care and treatment provided for its patients, and used audit findings to improve patient outcomes.

# Urgent and emergency services

- Care support workers carried out comfort rounds, ensuring patients had snacks and drinks at regular intervals.
- ED performed better than the England average for five out of six measured in the Royal College of Emergency Medicine (RCEM) audit for vital signs in children.
- ED was performing better than the regional average in the Trauma Audit Research Network's audit of patient survival following trauma.
- ED had structured plans for multidisciplinary working within the hospital, and with clinical and non-clinical external agencies.

However:

The department had not achieved the trust's target for staff appraisals.

## Evidence-based care and treatment

- We saw ED's treatment guidelines were based on guidelines published by the National Institute for Health and Care Excellence, and the Royal College of Emergency Medicine.
- We were shown the emergency medicine care group's local audit programme from April 2016 to March 2017. Many of the audits involved care and treatment provided in ED. For example, antibiotic prescribing, electrocardiogram accuracy, usage of coagulation profile in ED, patients referred to ED from the urgent care centre and ED documentation. We saw presentations based on the results of these audits, all of which made recommendations to improve patients' experience and the treatment they received in ED. The results and recommendations were shared with partner organisations and other departments in the hospital where they could make a positive impact for patients. The audits and their recommendations demonstrated a positive culture of self-analysis to improve care and treatment of the department's patients.
- Staff told us and we saw the department had a culture of using audits to improve the way the team looked after its patients.

## Pain relief

- Managers carried out weekly audits on completion of pain scores on patient records in ED, against a target of 90% compliance. From November 2016 to April 2017, the department performed better than the target in every month, scoring between 97% and 100%.

- Staff used a specialised nationally recognised tool, the Abbey Pain Scale, to assess pain being experienced by patients living with dementia, if they were unable to verbalise. The scale used non-spoken signs, such as facial expressions, changes in body language and behaviour to measure the likelihood the patient was experiencing pain, and to evaluate the effectiveness of pain relief medicine.
- We spoke with a relative of a young patient, who told us the triage nurse had given the child pain relief as soon as their pain assessment was completed.
- A senior nurse carried out weekly pain relief audits. We saw results of the audits, which demonstrated 92% compliance on average over the preceding three months. Audit results were shared with staff to improve the service provided to patients. Any issues identified with individual members of staff were addressed with training.
- In every set of patient notes we looked at we saw pain scores had been carried out, and pain relief administered unless the patient refused.

## Nutrition and hydration

- Care support workers carried out regular comfort rounds, during which they offered patients hot or cold drinks, and sandwiches at mealtimes. We spoke with a number of patients who had been in the department for several hours during the days we inspected, and all of them confirmed they had been offered drinks and food if they were able to have them.
- We saw records evidencing comfort rounds had been carried out for patients who had been in the department during the night, with drinks provided at 3am and drinks and food between 6am and 7am.

## Patient outcomes

- ED was not an outlier for any reported patient outcomes.
- In the 2013/14 Royal College of Emergency Medicine (RCEM) audit for paracetamol overdose, ED performed worse than the England average for three of the four measures and similar to the England average for one of the four measures. The measures for which the Manor Hospital performed worse than average were: plasma testing within 4 hours of arrival; the proportion of patients who received N-acetylcysteine (NAC) within one hour of arrival; and staggered overdoses receiving NAC within one hour of arrival.

# Urgent and emergency services

- In the 2014/15 RCEM audit for initial management of the fitting child, ED performed worse than the England average for two of the five measures and similar to the England average for the remaining measures. ED met the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival in the department. The measures for which the department performed worse than average were: recording eye witness history; and the proportion of discharged patients whose parents or carers were provided with written safety information.
- In the 2015/16 (RCEM) audit for vital signs in children, Walsall Manor Hospital performed better than the England average for five of the six measures and similar to the England average for one of the six measures. It performed better than the England average for:

Measure 1: All children attending the emergency department with a medical illness should have a set of vital signs consisting of: (a) temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score (both assessments of a patient's level of consciousness), and (b) capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.

Measure 2: Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set.

Measure 4: There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases.

Measure 5: Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

- In the 2014/15 RCEM audit of mental health in the ED, Manor Hospital performed better than the England average for three of the six measures and worse than the England average for one of the six measures. Of the two fundamental standards included in the audit, Manor Hospital did not meet the fundamental standard of having a documented risk assessment taken, and met the fundamental standard of providing a dedicated assessment room for mental health patients. The measures for which ED performed better than the England average were: provisional diagnosis

documented; patient assessed by a mental health practitioner from the organisation's specified acute psychiatric service; and details of any referral or follow-up arrangements being documented. The measure for which the department performed worse than average was: patient assessed for their level of alcohol and illicit substance dependency.

- The hospital did not take part in the RCEM's 2015/16 audits on venous thromboembolism (blood clot) risk in lower limb immobilisation in plaster cast, assessing for cognitive impairment in older people 2014/15 or procedural sedation in adults.
- Despite the department's strong performance, we saw action plans to improve patient care further based on the outcomes of these audits. This demonstrated the department was focussed on making real advances rather than simply meeting audit requirements.
- From March 2016 to February 2017, the trust's unplanned re-attendance rate to ED within seven days of discharge was 7%. This was worse than the national standard of 5% but better than the England average of 8%.
- The March 2017 Trauma Audit and Research Network (TARN) audit reported 0.6 more trauma patients out of every 100 treated had survived at Walsall Manor Hospital than the regional average, from January 2013 to December 2016.
- The trust scored about the same as other trusts for the five questions in the most recent CQC accident and emergency survey.

## Competent staff

- The trust had a target of 95% for completion of staff appraisals. In April 2017, 100% of doctors in ED but only 75% of nurses had had an appraisal. Staff who had had an appraisal told us it was a meaningful and supportive process.
- One of the department's experienced nurses had trained all nurses who worked on triage to use a modified Manchester triage system. The Manchester triage system is a nationally recognised structured process for identifying seriously ill patients on arrival at emergency departments. The department used a modified version because the normal process is computerised; however, Walsall Manor Hospital's ED's patient records were paper-based.
- We spoke with a trainee advanced clinical practitioner, who told us the trust were funding their master's course



# Urgent and emergency services

and allowing them one day a week study leave. They also told us they had four days each month consultant-led education, with middle-grade doctors. They said the informal support they received from senior doctors was excellent, and if they had any questions all they had to do to get help was “tug on a sleeve”.

- A newly qualified band 5 nurse said the department offered them good learning opportunities. They told us they had already completed trauma life support and intermediate life support training, and would be undertaking advanced life support training later in 2017.
- Staff told us the department’s doctors ran ad-hoc trauma training sessions for them during less busy periods, often during night shifts.
- The trust funded training for all nurses in ED to complete the trauma nursing core course, and provided internal training on trauma immediate life support.
- Newly qualified nurses completed a year-long development programme before being signed off as competent in emergency nursing. Nurses’ progress was reviewed at regular intervals throughout their first year, and any specific training needs were addressed as they were identified.
- Nurses told us the department’s practice development nurse provided support with their revalidation process, through professional development training and reviews of their portfolios and reflective practice documentation.
- A senior paediatric nurse who was a European Paediatric Life Support trainer provided certificated courses in paediatric basic life support for ED’s care support workers (CSWs).
- All of the department’s middle grade doctors were studying for the Fellowship of the Royal College of Emergency Medicine examination, with support from the ED consultants.
- We spoke with two CSWs who all told us they enjoyed rotating in to the paediatric area and valued the additional skills they learned while there.
- Medical and nursing staff were competent in identifying and treating patients at risk of sepsis and they demonstrated the sepsis pathway was used appropriately.

## Multidisciplinary working

- Senior nurses told us ED had a good working relationship with the wards and specialist services such as ambulatory emergency care and the frail elderly service.
- ED staff used a frailty assessment tool to assess all patients aged 70 or older. Any whose assessment showed them to be at elevated risk of harm were referred to and seen by the frail elderly service before being discharged.
- We saw a team from a local mental health trust working in the department for a number of hours, assessing and treating a patient who had presented with mental illness. Staff told us they had good support from staff at this trust, for patients experiencing mental illness.
- ED triage nurses were able to stream patients direct to services in the hospital such as ambulatory care, gynaecology, the urgent care centre, and the paediatric assessment unit, thereby avoiding patients having to wait in ED and reducing ED’s workload.
- ED managers had held meetings with local GPs and GP practice managers to discuss the most appropriate routes for their patients to be referred to the hospital, rather than the historic practice of sending patients via ED. Managers told us they had seen a reduction in GP-referred patients presenting at ED following these meetings, however it was too soon for the results to have been audited so no data was available.
- Managers told us the trust’s chief operating officer had instigated a culture change over the six months before our inspection, making target breaches in ED an organisational issue rather than an ED one. They told us delays in ED were now considered every ward and department’s problem, and ED was being given more support as a result.
- The lead mental health nurse in ED co-ordinated an external multidisciplinary team to concentrate on a number of patients who made frequent attendances at ED. The team consisted of the ED mental health nurse and partner organisations including addiction services, housing, primary care, mental health services, and other agencies. The team’s work was audited and showed a 47% reduction in attendance to ED, and a 55% reduction in admission to hospital for the specific group of patients.
- Staff told us patients streamed to the urgent care centre were sometimes sent back to ED, and there was no formal referral pathway in place for this process. We were shown a copy of a report on workshops held to

# Urgent and emergency services

improve patient flow and remove barriers between the urgent care centre (UCC) located on the hospital site, and ED. The workshops had been attended by representatives from ED and the UCC, and had identified seven areas where improvements could be made by both organisations. This demonstrated a positive partnership working culture.

## Seven-day services

- ED was open 24 hours a day, seven days a week.
- Staff had access to support from radiography, pharmacy, and specialist services 24 hours a day, seven days a week. Support by some services was provided on an on-call basis outside normal working hours.

## Access to information

- Staff were able to access clinical guidelines and local policies via the ED section of the trust intranet.
- Doctors also had access to best practice guidelines from external websites operated by organisations such as the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine.
- Information about patients in the department, such as their triage category, waiting times, and clinical condition was displayed on an electronic whiteboard behind the nurses' and doctors' station. This gave staff an overview of the department and its patients.
- A computer screen behind the nurses' and doctors' station displayed real-time information from the local NHS ambulance trust, showing how many ambulances were en route to the department, how many were waiting to hand their patient over and how many had handed over and were waiting to book clear. Staff could obtain details of the condition of patients on their way in to ED by ambulance from this system, which helped them plan the use of their cubicles and provide care and treatment more efficiently.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the end of March 2017, 98% of nursing staff and 76% of medical staff in ED had completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

- Nurses we spoke with all demonstrated an understanding of mental capacity and the process of assessing it in patients. They told us they would escalate concerns about a lack of mental capacity to a doctor for a decision to be made.
- While the department did not normally make Deprivation of Liberty applications due to the short time patients remained there, nurses and doctors we spoke with were able to describe the process and the circumstances in which an application may be necessary.

## Are urgent and emergency services caring?

Good

We rated caring as good because:

- Feedback from people who use the service, their families, and carers was positive about the way staff treated people. People were treated with dignity, respect, and kindness during almost all interactions with staff. People said staff cared about them.
- Nurses and doctors treated patients and their relatives with dignity and respect, and involved them in decisions about their care and treatment.
- Staff helped people and those close to them to cope emotionally with their care and treatment.

However:

- Staff did not proactively offer the services of the hospital's chaplaincy team to patients or relatives.

## Compassionate care

- From April to July 2016 ED achieved a 93% positive response in the NHS 'Friends and Family' test, which was better than the England average of 86%. However, from August 2016 to March 2017 only 75% of responses for ED were positive, which was worse than the England average of 86% for the same period. From April 2016 to March 2017, the response rate for ED was 11%, which was similar to the England average.
- During May 2016, Healthwatch Walsall conducted a survey of 79 patients who attended ED. In response to the question, "Do you feel that you have been treated with respect and dignity?" 82% of people said they had.

# Urgent and emergency services

- The department used one large cubicle as a review room for male patients, where up to four people could be accommodated at one time while waiting for admission, discharge, or test results. Managers told us no treatment or confidential conversations took place in this area. However, during the 'friends and family forum' meeting we attended one relative raised a concern that they had been able to overhear a personal conversation between a doctor and patient while waiting in the room.
- One patient's relative told us they could see a real difference in the ED over the preceding two years. They said the staff were doing a wonderful job in a department that was too small, and they were glad it was being extended.
- We saw paediatric-trained nurses providing care in the children's area. They treated their patients with respect and took extra time to explain what was happening and what was going to happen, using simple language the children could understand. A paediatric patient's relative told us the nurses had acted in a calm and reassuring manner, and did their best to alleviate their child's fears.
- One patient and their two relatives told us they were happy with the promptness and quality of care they had received from staff, and especially with the level of communication.

## Understanding and involvement of patients and those close to them

- We saw reception staff looking after distressed relatives of patients who had been brought in to ED by ambulance. Staff were calm and reassuring and demonstrated empathy with the relatives.
- Patients and their relatives told us they had been involved in decisions about their care and treatment throughout their time in ED, and staff had kept them informed about plans for and progress with their treatment.
- Parents of two children being treated in the paediatric area told us they were happy with the way staff had kept them informed about plans for their child's treatment, and involved them in decisions.

## Emotional support

- Staff were able to refer patients and their relatives to a counselling service if they needed help coping with distressing events.

- Staff had access to the hospital's multi-faith chaplaincy team, who could attend ED to provide spiritual or pastoral care for patients and their relatives. However, staff told us they did not offer this service proactively and only used it if patients or relatives specifically requested it.
- 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.
- The trust had provided training for four members of ED staff to conduct traumatic incident debriefs.

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

Requires improvement



We rated responsive as requires improvement because:

- The department was not achieving the Department of Health's target to admit, transfer or discharge 95% of patients within four hours of their arrival in the emergency department (ED).
- ED was performing worse than the England average for patients waiting in the department between four and 12 hours following a decision to admit.
- The department was no longer a suitable size to cope with the demands of rising patient numbers.
- Information leaflets were not available or obtainable in languages other than English.

However:

- Fewer patients than the England average waited in ED longer than 12 hours after a decision had been made to admit them.
- The dementia lead nurse had contributed to significant staff awareness and understanding of the needs of patients living with dementia.

Staff had access to translation services for languages other than English, and for British Sign Language.

# Urgent and emergency services

## Service planning and delivery to meet the needs of local people

- The department was no longer large enough to cope with the increased demand it was facing. This demand was likely to increase further over the next two years with the restructure of a neighbouring acute trust leading to more people falling within Walsall Manor Hospital's ED's catchment area. Managers were sighted on these actual and potential challenges and 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.
- In light of the increase in demand, additional funding had already been secured for staff, and staffing numbers had increased accordingly. Staff members we spoke with all told us this had improved patients' experience and improved morale in the department.

## Meeting people's individual needs

- Staff had access to a telephone translation service for patients who did not understand English. If required, arrangements could be made for interpreters to attend the department in person.
- However, the department did not have access to information leaflets for patients in languages other than English.
- A British Sign Language expert was available in the hospital if staff needed help communicating with patients who had impaired hearing.
- Staff demonstrated a good awareness of caring for people living with dementia. They told us they asked patients' carers to complete a 'patient passport' detailing how the condition affected the patient, and giving their history, unless the patient brought a similar document with them. Nurses, doctors, and other staff were aware of the butterfly symbol's use to identify patients who were living with dementia.
- We spoke with family members of a patient in one cubicle, who had a butterfly sign displayed. The family confirmed the patient was living with dementia, and showed us the patient passport they had been asked to complete. The family told us the care their relative had received was excellent, and it was obvious the department's staff understood the needs of patients living with dementia.

- During our unannounced inspection, we saw laminated butterfly signs prominently displayed on one patient's trolley. We spoke with the porter who was moving the patient from ED to a ward, who was able to explain what the sign meant.
- Nursing staff told us the dementia lead nurse was supportive and had improved their knowledge and understanding of the needs of patients living with dementia. They said the dementia lead nurse was making a positive difference for patients living with dementia and ensured they were treated according to their needs. A relative of a patient living with dementia described the ED dementia lead nurse as "wonderful" when we spoke with them.
- We were given a copy of the algorithm for patients living with dementia in ED, a simple eight-stage flowchart which ensured patients were identified early, were referred to appropriate staff teams and had assessments and records completed which were specific to their needs.
- We were also given a copy of the ED algorithm for patients living with learning disabilities. This was a similar flowchart, again ensuring those patients received care and referrals appropriate to their needs.
- If patients living with dementia self-presented at ED, or arrived without any family members or carers, the hospital's dementia team attended the department to assess the patient. Nurses described the dementia team as "excellent".

## Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. The trust 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 four hours. On average, from April 2016 to March 2017, the department achieved 74% against this target, and its performance showed a worsening trend over this period. ED staff and managers were aware of the department's performance in this

# Urgent and emergency services

area. A number of measures, such as the introduction of trainee advanced clinical practitioners and plans to expand the department, had been implemented or were planned to improve their effectiveness in this area.

- ED managers told us the bed management system still worked on paper and relied on the bed managers visiting wards to assess available space, and therefore the information could be up to three hours old and inaccurate. They told us the trust was looking at replacing this with an electronic, 'real time' system.
- From November 2016 to April 2017, the department 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 April 2016 to March 2017, only two patients waited longer than 12 hours from the decision to admit until being admitted. Both of these instances occurred in January 2017. This was significantly better than the England average of over 14 patients for the same period. Taking January 2017 in isolation, Walsall's over 12-hour delays were only 50% of the England average.
- 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%.

- From November 2016 to April 2017, the department 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%.
- From June 2016 to February 2017 the average time patients spent in ED was higher than the England average, increasing over the period. In February 2017 the average time patients spent in ED was 181 minutes, compared to an England average of 149 minutes per person.

## Learning from complaints and concerns

- From April 2016 to March 2017, ED received 29 complaints. Nineteen of the complaints related to clinical treatment, the other complaints were split across various other categories, such as waiting times, communication, and staff attitude.
- The trust took an average of 43 working days to investigate and close these complaints, which did not meet the target to deal with complaints within 30 days.
- We saw minutes of ED team meetings, during which staff were made aware of and discussed learning from complaints and concerns.
- We were told about a change in practice that had been implemented following a serious incident. This resulted in the decision that all patients living with learning or physical disabilities had to be reviewed by a senior doctor before being discharged from the department.

## Are urgent and emergency services well-led?

Good



We rated well-led as good because:

- Staff spoke very positively about the department's leadership, and told us they were supportive, approachable and 'a part of the ED family'.
- Staff were aware of and identified with the department's philosophy and the trust's values.
- Managers and staff were aware of a need for continued improvement. A structured improvement plan was in place.



# Urgent and emergency services

- Department managers engaged with staff, and patients and their representatives in a variety of ways, including social media and face-to-face forum meetings.
- Clinical and non-clinical staff of all grades throughout ED demonstrated a positive culture of wanting to continue their journey of improvement, and of mutual support and teamwork.

However:

- The department had three items still outstanding on the action plan compiled to comply with the requirements of the CQC report published following the inspection carried out in September 2015.

## Leadership of service

- The department was part of the trust's medicine and long-term conditions care group. The ED matron, the clinical director for emergency and acute care, and a care group support manager managed it. These managers reported upwards to the divisional nurse director, divisional director and divisional operations director for medicine and long-term conditions.
- Staff spoke very positively about the ED matron. They described them as approachable; always smiling, a "part of the ED family" and said they always made the effort to talk to staff and check on their welfare.
- Staff also spoke positively about other managers in ED. They told us they were very supportive and promoted a friendly team ethos.
- Doctors described the care group support manager as "involved and supportive". Nurses and care support workers described them as very supportive.
- We saw that the clinical director for ED provided effective medical leadership for the service. They had a strong impact on the improvements since 2015.
- Staff told us the trust's chief executive officer was visible around the hospital and in the department, but they rarely saw the rest of the executives, apart from those on the ED task force with whom they had a good relationship.
- Nursing staff, junior and middle grade doctors told us the ED consultants were all approachable, friendly, and supportive.

## Vision and strategy for this service

- We were shown the clinical strategy for ED and acute care from 2017 to 2022. The plan included 30 projects, broken down into the years they were planned for

implementation. Eighteen of the projects were scheduled for 2017/18. During our inspection, we saw evidence that many of them were already in place. Staff we spoke with often referred to one or more of the plans, which demonstrated a general awareness of the strategy throughout the department.

- Following our previous inspection of the trust, ED managers had worked with staff to produce a vision for the department. The vision was 'To provide integrated high quality care to all our ED patients by highly skilled and dedicated staff in a timely manner; to have an appropriately skilled and trained substantive medical, nursing and operational workforce; to have a purpose built department which will allow us to treat all patients with privacy and dignity and enables us to fulfil the highest potential of standards of care; and to have our staff feeling valued, engaged, appreciated and supported; and to know that they can develop their careers with us.'
- While staff we spoke with were not able to recall every part of the department's vision, they could describe its sentiments and were aware of it.

## Governance, risk management and quality measurement

- We saw details of the ED care group governance meetings from January, February, and April 2017. The overarching theme of all the meetings was 'improving for patients, improving for colleagues, improving for the long-term'. During the meetings, managers discussed subjects including findings from mortality audits, lessons learnt from incidents, key governance, and improvement themes for ED, feedback and learning from serious incidents, complaints and compliments, quality audits, the department's risk register, and new guidance from the National Institute for Health and Care Excellence.
- We were given a copy of ED's risk register. The register listed 35 known risks, together with actions taken and to be taken to reduce the chances of them occurring and mitigate their effects. Risks were graded using a score combining the likelihood they could happen and the potential harm if they did. Of the 35 risks, 29 were graded either as low or moderate, and six were graded as high. The six high risks were: failing to achieve the national target to discharge, refer or admit all patients within four hours of their arrival in ED; poor patient experience relating from failure to achieve the four-hour

# Urgent and emergency services

target; inappropriate delays in assessment and treatment as a result of failing to meet the four-hour target; demands on ED exceeding the department's ability to cope due to its physical size, affecting its ability to manage patients safely; reliance on locum middle grade doctors; and vacancies, sickness and other leave impacting on nurse staffing, and an increased reliance on bank and agency nurses. Each risk had an appropriate date for review, a responsible person for each risk and was consistent with the risks that we identified throughout our inspection.

- Managers carried out weekly audits on the completeness of triage and handover information on ED patient records, against a target of 90% compliance. From November 2016 to April 2017, the department performed better than the target for both indicators every month, scoring between 96% and 100%. Results of the audits were fed back during staff meetings.
- Managers from ED took part in the trust's quarterly paediatrics department meetings, where any incidents, complaints, or developments involving children were discussed.

## Culture within the service

- Managers and staff in ED all displayed a positive culture of wanting to improve the service they provided to their patients. They were proud to tell us about and show us improvements they had made since our previous inspection in September 2015, but also demonstrated an awareness they were on an improvement journey and still had more work to do.
- Senior staff told us they felt empowered to make changes for the benefit of patients, relatives, and colleagues.
- A newly qualified band 5 nurse told us ED staff had been very supportive when they were a student in the department. They said staff encouraged them and made sure they got involved with everything that was happening and made them feel a part of the team.
- All the staff we spoke with were proud to work in the department, of the team with whom they worked and the care they provided for patients. They all told us improvements had been made since our inspection in September 2015, but acknowledged they still had work to do to improve things further for their patients. They told us morale had improved a great deal over the last year, due to improvements in staffing and the environment.

- Clinical and non-clinical staff, regardless of grade, all told us they felt part of the ED team and were valued and treated with respect by their colleagues and managers.

## Public engagement

- The department held monthly 'friends and family forum' meetings, which were attended by managers from ED, trust members, former and current patients and their friends and family members. We saw minutes of the meeting held in February 2017, and attended a meeting which took place during our inspection. The meetings combined updates on developments in ED with an open forum discussion about patients' experiences, compliments, and suggestions for improvements.
- During the meeting, one patient's relative told us the staff had "turned the department around" and made significant improvements since our inspection in September 2015.
- Managers told us the next stage of consultation about the department's redevelopment would include patients' representatives.

## Staff engagement

- Senior managers had held a number of staff focus groups in 2016, to identify concerns and ideas for improvement. We were given a copy of the ED team session presentation responding to the comments from staff. The presentation detailed plans to improve eight areas of the department's work and environment: triage; waiting room; rapid assessment and treatment; cubicles; resuscitation; review rooms; paediatrics; and communication.
- Staff told us they were aware of and involved with the consultation process for the design of the proposed new build ED.
- Managers held monthly team meetings for staff, on the last Friday of each month. Staff who attended the meetings on their rest days were able to claim the time back in lieu. We saw agendas of the meetings held from April 2016 to May 2017, which evidenced discussions about incidents, complaints, equipment trials, audits, and guest speakers from other specialties in the hospital and from external agencies such as the King's Fund.
- The care group support manager was trialling a social media smartphone group messaging application to communicate with care support workers and with band

# Urgent and emergency services

6 nurses, sharing news and information about the department, incidents and social events. At the time of our inspection, the trial was well received and staff in those groups used it as an additional means of having a two-way dialogue with the manager. The manager told us they planned to set up messaging groups for other staff groups, because of the positive way in which it had been received and used by the trial groups.

- We were given copies of the 'Emergency Department Connecting' newsletter, which was produced by the management team and circulated to staff periodically. The newsletters gave updates on developments in the department; details of upcoming training and meetings staff could attend; feedback from staff and patients; information about the department's risks; and any other interesting or useful information. The tone of the newsletters was upbeat, positive, and encouraging, and championed the achievements of ED staff.

## **Innovation, improvement and sustainability**






- We were given a copy of the business case submitted to the trust board in February 2017. The document set out the strategic case for redeveloping ED. This would provide a department capable of providing a safe, effective service to the increasing numbers of patients it was seeing and expected to see, especially in view of the restructure of a neighbouring acute trust and its emergency care services. As part of this plan, ED's cubicle capacity was proposed to be increased to 41 from its current 23, and additional in-patient wards would be built to assist with patient flow. At its meeting in February 2017 the trust board approved the business case, and the plan had been submitted to NHS Improvement for ratification.
- Since the preceding CQC inspection, in September 2015, the trust had maintained an action plan detailing its progress against areas it was told it must or should

improve to meet the regulations of the Health and Social Care Act 2008. Fifty-eight points on the plan related to ED. At the time of our inspection, 55 of those were marked as completed. The outstanding points were: improving staff appraisal rates; ensuring staff could be identified easily by patients and visitors; and management of equipment and stock in the resuscitation area. All the uncompleted actions had progress recorded and reviewed, and we saw evidence of the changes that had been made during our visit.

- Due to changes in the structure of a neighbouring acute trust, which was moving from two hospitals, both with EDs, to one larger hospital, Walsall Manor's ED was expecting to see an increase in its patient numbers. Senior managers were sighted on this impact 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.
- Senior managers in ED told us they still had issues with shortfalls in their medical staffing. Actions they were taking to address this included: active recruitment from abroad; training a cohort of advanced care practitioners; working on a business model to employ physicians' associates; and upskilling their own nurses.
- On discharge from the department, in addition to friends and family test forms (FFT), patients were sent a free text message FFT survey. Patients who had given a landline contact telephone number were sent an interactive voice message FFT survey which has the facility to leave short voice comments about their experience in ED. . We heard recordings of several feedback messages, which were a mixture of positive comments about staff, and the care received, with some complaints about waiting times.



# Medical care (including older people's care)

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

## Information about the service

Medical care at Walsall Healthcare NHS Trust provides care and treatment for various specialities including general medicine, stroke medicine, geriatric medicine, cardiology, endocrinology, gastroenterology, respiratory medicine, and genitourinary medicine. There are 550 acute beds at the trust. Medical inpatient beds and 24 day-case beds are located across 11 wards. The trust had 33,017 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 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).

During the inspection, we spoke with 47 staff, 20 patients, and some of their relatives and reviewed 31 patient records. We spoke with various staff members including staff from the executive team, matrons, consultants, senior nursing staff, agency staff, student nurses, clinical support workers, housekeeping staff, occupational therapists and the infection control lead. We carried out a further unannounced visit to medical care on 06 July 2017.

## Summary of findings

During the last inspection in September 2015, we rated Medical care requires improvement across all domains except for caring which was rated good.

This was because;

- We had concerns about staffing levels, suitability of the physiotherapy environment and availability of equipment.
- Processes for the safe storage and administration of medicines on several of the wards we visited also concerned us.
- We had inconsistent feedback on reporting of actual and possible patient harm incidents. Most staff we spoke with told us they knew how to report an incident, However, some staff told us that they had been asked to change the wording of reports to lessen their impact.

Following this inspection we saw significant improvements across medical wards and rated the service as good overall, because;

- Senior managers were being proactive in solving difficulties with nursing recruitment.
- Staff had undertaken projects to look at areas for improvement and to determine what actions were needed to drive improvement forward.
- Staff were aware of how to report incidents and were encouraged to do so. Senior staff shared learning in unit and divisional meetings.

# Medical care (including older people's care)

- We saw some good infection control techniques such as hand washing and personal protective equipment (PPE). Staff put measures into place to manage an infection outbreak on some wards.
- The hospital participated in clinical audits and monitored its compliance against the National Institute for Health and Care Excellence (NICE) guidelines.
- The trust participated in the nurse preceptorship programme; this gave newly qualified nurses the opportunity to be supported by a mentor whilst developing their nursing skills.
- We saw evidence of good multidisciplinary team working where staff worked together to safely discharge patients or to plan patients care.
- We saw that staff adhered to the Mental Capacity Act, 2005 and that they applied Deprivation of Liberty Safeguards (DoLS) when a patient met the criteria.
- Most patients were happy with the care they received; they felt staff were kind and helpful and that staff treated them with dignity and respect.
- Staff respected patient confidentiality by closing curtains and knocking on doors.
- The trust had recently increased its ambulatory care service opening hours so that it was open from 8am to 8pm from Monday to Sunday. This meant that the hospital was able to close an overflow ward.
- There was a frail elderly service operating between 8am and 8pm daily. The service completed holistic assessments, treatment, support, referrals, and signposted patients to other services. This service helped to prevent unnecessary hospital admissions, with many patients being discharged the same day.
- We saw that the trust responded to complaints and kept patients or their relatives updated when timescales for responding were not met. Complaints were discussed at both ward and divisional meetings.
- The average length of stay for medical elective patients was better than the England average.

- Between October 2016 and March 2017, the trust performed better than the England average for referral to treatment times.
- Most staff felt their managers were visible, approachable and supportive.  
However:
  - The trust did not meet its target compliance rate of 90% for mandatory training. Compliance rates within adult and children's safeguarding training was low.
  - The trust was unable to meet NICE guidelines on staffing levels for stroke patients. The trust used clinical support workers to compensate for registered nursing gaps. We saw that many wards were regularly short staffed, staff told us this affected the time they spent with patients, completion of documentation and put pressure on existing staff.
  - Medication trolleys were not always adequate for medicines stored, which meant there was a potential risk of medication errors.
  - Staff did not always complete daily cleaning documentation to show they had completed daily cleaning tasks.
  - We found that nursing documentation did not contain a section for staff to review a patient's risk of falls.
  - Neutropenic patients did not have access to a dedicated area or ward for initial management. This meant that out-of-hours' nurses who may not have oncology knowledge were caring for neutropenic patients.
  - Nurses did not always assess patients' nutritional risks effectively. We saw that staff were not always completing malnutrition universal screening tools (MUST).
  - Only 80% of staff had received an appraisal; this did not meet the trusts target compliance rate of 90%.
  - We saw that there was not always someone trained on the acute medical unit to administer intravenous antibiotics through a peripherally inserted central catheter.

# Medical care (including older people's care)

- Some patients told us that medical professionals did not always keep them up to date in relation to their care and treatment.
- 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 impacted on the time patients needed to wait.
- Areas we identified during our last inspection (2015) such as staffing levels and training continued to remain a concern. However, we saw that the trust was being proactive in trying to address these.

## Are medical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- Compliance rates for mandatory training, including safeguarding training were low.
- Wards were regularly short staffed, there were several occasions when an advanced nurse practitioner (ANP) was not available on shift.
- We found that patients in extra beds on ward 29 had manual call bells, staff could not always hear these when they left the bay.
- We found that there was limited visibility of patients on ward 29 and that the fire exit on was not alarmed; this was a potential risk to patients living with dementia.
- Staff from the acute medical unit told us that they did not always have enough intravenous (IV) pumps available.
- Audit results in relation to the deteriorating patient showed that significant improvements were required.
- Some medical notes were bulky, had loose pages, and were difficult to navigate. Nursing documentation did not contain a section for staff to review a patient's risk of falls. Staff did not always keep medical records securely; we also found gaps in recording in some patients' records.
- Medication trolleys were not always adequate for medicines stored; this meant there was a potential risk of medication errors.
- Staff did not always complete daily cleaning documentation to show they had completed daily cleaning tasks.
- Neutropenic patients did not have access to a dedicated area or ward for initial management.

However:

- There were good incident reporting processes in place. Senior staff shared learning in unit and divisional meetings.
- Senior staff contacted families to apologise when duty of candour was triggered.
- We saw some good infection control techniques. Staff put measures into place to manage an infection outbreak on some wards.

# Medical care (including older people's care)

- Staff in the endoscopy department cleaned scopes in line with guidance from the department of health.
- The trust had completed a lot of work around the deteriorating patient. Sepsis pathways were in place and staff were aware of them.
- The trust scored well in an audit on acute medical admissions where the trust measured itself against quality indicators by the society of acute medicine.

## Incidents

- There were no never events within the medical service reported at the trust between April 2016 and March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The trust reported 41 serious incidents (SIs) in the medical service between April 2016 and March 2017. These included 21 falls, eight pressure ulcers, seven infection control incidents, four instances of sub-optimal care of a deteriorating patient and one confidential information leak. Staff were aware of how to report incidents and told us they were encouraged to do so.
- We reviewed two root cause analyses (RCA's) that the trust had completed in relation to serious incidents; we found these included lessons learnt and action plans. We also saw that the trust had implemented actions such as the provision of additional training using case studies and the implementation of new policies. We noted in one investigation that an independent review had been undertaken.
- We saw evidence that senior staff shared key themes and messages from incidents and investigations; for example, the trust shared information about the deteriorating patient in the January 2017 edition of 'Learning Lessons: a Quality and Safety Update'.
- Unit and divisional meetings took place within the medical service. We reviewed the minutes and presentations dated April 2017 and saw that incidents were on the agenda.
- Senior staff wrote to patients and families when an incident triggered duty of candour. Staff we spoke with were aware of the principles of duty of candour.
- We reviewed several duty of candour letters and found they contained apologies, actions, lessons learnt and the offer of a meeting. The duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care service to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- The director of nursing was the lead for duty of candour within the trust. The trust's incident reporting system generated a notification when staff reported an incident of significant harm.
- We saw that medical professionals presented monthly mortality findings, including lessons learnt at monthly care group meetings.

## Safety thermometer

- The trust participated in the NHS safety thermometer and data showed there were 19 pressure ulcers, 23 falls with harm and 10 catheter associated urinary tract infections in medical care between April 2016 and April 2017.
- Staff displayed safety thermometer information on whiteboards named quality and safety boards within the departments.
- Different coloured magnets represented safety information for each day of the month. The nurse in charge of the ward updated these boards daily.

## Cleanliness, infection control and hygiene

- The trust completed monthly hand hygiene audits. We reviewed the results from October 2016 to March 2017 and found that all wards scored an average of between 94% and 100%, which met the trust's accepted compliance rate of 90%.
- Staff nursed patients with infections in side rooms. The rooms had notices on the door advising relatives to speak to the nurse in charge before entering.
- Data from the trust's medical division (January 2017 to June 2017) showed there were seven cases of Clostridium difficile (C.diff) and no cases of methicillin-resistant Staphylococcus aureus bacteraemia (MRSA). We saw there was an action plan in place relating to C.Difficile and that all actions were completed.
- We reviewed environmental audits from October 2016 to March 2017 and found most wards achieved overall compliance rates of 85% and above.
- We reviewed an environmental infection control audit completed by Ward 3 dated June 2017. The audit looked at equipment, practice, clean and dirty utilities and the environment, the ward scored 90%. The audit identified

# Medical care (including older people's care)

a missed opportunity for hand hygiene, potential transmission of organisms to clean linen and that suction liners were open on bedside lockers with dust and debris at the base. We asked the trust for action plans in relation to this however, the trust did not provide this.

- We saw that wards had put measures into place to manage an outbreak of acinetobacter baumannii. Acinetobacter is a rare infection that typically occurs in healthcare settings. The trust had introduced additional screening measures (throat swabs) when urine, hairline, and groin swabs had not identified patients with the bacteria, the trust were working closely with stakeholders and sharing learning with other trusts.
- We noted that there was a policy in place for the management of infection outbreaks. Senior staff told us they would be adding the additional screening measure of a throat swab to test for acinetobacter baumannii to their policies.
- We saw that staff screened patients for MRSA on admission and logged this electronically, in line with trust policy. Staff retested patients after 28 days.
- Areas we visited were visibly clean. We saw there were green "I am clean" hangers and stickers on various pieces of equipment to show that staff had cleaned them.
- We saw that all staff were arms bare below the elbow and that most staff used personal protective equipment (PPE). PPE was easily accessible to staff in ward areas.
- Hand gels were readily available to staff and visitors. We saw that staff gelled and washed their hands regularly. Patients we spoke with told us that they saw staff washing their hands.
- Staff in the endoscopy department cleaned scopes as part of a three-stage process in accordance with the decontamination guidance outlined in the 'Department of Health: Health Technical Memorandum 01-06: Decontamination of flexible endoscopes'. There were segregated areas for dirty and clean scopes.
- Senior staff in the endoscopy department told us that they saw patients with known infections at the end of the daily list.
- Staff did not always sign daily documentation to show they had completed cleaning tasks. We reviewed daily cleaning task sheets from wards 3 and 4, and the endoscopy unit and found some gaps in recording.

## Environment and equipment

- We saw that there was limited visibility of patients on ward 29, especially when patients needed to be isolated in side rooms. Senior staff told us that they admitted patients who were most at risk into the bays closest to the nurses' station; however, there was still limited visibility.
- We saw that there were two holes in the wall in a patient bay on the acute medical unit (AMU); staff told us that they had escalated this.
- Most staff told us that they were able to obtain equipment such as intravenous (IV) infusion pumps from the equipment store. However, staff from the acute medical unit told us that they did not always have enough IV pumps available; this had been an issue on the unit when we carried our inspection in 2015.
- We checked the resuscitation trolleys on the wards and found they were tamperproof and that staff had completed and recorded daily checks.
- We saw that sharps and clinical waste were disposed of appropriately in clinical waste bags and into sharps containers.
- We found that equipment had been tested for safety and that stickers were applied to show this.

## Medicines

- A visible, proactive pharmacy team were based on the acute medical unit daily from 11am until 7pm to support with emergency admissions and discharge. The team included pharmacists and pharmacist technicians.
- We reviewed nine medication administration charts and found staff had signed and dated them and recorded any allergies.
- We checked the medication trolleys and found staff had locked these securely.
- We saw that staff nurses administering medications wore red tabards so patients, staff, and visitors were aware they should not be disturbed.
- Ward staff told us that they had a good relationship with pharmacy staff and that they could contact the on-call pharmacy outside hours.
- The pharmacist visited medical wards on a weekly basis to check and replenish stock and to check dates on medications.
- Staff were aware of the medication policy and told us that they could access this on the trust's intranet.
- Senior staff told us that if patients brought in their own medication it could be stored in their own locker and that this would be risk assessed.

# Medical care (including older people's care)

- We reviewed medications on several wards and found them to be in date.
- On one ward, we observed that an agency nurse had left a bottle of insulin and a bottle of dextrose unattended in an unlocked treatment room; on another ward, we observed that nursing staff had left the medication cupboard open.
- Senior staff were responsible for the safekeeping of the controlled drugs keys. We saw that two staff signed the controlled drugs registers and checked stock balances. We saw lists of authorised signatures in place.
- Doctors recorded medication changes on discharge letters including any reasons for the changes.
- Nursing staff kept a record of fridge and room temperatures; we reviewed these and found them to be within the recommended range.
- Staff in the chemotherapy day unit told us that some of the chemotherapy was prepared on site whilst some was prepared off site.
- We asked to see the storage of chemotherapy but staff advised us that the chemotherapy requiring refrigeration was being stored by the pharmacy; this was because the fridge had been broken since September 2016. Senior staff told us that a new fridge had now been ordered.
- We saw that Ward 14 had a pharmacy team who were involved in all aspects of patients' medicine requirements including attending clinical ward rounds. The ward had an independent prescribing pharmacist.
- We visited the acute medical unit and found two of the medicine trolleys were not adequate for medicines stored. They were cramped with chaotic medicine storage, which meant there was a potential risk of medicine errors. We escalated this to the ward manager who told us they would take remedial action. On re-inspection to the ward we saw this had been addressed.
- In the swift discharge suite, nurses could track patients' medicines using an online prescription tracker. This was helpful to determine where the medicines were, so that patient transport could be booked.
- Staff in the discharge lounge told us that they had sometimes used a taxi service contracted by the hospital to send medications to patients' homes; staff told us that this was due to delays in waiting for prescriptions.
- We reviewed patients' medical records, found that some were difficult to navigate, bulky, and had loose pages, this was important, as medical information could be lost or misplaced.
- Medical records were signed, legible, dated, and contained relevant information.
- We saw that ward staff kept medical records in closed trolleys; however, staff did not always lock these. This meant that staff did not keep patient records securely and they could be vulnerable to unauthorised access.
- The trust had implemented a new nursing assessment document that contained essential patient information, such as the malnutrition universal screening tool (MUST), and falls and bed rail assessments. We reviewed this documentation during our inspection and found there were gaps in recording in some of the records.
- We reviewed a sample of monthly peer audits that had been undertaken on patient records between June 2016 and January 2017. We found compliance to be consistently above 90%. The audits included if staff recorded patient allergies and if nurses had completed waterlow scores and skin assessments.
- We reviewed nine do not attempt resuscitation (DNACPR) decisions forms and found that they had been completed appropriately.

## Safeguarding

- The trust's target for safeguarding training was set at 90%. Only 50% of the required medical and dental staff had completed safeguarding children level 2, under 10% had completed level 2 safeguarding training in adults and none of the required staff had completed safeguarding adults level 3.
- Training rates for nursing staff in relation to safeguarding adults and children levels 1 to 3 fell considerably below the trust target of 90%. Compliance for all safeguarding training was below 70% with only 27% of nurses having completed safeguarding adults level 2 and 3.
- The trust had a training plan in place, which included safeguarding children and adults levels 1 to 3. Plans included additional drop in sessions for staff that did not have access to or were unable to use a computer and that managers factored in protected learning time to enable completion.
- We reviewed the adults safeguarding policy and found it was version controlled, had a review date of 2018,

## Records



# Medical care (including older people's care)

contained information on staff roles and responsibilities, procedures and the different types of abuse. The policy also contained a safeguarding referral form for staff to send to the local authority.

- Staff were aware of the trust's safeguarding lead, what to do if a patient disclosed abuse, and how to access the trust's policies and procedures.
- Senior staff told us that female genital mutilation (FGM) was included in mandatory safeguarding training and that the trust had a task and finish group who were working on clinical pathways and updating the trust's FGM policy.

## Mandatory training

- Mandatory training included conflict resolution, equality and diversity, fire safety, infection control, information governance and patient handling.
- Data from the trust showed that mandatory training figures were low with medical and nursing staff not meeting the trust target 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. Nursing staff achieved better results, for example; load handling and patient handling, which had compliance rates of above 90%.
- Safeguarding training figures in adult and children's safeguarding were also low with medical, dental and nursing staff not reaching the trusts training target compliance rates.
- Senior staff told us they tried to release staff for training but that that training figures were low due to staffing levels and they recognised this was an issue. We asked senior staff how the trust was improving mandatory training figures. Senior staff told us the trust was changing mandatory training to a two yearly basis. We also saw the trust had a training plan in place, which identified the need for staff to have protected time to complete training and for the trust to make further training sessions available.
- The trust addressed sepsis within the deteriorating patient escalation policy. The policy included details on the commencement of sepsis screening and pathways. We saw that wards kept paper copies of the sepsis-screening tool.
- We saw that senior staff had added sepsis to the agenda for clinical update sessions April 2017 to March 2018.

## Assessing and responding to patient risk

- We reviewed an audit of acute medical admissions in 2016 and saw that the trust measured itself against clinical quality indicators produced by the society of acute medicine. The audit showed that a decision maker saw 100% of patients within four hours, 94% of admitted patients within eight hours and 100% of admitted patients were seen by a consultant physician within 14 hours.
- The audit of acute medical admissions 2016 also found that only 32.5% of patients had their observations taken within the recommended time of 15 minutes from admission. A recommendation from this audit was for senior staff to feedback to the nursing team the importance of taking patient observations within 15 minutes of arrival.
- We saw that nurses completed risk assessments, such as the malnutrition universal screening tool (MUST), waterlow, bed rails, moving and handling assessments and assessments of falls and mobility. We reviewed these and found staff did not always complete them in full. Senior staff told us that they felt more education was required in relation to completing the MUST records.
- We found that the assessment of falls and mobility in the nursing assessment documentation did not contain a section for staff to review a patient's risk of falls.
- We observed that nurses recorded patient observations, such as temperature, blood pressure, and heart rate on an electronic patient observation system.
- Nurses told us that there could be issues at times with this systems devices; for example they sometimes lost signal, when this happened staff told us they used another device or recorded the observation in paper format.
- 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

# Medical care (including older people's care)

(NEWS) of five or above was 47%, this improved to 62% in February 2017, but worsened to 57% in March 2017. NEWS is an early warning score used by medical staff to determine the degree of illness of a patient.

- We saw that the trust had implemented an adult deteriorating patient escalation policy. The policy set out the roles of staff and contained a chart on NEWS, the frequency of monitoring required in relation to NEWS scores and the clinical response required when a NEWS score was a cause for concern.
- We spoke to staff about the NEWS scoring method and found them to be knowledgeable around this.
- The trust had put in place a deteriorating patient stamp to indicate when staff had escalated a deteriorating patient to a doctor. We observed the stamp in two patients' medical notes.
- We reviewed ward meeting minutes from April 2017 and saw that staff had discussed deteriorating patient procedures.
- We saw that there was an inpatient sepsis screening and action tool in place and that medical staff were using this. The document contained a flow chart to determine if medical staff needed to implement the sepsis six pathway.
- The sepsis six pathway document detailed actions and timescales, such as administering oxygen and taking blood cultures.
- Each ward had a sepsis lead to provide staff with support and information in relation to sepsis.
- We reviewed the sepsis and deteriorating patient task and finish group live action sheet (May 2017) and saw that actions were on track or had been completed.
- We visited the acute medical unit (AMU) and found that staff had not always left call bells within patients' reach. This meant that patients were not able to call for help if required.
- Neutropenic patients did not have access to a dedicated area or ward for initial management. This meant that out-of-hours' patients were cared for by nurses who may not have oncology knowledge.
- We saw that there were additional beds in several of the bays on ward 29; these did not have trunking for oxygen, curtains, or a call bell. Ward staff provided patients with manual call bells and screens for privacy. Staff told us that they would move patients requiring oxygen to

another bed or that staff would use the portable oxygen cylinders. We saw there was a standard operating procedure (SOP) in place for adult outliers and buffer capacity.

- On our unannounced visit we returned to ward 29 and found one patient had been on the ward for two days and had not been provided with a call bell; another patient told us that staff could not hear them when they rang theirs. We saw that staff completed a risk assessment and checklist for patients in the extra beds.
- We noted that a fire exit on ward 29 was not alarmed. The fire exit led outside onto a fenced and gated garden area, beyond the gate was a hospital car park and a road. Staff were concerned that a patient with dementia may leave the ward and climb over the fence and that there was no alarm to alert staff. We spoke to senior staff who told us that they had put in a requisition for this.

## Nursing staffing

- Walsall Healthcare NHS Trust reported a vacancy rate in nursing of 12.8% within the medical service. Staff turnover rates as of March 2017 were 11%, this was slightly worse than the trusts overall target rate for staff turnover which was 10%.
- Sickness rates during the same time period stood at 4.1%. The trusts overall target rate for sickness was 3.4%.
- Between April 2016 and March 2017, the trust recorded an average bank and agency usage of 17.3%.
- Senior trust staff told us that the trust used the safer nursing care acuity tool to assess staffing levels on inpatient wards. This meant a staff to patient ratio of one nurse to eight patients (acute) and one nurse to ten patients (sub-acute) was used. However, senior staff advised that due to registered nursing vacancies staffing arrangements did not always reflect the skill mix.
- We spoke with two agency nurses during our inspection; both discussed concerns about nurse to patient ratio. One agency nurse told us that they had needed to look after 15 acutely unwell patients; another told us they had looked after 16.
- Due to over establishment of clinical support workers, senior staff told us that they used them to compensate for registered nursing gaps.
- Senior staff told us they were sometimes counted in the staffing numbers when staffing levels were low.



# Medical care (including older people's care)

- Senior staff also told us that they were unable to meet NICE guidelines on staffing levels for stroke patients. They said that they had escalated this to the divisional board and that there was an ongoing review of the stroke service.
- Most staff we spoke with discussed their concerns in relation to nurse staffing levels on the wards. There was 232 nursing staff in post within medical care as of March 2017.
- Staff told us that decreased staffing levels affected completion of documentation, the time spent with patients and that it put pressure on existing staff.
- Staff told us that if they were short staffed, they pulled together in an attempt to lessen the impact on patients.
- Nursing staff were completing incident reports when they were short staffed. We reviewed a sample of these from wards and found that staff had graded the incidents as low or no harm.
- Staff on the acute medical unit told us that there had been four agency staff on shift one night during our inspection, which meant agency staff were handing over to agency staff and a lack of continuity for patients.
- Staffing levels were recorded on the patient safety boards within each ward. We saw that wards 15 and 17 had been rated amber twice, which meant both wards had been short of one staff member on two occasions in June 2017; ward 15 had been short of one staff member on three occasions.
- One patient we spoke with told us that staff were always rushing around; another said there was not enough staff and that staff were always rushed.
- Senior staff told us that staff already on shift remained on the hospital ward whilst the senior member of staff completed their handover. This meant staff did not leave patients alone while handover took place.
- In January 2017, the proportion of consultant staff reported to be working at the trust (34%) was lower than the England average (37%) and the proportion of junior (foundation year 1-2) staff was much higher at 36% in comparison to the England average of 20%.
- Senior staff told us that they covered short-term gaps in medical staffing internally if possible. The trust was involved in a recruitment programme with an overseas college of physicians and surgeons and advised us they would be interviewing for middle grade doctors in July 2017.
- Senior staff told us that there were four occasions in May 2017 and seven occasions in June 2017, when an advanced nurse practitioner (ANP) was not available on shift. The trust told us there were three ANP posts vacant but that the posts had been recruited into with employment due to commence in August 2017.

## Major incident awareness and training

- Trust wide data showed that only 56 out of 188 eligible staff (30%) had completed major incident training as of March 2017. We saw that the trust had addressed fire safety in the trust's training plan and that they were making additional classrooms and departmental training available.
- We reviewed the trust's major incident plan dated May 2016 and supporting action cards. The plan contained information on roles, duties and contained supporting notes and guidance.
- Staff were aware of the major incident plan and that they could access this on the trust's intranet.
- Fire alarms sounded while we were on ward 29, we noted that the fire warden took approximately six minutes to respond. We asked senior staff what was an acceptable time for a fire warden to attend a ward when a fire alarm was sounding due to a false alarm. Senior staff told us that the trust employed fire wardens within each area and that they acted immediately on the sounding of a fire alarm.

## Medical staffing

- Between April 2016 and March 2017, the trust reported a vacancy rate of 0%.
- The trust reported a high staff turnover rate of 43% between April 2016 and March 2017.
- Data from the trust showed that there was a reported sickness rate of 1.6%.
- The hospital reported an average bank and locum usage rate of 19.6 % within the medical service.

## Are medical care services effective?

Good



We rated effective as good because:

- Consultants completed regular ward rounds.

# Medical care (including older people's care)

- The hospital participated in clinical audits and monitored its compliance against the National Institute for Health and Care Excellence (NICE) guidelines.
- Patients told us that staff reacted quickly to their needs for pain relief.
- Patients had access to fluids at all times; staff replenished patients' fluids regularly. There was flexibility for families who wished to come onto the wards to support their relative with nutrition.
- The trust performed better than the England average in relation to patient satisfaction around diabetes.
- The proportion of fit patients with advanced non-small cell cancer receiving chemotherapy was significantly better than the national level and better than the national aspirational standard.
- The trust participated in the nurse preceptorship programme.
- We saw evidence of good multidisciplinary team working.
- Staff adhered to the Mental Capacity Act, 2005 and that they applied Deprivation of Liberty Safeguards (DoLS) when a patient met the criteria.

However:

- Nurses did not always assess patients' nutritional risks effectively; malnutrition universal screening tools (MUST) were not always completed.
- The trust did not meet the aspirational standard for the proportion of patients who had a lying and standing blood pressure assessment.
- Only 80% of staff had received an appraisal, this did not meet the trust's target compliance rate of 90%.
- We saw that there was not always someone trained in the acute medical unit to administer intravenous antibiotics through a peripherally inserted central catheter (PICC line).

## Evidence-based care and treatment

- Ward rounds took place five days a week on most general medical wards following a board round. Wards 3 and 4 (Elderly care) had consultant ward rounds between two and three times per week.
- Consultants on the acute medical unit (AMU) and ward 29 completed ward rounds seven days a week.
- AMU consultants were available seven days a week from 8am to 8pm to oversee new patient admissions.
- Selected patient reviews took place on Saturday mornings following a board round.

- Trust staff completed an audit in 2017 as part of a seven-day service review. The audit found that 86% of patients admitted onto the AMU during a weekday and 84% at the weekend were reviewed by a consultant within 14 hours of admission.
- The hospital carried out a programme of clinical audits where it actively audited compliance against NICE guidelines. For example, we saw audits had been undertaken on acute kidney injury, prevention and detection management, intravenous fluid therapy and head injury management in the over 65s. Audits took into consideration NICE guideline and standards, results and actions.
- The trust participated in national audits including the heart failure audit, the national diabetes inpatient audit, myocardial ischaemia national audit project, the lung cancer audit and the national audit of inpatient falls.

## Pain relief

- Patients we spoke with told us they had adequate pain relief and that nurses brought them pain medication quickly.
- Staff assessed and documented patient pain when carrying out comfort rounds. We saw in documentation that nurses generally completed comfort rounds on a two hourly basis. However, we reviewed one patient's record and saw that the comfort round documentation had not been completed for over 7 hours, from 10am to 5.30pm. We saw that nurses completed pain scores on the electronic patient observation system.
- Senior staff told us that the trust did not have any audits registered for pain relief.
- The trust had an acute and a chronic pain service. The teams consisted of doctors and nurses who provided advice and support to patients.
- Senior staff told us that the existing pain team was working towards implementing the pain medicines standards from the faculty of pain medicines and that the trust had supported a business case for the development of a full multidisciplinary team as set out in the Faculty of Pain Medicines Standards.

## Nutrition and hydration

- We noted that nurses assessed patients' nutritional risks using the national malnutrition universal screening tool (MUST). However, we saw nurses had not always completed these fully.

# Medical care (including older people's care)

- Senior staff completed nutritional audits on a ward-by-ward basis. We reviewed the data from 2017 and found low compliance rates of completing MUST scores on admission on some wards. For example, in May, only 33% of patients on ward 4 had a MUST assessment on admission and only 40% had an assessment on ward 16.
- Wards 3, 14, 15 and 16 scored 33% or below for MUST weekly screening since admission in May 2016. We saw that senior staff had devised an action plan to address compliance rates. Actions included nutrition to be part of the clinical update, and mandatory training, to include the importance of nutrition, thickening of drinks and training around the MUST. Additionally the action plan identified the need for nutritional link nurses.
- We saw that patients and their relatives had access to drinking water; patients told us their staff replenished their water regularly.
- We saw that staff monitored patient's nutrition and dietary intake on fluid monitoring charts and in food diaries; however we found that staff did not always total the fluid charts, this meant we were not assured that patients were drinking sufficient amounts of fluid each day to stay hydrated.
- Staff referred patients to dietitians when required. We saw that a clinical nurse specialist for nutrition had seen a patient following a referral for a percutaneous endoscopic gastrostomy (PEG).
- Senior staff told us that they encouraged families to come on to the ward at mealtimes to offer support to their relative if they wished to.
- We saw that a red tray system was in place in the swift discharge suite to alert staff that a patient required support with eating and drinking.

## Patient outcomes

- Between January 2016 and December 2016, patients at the trust had a similar risk of readmission to the England average for elective specialities and a higher than average risk for non-elective specialities. Of the most common specialities, gastroenterology and non-elective general medicine had higher than expected risk and all others specialities had similar or slightly lower levels of risk, with elective haematology being the lowest.
- The trust participated in the quarterly Sentinel Stroke National Audit Programme (SSNAP). The trust scored a grade C, meeting the standard requirement in the latest available audit (August to November 2016). However,

overall scores were worse than in the previous audit April to July 2016, when the trust had scored a B overall. We saw that there was an action plan in place to address the decline in performance. Actions were that the results of the audit would be presented to the elderly care group in June 2017 and that the current status and mitigation of risk would be reviewed. The SSNAP is the single source of stroke data in England, Wales, and Northern Ireland. There were three main components to the audit including clinical audit, acute organisational audit and post-acute organisational audit.

- 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, they were also better in six of the seven standards relating to discharge. For example, the amount of patients that received input from a consultant cardiologist was 76.5%, which was better than the England average of 58.6%.
- The trust also participated in the National Diabetes Inpatient Audit (NaDIA). The NaDIA measures the quality of diabetes care provided to admitted patients with diabetes whatever the cause, and aims to support quality improvement. In 2016, 84% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes whilst in hospital. The trust performed better than the England's average in relation to patient satisfaction around diabetes care in 2015 and 2016.
- Results from the Myocardial Ischaemia National Audit Project (MINAP) showed that between April 2014 and March 2015, 43% of non-ST-elevation myocardial infarction (nSTEMI) patients were admitted to a cardiac unit or ward at the Hospital, compared to the England average of 55%. Results also showed that 94.8% were seen by a cardiologist or member of the team compared to an England average of 95.0%. We reviewed the trust's action plan in relation to the audit and saw actions were being put into place. For example, the trust was introducing a best practice tariff from April 2017, through quarterly reports to the care group. Additionally, the trust was initiating a project to review internal pathways to ensure patients were receiving the best practice in line with national guidance.
- Walsall Healthcare NHS Trust participated in the 2016 lung cancer audit. Results showed, the proportion of patients seen by a cancer nurse specialist was 79.7%,

# Medical care (including older people's care)

which was marginally short of the audit minimum standard of 80.0%. Senior staff felt this was due to issues relating to data collection and submission, as a lung cancer specialist had seen the majority of patients.

- The proportion of patients with histologically confirmed non-small cell cancer (NSCLC) receiving surgery was 12.3% this was similar to the national level.
- The proportion of fit patients with advanced NSCLC receiving chemotherapy was 80.6%, significantly better than the national level and better than the national aspirational standard of 60.0%.
- The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 58.8% this was significantly worse than the national level.
- We reviewed the action plan around the lung cancer audit and found actions included the development and submission of a business case, to expand and progress the service in line with best capacity and demand, and for the audit results to support and drive the listening into action programme in respiratory services.
- Data from the national audit of inpatient falls showed that a multi-disciplinary working group for falls discussed falls data within the trust. The trust met the audits national aspirational standard of 100% for patients having a vision assessment, being assessed for the presence or absence of delirium, and the proportion of patients who had an appropriate mobility aid within reach. The aspirational standard of 100% was not reached for the proportion of patients who had a lying and standing blood pressure assessment, where the trust scored 90%. We reviewed the trust's action plan in relation to this and saw that data collection was in progress.
- The endoscopy service was not JAG accredited; senior staff told us they were working towards this. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale standards.

## Competent staff

- Within medical care services 80% of staff had received an appraisal. This did not meet the trust's target of 90%. Senior staff told us that the trust was in the process of training band 6 nurses to complete staff appraisals and that band 7 nurses would oversee this.
- We saw that there was a bank and agency staff induction sheet in place for bank and agency nurses

who had not worked in the ward or department before. However, we spoke to one agency nurse who had completed six shifts on a ward and had not completed the checklist. The checklist covered ward orientation, nursing documentation and patient experience.

- We reviewed a patient's medical notes on AMU and saw that on one shift there was no one in the department that was trained to administer intravenous antibiotics through a PICC line.
- Senior staff in the chemotherapy department told us that they recognised there were gaps in knowledge around PICC lines and that they were looking at completing some ward based training.
- Health Education England completed a quality review outcome report (May 2017). The review noted that procedural skills were not being checked for new registrars. The trust had submitted an action plan which included the implementation of a self-assessment document for procedural skills during induction.
- The trust trained clinical support workers in vital signs monitoring. We saw clinical support workers completing these successfully.
- The trust participated in the nurse preceptorship programme. The programme ensured that an experienced practitioner supported newly qualified nurses as they developed their nursing skills. Nurses undertaking preceptorships had a mentor.
- Development opportunities were available to clinical support workers wishing to take up the associate nurse role.
- Senior staff told us that nursing staff were responsible for their own competencies and that they identified any training required in annual personal development reviews.
- Senior staff told us that if they had concerns that staff were not competent to carry out their role they would escalate the concerns to the matron.

## Multidisciplinary working

- We saw that the multidisciplinary team saw patients with complex needs. The multidisciplinary team included doctors, nurses, dietitians, physiotherapists, and occupational therapists.
- We observed a multidisciplinary board round where staff discussed each current patient including their medical status and discharge arrangements. Board rounds took place on a daily basis followed by ward rounds on wards 1, 14, 15, 16, 17, and 29.

# Medical care (including older people's care)

- We saw that staff from the multidisciplinary team were responsible for updating the red and green boards implemented on some of the medical wards. The red and green boards identified what actions staff had taken to move patients towards discharge each day. When staff identified a red day, staff could look at what could be done to move things along for the benefit of the patient pathway or escalate reasons out of the wards control in order for care group managers or the trust to address them.
- The multidisciplinary team met daily on the swift discharge suite with a purpose of arranging patients' discharge. The team consisted of nursing staff, therapy staff, and social care.
- Nurses, pharmacists, and ward clerks worked together in AMU to reduce the amount of missed medication doses. An action plan had been developed, which included a green bag for medicines to transfer with the patient and a green dot to remember to send medicines was placed on the patient's board.

## Seven-day services

- The trust had arrangements in place for 24-hour a day, seven days a week medical cover, which included weekdays, evenings and weekends.
- The ambulatory care service operated from 8am to 8pm Monday to Sunday.
- The endoscopy department's normal opening hours were Monday to Friday from 9am to 5pm.
- The frail elderly service operated from 8am to 8pm Monday to Friday and from 8am to 4pm at weekends.
- Occupational therapists visited medical wards to assess and review patients seven days per week.
- The hospital had an oncology day unit that operated from 9am to 5pm, Monday to Friday. Outside of these hours, the trust had an on-call oncologist they could contact.
- There was a medicine on call team that provided 24-hour cover, seven days a week. The team consisted of consultants, acute and general physicians, junior doctors and a registrar. There was additional cover for stroke and elderly care wards during weekday evenings and weekends.
- The hospital's pharmacy department was open from Monday to Friday, from 9am to 6pm; Saturdays from

10am to 3pm and on Sundays from 11am to 2pm. Emergency pharmacists were available via a bleep from Monday to Thursday from 7pm to 9am, from 7pm to 10am on a Friday and from 7pm to 11am on a Saturday.

## Access to information

- Doctors sent completed discharge summaries to patients' GPs following their discharge. Senior staff told us they followed up discharge summaries with a call to the patients' GP to ensure they had received it.
- We reviewed a patient's discharge summary; it was comprehensive and contained relevant information, such as the patients' medications, medication changes, diagnosis, and allergies.
- Patients' medical and nursing records were in paper format. Staff recorded patient observation records on the electronic patient observations system.
- Staff had access to computers where they could access trust policies and procedures.
- We saw that some computers were not password protected, which meant some computers were vulnerable to unauthorised access.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had consent to examination or treatment policy in place. The policy provided staff with information included on capacity to consent, Deprivation of Liberty Safeguards (DoLS) and informed consent. We reviewed the mental capacity training records of staff from nine medical wards and saw that nearly all of the required nursing staff had completed this.
- We saw that doctors adhered to the Mental Capacity Act, 2005 by completing mental capacity and best interest assessments when a patient's capacity was in question.
- We reviewed patient medical records and saw that when required, doctors had completed mental capacity assessments in relation to medical management and resuscitation status.
- We saw evidence that staff applied DoLS when patients met the criteria.
- We noted that an interpreter had supported a doctor to assess a patient's capacity in relation to their care and treatment.
- We reviewed four chemotherapy consent forms and found that patients had signed these.



# Medical care (including older people's care)

## Are medical care services caring?

Good 

We rated caring as good because:

- Most patients were happy with the care they received. They felt staff were kind and helpful and that staff treated them with dignity and respect.
- Staff respected patient confidentiality by closing curtains and knocking on doors.
- The trust had a 24 hour a day, seven days a week chaplaincy service provided by Christian chaplains and a partial weekly service by Roman Catholic chaplains. A 24 hour a day, seven days a week service for smaller faith communities was to be reinstated following the Safety and Quality Committee decision in July 2017. We saw that staff supported and reassured distressed patients and their families.

However:

- Some patients told us that they did not feel that medical professionals always kept them up to date in relation to their care and treatment.

### Compassionate care

- The NHS Friends and Family Test (FFT) response rate for medicine at the trust was 27%. This was similar to the England average of 25%. The FFT is a survey that asks patients whether they would recommend the NHS service they received to friends and family.
- The percentage of patients that would recommend the service to family and friends varied between August 2016 and January 2017, with most medical wards scoring between 75% and 100%. The exception to this was ward 3, which had consistently low scores (18% to 30%).
- Senior staff told us that the low scores on ward 3 were likely due to the high level of patients with dementia as they were not always able to answer yes or no to the questions and that they were looking at ways staff could make the test more dementia friendly.
- We saw that staff respected patients' privacy and dignity by ensuring they closed any curtains and doors. Patients in side rooms told us that staff knocked on their doors before they entered.

- Most patients and their relatives told us that staff introduced themselves and that they were kind and helpful.
- We observed staff being patient and caring with a patient with a learning disability who had left the ward and did not want to return.
- One patient told us that if the hospital was a football team, Walsall Healthcare NHS Trust would be the one they would choose.

### Understanding and involvement of patients and those close to them

- Relatives could attend wards outside of visiting hours to assist with care and support if this was required.
- We saw that staff recognised patients that needed additional support to help them be involved in their care and treatment for example; we saw staff had requested an interpreter when a patient's first language was not English.
- We observed a staff member updating a relative on a patient's condition.
- One visitor we spoke with told us that staff always passed on their messages and asked them how they could help.
- There were two patients that told us medical professionals did not always keep them up to date in relation to their care and treatment.

### Emotional support

- The trust had a 24 hour a day, seven days a week chaplaincy service provided by Christian chaplains and a partial weekly service by Roman Catholic chaplains. A 24 hour a day, seven days a week service for smaller faith communities was to be reinstated following the Safety and Quality Committee decision in July 2017.
- We saw staff on a ward providing a distressed patient and their family with reassurance and support.
- We saw that staff displayed the contact details for the stroke helpline on the notice board outside of the stroke ward.

## Are medical care services responsive?

Good 

We rated responsive as good because:

# Medical care (including older people's care)

- The trust had recently increased its ambulatory care service opening hours so that it was open from 8am to 8pm from Monday to Sunday. This meant the hospital were able to close an overflow ward.
- There were guidelines in place for staff to follow when patients presented at the hospital with symptoms of a stroke.
- There was a frail elderly service operating between 8am and 8pm Monday to Friday and from 8am to 4pm Saturday and Sunday. The service completed holistic assessments, treatment, support, referrals, and signposted patients to other services; this helped to prevent unnecessary hospital admissions with many patients being discharged the same day.
- Regular board rounds took place, which provided an opportunity for multidisciplinary discussions around the patient.
- The average length of stay for medical elective patients was better than the England average.
- Between October 2016 and March 2017, the trust performed better than the England average for referral to treatment times.
- We saw that the trust responded to complaints and kept patients and or their relatives updated when timescales for responding to the complaint were not met. Complaints were discussed at both ward and divisional meetings.

However:

- 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.

## **Service planning and delivery to meet the needs of local people**

- The trust had an ambulatory care service based on ward 29. The service had recently extended its opening hours from 8am until 8pm, Monday to Sunday.
- The trust had different coloured routes that visitors and patients could follow to help them find their way to the ward. There was a large information board at the entrance of the hospital; the board displayed all the wards and their corresponding routes.

- The trust had guidelines and pathways for staff to follow when patients presented at the hospital with symptoms of a stroke including use of the face, arms, speech, time test (FAST), assessment, investigation and treatment, and thrombolysis.
- Staff admitted patients with a stroke diagnosis to a designated stroke ward (ward 1). Stroke nurses carried a bleep and assessed patients to determine suitability for transfer to the ward.
- Staff from the oncology day unit told us that they received an alert when patients receiving chemotherapy or who had received chemotherapy within the last six weeks were admitted to the trust. Staff also told us that there had been an increase in lists meaning there was not always enough chairs for patients to sit on and that this affected patient waiting times.
- Physiotherapists provided services to stroke patients in a gym converted from a bay on the stroke ward. Senior staff told us the trust may need to open the gym to stroke patients if there were not enough patient beds.

## **Access and Flow**

- The trust had a discharge lounge named the swift discharge suite. The suite had several bays for patients that were medically fit and awaiting discharge.
- Consultants from ambulatory care told us that they had been able to close an overflow ward (12) due to increasing ambulatory care opening hours.
- The frail elderly service completed holistic assessments, treatment, and offered support and referrals including signposting frail elderly patients to other services. We reviewed weekly performance documentation in relation to the service and saw that between 08 May 2017 and 22 May 2017, 670 patients had accessed the service with the service discharging 204 patients on the same day. We saw that staff referred patients to the community care pathway, social care, and falls services.
- Board rounds took place on a daily basis, which provided an opportunity for professionals to share up-to-date information on patients, including if they were medically fit for discharge and to discuss any discharge plans.
- We saw that staff made referrals to social care and that they completed discharge-planning summaries.
- Between April 2016 and March 2017, 67% of patients remained on the same ward during their hospital admission. Thirty-three percent of patients moved wards more than once.

# Medical care (including older people's care)

- The length of stay for general medicine and non-elective geriatric medicine was higher than the England average.
- Between February 2016 and January 2017, the average length of stay for medical elective patients at the trust was three days. This was better than the average of four days.
- For medical non-elective patients the average length of stay was seven days this being similar to the England average of just under seven days (6.9).
- The trust had undertaken a quality improvement project for hospital discharge. The project looked at reasons for delay in discharge. The most common reasons for delays in discharge were prolonged medical illness, delayed progression through therapy and delays in social work assessments. Additional factors included patients becoming medically unwell and awaiting next of kin input. Doctors who completed the project made several recommendations for example, discussions between senior management and health and social care services to enable quicker responses and to ensure discharge planning began on admission.
- 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 that 98.1% of patients were treated within 18 weeks, this was better than the England average of 89.6%.
- We saw that red and green boards were in place to help the trust identify what staff were doing to move patients towards discharge each day. Senior staff told us that information from the boards was captured in a spreadsheet and sent to care group managers on a weekly basis. This helped identify the reasons for delays in patient discharge.

## Meeting people's individual needs

- The trust employed two acute learning disability liaison nurses, who staff could contact for advice and information.
- There was a system in place to alert staff that a patient had dementia on the trusts patient management system. The older people's mental health team completed this, ward staff were unable to do this. The flag took the form of a butterfly. There was no electronic flagging system in place for people with a learning disability.
- The trust did not have a specialist nurse for dementia; however, there were four dementia support workers employed by the trust. Senior staff told us that the older people's mental health team would provide ward staff with support around dementia if required. Staff assessed and recorded patients' cognition on admission, this was recorded in the patients nursing assessment document.
- We reviewed the dementia awareness training records of wards that were predominantly elderly care (wards 3, 4 and the Swift discharge suite) and saw that the completion rate was 94% and above; this met the trust target rate of 90%.
- We saw that key ring size communication cards were available for staff to use with patients with a learning disability. The pictorial cards had pictures of emotions, food and yes and no.
- Staff showed us a learning disability resource pack that contained information for staff on learning disability and contained various fact sheets.
- Patients with a hearing impairment could request the use of a hearing loop. The trust had no flagging system in place to alert staff if a patient was deaf or blind.
- Corridors, shower rooms, and ward areas were wheelchair accessible. Lifts were available to all floors.
- The trust had notice boards on display near the entrance to the wards. The notice board provided patients and their families with information on translation services, chaplaincy services, the friends and family test, helplines, discharge, staff information and how the ward was performing in audits, such as the Sentinel Stroke National Audit Programme (SSNAP).
- We observed a tea party taking place in the swift discharge suite. The patients ate strawberries and cream and sang along to music. Volunteers ran the tea party, which six patients attended. Volunteers held tea parties for patients every Thursday afternoon from 2pm until 4pm.
- The swift discharge suite had an area for patients to read and complete activities, all patients on the swift discharge suite were medically fit for discharge.
- The swift discharge suite had two butterfly bays (one male, one female) for dementia patients. Staff told us that these worked well as long as there was enough staff. Other wards told us they had trialled the butterfly system where all patients with dementia were cared for in one bay but that this had not worked.



# Medical care (including older people's care)

- Staff told us that there was a psychiatric team based at the hospital and that they would come to the wards quickly when required.
- There was car parking available for patients and visitors, machines were close to the entrance for payment. Weekly concessionary passes were available for regular visitors to the hospital.
- Patients told us that they had a choice over what they ate and that staff brought them menus to choose from.
- Relatives and patients could purchase food and drink from the hospital's shop or restaurant.

## Learning from complaints and concerns

- Between April 2016 and March 2017, there were 116 complaints about medical care.

Complaint themes included clinical treatment (74), communication and discharge (9), diagnosis (3) and medication errors (2). We saw that the trust had a policy in place for the management of complaints and concerns.

- The trust based timeframes for investigation on the level of seriousness of the complaint and timeframes were 10, 30 and 45 working days. Senior staff told us that they would agree the timeframes with the complainant. The trust took on average of 39 days to investigate and close complaints.
- We saw that the hospital provided complainants with an acknowledgement letter and details of any investigations undertaken. We also saw that senior staff wrote to a complainant to apologise that the investigation was taking longer than expected. We reviewed several complaint responses and saw that senior staff had completed an action plan in response to one of the complaints. Actions identified included further training for staff in dementia, and that senior staff would share an anonymised copy of the complaint with all ward staff.
- We saw that the trust provided the contact details of the Parliamentary and Health Service Ombudsman (PHSO). The PHSO makes final decisions on complaints that were not resolved by the NHS in England and UK government departments along with other public organisations.
- We noted that staff displayed details of who to contact if a patient or relative had a complaint on notice boards outside the wards, they also displayed contact details for the patient advice and liaison service (PALS).

- Senior staff told us that they contacted patients to discuss complaints; they felt this assured patients or their relatives who had made a complaint and that it had improved communication.
- We saw that staff discussed compliments and complaints at ward and divisional quality team meetings.

## Are medical care services well-led?

Good



We rated well-led as good because:

- Senior managers were being proactive in solving difficulties with nursing recruitment.
- Staff had undertaken projects to look at areas for improvement and to determine what actions were needed to drive improvement forward.
- Most staff felt their managers were visible, approachable, and supportive.
- There were clinical strategies in place (2017-2022); these were split between the medical divisions.
- Staff were aware of the trust values and these were displayed throughout the hospital.
- We saw that actions were put into place when risks were identified for example; the division had completed a lot of work around the deteriorating patient.
- There were performance dashboards in place that measured ward performance.
- Senior staff provided feedback to the board on subjects such as risks, length of stay and quality indicators.
- Most staff felt valued, respected, and proud of the job they did.

However:

- Areas we identified during our last inspection (2015), such as staffing levels and training, continued to remain a concern. However, we saw that the trust was being proactive in addressing the concerns.

## Leadership of service

- The leadership team in medical care consisted of a divisional director, a director of operations and a divisional director of nursing.

# Medical care (including older people's care)

- Medicine and long-term conditions were divided into six care groups, these being emergency and acute care, long-term conditions, adult community, cardiology, gastroenterology, and elderly care.
- Each care group had a team of three consisting of a matron, clinical director and a care group manager.
- We saw that staffing concerns highlighted during our last inspection in 2015 continued to be of concern. However, we saw that senior managers were being proactive in solving the issues around difficulties in the recruitment of nursing staff. For example, the trust was participating in the associate nurse programme and looking at overseas recruitment. The nursing associate programme is a new health care initiative introduced by the department of health (DOH) to bridge the gap between allied health professionals and registered nurses.
- Mandatory training figures, including safeguarding training were low. Medical and dental staff did not meet the training target for all core mandatory training courses within the medical core service. Nursing staff met the training target for load and patient handling but failed to meet the targets for other courses. Time for staff to attend training had been identified as a concern in our 2015 inspection of the service. However, we saw that the trust now had a training plan in place; the plan recognised the need for managers to factor in protected learning time to enable training completion.
- Most staff told us that their managers were visible, supportive, and approachable. Staff told us the chief executive officer facilitated regular staff briefings; they also told us and that the chief executive officer was available for individual staff discussions on a weekly basis.

## Vision and strategy for this service

- The trust had a five-year strategy plan in place, operational care groups had inputted into the plan.
- We saw there were clinical strategies in place for 2017-2022 within medical care, which were split into elderly care services, long-term conditions, and speciality medicine.
- We saw that the trust displayed their values on posters throughout the hospital. Staff knew of the values but were not always able to articulate them individually.

## Governance, risk management and quality measurement

- Monthly care group and divisional meetings took place. We saw divisional leads had presented information to the board on length of stay, quality indicators, risk registers, risk, and deteriorating patients. Senior staff told us they had weekly divisional huddle meetings.
- Quality improvement projects on discharge and hypoglycaemia in the elderly had been completed, these looked at specific areas, and how they could be improved. We saw that a task and finish group had been initiated to look at concerns and lessons learnt from the sub-optimal care of deteriorating patient serious incidents from 2015 to 2016.
- We saw that senior staff acted on key concerns, such as the deteriorating patient and infection control outbreaks. We saw actions were implemented and monitored to mitigate the risks. We met with the head of infection control, the medical director, and the director of nursing and were assured that the trust had managed an infection control outbreak effectively and that they were sharing lessons learnt with other NHS trusts.
- We saw that the medical department had its own risk register and senior staff knew what was on the register. There were sixty risks on the medicine and long term conditions risk register, risks included staffing levels, inadequate wi-fi connection to some ward areas, medicine storage temperatures in the summer and inadequate facilities to break bad news, all risks had an identified review date. Senior staff discussed risks and risk registers at care group meetings and these care group meetings fed into monthly divisional meetings. We saw the risk register included the risks we saw on inspection and was consistent with what we identified.
- Each ward had a performance dashboard where senior staff measured performance against trust targets. The dashboards also indicated if performance had improved, remained the same, or deteriorated.
- The trust had a medical advisory committee (MAC) whose role was to formulate and, or receive policies and procedures, to determine priorities for the development of medical and dental services within the wider context of the trust strategy, and receiving and considering reports and papers both internal and external. The committee met on a monthly basis and reported to the quality and safety committee.

## Culture within the service

# Medical care (including older people's care)

- Most staff we spoke with felt respected, valued, and were proud of the job they did. They were aware of the trusts' whistle blowing policy and how to access it if required.
- Staff spoke of good working relationships with colleagues and of teamwork to ensure the best outcomes for patients.
- Staff were proud of the work they did and of the improvements made to the service.
- Staff told us they were frustrated due to the continual reconfiguration of wards and that they did not know how long they would be in one place.

## Public engagement

- Matrons held focus groups called matron connect with patients and their carers in order to obtain their views, listen to their experiences and suggestions.
- The trust collated patients' views through the NHS Friends and Family Test. We viewed "you said we did" boards where staff had implemented change because of public opinion.

## Staff engagement







- Staff were involved in listening into action groups where they could share their views and concerns at a trust wide level and turn them into actions.

- Matrons told us they were invited to trust board meetings to present information from learning into action groups.
- Senior staff had set up whatsapp groups so staff could communicate with colleagues and managers.
- Staff participated in the national NHS staff survey; however, the trust did not publish individual core service data.

## Innovation, improvement and sustainability

- The hospital were piloting a new initiative, which saw pharmacy technicians being trained to complete medication rounds, if successful it was hoped this would free up some of the nurses time.
- The trust had implemented an observation first campaign. Clinical support workers were encouraged to take patient observations first prior to carrying out other duties. A deteriorating patient stamp was in use in patients' medical notes, this was in red ink to make it easy to see when a patient's condition had deteriorated and when escalation was required in line with the deteriorating patient policy.
- We saw that staff were now receiving training, including clinical updates on the deteriorating patient, which was an improvement since we last inspected in 2015.
- The diabetes and endocrinology department had been successful in securing funding for a two-year patient education service for patients with type-2 diabetes.

# Surgery

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Manor Hospital is the main acute site providing acute services for Walsall Healthcare NHS Trust.

The surgical service consists of four main care groups, which provides the public with musculoskeletal, general, and head and neck surgical procedures. The critical care unit is a part of the surgical division, but was not inspected under the surgical framework. Findings from the critical care unit are reported in the critical care section of the hospital's report.

The hospital provides inpatient and day surgery services for specialisms including ear, nose and throat, trauma and orthopaedics, breast and cancer services, general surgery including gastroenterology, urology and oral surgery.

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 three of which have laminar flow and associated areas for anaesthetics and recovery. The hospital had 100 surgical inpatient beds and nine day-case beds. There are 26 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 24 beds on the elective general surgery ward (ward 20b). The SAU has eight beds and 6 assessment chairs and the day case unit has eight beds.

We inspected the surgical services on 21 and 22 June 2017 as part of our announced inspection. We revisited unannounced on 5 July 2017.

The surgical team consisted of a CQC inspector and two specialist advisors, one consultant and one theatre practitioner.

During the inspection, we visited all of the surgical wards. We visited theatres and recovery in the new part of the hospital, the surgical assessment and day-case units, the arrivals lounge and the pre-assessment unit.

We spoke with 36 staff members and 12 patients. We observed patient care, documentation for trust processes such as cleaning rotas and safety checks, reviewed data sent through from the trust and nationally available data, and reviewed 15 medical records.

Since the previous inspection, staff told us about and we saw a number of areas where the trust had improved. Improvements included cleaning of theatres, staff awareness of the mental capacity act, consent processes, medical devices training, many improvements and initiatives to improve access and flow, and a stronger leadership.

# Surgery

## Summary of findings

During the last inspection in September 2015, we rated Surgery services as requires improvement across all domains except for caring which was rated good.

This was because;

- There was poor incident feedback to staff.
- There was a lack of regular night deep clean of theatres which compromised infection control processes.
- We found there was excessive storage of equipment and out-of-date equipment specifically in the children's surgery.
- We identified concerns relating to training on medical devices such as intravenous pumps.

Following this inspection we saw significant improvements to the responsive and well-led domains across surgery wards and theatres. However, we rated the service as requires improvement overall, because;

- Staff were not always managing deteriorating patients appropriately. Significant improvements were needed to ensure deteriorating patients were identified, escalated and reviewed by a doctor in a timely manner.
- There were significant issues with the hip fracture pathway, which was evident in poor audit results and data on patient outcomes.
- Staffing was an issue and skill mix was not always correct. There was high vacancy, turnover, sickness absence and agency rates, and a low fill rate at night. The service filled these gaps with agency and clinical support workers.
- Staff inconsistently completed trust documentation in patient records. We observed inconsistencies throughout the records with staff initials, signatures and job roles. Not all entries were legible.
- Safeguarding adults and children staff training compliance rates were low. Not all staff were trained to level 3 in safeguarding children, which is a requirement of the Intercollegiate document (2014).
- Mandatory training was not up to date, which saw none of the mandatory training modules achieving the trust's completion target of 90%.

- A lack of storage in theatres and on some wards meant items were not always stored appropriately. Intravenous fluids and nutritional drinks were not always protected from tampering and people who used services had access to razors and harmful chemicals.
- The service was still not meeting referral to treatment times and patient outcomes. Improvements had been made but there was still more to be done.
- The service was not fully compliant with the Accessible Information Standards.
- Staff morale was low in areas due to staffing levels and limited developmental opportunities for junior physiotherapists.

However:

- There was a good incident reporting culture. Staff understood the need to raise concerns and report incidents, and were supported when they did.
- Concerns and incidents were investigated appropriately, and lessons were learned, shared and acted upon. Improvements were made to the quality of care as a result of complaints and concerns.
- The service routinely monitored and collected data to ensure safety and effectiveness. There was involvement in relevant local and national audits.
- Quality and safety was monitored and used to identify where improvement was needed, and actions were taken as a result, working together with external stakeholders.
- The application of the World Health Organisation (WHO) checklist and five steps to safer surgery was appropriate and effective.
- Staff were active and engaged with local safeguarding procedures, and involved relevant organisations.
- Medicines were stored securely and appropriately.
- Staff were knowledgeable about consent and mental capacity. Consent and treatment was obtained appropriately and in line with legislation and guidance.
- There were robust governance processes in place and risk registers reflected risks across the division.
- The service took into account the needs of individual people. Processes were in place to remove barriers for those who found it hard to use or access services.

# Surgery

- The service planned and delivered people's care and treatment in line with current evidence-based guidance, standards and best practice.
- There were good processes in place to ensure discharge arrangements were safe, which included relevant specialist teams and took account of people's individual needs and circumstances.
- Multi-disciplinary teams were coordinated and collaborative to ensure good assessment, planning and delivery of people's care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Managers identified the learning needs of staff and supported them to deliver effective care and treatment through appraisals. Training was accessible to meet those learning needs.
- Staff treated people with dignity, respect and kindness involving people in their care and with making decisions.
- People's confidentiality, privacy and dignity was maintained and staff responded compassionately when people needed their help.
- Feedback from people who used the service was positive.
- The service had a clinically lead model with a clear vision and strategy that was focused on quality and patient safety.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- The service was transparent, collaborative and open with all relevant stakeholders about performance.

## Are surgery services safe?

Requires improvement 

We rated safe as requires improvement because:

- Staff were not managing deteriorating patients appropriately. Observations were not done in a timely manner, meaning patients were not identified or escalated appropriately. Patients were not always reviewed by doctors promptly once escalated.
- Staffing was an issue and skill mix was not always correct. The service had high vacancy, turnover, sickness absence and agency rates and there was a low fill rate particularly at night.
- Staff inconsistently completed trust documentation in patient records and not all entries were legible. We observed inconsistencies throughout the records with staff initials, signatures and job roles.
- Staff were not all up to date with mandatory training. Training data showed low uptake in most modules with none of the mandatory modules achieving the trust's annual target of 90%.
- Safeguarding training compliance rates were low for both medical and nursing staff.
- Storage was an issue in areas and we saw items were not always stored appropriately.
- Intravenous fluids and nutritional drinks were not always protected from tampering.
- Sharp and hazardous items were accessible to people who used services in some areas.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so.
- There was a good track record and evidence of steady improvements in safety.
- The service carried out appropriate thorough reviews or investigations that involved all relevant staff and people who used services.
- The service learned lessons and communicated them widely to support improvement in other areas as well as services that were directly affected.
- Medicines were stored securely and appropriately and staff took a proactive approach to safeguarding.



# Surgery

- There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- We observed staff carrying out the World Health Organisation (WHO) Checklist and the five steps to safer surgery appropriately and effectively.
- We saw five steps to safer surgery documentation completed appropriately in patient records.

## Incidents

- Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in surgery that met the reporting criteria set by NHS England between April 2016 and March 2017. This included nine pressure ulcers, four treatment delays, three diagnostic incidents, two venous thromboembolism (VTEs), one fall and one classified as 'other'. A VTE is a condition where a blood clot forms in the vein.
- There was a good incident reporting culture and staff were encouraged to report all incidents. Staff at the hospital reported 1,834 incidents in surgery between November 2015 and April 2017. The majority of incidents reported were recorded as no harm (58%), with 39% categorised as low harm, 2% moderate harm and less than 1% categorised as major or death. There was evidence that staff also reported near misses.
- Staff we spoke with told us they had access to the electronic incident reporting system. They were able to explain how to report an incident and gave a number of examples of lessons learned from incidents. Lessons involved improved practice in surgery and the implementation of policies and procedures.
- The hospital carried out serious incident reports in line with the National Patient Safety Agency NHS guidelines. There was evidence of lessons learned and duty of candour. Reports we reviewed were comprehensive and

included descriptions of the incidents, discussions with family members and relevant staff, identified learning points including shared learning points, and action plans to mitigate the risk of re-occurrence.

- Staff discussed incidents, mortality and morbidity in care group meetings. The hospital did not formally minute these meetings but staff recorded key points of discussion in action logs. We reviewed weekly action logs from 6 January until 31 March 2017 and saw evidence of mortality and morbidity discussions.
- All staff we spoke with were aware of duty of candour. They were able to explain the action they would take if an incident were to happen, which included a written apology to the patient, and what it meant.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

## Safety thermometer

- The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month and submitted within 10 days of the suggested data collection date.
- The hospital's surgical services used the NHS Safety Thermometer to monitor and record the prevalence of patient harms. Data from the Patient Safety Thermometer showed that the trust reported 19 new pressure ulcers (with variable rates over the year), five falls with harm and five new catheter urinary tract infections between April 2016 and April 2017 for Surgery.
- All the surgical wards we visited displayed patient safety information for the public and staff to see. These boards included a daily and monthly report on falls and pressure ulcers that had occurred on the ward. The board used a simple colour code to indicate good or bad performance as well as a print out of last month's performance in the form of pie charts.

# Surgery

- Senior nurses we spoke with told us they carried out themes and trends on safety thermometer data on a monthly basis and this was fed back to staff verbally at ward meetings.
- Staff were able to tell us about an initiative that resulted from safety thermometer data. This initiative came in the form of a campaign called 'Think Skin' and we saw leaflets for this campaign at the front of patient nursing care records. The campaign focused more on pressure ulcer prevention and better documentation.

## Cleanliness, infection control and hygiene

- Wards and departments we visited were visibly clean and tidy. There were hand gel dispensers at the entrance of the wards and at the end of patients' beds, and washing basins at the entrance of each bay. Staff we spoke with were aware of the importance of cleanliness and told us there were infection prevention and control policies that they were able to access on the intranet.
- There were no reported MRSA infections on all of the surgical wards in the last six-months. There was one reported C.diff infection in January 2017.
- Surgical wards displayed their performance in cleanliness and infection protection on a monthly basis. This included Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C.diff) numbers, as well as cleanliness scores for the ward. Staff screened elective and emergency patients for MRSA as required by the Department of Health.
- Staff screened elective patients in pre-assessment clinics, usually two to six weeks prior to surgery. Results were valid for six weeks after which the patient was re-screened if they had not yet received surgery. For emergency patients, staff screened for MRSA either in ED or in the SAU.
- The hospital carried out monthly hand hygiene audits for the surgical division. We reviewed audit results from November 2016 to April 2017. The trust's target was 100% with an acceptable compliance rate of 90%. Three of the six wards consistently scored 100% for hand hygiene for the six-month reporting period.
- The wards had infection prevention and control link nurses on wards who were responsible for attending infection prevention and control meetings and communicating learning and changes to the rest of the ward staff. They were also responsible for ensuring personal protective equipment compliance.
- The hospital had designated cleaning staff called housekeepers to clean wards. Cleaning equipment was stored appropriately and there were colour-coded bins for hazardous waste and general waste with clear labelling. The hospital used single use mop heads, cloths and fibre roll for cleaning.
- Designated cleaners cleaned theatres at the end of the day's theatre list and every six months the theatres had a deep clean by an external company, who stripped the theatres and cleaned all walls and ventilation.
- We observed theatre staff were completing cleaning rotas appropriately and in line with trust's policy. We saw ward staff were not consistently completing cleaning rota documentation, which meant it was not clear if staff always fulfilled their cleaning responsibilities.
- The service had standard operating procedures in place for preventing the risk of surgical site infections in theatres. The procedures were based on national guidance and legislation. Staff were aware of the procedures they needed to take and knew where to access the guidance.
- Theatres had appropriate arrangements in place for the separation of dirty and clean equipment. Equipment was sent to the hospital's sterilisation unit for sterilising and resealing. Staff disposed of single use equipment appropriately and in line with trust policy.
- Between March 2016 and March 2017, the trust reported 11 surgical site infections for the surgical division. Surgical site infections (SSIs) are a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. All SSIs cases were subjected to a root cause analysis (RCA) investigation.
- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2015 and 2016 for assessments in relation to cleanliness. The trust scored 99% in 2015 and 98% in 2016 against an England average of 98% for both years.
- The hospital carried out comprehensive monthly infection control audits of theatres, which looked at the environment, waste, personal protective equipment (PPE), sharps, equipment and dirty utility.



# Surgery

- We reviewed audit results for November 2016 for the West Wing Theatres and for the DTC Theatres. The trust's target was 85% and both sets of theatres were compliant. The only area that failed the audit was the scrub room for the West Wing Theatres (80%).
- The trust had an annual target of 90% for mandatory infection control training for medical staff and nursing staff within the surgery division. As at 31 March 2017, completion rates for the infection control training module were 64% and 72% for medical staff and nursing staff respectively.

## Environment and equipment

- The hospital had 11 operating theatres that were in use, three of which had laminar flow. Laminar flow is used for orthopaedic surgery procedures to reduce the risk of surgical infections.
- They had a dedicated bariatric theatre with equipment specifically for bariatric use and two dedicated emergency theatres.
- The recovery area had eight bays of which one was dedicated to paediatrics. The layout of the DTC theatres worked well and aided with patient flow.
- The hospital had a surgical assessment unit (SAU), which comprised of two separate bays, one male and one female, and one surgical assessment room. The bays each had six assessment chairs and four beds. The female bay was not visible to the nurses' station on SAU but it was in eye line sight of the nursing bay for ward 10.
- The SAU had recently undergone a necessary move of locations occupying one-half of ward 10. The trust was carrying out building work on the new intensive care unit on the floor above, which meant the ceiling of the original SAU had to be pulled down.
- Staff acknowledged that the move of the SAU was not ideal, as they had lost some bed capacity from both the SAU and ward 10. However, some staff spoke about the move being positive as decreasing staff levels on ward 10 were causing concerns. Both the loss of bed capacity and staffing of the unit and ward 10 were on the risk register.
- Storage was a problem in theatres and wards. The hospital had decommissioned one of the theatres to use as a storage room. On one ward in the older part of the hospital, we found the equipment rooms were cluttered with equipment waiting to go back to the equipment library. We also saw ward staff storing equipment in corridors and the end of bays. We did not see lack of storage on the risk register. The newer part of the hospital was clutter free, bright and airy and had plenty of room for storage.
- We observed a sluice on one of the wards in the new part of the hospital that did not have a lock on the door. Inside the sluice, there were razors and COSHH items stored incorrectly that could potentially cause harm to unauthorised people. We escalated this to the ward manager who assured us they would take remedial action.
- Surgical wards had one resuscitation trolley per ward, which were locked with tamper proof seals and secured to the walls. We saw staff carried out daily checks of the resuscitation trolleys and recorded checks appropriately in the log. We saw staff were breaking the seal weekly to check the contents of the trolley, which was recorded appropriately. We asked a staff member to break the seal and saw that all the items were present and in date.
- Each theatre we visited had two trolleys one of which was a difficult intubation trolley. Staff checked both trolleys daily and staff had signed the logbook accordingly. All theatre trolleys were securely stored with tamper proof seals.
- There was a paediatric resuscitation trolley and a difficult intubation paediatric trolley in the recovery area.
- The hospital had facilities to allow reasonable adjustments for patients with learning difficulties. Staff told us they allowed carers, parents or link nurses to go to anaesthetics with the patient and those patients were taken to a separate recovery where their carer, parent or link nurse waited for them to return and would be there before the patient woke up.
- The hospital carried out monthly environmental audits for the surgical division. We reviewed the audit results from November 2016 to April 2017. None of the six wards had consistently scored above 85% for the six-month period. The best performing wards were wards 20b and 20c. They scored above 90% for four of the six-month period and above target for five of the six-month period.
- The hospital had good processes in place for the maintenance of medical equipment and staff were aware of the process. Staff told us that medical equipment training was accessible and carried out face

# Surgery

to face. All ward staff had medical equipment training and helped train each other. All electrical and medical equipment we reviewed had been serviced within the previous 12 months

## Medicines

- Pharmacy support was available on each ward and available to nursing staff for advice on medically complex patients. Pharmacy support was present Monday to Friday fully staffed and on weekends with reduced staffing. There was a pharmacist on call at night-time to support wards. We saw evidence of medicines intervention and review by pharmacist in patient records that we reviewed.
- We reviewed 15 medical records, which included prescription and medicine administration charts. These charts included documentation of patient allergies and we saw staff completing this appropriately. The majority of the entries were legible and were signed and documented correctly.
- Medicines were stored securely in locked cupboards and fridges within locked clean utility rooms in the new part of the hospital. In the older part of the hospital, medical storerooms had doorframes but no doors.
- Most wards stored intravenous fluids and nutritional aids securely in locked rooms. However, on ward 10, staff stored intravenous fluids and nutrition drinks in the medicine storeroom in an unlocked rack. As this room had no door, these items were not protected from tampering.
- The hospital had a good process in place for pharmacy and stores re-stock. Staff told us if they run out of medicines or equipment, they call and the equipment is delivered to the ward.
- Delays in take home medicines (TTO) were not a general issue for staff. Staff said if requested early, pharmacy delivered the TTOs to the wards around 2pm. If requested a little later they would be delivered around 5pm.
- We saw patients had returned to wards to pick up TTOs after they had been discharged. A nurse explained that they would offer patients to go home if they did not need medicines straight away and return for TTOs instead of waiting around. This option was only offered to patients who were well enough.
- From April 2016 to March 2017, staff reported 139 medicine errors across the surgical division on the trust's internal incident reporting system. Of these reported errors, staff classified 72% as low harm and 25% as minor harm. The near miss and moderate categories both accounted for 1% each of the overall medicine errors reported. The most common incident staff reported was errors to medicine prescriptions, which accounted for 33% of the total medicine errors reported.
- Staff carried out daily fridge temperature checks and room temperature checks for storing medicines, and recorded temperatures appropriately. There were audits of temperature checks at the end of each month. We saw staff had inconsistently completed these audits across wards.
- Staff stored, checked and administered controlled drugs appropriately. Staff securely stored the medicine cupboard keys and all staff knew where to access them when needed.
- We reviewed controlled drug logbooks on a number of wards and saw that staff carried out checks on a daily basis, we did not find any gaps in CDs checks and signatures. There were monthly CD audits on CD checks but we saw staff had not consistently completed these audits across the wards.
- We observed nurses on medical rounds wearing red tabards with "do not disturb" on them so they were able to conduct their medicine round without being approached by other staff or the public.
- Medicine trolleys were stored in the clean utility rooms, which were controlled with key code access and were secured to the wall with lock and chain. The nurses did not leave the trolley at any time whilst on their drug round.
- We observed a number of antimicrobial protocols on the intranet that covered prescription, standards and restrictions for example. Staff were aware of these protocols and knew how to access them. The protocols were based on National Institute for Health and Care Excellence (NICE) guidelines, Scottish Intercollegiate Guidelines Network (SIGN) and local sensitivity research.
- The hospital had a self-administration policy for medicines. Staff knew where to access this policy and told us that patients needed to sign a consent form to allow them to self-administer and that it was usually used for insulin rather than regular pain relief. Staff told us that patients did not need to fill out a consent form for inhalers for patients with asthma.

## Records

# Surgery

- Medical patient records and nursing records were stored separate and were both in paper form. Some of the assessments that staff would normally record in the nursing records were held on an electronic observation system. There was another electronic patient management system which included results and letters from clinics. The staff hoped in the near future that this system would also include referral letters from external organisations, such as patients' GPs.
- We reviewed 15 patient records and found areas that required improvement. For example; we saw inconsistencies throughout the records with staff initials, signatures and job roles. Some entries had signatures only, some entries had initials or printed names only, some entries had job roles alongside signatures and some did not.
- We saw some mistakes in nursing records crossed out with no initials to verify the alteration. Most entries were legible with a few that were illegible. A few were only signed, there was no name printed so it was not easy to determine who the person was that had written the entry.
- We saw records where staff had not completed assessments appropriately. We noted a number of records where the perioperative skin assessment document had not been completed. We also noted that a trust document they called KMR1 that stated needed to be completed on every patient episode was not being completed fully. We saw one set of records where the patient had been placed on the fractured neck of femur pathway. Staff had not completed a number of the pages within the care pathway booklet.
- Some of the risk assessments for patients were held on the electronic observation system and some were in paper format. We reviewed some records that still had the paper form for some assessments and notes from staff to say, "See Vitalpac" so staff knew it had been done and was recorded in a different place. This was not universal across all surgical wards. Records we reviewed had the assessment forms present with no note, or did not have the assessment form present at all.
- Staff told us that patients were not able to go to theatre if they had not had a venous thromboembolism (VTE) assessment carried out.
- The electronic patient observation system flagged red with a 'v' symbol if the patient was due their assessment. The system flagged patients who had just moved to a different ward so nurses would see they had to have their assessments done again.
- There were diagnosis and management plans present and consent forms that were signed by patients both before the day of the procedure and on the day of the procedure. In elective surgical patient notes, we saw evidence of good pre-operative assessments.
- The hospital was using the five steps to safer surgery version 9. They carried out monthly audits using 10 random records a month. Audit results showed that staff were carrying out the WHO checklist and five steps to safer surgery in line with good practice. We saw staff were completing this checklist in records we reviewed.

## Safeguarding

- Safeguarding training for the surgical service saw low completion rates that did not meet the trust's annual target of 90%.
- As at 31 March 2017, only 20% of medical staff and 33% of nursing staff within surgery had completed safeguarding adults level 2. Safeguarding adults level 3 had a completion rate of 41% for nursing staff and 2% for medical staff within surgery.
- There were 56% of medical staff and 61% of nursing staff within surgery who had completed safeguarding children level 2. Safeguarding children's level 3 had a completion rate of 60% for nursing staff. All professional staff working with children should be trained to level 3 as per the Intercollegiate document (2014). The only safeguarding training course that met the trust's target was for safeguarding children level 1 for nursing staff with a 100% completion rate.
- The trust's mandatory safeguarding training included FGM, and the trust's task and finish group were working on updating the trust's FGM policy and clinical pathways.
- All staff we spoke with showed an awareness of safeguarding. We saw examples of where staff were concerned about patients' welfare and had triggered a safeguarding referral section two, which included involvement from a social worker.
- Staff told us if they had safeguarding concerns they would send a referral to the safeguarding team who would support them. They all knew who the

# Surgery

safeguarding lead was and were all positive about the support they provided. All staff we spoke with knew where to access the safeguarding policy on the trust's website.

## Mandatory training

- The trust had a mandatory training programme that consisted of six main modules. These were conflict resolution, equality and diversity, fire safety, infection control, information governance and patient handling. The trust set an annual target of 90% for completion of mandatory training, which none of the modules had achieved.
- As at 31 March 2017, the lowest completion rate for medical staff within surgery was for information governance with 42% and the highest completion rate was for patient handling with 83%.
- The trust met training completion targets for nursing staff within surgery for patient handling. From the other five modules, the lowest completion rate for nursing staff within surgery was 41% for information governance and the highest was 78% for equality and diversity.
- Staff told us that the hospital provided most of the mandatory training via eLearning. Medical equipment and manual handling training was conducted face to face and the wards had manual handling champions to support staff in their day-to-day wards.
- Staff we spoke with told us that training was well organised and the content was sufficient for their job roles. The hospital sent staff an email when their mandatory training was due to expire.
- There was no specific training for sepsis; instead, sepsis was covered within the deteriorating patient escalation policy. Staff were aware how to access this policy and were knew when to screen for sepsis and when to trigger the sepsis pathway.

## Assessing and responding to patient risk

- The hospital used an electronic observation system, which recorded a national early warning score (NEWS) based on the patient observations that were input into the system.
- The system automatically produced a NEWS score and the time between observations would automatically update dependent on the NEWS score derived. The system would alert the nurses when patients were next due their general observations.

- The NEWS is a guide used by medical services to determine the degree of illness of a patient quickly. It is based on a simple scoring system in which a score is given to six vital physiological measurements that nurses routinely take on admission and when monitoring patients. The higher the score the more acutely ill the patient is.
- There are actions that staff should take when patients present with scores above a certain level. These included increasing observations so patients were monitored more closely and more often, to escalation to consultants for review.
- Patients who had a NEWS score of above five were placed on the deteriorating patient pathway and had a red stamp placed in their notes. This stamp had space for the staff member who was escalating to fill out the time and date of escalation, along with the patient's NEWS score, the staff members name and the name of the person they escalated to. There was also space for the reviewing consultant to put their name and the time and date that they reviewed the patient.
- Surgical consultants we spoke with told us that medical geriatric consultants provided input in patients who were elderly and had complex medical needs.
- The hospital had good processes in place for theatres in case of emergencies. During team briefs at the start of surgery lists, staff were allocated a role they should undertake in case of emergencies during surgery. Theatres had alarms staff could ring if there was an emergency and there was an urgent phone number theatre staff could call if a consultant or registrar was needed to attend.
- At the time of our inspection, the emergency alarm in a number of theatres was not working. The trust were aware of the issue, they had arranged for the issue to be resolved and had put things in place in the interim.
- The hospital was using the five steps to safer surgery. The five steps to safer surgery is a surgical checklist that involves briefing, sign-in, timeout, sign-out and debriefing. The checklist requires items to be checked at three points of the patient journey through theatre, the sign-in, before the start of surgical intervention (timeout), and before any member of the team leaves the operating theatre (sign-out).

# Surgery

- We observed staff carrying out the World Health Organisation (WHO) Checklist and the five steps to safer surgery appropriately and effectively. We saw five steps to safer surgery documentation completed appropriately in patient records.
- We witnessed an example of where the surgical checklist worked and prevented a never event. A member of staff noticed an anomaly between the NHS number written on the consent form and that on the patient's wristband. The surgery was stopped and did not continue until the surgical team were able to confirm the patient on the table had consented to the procedure. Staff reported the incident as a 'near miss' straight away.
- The hospital had a sepsis pathway that included the use of an inpatient sepsis screening and action tool based on the national sepsis six from The UK Sepsis Trust. Staff were trained in sepsis and were aware of when to trigger the sepsis pathway. Each ward had a sepsis box that contained all the equipment needed to treat patients identified as having sepsis.
- The hospital audited the management of deteriorating patients 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.
- Other measures in the deteriorating patient audit showed significant improvement towards the end of the 2016/2017 years. These were for percentage of notes that contained a record of the patient's trigger score when above five, and the percentage of patient records with a record of nursing staff escalating to doctors.
- The review also identified an over establishment of care support workers. However, due to the vacancies the trust was experiencing for registered nursing, the over establishment of care support workers had helped to alleviate some of the pressure.
- Wards displayed ward staff establishments on the information board for patients and visitors to see. This included actual staffing levels for the shift next to the figures of the staff they should have on shift.
- We reviewed actual versus planned nursing staff figures for December 2016 to March 2017, which showed a low fill rate at night for wards 9, 10 and 11. The hospital had a higher than planned fill rate for other care staff to compensate for the nursing gaps, which meant not all shifts had the correct skill mix present.
- The SAU was staffed with two registered nurses with a senior nurse coordinator. The registered nurses were supported by a health care assistant. The shift patterns for SAU were long day shifts from 7am to 7.30pm. When demand was high, the SAU was kept open overnight. When this happened the staff on ward 10 looked after the SAU and requested an agency nurse to help with the extra capacity.
- Agency staff we spoke with told us they had a local induction at the start of their first shift. There were no formal competency checks for agency staff on the wards, the senior ward staff told us the trust's nursing staff booking department ensured that agency staff being booked met the trust's requirements. Senior staff on some wards told us they had block booked regular bank and agency to help meet the establishment.
- Handovers between nursing staff were structured and the nurse discussed each patient they were looking after and handing over. Nurses discussed where the patients were regarding their treatment plan, whether the patient had a slot for surgery and what arrangements were in place for patients who were due to be discharged. Handovers took place at the start and end of shifts.
- Most staff we spoke with said that staffing was an issue and at times, they felt that they "were rushed off their feet." They told us that there was a lot of agency usage and many staff would do bank shifts because there was not enough substantive staff to fill the gaps. They were aware of the trust's recruitment programme and knew that there had been more appointments of nursing staff. All staff we spoke with were looking forward to the new nursing staff starting.



# Surgery

- Patients we spoke with felt there was generally enough staff to meet their needs during the day but felt at night time there was not enough staff, which meant at times they had to wait longer for staff to answer their call bells. One patient told us, “The staff do an amazing job, there is just not enough of them. I get emotional thinking about how stretched they are.” Fill rate data the trust provided supported patients’ views.
- As at 31 March 2017, the hospital reported a vacancy rate of 18.5% for nursing staff in the surgical division. The trust had an overall target rate for turnover of 10% and as at 31 March 2017, the hospital reported a rate (9.6%) that met the trust’s target.
- The trust had an overall target rate for sickness of 3.4%. As at 31 March 2017, the hospital reported a sickness rate (4.9%) that did not meet the trust’s target. Between April 2016 and March 2017, there were seven areas within the surgical division where the sickness rate was higher than the trust’s target.
- In the same period, the hospital reported an average bank and agency usage rate of 19.4% in the surgical division.
- Patient ward rounds happened daily and included a medical handover from the nightshift consultant to the dayshift consultant. The handovers were structured, well-detailed and included relevant staff from multi-disciplinary teams.
- In January 2017, the proportion of consultant staff reported to be working at the trust was lower than the England Average and the proportion of junior (foundation year 1 to 2) staff was higher. The trust reported that 38% of their medical staff were consultants against an England average of 44%, and 19% of their medical staff were junior against an England average of 10%. The rest of the medical workforce included staff within the registrar group and at the middle of their career.
- As at 31 March 2017, the hospital reported a vacancy rate of 10.1% for medical staffing in the surgical division, which was in line with their target. Medical staff turnover rates were higher than the trust’s target and the trust used on average 12.4% of bank and locum medical staff between April 2016 and March 2017. The sickness rate for medical staff (2%) met the trust’s target (3.4%).
- Information regarding locum arrangements or induction was not available.
- Medical staff we spoke with generally said that there was a shortage of staff in areas, but felt they had great support regardless of staff shortages.
- Staff expressed their concerns around shortages of middle grade anaesthetists, which was having a negative impact on the service they were able to provide as a department. They said that they were not able to assess all the patients that they should be assessing due to staff shortages.

## Surgical staffing

- The hospital had newly restructured the management structure of the surgical services to move towards a clinically led service. Consultant presence was seven days a week using a ‘hot week’ system, where a consultant per speciality covered for the whole week on-site during the day and on-call during the night.
- Junior doctors we spoke with told us that consultants were easily available when they needed and that they were well supported by consultants both during the day and at night. The trust operated consultant cover per care group across the surgical division.
- Ward based Foundation year level 1 (FY1) doctors, with either a Foundation Level 2 (FY2) doctor or consultant covered wards every day from 8am until 4.30pm, with support from a registrar if needed. Consultants from other specialties were available onsite seven days a week with varying hours depending on speciality.
- Theatres were supported by middle grade doctors 24-hours a day, seven days a week and a general emergency theatre consultant was on-site from 8am to 6pm, then on-call from home outside of these hours.

## Major incident awareness and training

- The hospital had major incident plans in place and staff were able to tell us what these were and where to access them.
- Although the trust provided staff with major incident training, the uptake of this training was very low and failed to meet the trust’s target of 90% completion. Information the trust provided showed that at Walsall Manor Hospital, 56 out of 188 eligible staff (30%) had completed major incident training as at 31 March 2017.
- All staff we spoke with were aware of the trust’s major incident and business continuity plans. They told us the plans were accessible on the intranet and some staff had printed off hard copies.

# Surgery

- Senior staff told us that the care group managers would allocate senior nurses positions if a major incident were to occur. Staff told us that since the country had been on high alert, the hospital had made all of the wards buzzer access so staff could control who came in and out of the wards.
- The hospital had good processes in place for deferring elective activity to prioritise unscheduled emergency procedures. There was no formal documented escalation protocol but staff would manage emergency cases through monitoring capacity and flow and having discussions with the clinical directors.
- Elective gaps were identified the week before so consultants knew where the gaps were a week in advance, and there was a Friday plan for the weekend, followed by a Monday morning capacity meeting to prepare for the week.

## Are surgery services effective?

Requires improvement 

We rated effective as requires improvement because:

- People were at risk of not receiving effective care and treatment in some specialities.
- Outcomes for people who used services were not always meeting national standards or achieving expected results.
- There were significant issues with the hip fracture pathway. Outcomes for patients were poor in the Hip Fracture Audit 2016 and PROMs 2015-2016.
- The proportion of patients treated with curative intent in the strategic clinical network was significantly lower than the national aggregate.
- There was higher than expected risk of readmission for both elective and non-elective surgical admissions compared to the England average.
- There was little evidence of continual malnutrition assessments after a patient's initial assessment on admission.
- There was potential for causing delay in accessing all relevant information in a timely manner due to the way in which information about a patient was held.
- There were no formal pathways in place for patients who were critically ill following an admission to intensive care.

However:

- The hospital planned and delivered people's care and treatment in line with current evidence-based guidance, standards and best practice.
- People received coordinated and collaborative care from a range of different staff, teams and services.
- Staff assessed people's pain needs appropriately and in line with best practice. A specialist pain team supported staff and people with complex medical needs.
- Discharge plans took account of people's individual needs, circumstances, ongoing care arrangements and expected outcomes.
- Information was accessible to GPs and community teams and social services were involved for people with complex needs.
- Consent to care and treatment was obtained in line with legislation and guidance and staff supported people to make decisions.
- The service monitored the process for seeking consent appropriately.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Managers supported staff to deliver effective care and treatment through appraisals. They identified the learning needs of staff and training was accessible to meet those learning needs.
- There was participation in relevant local and national audits, including clinical audits as well as benchmarking.

### Evidence-based care and treatment

- The hospital based their policies and pathways on National Institution for Health and Care Excellence (NICE) guidelines.
- Staff carried out assessments in line with NICE guidelines. Staff monitored and managed acutely ill patients using the National Early Warning Scores (NEWS), which they recorded on an electronic patient management system. The system automatically adjusted the regularity of observations dependent on the NEWS and alerted staff when observations were due. The escalation process for deteriorating patients was in line with national guidance (NICE CG50).
- Venous thromboembolism (VTE) assessments were carried out pre-operatively, which staff recorded on an electronic patient management system. Staff told us that patients required a new VTE assessment each time



# Surgery

a patient moved wards or if the patient had not gone for surgery within 48 hours of their assessment.

Assessments were in line with national guidance (NICE QS3 standard 5).

- There was no formal pathway for patients who were critically ill but there were processes in place to ensure patients were supported adequately. The registrars and consultants on the intensive care unit decided whether patients were well enough to be cared for on the wards. The nursing staff on ITU came to the ward with the patient to give a comprehensive handover to the ward staff. The outreach nurses then reviewed the patient on a daily basis until the patient was discharged from hospital.
- Patients on intravenous fluid therapy had their fluids prescribed by consultants or junior doctors. All patients on wards had their fluid balance checked as part of the daily nursing care record regardless of whether the patient was on IV fluid therapy.
- Staff told us they used dipstick testing on the wards if a patient was showing signs of infection and if the dipstick test showed there was an anomaly, a urine sample was sent to the laboratory for testing. Men with urine infections on the ward were referred to urology and patients who were on antibiotics that were not clearing up an infection had urine cultures carried out (NICE QS90).
- The hospital had reviewed and developed a new Sepsis pathway within the previous 12 months. The new pathway involved the use of an inpatient screening and action tool based on the sepsis six in accordance with The UK Sepsis Trust.
- Staff were knowledgeable about the pathway and knew what actions they needed to take. Staff told us that if a patient triggered a score of three or more staff tested patients' lactate levels and blood results. If these were out of range, the staff triggered the pathway. Each ward had a sepsis kit box, which contained everything staff needed to treat a patient with suspected sepsis.

## Pain relief

- Staff asked patients about their pain during vital observations. The electronic patient observation system had a scale of 0-3 where zero was no pain, one was mild, two was moderate and three was severe. Staff told us they asked if patients were experiencing mild,

moderate, and severe or no pain instead of a numbered scale. For patients with low functioning learning disabilities or dementia, staff used the Abbey pain scale to assess patients' pain and discomfort.

- The hospital had a dedicated pain team, which included a specialist pain nurse and a specialist pain consultant. The hospital was in the process of securing an additional pain consultant to add to the team.
- Staff on the wards told us they could contact the specialist pain nurse via a bleeper, the specialist pain nurse then attended the ward to support the ward staff. Staff told us the specialist pain nurse liaised with patients and reviewed their pain medication to use an alternative or see if any medication could be given via a different route.
- The specialist pain nurse audited pain management biannually. Staff told us the specialist nurse identified any training needs for staff on the wards related to pain management and referred staff for extra training.
- All patients we spoke with were satisfied with their pain relief and said that staff checked on their comfort regularly.

## Nutrition and hydration

- The hospital used a national malnutrition tool called the Malnutrition Universal Screening Tool (MUST). Staff told us the MUST was completed for patients on a weekly basis. We saw that staff were initially completing MUST assessments on admission but there was little evidence of continual assessment. We saw staff took appropriate actions when MUST scores were high.
- Staff monitored fluid balance for all patients not just those patients who received fluid therapy. We saw staff were completing fluid balance charts daily and appropriately.
- Staff effectively managed nausea and vomiting following surgery. The electronic patient observation system prompted staff to assess nausea or vomiting post-surgical procedures.
- Staff said if patients suffered with nausea or vomiting they treated with an anti-sickness medicine. There was no scale for nausea or vomiting, however if the patient was not feeling better within 30 minutes of anti-sickness administration, the nurses requested for the doctor to review the patient.
- The hospital designated consultant dietitians per area. Patients who did not have a functioning gastrointestinal tract and required total parenteral nutrition (TPN) had

# Surgery

daily reviews from the nutrition team. Staff told us the nutrition team and consultant dietitians worked proactively with nutrition plans for patients undergoing gastroenterology surgery.

- Doctors prescribed saline for patients when diet and fluids were restricted, unless the patient had a low blood pressure in which case they prescribed a crystalloid solution (PlasmaLyte dex saline).
- The surgical wards had protected meal times and rest time for patients after lunch. We observed meal times and saw little to no visitors present, however the trust did not audit the protected times.

## Patient outcomes

- People were at risk of not receiving effective care and treatment in some specialities. Patient outcomes were variable between specialties and particularly bad for patients with hip fractures.
- The trust did not perform well in the 2016 Hip Fracture Audit. The audit showed that 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 whereas the national standard was 85%.
- The trust also did not meet the national standard for perioperative surgical assessment rates although it did perform better than the national average (86.2%). The national standard is 100% and the trust achieved 91.5%.
- The trust fell in the worst quarter of trusts for length of stay, which was 25 days. The last two measures on the audit showed the trust performed within expected range for the risk-adjusted 30-day mortality rate (6.8%). The proportion of patients not developing pressure ulcers was 98.4%, which was about the same as other trusts.
- In the Patient Reported Outcome Measures (PROMs) survey, patients were asked whether they felt better or worse after receiving groin hernias, varicose veins, hip replacements and knee replacements.
- In the 2015/2016 PROMs survey, the trust performed worse than the England average for hip replacements and there was a mixed performance for varicose veins. The trust was about the same as the England average for groin hernias and knee replacements. The trust saw more patients than the England average reporting feeling better, but also more patients than the England average reporting feeling worse after their procedure.
- The trust did not perform well in the 2016 Oesophagogastric Cancer National Audit however, it is noted that the hospital did not carry out surgical procedures for patients with this type of cancer. The trust provided poor quality data for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicated that more than 15% of records had the referral source missing.
- The proportion of patients treated with curative intent in the strategic clinical network was 34.7%, which was significantly lower than the national aggregate. This metric is defined at a strategic clinical network level, where the network can represent several cancer units and specialist centres. The result can therefore be used as a marker for the effectiveness of care at a network level. Better cooperation between hospitals within a network would be expected to produce better results.
- Between January 2016 and December 2016, patients at Manor Hospital had a higher than expected risk of readmission for both elective and non-elective admissions compared to the England average.
- At individual specialty level, readmission rates were higher for elective and non-elective general surgery, elective urology and non-elective trauma and orthopaedics. Rates for non-elective urology were similar to the expected rates and rates for elective trauma and orthopaedics were slightly lower than the expected levels.
- The trust participated in a number of national audits with a variable performance across specialties.
- The 2016 Bowel Cancer Audit showed a trust performance that was generally in line with national averages. The audit identified that the percentage of patients (79%) with a length of stay greater than five days after major resection was worse than the national aggregate and worse than the previous 2015 figure (72%). All other measures reported fell within the expected range.
- The trusts performance in the National Laparotomy Audit 2016 was variable with some measures performing not so well and others performing well. They achieved a red (<50%) rating for the crude proportion of cases with pre-operative documentation of risk of death based on 106 cases, this was much worse than the national average.

# Surgery

- The hospital achieved an amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames, based on 83 cases, which was worse than the national average.
- The measures where the hospital performed well were for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in theatre, based on 60 cases the hospital achieved a green rating (>80%), which was better than the national average.
- The hospital monitored comparative outcomes by clinicians through national audits such as the National Emergency Laparoscopy Audit. They did not compare mortality and morbidity per consultant due to small numbers, which causes statistical variances and make it difficult to monitor.
- Mortality and morbidity was instead assessed in quality and safety meetings. Surgical site infection rates were compared per care group on a monthly basis.

## Competent staff

- As at 31 March 2017, 87% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%. The staff group with the lowest appraisal rate was allied health professionals with only 63% of staff having had an appraisal. The medical and dental staff group had an appraisal rate of 89% and the nursing and midwifery staff group had an appraisal rate of 85%.
- Staff we spoke with thought their appraisals were effective. They told us that they discussed how they felt they were performing, identified development needs and study sessions that would benefit as well as having feedback from their manager and giving their manager feedback.
- Staff we spoke with told us their line managers supported them with gathering evidence for their revalidation. The trust supplied their policy and procedure documents which were in date. The documents detailed the responsibilities of line managers and the individual in ensuring that they collected appropriate evidence and placed in the individual's portfolio. The trust outlined its responsibility to monitor revalidation.
- Revalidation is the process by which licensed doctors and registered nurses are required to demonstrate on a regular basis that they are up-to-date and fit to practice. Revalidation aims to give extra confidence to patients that the trust and the General Medical Council regularly check doctors, and the trust and Nursing Medical Council regularly check their nurses.
- Staff told us that for procedures they do not carry out on a regular basis they were required to undertake a competency check for example, some medical equipment sign offs. All competencies were recorded on the electronic staff record system, which generated a letter every six months to staff members letting them know the competencies that were due.

## Multidisciplinary working

- We observed good internal multidisciplinary team working between ward staff and specialty teams. Handovers included relevant staff to discuss individual patient treatment plans. Physiotherapists and occupational therapists attended wards daily and there was a pharmacy support based on the ward.
- Staff were able to access specialist input when necessary, which included the safeguarding team, pain management team and palliative care team. All staff we spoke with felt they were well supported by internal speciality teams and felt the communication and relationships with other teams was strong.
- We observed a good team-working ethic between consultants from different specialities. The surgery consultants held a weekly meeting with the geriatric consultants to support surgical teams with treatment plans for elderly patients. Staff told us that geriatricians reviewed 92% of elderly patients treated by the surgical division.
- The hospital had a service level agreement with another local trust for neurological and spinal traumas. There was an electronic referral system staff used to refer patients and to seek specialist advice. Staff we spoke with said this system worked well and they received specialist advice quickly.
- In February 2017, the trauma and orthopaedics care group held a combined group work-stream with the clinical commissioning group and general practitioners (GPs) in the local area. In this meeting, they looked at pathways and the need to involve GPs more in elective and emergency pathways. They also looked at patients with comorbidities including those patients with a body mass index (BMI) above 35.
- The hospital had a service level agreement with a consultant employed at another local hospital to help with the backlog in oral surgery.

# Surgery

- Discharge arrangements for elective patients were discussed in clinical assessments prior to surgery taking place. Emergency patients discharge plans were incorporated in daily ward and board rounds and included relevant staff and specialist teams for example, social services and occupational therapists.

## Seven-day services

- The hospital had 24-hour, seven days a week consultant presence where they were on-site during the day and on-call off-site during the night. Junior medical staff we spoke with said they felt well supported by the consultants and that the consultants were very approachable at all times.
- Consultants carried out daily ward rounds and we saw in the records we reviewed that patients were being seen as soon as possible and within 14 hours of arrival.
- Elective surgical lists generally ran from Monday to Friday 9am until 5.30pm. The hospital had waiting list initiative lists running all day on either a Saturday or a Sunday. For trauma surgical cases, lists ran on an afternoon Monday, Tuesday, and Wednesday, all day on Thursday and Friday and Saturday and Sunday mornings. There was a 24-hour a day, seven days a week emergency theatre.
- Physiotherapist service ran on Monday, Thursday, and Friday from 8am to 6pm, Tuesdays and Wednesday from 8am to 4pm. There was a reduced physiotherapy service on weekends for emergency patients or patients that were not reviewed on the list for the previous day. The hospital had a respiratory physiotherapist who was on call 24-hours a day, seven days a week.
- Pharmacy services support was present Monday to Friday fully staffed and on weekends with reduced staffing. There was a pharmacist on call at night time to support wards. We saw evidence of medicines intervention and review by pharmacist in patient records that we reviewed.
- Radiology services operated seven days a week. Staff on wards were able to request portable x-ray machines 24-hours a day, seven days a week. Staff said they did not have an issue with the radiology service on a weekend but did struggle with porters to take patients to the radiotherapy department on weekends.

## Access to information

- Patient records were paper based and electronic with medical and nursing records in separate folders. Some assessments were held electronically on a patient observation system and others were still in paper format.
- This arrangement had the potential for causing delay in accessing all relevant information in a timely manner due to the way in which information about a patient was held, particularly for temporary staff. This was due to some wards inconsistently retaining duplicate paper copies of assessments that were held on the electronic patient record system. We saw that where the duplicate paper copies were retained they were inconsistently completed. On some wards we saw paper copies were completed in full, others were not completed and left blank, and others had a line through with 'see Vitapac' written across. However, staff we spoke with said they did not have an issue with accessing information.
- There were good systems in place for requesting patient records from storage to the wards. Staff we spoke with said patient records were easily accessible. Information held under patients on the electronic system was easily accessible for staff to see patient assessments and the system allowed patients to easily be transferred to other wards.
- There were good systems in place for ensuring the hospital sent relevant information to GPs and to patients about their surgery, which included implant information. Staff could print discharge summaries off the system for patients and the system had the ability to send discharge letters electronically and directly to GPs in the Walsall area.
- Patients who were with GP practices outside of Walsall had their discharge letters sent via post. All patients were given information leaflets about their surgery along with a discharge letter addressed to them.
- Staff told us that GPs had direct access to consultants and registrars via the telephone. A list of medicine changes were communicated to GPs and relevant staff at care homes at the end of the discharge summary that was sent out on discharge.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with had good awareness of Deprivation of Liberty Safeguards (DOLs) and the mental capacity act (MCA) and told us they had received

# Surgery

training. The hospital had DOLs champions and had processes in place to support staff if they needed. Staff were encouraged to report DOLs on the internal incident reporting system.

- There were good processes in place for gaining consent from patients prior to surgery. We saw consent forms signed and dated in pre-assessment clinic records and further consent forms signed and dated from the day of surgery. Staff told us if a patient lacked capacity, they would contact the safeguarding lead for advice. They said when appropriate they would make best interest decisions for patients.
- We saw appropriate staff talking patients through a consent form and providing patients with information leaflets about their surgery. We saw that patients were given a reasonable amount of time to digest information before being asked to sign the consent form.
- The hospital audited their consent processes after the last inspection where concerns were raised around consent. Actions from audit results included the use of a specialist organisation with expertise in informed consent to review all of the hospital's consent policies and to help with resources, such as patient information leaflets, to ensure they were meeting the national requirements for informed consent. Senior staff told us that all staff gaining consent had to undergo training from the specialist organisation.
- We saw one set of records for a patient deemed to lack mental capacity. Staff had followed correct processes and had sought a signature of the lasting power of attorney (LPA). However, the LPA had not completed the documentation correctly; there was no printed name or date next to the LPA signature. This meant it was not clear who the LPA was.
- There was a good uptake of MCA and DOLs training. As at 31 March 2017, 77% of medical staff and 96% of nursing staff within surgery had completed MCA training and 79% of medical staff and 97% of nursing staff within surgery had completed DOLs training.

## Are surgery services caring?

Good



We rated caring as good because:

- Feedback from people who use the service was positive. People were treated with dignity, respect and kindness and staff showed they cared about people. We observed a number of patients returning to wards to catch up with staff, staff were visibly thrilled to see them and the progress they had made.
- People were involved with their care and making decisions. Staff spent time to talk to people in a way they understood.
- Staff took patient confidentiality seriously and maintained privacy and dignity of people throughout their stay.
- Staff responded compassionately when people needed their help. Staff helped people and those close to them to cope emotionally with their care and treatment. People were enabled to manage their own health and care when they could to maintain independence.

### Compassionate care

- The trust participated in the national NHS Friends and Family Test (FFT) and saw a response rate for surgery of 40%, which was better than the England average of 29%. Scores for surgical wards were generally high from August 2016 to January 2017, with no wards scoring below 89%. Ward 20a and ward 9 saw the highest response rates (53%) and consistently scored 100%. All wards we visited displayed their FFT results on the public notice boards.
- We observed staff showing an encouraging, sensitive and supportive attitude towards patients. Staff were encouraged to report all incidents including concerns about disrespectful, discriminatory, or abusive behaviour.
- Staff ensured that patients' dignity and privacy was protected by closing the curtains around patient beds when carrying out any treatment or when discussions were being held about their treatment. Handovers were held in staff only rooms with the door closed. Patients we spoke with told us that staff were always very respectful and maintained their confidentiality.
- Patient-led assessments of the care environment (PLACE) 2016 reported privacy and dignity for the trust as 83%, which was the same as the England average score.
- We observed staff responding to patients in a compassionate and appropriate way when patients



# Surgery

were experiencing pain, discomfort, and emotional distress. Patients told us that staff regularly took the time to sit with them when they were feeling low to listen to them and make them feel better.

- All patients we spoke with were positive about the care and treatment they received by staff. Two patients said, “The staff do so much considering there are so little of them.” We saw a number of patients returning to wards to visit the staff. Staff were visibly thrilled to see the patients and the recovery patients had made.
- Staff supported people using services to be mobile and independent post-operatively by referring patients directly to physiotherapy straight after their operation when required. On the elective wards, staff encouraged patients to get out of bed, washed and dressed everyday as part of their rehabilitation and to make patients feel less clinical and more homely.

## Understanding and involvement of patients and those close to them

- We observed staff explaining conditions and treatment plans to patients in a manner that the patients understood. Staff recognised when people who used services needed additional support to help them understand and be involved in their care and treatment. All patients we spoke with said they understood what their treatment and surgery involved and that their views and opinions were taken into account.
- Staff told us that patients with learning disabilities had a “This Is Me” booklet to help staff understand their needs. Carers and relatives were able to stay with patients with learning disabilities and complex needs outside of visiting hours and were involved in the patient’s treatment plans. We saw discussions with patients and family members recorded in patient records.
- We saw staff giving patients information leaflets about the surgery they were having and sitting with patients to go through these leaflets with them. Staff gave patients the opportunity to ask questions about their care and treatment.
- Staff involved those close to patients so that correct clothing could be brought into hospital ready for the patient’s discharge.

## Emotional support

- Staff told us the service was able to provide emotional support for those patients who needed it. We saw nursing staff providing emotional support to patients on the ward and were told they were able to refer patients to the psychiatric team if required.
- Staff said the psychiatric team was easily accessible and that they had good support from the team. Patients we spoke with felt that staff gave adequate importance to their emotional needs as they did to their physical needs.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. We saw a staff member taking the time to sit with a patient who was struggling emotionally with their condition. The staff member sat next to the patient and listened to them, showing them appropriate affection.
- The hospital had a chaplaincy team who were able to provide spiritual care for patients and staff at the hospital. The team were supported by a large group of volunteers who visited patients on the wards or brought them to services at the Chapel and sacred areas.
- The four main religions in Walsall were Christianity including Roman Catholic, Muslim, Sikh, and Hindu. Chaplains were able to provide services for all four of the main religions as well as supporting people of all beliefs and backgrounds.

## Are surgery services responsive?

Good



We rated responsive as good because:

- The service had responded to poor performance with their referral to treatment times and was working together with local stakeholders to improve performance. This included the development of care pathways and a virtual clinic, the utilisation of the SAU and day-case unit, the improved efficiency of the arrivals lounge and weekend initiative surgical lists.
- There were good processes in place to ensure discharge arrangements were safe and included relevant specialist teams for patients with complex needs.
- Service leaders only cancelled operations when necessary and were quick to rebook patients within 28 days. The service saw a low last-minute cancellation

# Surgery

rate for the period of April 2015 to March 2017. Over the two-year period, there were 309 cancellations of which three breached the 28-day timeframe. The proportion of cancelled operations as a percentage of elective admissions was generally better than the England average.

- The service was planned, delivered and coordinated to take into account the needs of different people, and processes were in place to remove barriers for those who found it hard to use or access services. Translation services were accessible and there was support in place for patients with learning disabilities and those of different religious faiths.
- People knew how to complain or raise a concern and staff treated them compassionately when they did so. Complaints and concerns were taken seriously, responded to in a timely way, and listened to. Improvements were made to the quality of care because of complaints and concerns and staff were able to give examples.

However:

- Although we acknowledged the service was responding and improving their performance with referral to treatment times, there was still some way to go with improvements.

At the time of inspection, there was no flagging system in use for patients living with disabilities or with hearing and sight impairments. A flagging system for these patient groups is required under the Accessible Information Standards. The hospital did have a flag for patients living with dementia and were in the process of developing new software to adapt the system and include other patient groups.

## **Service planning and delivery to meet the needs of local people**

- The service had identified where people's needs were not being met and used the information to inform how services were planned and developed.
- Over the previous 12 months, the service increased their performance in referral to treatment time of cancer patients and increased their day case surgery. The hospital had a shared care pathway for breast cancer and prostate cancer follow-ups, which used the help of GPs.

- The hospital had identified that there was a bottleneck with arrivals and had restructured the flow of the arrivals department to assist with the flow of the patient journey. The restructuring and new management of the department had improved the flow.
- Service leaders worked with the healthy Walsall partnership and clinical commissioning groups (CCG) to focus on pathway development. The CCG looked at the highest and lowest referrals and demand by speciality based on last year's figures and National Inflation rates.
- The urology service had developed pathways to improve responsiveness so staff could identify and target those people most at need. Service leaders worked closely with CCGs to drive forward necessary improvements for the service, for example the approval for a new pain consultant.
- As part of the healthy Walsall partnership, the hospital had invested in software that allowed information sharing across GPs and district nurses. Staff found the mobile hardware helpful, as they were able to see real-time data making the service more patient-centred.

## **Access and flow**

- The trust had been struggling with the referral to treatment time (RTT) for admitted pathways for surgical services. Between October 2016 and March 2017, the trust's overall performance was worse than the England average. Performance over time had been stable but below the England average throughout.
- We saw cancer, 62 day referral to treatment from consultant upgrade performance declined to 82.14%, against a target of 91% compared to 90.70% in January and March's 2017 performance which showed 87.88%.
- The trust provided no RTT data between April 2016 and September 2016. The only speciality to perform better than the England average was ear, nose and throat (ENT) surgery. Oral surgery (27.7%) fell significantly lower than the England average (68.0%).
- The trust had identified areas to improve RTT and patient flow through the hospital. The service had implemented weekend initiative lists to manage elective surgery waiting times and had enlisted the help of a consultant from another local hospital to help with oral surgery.
- The increased activity of day-case patients helped with flow. From January 2017 to June 2017, the service saw



# Surgery

on average, 700 day case surgical procedures per month. The utilisation of the surgical assessment unit (SAU) and the introduction of a virtual clinic also helped with flow through the hospital.

- Care group managers and senior nurses worked with capacity coordinators to monitor patient flow. They attended capacity meetings that were held a number of times throughout the day. During these meetings, senior nurses gave information on bed capacity per ward to identify the escalation level.
- Admission processes for emergency patients were through the SAU, via ED, before admission to the wards when necessary. Staff on the SAU had developed many pathways to help patient progression and to avoid unnecessary admission. The trust provided admission avoidance rates for the unit from April 2016 until May 2017. Rates were consistently above 47%.
- Surgical staff developed the virtual clinic for patients who did not have an urgent need. Staff assessed patients, took bloods or observations before sending eligible patients. Any scans or radiography were booked within 72 hours of SAU assessment and consultants gave patients results over the phone.
- This allowed patients to stay home instead of occupying a hospital bed whilst waiting for investigations and results. Staff told us patients had an open return policy where if their symptoms got worse they could attend the surgical assessment unit or ED.
- The admission process for elective patients was through the hospital's arrival lounge. Patients waited in the reception waiting room before being taken through to arrivals. Arrival's staff prepped patients for surgery and theatre staff collected the patients to take them through to theatre.
- From theatre recovery, patients were either taken to a surgical inpatient ward for those planned overnight surgery procedures and day-case patients were taken to the day case unit. Staff were proactive and discussed the possibility of day-case patients needing an inpatient bed in the morning briefing.
- The hospital utilised the day-case unit where day-case patients required an overnight stay if there were no inpatient beds available, they did not use the theatre recovery area to house inpatients overnight. In the previous 12 months, the day-case unit had remained open for 125 days. The hospital had safeguard measures in place to ensure staff identified and transferred appropriate patients.
- Discharge arrangements were discussed in pre-operative assessments for patients who were having elective surgery. For patients who were emergency cases, discharge was discussed in board rounds. Staff included other teams when necessary such as social services and frail and elderly patient (FEP) nurses. The wards had support from a discharge coordinator to help with patient discharges.
- Staff we spoke with told us that patients were sent validation letters that explained any disruptions and contained contact numbers for the bookings team. They said patients were able to contact them if they had any problems whilst waiting for their surgery. Patients were asked about dates they were not available and if they had holidays booked, they were offered a date to suit them.
- Service leaders told us they only cancelled or delayed care and treatment when necessary, which varied with emergencies and demand. They told us that they explained the reason for cancellation via a phone call for patients whose surgeries were cancelled within a week of their surgery date, or via letter if the surgery was cancelled more than week before.
- The trust provided data for last-minute cancellations. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If the trust had not treated a patient within 28 days of a last-minute cancellation then it is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
- From April 2015 until March 2017, the hospital reported 309 cancelled operations of which only three patients were not treated within 28 days. The proportion of cancelled operations as a percentage of elective admissions between April 2015 and December 2016 was better than the England average, but was worse from January to March 2017. Cancelled operations as a percentage of elective admissions include only short notice cancellations.
- The trust's average length of stay for both elective and non-elective patients was about the same as the England average. Between February 2016 and January 2017, the average length of stay for surgical elective

# Surgery

patients at Manor Hospital was 3.2 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 5.0 days, compared to 5.2 for the England average.

- Medical and surgical wards had a buddying system in place where junior doctors from medicine and surgery were paired, which helped with caring for surgical outlying patients.
- The service had introduced a new standing operating procedure to ensure that surgical outliers were cared for on appropriate wards. Staff we spoke with said there were sometimes medical patients outlying on surgical wards but did not feel this impacted on elective surgery.
- The service managed the provision of emergency surgery at night, weekends and public holidays the same way as they did during the week with slight differences due to limited elective activity on weekends.
- The hospital did not take emergency ENT patients at the weekend, as they worked on a five-day model. A specialist registrar at another local hospital supported any emergencies on the weekend and transferred ENT patients to that hospital.

## Meeting people's individual needs

- The hospital planned, delivered and coordinated the surgical service to take account of the needs of different people, for example, theatres accommodated different religions. Headscarves were allowed to stay on but staff would cover them with protective hats, staff explained to Jehovah witnesses the risk of bleeding and offered the self-saver service.
- There were dementia specialists who supported ward staff looking after patients with complex needs. The hospital used orange plates for patients that required more pureed food, or needed help with eating.
- Appropriate arrangements were put in place to take account of individual needs of people being discharged who had complex health and social care needs that required special considerations. We observed a multidisciplinary meeting where staff members were organising the involvement of social services for the discharge of a patient with complex needs.
- The trust had a new translation service for patients and those close to them that provided face-to-face, over the telephone and written translation services when requested. Staff said the translation services were easily accessible and we observed staff discussing the need for an interpreter and booking the service for a patient.

- The hospital had a loop system for the hearing impaired and was able to book interpreters for British Sign Language. Staff told us that if they required documents in braille, they were able to request this.
- Learning disability nurses supported ward staff along with ward-based learning disability link nurses. Some patients with learning disabilities bought hospital passports that staff used to plan the patient's care. If there was no hospital passport, the specialist nurses requested one or completed one if the patient did not have one.
- There was a free transporting service for patients and relatives with limited mobility. We saw this service was advertised in corridors and had a number service users could call to arrange a pick up.
- The newer part of the hospital had spacious corridors and doorframes to allow wheelchair access. The older part of the hospital was more cramped and lacked storage, which could have hindered access in some areas for wheelchair users.
- The hospital had a flagging system for patients living with dementia. The system allocated a butterfly next to patients with confirmed dementia, which was visible in theatre and on the wards.
- The only team able to add the flag was the older people's mental health liaison team, who along with dementia support workers, supported ward staff when needed. The specialist staff were notified of admissions either by ward staff or by the patients' relatives or carers.
- Ward staff assessed patients with dementia as part of the generic nursing and medical assessment process and the nursing team then completed the "This Is Me" document with the help of carers and relatives. This document included key things such as nutrition, environment and communication.
- As at 12 June 2017, 73% of surgical staff had received 'forget me not' dementia friendly training. Staff received this training in their induction and at monthly dementia awareness sessions.
- Staff on ward 9 had dedicated a patient bay for patients living with dementia, which they called the "Butterfly Bay." The bay was decorated as a vintage tearoom and was a chance for patients to sit together, interact and be involved in a number of activities.
- Relatives and carers of patients with dementia and learning disabilities had flexible visiting and were

# Surgery

encouraged to support the care delivery of their loved ones through supporting at meal times and attending the ward when their loved one displayed behaviours that were challenging for staff.

- The hospital audited key domains of care for adults with dementia. This audit included falls assessments, nutritional assessments and the use of the butterfly identifier as examples.
- There was no current flagging system for patients with learning disabilities or disabilities such as hearing and sight impairments, which is a requirement under the Accessible information Standards.
- However, the hospital was in the process of developing IT software to allow for flagging of these patient groups. Currently, the staff assessed and identified individual needs as part of the generic nursing and medical assessment process.

## Learning from complaints and concerns

- All patients we spoke with said they knew how to make a complaint or raise concerns if they needed to. One patient told us they had raised concerns and that staff listened to their concerns and took them on-board.
- We saw posters and leaflets displayed around the hospital that contained contact details for the trust's patient liaison and advice team (PALs). Patients were able to write formal complaints via letter and send to PALs or complete and submit a form on the trust's website.
- Senior staff told us they tried to reach a resolution with patients as soon as possible on the wards. If they were unable to achieve this, the PALs details were passed to patients and their families. Timeframes for investigations were dependent on the level of seriousness of the complaint and were 10, 30 and 45 working days.
- Lessons from complaints were discussed with ward staff in divisional and care group meetings. Staff were able to give us an example of lessons learned from a complaint about a surgical procedure. The issue was to do with consent, which had led to serious consequences. All of the surgical team and the staff on the wards were aware of the complaint and knew about the change of the consent forms as a result.
- Between April 2016 and March 2017, there were 89 complaints about surgical care. The trust took an average of 51 days to investigate and close complaints,

this is not in line with their complaints policy, which states complaints should be dealt with within 45 days, dependent on the seriousness of the complaint. Of the 89 complaints, 56% (50) related to clinical treatment, the remaining complaints covered a number of different areas.

## Are surgery services well-led?

Good



We rated well-led as good because:

- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. The service was transparent, collaborative and open with all relevant stakeholders about performance.
- Since the restructure and the implementation of the clinically lead leadership model, the service had a clear vision and strategy, which was focused on quality and patient safety. Staff were engaged with the service's vision and strategy and their role in achieving it.
- The service proactively engaged and involved all staff and ensured that the voices of all staff were heard and acted on through the implementation of listening into action. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued.
- Staff actively raised concerns and those who did were supported. Concerns were investigated in a sensitive and confidential manner, and lessons were shared and acted upon. All staff knew how to contact Freedom to Speak Up Guardians and were given examples of where they had been used.
- There were robust governance processes in place and the service was supported by specialist governance advisors. Risk registers reflected risks across the surgical division and were allocated responsible leads and reviewed appropriately. Quality and safety was monitored and used to identify where improvement was needed, and actions were taken as a result.
- The service was complimented by the Deanery about the engagement of the junior doctors and the training

# Surgery

and learning culture at the hospital. The service was highly regarded by doctors who trained at the hospital and there were waiting lists for them to return for permanent roles in some specialities.

However:

- Staff morale was low in areas due to staffing levels. Although staff understood the challenges the trust had faced in recruitment and were looking forward to issues being resolved.
- There were limited development opportunities for junior physiotherapists, which left them feeling undervalued and unfairly treated.
- Safeguarding policies were out of date. The policy included standards that are no longer applicable and terms that are no longer used. Relevant references and guidance was not included, whilst out of date standards and terms were.

## Leadership of service

- The service had implemented a new clinically lead structure within the previous 12 months. The leadership of the surgical division comprised of a divisional director who was a clinician, director of operations and a divisional director of nursing. Clinical directors led four main care groups who were accountable to the directors of the surgical division.
- Staff were able to identify surgery, medical leads and nursing leads and their roles and responsibilities.
- Leaders of the service had the capacity, capability and experience to lead effectively. They had the skills, knowledge and experience required to lead. Staff we spoke with were positive about their senior sisters and the support they received.
- Leaders demonstrated that they understood the challenges to good quality care and they identified the actions needed to address them. For example, they mentioned one challenge for hip and knee recovery, which was lack of patient understanding about work they needed to do to help with their progression once they had been discharged.
- Leaders were in the process of implementing a joint school for patients and their loved ones to attend before surgery, which would educate patients on what was required of them post-surgery.
- Staff generally told us that leaders were approachable and visible on wards. They said that leaders encouraged

supportive relationships amongst staff. However, some staff we spoke with in theatres told us that some leaders were not visible and that they did not get as much support as they could do.

## Vision and strategy for this service

- The service had a clear vision where quality and safety were the top priority. There was a robust, realistic strategy for achieving the priorities and delivering good quality care. For example, they were looking towards implementing an enhanced recovery ward and moving the SAU to a more suitable position. There were many pathways being developed alongside the local CCG and with the Healthy Walsall Partnership.
- Staff we spoke with knew and understood what the vision for the service was and knew their role in achieving the strategy.

## Governance, risk management and quality measurement

- The surgical division had governance advisors that helped join up the division's governance and feedback to care group level. There were monthly divisional board meetings and monthly care group meetings.
- We reviewed divisional board meeting minutes from February, March and April 2017, which discussed referral to treatment times, divisional strategies, finance reports and care group updates for patient safety.
- We reviewed monthly care group meeting minutes for the same months and saw evidence of discussion for mortality and morbidity, patient safety and actions for improving after audits.
- There were electronic ward level risk registers, which linked with the governance team and fed through to the divisional risk register. We reviewed the divisional risk register, which reflected the risks across the surgical division and was consistent with what we identified on inspection.
- Each risk had attached actions, a responsible lead and a review date. The oldest risk on the risk register was May 2014; actions for this risk had been completed but it was an ongoing risk. There was evidence of review and the risk score had been reduced.
- Senior staff were able to tell us what was on their ward risk register and these aligned with what staff told us

# Surgery

was on their worry list. Staff we spoke with knew how to access the risk register and said their main worry was staffing. Staff were clear about their roles and they understood what they were accountable for.

- There was a comprehensive and systematic programme of clinical and internal audit, which was used to monitor quality and systems.
- Staff were able to access audit results on the patient management system and used the results in audits to identify what action should be taken to improve performance and patient safety.
- The surgical service had eight service level agreements (SLA) with four local NHS trusts. Each surgical care group were responsible for managing and monitoring their relevant SLA. They monitored SLAs by looking at the external organisations' performance for example, through response times, activity levels, incidents and patient satisfaction. Care groups escalated issues to the divisional quality board and at review meetings with the external organisations.
- However, the trust's safeguarding policies were out of date and did not contain relevant information. The safeguarding adults policy did not reference the statutory guidance to the care act and it included CQC essential standards that are no longer applicable, and the term vulnerable adults, which is an out of date term. The safeguarding children policy had no reference to the mental capacity act and did not include reference or guidance on FGM. The documents did not clearly define who the safeguarding leads were.

## Culture within the service

- Most staff we spoke with felt respected and valued. They said leaders were visible and approachable and were very supportive in helping them to carry out their role.
- Staff told us that leaders were good at recognising potential in staff and were supportive and constructive when they had identified areas for performance improvement. We observed a near miss incident in theatre involving a staff member making a mistake. The team resolved the issue quickly and the clinical director who was performing the surgical procedure took time out to debrief the member of staff and offer comfort.
- The culture displayed by the leadership team and the staff on the ground during the inspection was centred

on the needs and experience of people who used services. Candour, openness and honesty was encouraged and staff were supported with this through specific training.

- The hospital had a number of Freedom to Speak Up Guardians and staff we spoke with knew how to contact them, they said the hospital attached the contact details to their wage slips.
- Staff said the culture had improved since the implementation of the guardians and did not feel there were any concerns with bullying. We were given examples of where staff had used the guardians who had helped to resolve issues for them.
- Physiotherapy staff felt that there was a lack of developmental opportunities for junior positions, which left them feeling undervalued and treated unfairly.
- The leadership team acknowledged that although they had made some improvement with consultants' attitudes, they had some consultants whose attitude they still needed improvement.

## Public engagement

- Matron for elective surgery advertised a "Tea with Matron" session every Thursday afternoon for patients to sit with matron and ask any questions they had about their surgery.
- We saw feedback surveys for patients to fill out in the surgical day case unit, and observed staff encouraging patients to complete these. The surveys asked patients what they felt about the service and if there was anything the service could do to improve.
- Staff on wards told us the wards carried out their own inpatient surveys as well as the NHS Friends and Family Test.

## Staff engagement

- The hospital had implemented listening into action (LIA) sessions that were ongoing, to gather and act on staff members' views and experiences to shape and improve the services and culture.
- Staff told us that they had seen many positive improvements since the implementation of LIA and felt that the culture was more positive too. They felt that their views and opinions were more valued and respected.

# Surgery

- Staff we spoke with felt engaged and able to express their views on how to improve services. They felt leaders listened to them and reflected their views in the planning and delivery of services.
- The surgical assessment unit and the arrivals lounge were nurse led units; staff on these units were actively engaged in helping to aid patient flow through the hospital.
- Both leaders and staff understood the value of staff raising concerns. When concerns were raised, there was appropriate action taken.
- The hospital had compliments from the Deanery about the engagement of their junior doctors and the very positive training culture.
- Trainee doctors we spoke with told us they enjoyed their time at Walsall and that they wanted to return as part of their rotation. Some expressed a wish to come back as consultants if possible as the training they received was very good.
- Staff morale was quite low in areas due to difficulties in staffing levels. However, we saw this was an item on the risk register and the hospital had staff lined up to fill roles. Staff were aware of the challenges the trust had faced and were looking forward to the issues being resolved.
- Staff felt confident to raise any concerns they had and were encouraged to do so by their managers and the







hospital through the Freedom to Speak Up Guardians at the trust. They were aware of relevant policies to access and knew how to contact the Freedom to Speak up Guardians.

## **Innovation, improvement and sustainability**

- The service recognised that the current layout of the surgical assessment unit and use of speciality on ward 10 was not always fit for purpose. The leaders listened to staff views and took on board their ambitions of turning ward 10 into an enhanced recovery ward with a high dependency unit alongside.
- The hospital had “Blooming Marvellous” awards where staff members were able to nominate each other for good practice. Blooming marvellous awards were given out every three months. There were other awards within the trust called “Rising Stars” and certificates awarded for patient safety. For example, certificates for being pressure ulcer free for 250, 500 and 750 consecutive days.
- Staff on ward 9 had changed a bay on their ward into a “Butterfly Bay” decorated as a vintage tea party, which was specifically for patients with dementia. The bay enabled elderly patients with dementia to sit together and be involved in activities. It was a very peaceful bay and patients appeared calm and happy there.



# Critical care

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Walsall Healthcare NHS Trust has 13 funded critical care beds located at Manor Hospital. These are

contained within two wards; ward 18 is a high dependency unit (HDU) and ward 19 is an intensive care unit (ICU).

ICUs and HDUs are specialist wards providing intensive treatment and monitoring for people who are in a critically ill or unstable condition.

Patients in hospital are classified to help identify their care and treatment needs. For example, level one patients can be supported on medical wards as they do not require organ support, although may be receiving intravenous treatment or using an oxygen mask. However, level two patients require the support of a HDU due to the need for single organ support. Level three patients located in ICU need support for two or more organs (or needing mechanical ventilation alone) (Department of Health, 2001).

Patients nursed in ICUs receive one to one nursing care whereas those located in HDU generally have one nurse to two patients.

The HDU had a total of eight beds where there were two bays of four beds each. The ICU had five funded beds which included an isolation room. The critical care service has the capacity to provide three additional beds over the number of funded beds when required.

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 for level three patients (a bed day is the length of stay by an admitted patient).

The hospital has a critical care outreach team who work on medical wards to manage critically ill patients in the hospital. The critical care outreach service is provided 7 days per week from 8am until 8pm by critical care nurses. Between 8pm and 8am, advanced nurse practitioners (ANP) provided cover. The purpose of the critical care outreach service is to assess acutely ill and/or deteriorating patients on wards and advise the patient's team on monitoring, investigations, and management plans. The aim is to stabilise and improve patients at ward level and so avoid the need for admission to critical care.

The hospital had begun to build a new critical care unit on the hospital grounds that met the required building regulations and patients' needs. This was expected to be completed by October 2018.

We inspected the CCU on 21 and 22 June 2017 and followed this up with an unannounced inspection on 2 July 2017.

During the inspection, we spoke with 33 members of staff including consultants, junior doctors, pharmacy staff, healthcare assistants, registered nurses, physiotherapists, practice development nurses, administrative staff, and



# Critical care

immediate and senior management of the unit. We reviewed eight patient records and observed three handovers including nursing and medical handovers. We also conducted several observations of direct clinical care.

Before and after our inspection we reviewed data and performance information about the CCU.

## Summary of findings

During the last inspection in September 2015, we rated Critical care as requires improvement across all domains except for caring which was rated good.

This was because;

- Checking systems to ensure fridges were maintained at the correct temperature was not always carried out.
- Staff were not documenting when they were administering bolus intravenous sedatives.
- Local audits were conducted in critical care but there was no action plans to support them
- There was not effective multidisciplinary team working
- The number of delayed discharges was worse than the England average when compared with other similar sized units since April 2014 and the risk register did not reflect all risks across the service.

Following this inspection we saw many of the previous concerns had been addressed, however there was still more work to do. We rated this service as requires improvement because:

- The CCU environment was in need of a refurbishment. The high dependency unit (HDU) and intensive care unit (ICU) were located on separate wards, which were a few minutes' walk distance from each other.
- We saw there was only one isolation room for the whole of the CCU. This was located on ICU and was not sufficient to manage infection prevention and control when more than one patient presented with an infectious illness or a patient had compromised immunity.
- Limited space between beds on HDU meant staff had a limited area to treat a patient in an emergency situation.
- We saw there were not enough capnography machines (to measure ventilated patients' carbon

# Critical care

dioxide levels). This had consistently been raised as a risk during clinical governance meetings for almost a year, however was not actioned until after our inspection.

- Mandatory training levels were below trust target for the majority of modules including safeguarding.
- The outreach staff did not maintain competencies and skills relating to critical care, and were isolated from the main CCU team.
- There were no follow up clinics for patients discharged from CCU as required under the Core Standards for Intensive Care Units.
- We saw that the CCU had mixed sex breaches due to delayed discharges. Bed occupancy was consistently high.
- A Mental Capacity Act assessment was not conducted, nor Deprivation of Liberty Safeguards (DoLS) applied for when using bed rails to prevent patients with a lack of capacity from falling out of their bed.
- There was a lack of suitable facilities to accommodate visiting relatives, friends and carers.
- Not all risks were recorded and managed under the CCU risk register, despite being discussed at clinical governance meetings.

However:

- Staff were aware of how to report incidents, had a good understanding of the duty of candour, and provided evidence of learning from incidents.
- No never events had been recorded for the reporting period April 2016 to March 2017.
- Mortality and morbidity meetings were multidisciplinary and conducted monthly. The chair emailed presentations to any required person who had not attended.
- In the main we observed infection prevention and control to be effective. Staff adhered to hand hygiene guidance during the inspection; this was supported by audit results.

- Records were well maintained; legible, securely held and accessible to all relevant staff. Appropriate risk assessments were included within a single patient documentation booklet.
- Staff had a clear understanding of safeguarding adults and children and how to raise a concern. This was despite staff training being below the trust target.
- Data shared with the Intensive Care National Audit and Research Centre (ICNARC) demonstrated the critical care unit were performing either within expected levels, or better than expected levels as compared to similar sized units.
- We saw the unit was run in a multidisciplinary way; including input from pharmacists, physiotherapists, pain management nurses and specialist nurses for organ donation.
- All staff during the inspection were caring and compassionate towards patients in their care. We saw staff worked hard to provide a respectful environment for patients.
- The unit did not transfer any patients to a different hospital for non-clinical reasons.
- The unit had provision for patients with additional needs, for example patients with learning disabilities and bariatric patients.
- Staff reported local leadership were supportive and worked well to ensure substantive staff could carry out their duties.
- The critical care unit had a risk register assigned to it which addressed a range of risks; which were regularly reviewed.
- Substantive staff reported a rise in morale and a positive culture since the start of the new build critical care unit. Staff told us that they had some input into the planning of the unit.

# Critical care

## Are critical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- The environment the critical care unit (CCU) was located in was not fit for purpose. The service was based across two separate wards, with only one isolation room located on the intensive care unit (ICU) and none on the high dependency unit (HDU). There was limited space within HDU bays, which may restrict staff when dealing with a medical emergency. The trust had recognised this and was in the process of building a new CCU that met health building specifications. This was due for completion in 2018.
- There were 'overspill' beds so that ICU could accommodate three extra patients; these beds were placed in an adjoining unused surgical recovery room. This area was an empty room into which patient beds and equipment were wheeled. If the door was shut, this area would not be visible to the main ICU.
- We saw the CCU had a lack of vital equipment such as capnographs, which monitor carbon dioxide within ventilated patients. This remained at the unannounced follow up inspection. However, since this time, the trust has provided assurances that they had procured this equipment and it was in use.
- We saw that staff were below the trust target for the majority of mandatory training modules. This included safeguarding adults level two; whereby as of March 2017, only 10% of eligible nursing staff were up to date with training requirements.
- We saw that there was no clear process of escalating concerns regarding patients located on the medical wards to the critical care outreach team.
- We found that critical care outreach team staffing was not adequate, particularly during the night. This was due to no trained outreach staff being available during the night. Instead, advanced nurse practitioners covered this role.

However:

- We found that staff were aware of their incident reporting responsibilities, and demonstrated a good

understanding of the process involved. Staff were familiar with the duty of candour (see incidents below for a definition). Staff received regular learning and updates following incident investigations.

- We observed good standards of staff hand washing and use of personal protective equipment in order to reduce the risk of infection. There were plentiful supplies of antibacterial hand gel for both staff and visitors.
- Medicines were stored safely and according to medicine management guidelines. We found that staff escalated issues quickly, such as fridge temperatures being out of range.
- Up to date safety thermometer reports were displayed on the walls in both ICU and HDU and were visible to staff and patient visitors. We saw recent results indicated the wards were achieving targets, such as zero patient falls and appropriate staffing levels.

### Incidents

- Staff were aware of how to report incidents through the trust electronic reporting system and could describe learning through meetings, briefings, and teaching sessions. Staff gave a range of examples of specific incidents that had occurred and provided details of how they had changed practice as a result. Staff reported they received an email confirmation after they had submitted an incident using the trust electronic incident reporting system.
- Data from the trust showed that from March 2016 to March 2017, the critical care unit (CCU) reported 489 incidents. Of these, 366 incidents related to the high dependency unit (HDU), 122 related to the intensive care unit (ICU) and one related to the critical care outreach team.
- In this reporting period, the CCU reported one incident which was graded level five as this was a patient death. The trust referred this to the coroner. The service reported no level four (severe harm) incidents. Eight level three (moderate harm) incidents were reported and 480 'minor harm', 'no harm' or 'near misses' were reported. One of these incidents (a pressure ulcer) was reported as a serious incident (SI) under the Serious Incident Framework 2015.
- The category with most reported incident was 'transfers' (delayed discharges to medical wards) with 106 incidents reported. The second most commonly reported incident was 'wounds sustained during Walsall Manor Hospital care' (75 incidents). These related to

# Critical care

tissue viability concerns such as pressure ulcers and skin tears. In addition, 22 incidents related to pressure ulcers specifically were reported; some of which we saw were identified as originating in the department. We saw 59 incidents related to infection prevention and control.

- We saw root cause analyses (RCAs) and serious incident reports for incidents that required these. For example, we saw the investigation into a pressure ulcer gained within ICU, which was recorded as a SI. This detailed issues raised with the care given to the individual patient; and associated actions to rectify these to protect other patients. Dates were identified for the achievement of these actions.
- This particular incident met the threshold for the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- We saw evidence that CCU carried out their duty of candour appropriately. For example, one incident relating to inadequate fluid and nutrition monitoring was investigated and found to meet the threshold. We saw a copy of the letter, which demonstrated that the trust had held a face-to-face meeting with the patient, and that apologies were made. This letter contained details of the investigation and the findings. This was discussed at the general surgery meeting within the trust.
- We saw evidence that the trust followed the duty of candour after the investigation of the above mentioned death of a patient. In this occasion, the investigation report showed the death did not result from poor care; however, the trust did identify learning from the incident. A letter was sent to the patient's relatives outlining the main findings of the investigation, and any areas of learning in addition to apologising to the relatives. One development following on from this incident was a new sedation policy.
- Staff showed an understanding of duty of candour with regards to being open and honest with patients and relatives following mistakes or incidents. Duty of candour training had been provided as part of a clinical update.
- 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.

- We saw learning from incidents was shared with all staff groups within CCU via team meetings, although these did not include outreach staff, and clinical governance meetings. Minutes to meetings were available either in hard copy in staff areas or via the intranet and email for those staff unable to attend.
- Data provided from the trust showed that they held morbidity and mortality meetings regularly; we saw minutes from three meetings between January 2017 and April 2017. Attendees showed a multidisciplinary approach (medical grade) to discussing deaths within the surgery care group; in which the CCU was part of. The group discussed deaths within CCU and learning points from all deaths identified. Furthermore, we saw a specific presentation that focussed upon the deaths of patients with learning disabilities throughout 2015 to 2016 within the surgery care group. Again, this included patients who had been seen within either ICU or HDU. Themes, good care, and areas for improvement were identified. Medical staff confirmed the presentations from these meetings were emailed out to them.

## Safety thermometer

- The trust used the safety thermometer to record the prevalence of patient harm and to enable frontline staff to immediately analyse any concerns, and to improve performance. The trust collected data collection for the safety thermometer on one day each month.
- We saw safety thermometer information was visible to both staff and visitors within the high dependency unit (HDU) and the intensive care unit (ICU); data from June 2017 was displayed. The safety thermometer within HDU for June 2017 showed that there were no falls or pressure ulcers on the day of the data collection.
- We saw data from the trust provided prior to inspection that showed one new pressure ulcer, no falls with harm and no new catheter urinary tract infections (UTIs) had occurred between April 2016 and April 2017.

## Cleanliness, infection control and hygiene

- During the inspection, we observed that both the high dependency unit (HDU) and intensive care unit (ICU) were visibly clean. The only exception was we observed fresh blood on a piece of equipment. When we pointed

## Critical care

this out a member of staff immediately cleaned this area. Some equipment had labels to indicate it was clean and ready for use, some equipment did not. Staff told us that the labels had run out and were on order. Staff we spoke with were aware of which equipment was clean and ready for use.

- Staff followed the trust policy regarding infection prevention and control. All staff were 'arms bare below the elbow' to enable effective hand washing; therefore minimising the risk of passing on infections. Handwashing facilities and personal protective equipment (PPE) were available. We observed staff used PPE as required; and washed and gelled hands regularly. We saw plentiful supplies of antibacterial hand gel were available around and between the wards.
- The trust provided audits for staff adherence to aseptic non-touch technique (ANNT; specific techniques to protect people from health care associated infections) for 2016 and January 2017 to April 2017. Between January 2017 and April 2017, the CCU achieved 100% compliance. This was an improvement on the previous year where compliance ranged from 85% to 97%.
- We saw nursing staff within the CCU undertook monthly hand hygiene audits which included monitoring doctors, nurses, health care assistants (HCAs), and other staff. The trust provided us with a selection of audit results for ICU from June 2016 to February 2017; all audits demonstrated 100% compliance with effective hand hygiene techniques. We saw an audit for HDU dated March 2017. This also demonstrated 100% compliance with hand hygiene.
- The trust monitored patients who required intravenous fluids and medication for infection prevention. We saw monthly audits from May 2016 to March 2017 for both ICU and HDU. We reviewed a sample of these, which showed that in the main, staff were complying with best practice guidelines to prevent infection. However, we saw in HDU, during March 2017, four patients had the same cannula for over 72 hours and it was not identified whether this was due to clinical decision or not.
- The CCU submitted data to the Intensive Care National Audit and Research Centre (ICNARC); part of which related to infection control within the CCU. We saw that from April 2016 to March 2017, the trust performed better than the national average in relation to the measures of 'unit-acquired infections in blood' and 'high-risk sepsis admissions from the ward'.
- As per trust policy, in order to prevent infectious patients infecting others or to protect patients with compromised immunity, side rooms should be used as an isolation area. However, we saw in CCU, only one side room was available located within ICU. Data from the trust showed that from March 2016 to March 2017, 60 incidents were reported regarding infection prevention including one relating to *Clostridium difficile* (C.Diff). Forty one of these incidents referenced a lack of isolation facilities within CCU; therefore inability lack of isolation facilities meant they were not always able to follow the trust policy regarding isolating infected patients.
- We also saw an incident whereby a sink in ICU had tested positive for a bacterial infection; however, facilities were unable to provide a portable sink, which raised the risk of staff having to walk further within the unit with infected hands in order to wash them.
- During the inspection, we observed a patient within ICU had tested as positive for Methicillin-sensitive *Staphylococcus aureus* (MSSA) as reported in the patient's record. We asked staff caring for this patient what infection prevention and control precautions they were taking. Staff were not aware the patient had received a positive result for MSSA. However, staff did then take action to discuss the management of this patient and they put a sticker on the patient's notes to inform staff of the infection.
- We asked the trust what action they should be taking in situations where the isolation room was already in use, and other infected patients are identified. The trust told us if more than one infected patient was in the ward area they were 'cohorted' (put in beds next to each other). However, at this time, this patient was the only patient with an infection. Additionally, within ICU, due to the layout this meant patients would still be within the same general area as non-infected patients as there were no separate bays.
- Data from the trust presented results of a *Clostridium difficile* (C.Diff) audit completed within October 2016. This audit assessed the unit on a specific day and looked at areas such as infectious patients having their own commode, appropriate use of the isolation room and the equipment and environment being suitable to prevent infection. On this occasion, the unit scored 100% against all measures.

# Critical care

- We saw an investigation following identification of a patient with C.Diff. This showed that staff followed the correct steps within ICU, such as staff taking samples for microbiology testing and sent in a timely manner.
- Mandatory training for all staff included infection prevention and control (IPC). Data from the trust showed that as of the end of March 2017, 80% of CCU management were trained in IPC, and 88% of ward staff were trained against a trust target of 90%.

## Environment and equipment

- The high dependency unit (HDU) and the intensive care unit (ICU) were cramped and not fully fit for purpose. For example, ward 18 and ward 19 were not situated next to each other. Staff and visitors had to walk approximately five minutes from one to the other; which was not practical when patients were being transferred from HDU to ICU or vice versa.
- When patients requiring ICU exceeded available beds, patients were re-located into an adjoining room which was an unused theatre recovery room. When this happened, an agreement was in place to have an additional doctor at night. The trust had recognised the limitations of the physical environment and as a result was in the process of having a new critical care unit (CCU) built which was specifically designed for this purpose. We saw the business plan for this new build was designed as to conform with Health Building Notes (HBN) 04-02, as per the Core Standards for Intensive Care Unit (2013).
- Staff highlighted concerns, which we also observed, during the inspection, that should the resuscitation trolley be required for a patient within HDU, there would be extremely limited access to the other patients (four patients could be located in one bay). If any other patient also required urgent care, this would be difficult to facilitate within the cramped area.
- ICU was accessed through a secure door; an intercom and a buzzer were used to gain entrance. However, HDU had both a front and back set of doors to this ward. The back doors were not secure; therefore, unauthorised people could gain access.
- Data from the trust highlighted specific problems with the environment and facilities within CCU such as a lack of washing and toilet facilities for patients within CCU. This meant patients either had to be taken to an area that contained these facilities, or receive a bed bath and use bedside toilet facilities. In addition, some patient beds were not weighing patients as they should in order to plan treatment. However, we saw plans to mitigate this included using separate scales that weighed the whole bed to calculate patient weight, or to transfer the patient onto a bed which did weigh properly. New beds were going to be trialled, which would include a weighing function. However, the trust would procure these when the new CCU was complete. We were told that in the meantime the current beds would be repaired we saw this had been highlighted as a risk to address in clinical governance meetings during 2017.
- During the inspection, we identified that there were not enough capnography machines available for patients. A capnograph is an essential piece of equipment which measures how much carbon dioxide is present in a ventilated patient's breath. This helps to assess for respiratory distress, cardiac arrest and displacement of an artificial airway. We saw the service only had three machines for all patients in both ICU and 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. Furthermore, we saw that the three available machines were not being used despite patients requiring this monitoring. Medical staff told us that they had raised this issue previously. However, nothing had been done to provide sufficient equipment. We also saw within clinical governance meeting minutes dated January 2017; a lack of capnographs was raised in July 2016. The action plan identified that the trust should have procured the machines by October 2016. However, at the time of inspection we were not assured these items had been ordered. We escalated this issue with staff at the trust including the medical director. Following the inspection, the trust told us that new equipment which also worked as capnographs were being trialled within CCU for potential future procurement. Staff told us that this equipment was to be in place for use on the Monday following the inspection (26 June 2017). However, when we returned for an unannounced visit on 2 July, 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 with a clean in between swapping this.



# Critical care

- According to an update to the Core Standards for Intensive Care Units (2016), capnography is considered to be used within over 90% of UK CCUs; research indicates that it improves the safety of endotracheal intubation in critical care patients.
- Following the inspection, we requested further assurance from the trust regarding this concern. Information received later in July 2017 confirmed an adequate amount of machines were now within CCU and that 79 out of 91 staff had undertaken training to use these as of 10 July 2017. We were also told a new standard operating procedure was being written about capnography use within the service.
- During the inspection, we spoke with staff involved in the trialling and ordering of new equipment relating to the CCU. Staff told us, and showed us examples, of equipment that would be trialled with the intent of procuring if it worked well.
- Equipment we checked was serviced in line with requirements, and electrical testing was up to date. This included clinical equipment such as beds and monitors, and domestic equipment such as microwaves and kettles.
- We saw that equipment to enable a full range of physiotherapy exercises was limited in both ICU and HDU, for example chairs and there was limited space available. Physiotherapists told us they had to devise modified forms of exercises to aid patients to achieve their rehabilitation prescriptions.
- During the inspection, staff said new equipment had been procured since the last inspection in 2015. For example, the CCU had access to new ultrasound machines, and video laryngoscopes (which allowed viewing of the voice box).
- We saw data from environment audits for HDU and ICU conducted monthly between November 2016 and April 2017. For HDU audit compliance scores ranged between 84% (November) and 95%. This meant HDU met the trust target in all months except November 2016. ICU achieved between 76% and 100%; the only month when the ICU did not achieve the trust target for compliance was February 2017.
- The resuscitation trolley was checked daily in line with requirements; and all stock we looked at was in date and sealed. The same applied to emergency intubation trollies. We saw the same results for the difficult airway trollies.

- We found during our inspection, that antiseptic fluid was being stored in an unlocked sluice room within HDU. We raised this with staff on the unit who removed it and stored it securely.
- We saw adequate sharps bins, clinical waste bins and general waste bins to dispose of waste. These were located and disposed of appropriately. We saw domestic cleaners completing their duties effectively to maintain the environment.

## Medicines

- We saw the trust had an up to date medicines management policy which all staff had access to.
- During the inspection, we checked both fridge and room temperatures where these areas contained medicines. We saw that for one fridge that was used to store medicines, the temperature had been recorded as out of range on one occasion. However, we saw that this had been escalated and dealt with appropriately. Apart from this, we saw fridge temperatures were within range. Ambient room temperatures were monitored and were seen to be within range. Therefore, medicines were stored at a temperature suitable to maintain effectiveness.
- We conducted a random check on medicines stored within the critical care unit (CCU) and found all those checked to be within their expiry date and stored appropriately. We saw medicine fridges and rooms were kept locked when not in use. The nurse in charge on the ward held the key.
- Controlled drugs (medicines that are controlled by the misuse of drugs legislation such as morphine; CDs) were stored separately in line with good medicines management guidance. We checked these medicines and found they were stored within appropriate temperatures, checked twice daily and within date.
- Patients' personal medicines were securely stored within bedside cabinets.
- We saw oxygen cylinders were stored on a stand; however within the intensive care unit (ICU), these were being used to prop open a door at the time of inspection.
- Following the previous CQC inspection in 2015; it was reported that bolus doses of medication (this is a prescribed additional dose of prescribed medication) was not being recorded on medicine or fluid charts for

# Critical care

patients. Since this inspection; the trust audited bolus drug administration within the CCU. Audits dated from January to April 2017 showed 100% compliance with trust requirements around bolus administration.

- We saw a serious incident investigation involving a bolus administration of medicines that occurred in January 2017; as part of this investigation, the trust reviewed use of sedation. However, it was reported that that the patient had the correct dosages and type of medicine. Furthermore, the Clinical Guidelines in relation to sedation were also adhered to and administered within agreeable limits. Despite this, staff told us about shared learning following this incident about medicines management and an updated policy on sedation.
- We saw that the observation charts next to each patients' bed, and medication records within patient records, had been amended to allow space to record bolus doses of medication; this was to ensure each dose was recorded at the time of administration to prevent staff from giving too much over the course of a 24-hour period. In addition, we saw bolus doses were recorded in patient records.
- We checked four patient records specifically for medicines management compliance. Within all four records, prescriptions were up to date, signed, and dated, allergies were recorded, and any required antibiotics were prescribed as per guidelines.
- We saw results of ward medicine storage audit for the (high dependency unit) HDU and the ICU. A trust pharmacist conducted both audits within May 2017 and reported 100% compliance. The results of these audits were kept within staff information folders so unit staff could view the results.
- We saw updates to medicines management were printed out and left in staff areas to disseminate information.
- We observed a medicines round and saw that two nurses checked medicines prior to administration to the patient.

## Records

- Throughout the inspection, we reviewed seven patient records. These were kept securely on shelves behind the nurses' stations within both the high dependency unit (HDU) and the intensive care unit (ICU).
- Patient records were paper based and contained an 'all in one' patient documentation booklet for the critical

care unit (CCU) which incorporated initial information, a variety of risk assessments, medical and nursing entries and medication details. These patient booklets demonstrated best practice in record keeping.

- Within patient records, we were able to easily identify the patients' pathway through to the CCU. We were able to see the date and time of admission to CCU, the reason for admission and the level of care required.
- Risk assessments included the Malnutrition Universal Screening Tool (MUST), venous thromboembolism (VTE) assessments, Waterlow assessments (for pressure ulcers) and rehabilitation assessments.
- We saw records included relevant consent to treatment forms, completed mental capacity assessments, best interest assessments and Deprivation of Liberty Safeguard (DoLS) applications where necessary. We observed up to date and correctly completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms where appropriate. Staff consulted with families and appropriately recorded where documentation required this.
- Details of care bundles administered to patients dependant on need were recorded within the patient records.
- Entries made were legible, comprehensive and dated. The majority of records were ordered in a logical fashion with the most recent records first. We did observe one patient record that was extremely full due to the patient having attended the hospital on many occasions. This particular record had not been filed in a manner, which enabled the quick finding of relevant information. We saw patients had observation charts beside each bed, which nurses updated regularly and replaced after each 24-hour period.
- Each patient bed had a wipe-clean board by it containing the patient's name and rehabilitation requirements. The physiotherapy team updated these boards with details of daily exercises and activities for nurses to aid patients with. No other identifying information was present on these boards.
- Patient paper based records were kept behind the nurses stations on both HDU and ICU; therefore all staff attending the unit could access and update these easily.

## Safeguarding

# Critical care

- The trust had a safeguarding children policy and a separate safeguarding adults' policy, both in date and due for review in 2018. We found these policies to be insufficient in detail.
- Data provided prior to the inspection showed that as of March 2017 only 10% of eligible nursing staff (63 eligible staff) were trained in safeguarding adults level two; with 50% of eligible staff (2 staff) trained in safeguarding adults level three. Fifty one percent of eligible staff were trained in safeguarding children level two (out of 65 staff). These percentages were against a trust target of 90%; therefore fell well below this. Of administrative staff, 100% were trained (three staff).
- We saw minutes from a trust wide safeguarding committee meeting held in May 2017 which reported that safeguarding training compliance was under target throughout the trust; this was discussed with actions for managers to encourage staff to attend. However, we saw that attendees of these meetings from February, March and May 2017 did not include staff or management from the critical care unit (CCU). Therefore, we were not assured this was a robust process.
- Staff told us they had completed training on 'PREVENT' (a government strategy, which aims to safeguard people and communities from the threat of terrorism) within their safeguarding training.
- Staff also reported that they had received a presentation about female genital mutilation (FGM).
- Staff demonstrated a good understanding and awareness of safeguarding adults and children. Staff told us of their responsibilities in reporting any safeguarding concerns dependant on their grade. For example, junior staff would speak with the nurse in charge and the anaesthetist on duty; then complete an incident form and refer this to the safeguarding lead within the trust.
- Staff provided an example of pressure ulcers triggering a safeguarding referral. They told us that they would contact the medical photography and the tissue viability teams, in addition to reporting their safeguarding concerns.
- We were told of an incident where a patient disclosed they were a risk to others; as a result, the trust safeguarding procedures were following including police involvement.
- The trust target for mandatory training was 90%. Data from the trust showed that as of March 2017, critical care (CCU) staff were below this across the majority of the mandatory training modules.
- Mandatory training topics included safeguarding vulnerable adults and children, information governance, patient handling, dementia awareness, mental capacity, load handling (administrative staff only), adult basic life support (BLS), conflict resolution, equality and diversity, fire safety and infection prevention and control.
- Training figures included nursing staff, additional clinical staff, administration, and managerial staff. Medical staff were not specifically allocated under CCU therefore their training figures were collated under the surgical care group. Furthermore, critical care outreach staff were managed under a different care group therefore; we could not identify specific outreach team members for compliance.
- Training modules where staff had achieved the target of 90% or over included patient handling (97%; 63 out of 65 staff), dementia awareness (100% for both nursing and administrative staff, and 88% for other clinical staff), mental capacity (100% for nursing staff), and load handling (100%, administration staff only).
- Modules where staff had not achieved the training target included information governance (42%; 27 out of 65 staff), conflict resolution and infection prevention and control (both 71%; 46 out of 65 staff), equality and diversity (74%, 48 out of 65 staff), fire safety (57%, 37 out of 65 staff) and adult BSL (77% for nursing staff and 50% for additional clinical staff).
- We saw that mandatory training compliance was discussed with staff within team meetings, we were not fully assured that there was a firm action plan in place at the time of inspection to ensure this happened. There was a plan to contact staff via text message to remind them about mandatory training; however, this idea was in its infancy and had not yet been discussed with staff about this use of personal numbers.

## Assessing and responding to patient risk

- Please see 'environment and equipment' for information about capnography equipment that also concerns assessing and responding to patient risk through measuring CO2 levels in ventilated patients.
- We saw patient records contained a variety of risk assessments designed to identify any deterioration within patient care. The included the malnutrition

## Mandatory training

# Critical care

universal screening tool (MUST), nasogastric tube position risk assessments, falls risk assessment, Waterlow score to identify pressure ulcers, facial skin assessments for patients using breathing masks, venous thromboembolism (VTE) risk assessments and allergy recordings. This complied with the National Institute of Health and Care (NICE) clinical guideline 50.

- During the inspection, we looked at patient records and saw that risk assessment documentation was complete and up to date; and staff were aware of actions to take to manage any risks that were identified. For example, several patients within the critical care unit (CCU) during our visits had pressure ulcers; we saw these were being managed appropriately with the support of the trust wide tissue viability team in order to reduce the risk of these worsening; and to improve skin damage already present. We saw that staff recorded measures taken and actions set to manage risks within patient records.
- However, we did observe that one patient had an endotracheal tube, which had not been fitted appropriately and was aggravating a pressure ulcer on the patient's mouth. We raised this with staff who were aware of this and changed the tube ensuring it did not lie against the pressure ulcer. This had also been reported as an incident.
- The national early warning score (NEWS) was used to identify deteriorating patients; we saw staff completed regular observations to monitor patients and to assess if any patient needed escalating for additional care.
- We saw patients were screened for sepsis and sepsis care bundles were implemented and recorded where necessary. We observed that since the previous CQC inspection in 2015, a new sepsis bundle had been implemented.
- The CCU included an outreach team who worked with deteriorating patients who were on wards within the hospital. The purpose of the outreach team was to assess critically ill or deteriorating patients and advise ward staff about further monitoring, investigations and management plans. Therefore, the outreach team either avoided the need for a patient admission to CCU or ensured that patients had timely admission to CCU; whilst ensuring these patients were monitored and supported appropriately on the ward.
- The critical care team was available seven days a week, between 8am to 8pm. During the night, a night team consisting of one advanced nurse practitioner (ANP) was available to continue this service. However, this team

provided cover for any deteriorating patient, or medical emergency across a number of wards and hospital areas therefore were not able to focus all of their time on critical care patients within the ward areas.

- We identified that the critical care outreach team were not up to date with critical care competencies, or appropriately trained. Please see 'Competent Staff' within the effective domain.
- The West Midlands Critical Care Network raised concerns, during a peer review in January 2017, regarding the appropriate escalation of patients on medical wards who required additional assessment, care, and treatment by critical care outreach staff. It identified that there was no clear process for when to contact the outreach team or to alert the CCU to a deteriorating patient.
- During the inspection, we noted that 'time outs' were not being done prior to invasive procedures in ICU. 'Time outs' form part of the National Safety Standards for Invasive Procedures (NatSSIPs); it is recommended this step is followed during surgical or invasive procedures to minimise risk to the patient.
- We saw that patients within the unit could become agitated or aggressive due to the nature of their condition or becoming confused due to the environment; staff told us of techniques used to manage this, including sedation. We observed staff use verbal de-escalation techniques effectively to calm a patient down and enable care to be delivered.
- We saw that patients with tracheostomies cared for on medical wards had bedside emergency kits and bedside signs to alert staff to patients with difficult airways. However, we also noted that there was not a specific ward round to care for patients with tracheostomies, or consultant led outreach sessions for these patients. In addition, these bedside signs were not present at the bedside of patients with a tracheostomy within CCU; the fourth National Audit Project (NAP4) recommended that all patients with a tracheostomy should have a bedside sign.
- Staff told us that due to ICU and HDU being separate wards; patients who 'stepped up' from being level two (able to be managed under HDU environment and staffing) to level three (requiring more intensive care) and vice versa ('stepped down'); could potentially remain in the same ward and the staffing would be

# Critical care

adjusted accordingly. This generally happened if there were no free beds the ward in which the patient needed to be. However, this may have resulted in inadequate equipment being present to care for level three patients.

## Nursing staffing

- During the inspection, we saw there were adequate staff to manage the unit for both HDU and ICU despite one member of staff being off sick for one day. However, we noted on one day of inspection, a supernumerary nurse was redirected from HDU to support staff on a separate medical ward.
- The Royal College of Nursing (RCN) provides guidance for nurse staffing within critical care units (CCUs). This identifies that for level three facilities (intensive care units; ICU) staffing should be at a ratio of one nurse to one patient as a minimum. For level two facilities (high dependency units, HDU) a ratio of one nurse to two patients is appropriate. Outreach services for critical patients on wards must also be provided.
- The trust reported they worked to this model; and did not use an acuity tool. A supernumerary nurse for each shift was incorporated into the trusts staffing model as per the Core Standards for Intensive Care Services.
- Data from the trust showed the percentage of actual staff in ICU and HDU were based on the planned staffing requirements. Staff told us the trust had made provision for the unit to go over nursing headcount if required for safe staffing.
- For March 2017, HDU was staffed as planned for 96% of the time in both the day and night for nurses. Healthcare assistant (HCA) staffing in HDU was 83% during the day, and 97% at night.
- During the same time period, nursing staffing for ICU was 91% during the day and 92% at night. For HDU, this was an improvement for nurse staffing for February 2017.
- Data from the trust showed the whole time equivalent staff (WTE) that should be in place for appropriate staffing for CCU. This included two senior sister nurses, one WTE practice development nurse (PDN), 13.8 WTE band six nurses, 45.5 WTE band five nurses and 5.5 band 2 staff (such as HCAs).
- As of May 2017, the trust reported they had in post 37 total staff in ICU (including two PDNs) and 38 total staff in HDU. Of these staff, the trust reported that adequate numbers had received appropriate critical care training in order to provide a good skill mix during shifts.

- The trust reported that as of March 2017, the CCU had a sickness rate of 4.2%. Updated information reported this as 5.8% between April and June 2017. We saw this increase was discussed within team meetings.
- Bank and agency usage averaged 16% in CCU between April 2016 and March 2017. We saw that for April to June 2017, this had dropped to 2%. During the inspection, staff told us that due to a rise in staff sickness, they tended to use their own CCU staff on the bank where possible. We also saw that staff were able to move between ICU and HDU if nurse to patient ratios required this. We spoke to substantive staff members who worked on the bank for CCU, who reported they covered a number of shifts this way.
- We observed handovers; which occurred at least twice a day, to ensure staff coming on shift were aware of the requirements of the patients during their shift.
- Two nurses staffed critical care outreach services from 8am to 8pm every day of the week. We saw there was a vacancy for 0.8 whole time equivalent (WTE) for a critical care outreach nurse at the time of our inspection. Advanced nurse practitioners (ANPs) covered out of hours overnight. During the inspection, staff told us that one ANP covered 10 wards; this included duties additional to the critical care outreach role. Critical care outreach staff were managed under the medical directorate and therefore did not form part of CCU staffing numbers.
- A range of different staff members told us that bank staff (substantive staff from CCU) now staffed uncovered outreach shifts. Staff told us that this was a recent change, and previously shifts went uncovered.
- The CCU supported third year student nurses through placements; allocating them a mentor to develop skills and capabilities.

## Medical staffing

- Anaesthetist registrars and consultants (trained as intensivists) delivered medical care and treatment of patients; these staff were managed under the surgery division and did not form part of the critical care unit staffing numbers. However, we saw there was adequate specialist medical cover to manage patients within CCU.
- We saw there was a designated clinical lead for the critical care unit (CCU) as per the Core Standards for Intensive Care.
- Data from the trust reported that the shift pattern for medical staffing covered the CCU from 8am to 9pm.



# Critical care

During weekdays, one to two junior doctors covered CCU. Out of these hours; there was consultant cover between 9pm and 6am; with on call consultant cover between 6pm and 8am. During weekends, consultants provided 24 hour on call cover.

- During the daytime at weekends, one junior doctor (registrar) was allocated to the high dependency unit (HDU), and one to the intensive care unit (ICU). Should only one registrar be available, a consultant would come in to act as registrar on a locum basis.
- Consultant work patterns showed that they covered ICU for weeklong blocks, but were not able to do this for HDU. Instead, HDU would be split between two consultants over a week. It is recognised that longer blocks of care (such as a week) can ensure a more effective continuity of care for patients.
- We saw on the risk register for the critical care unit (CCU) that recruitment of middle grade anaesthetists was an identified risk, with a national shortage of this specialism at this grade. We saw this risk was added to the risk register in 2015 and had ongoing actions to reduce this risk, including additional money to spend on staffing. The trust completed these actions in January 2017, with ongoing monitoring of recruitment.
- We observed during our inspection that consultants attended critical care patients quickly and responded with urgency to requests. Medical handovers were comprehensive and enabled a good exchange of relevant information between day and night staff.
- However, CCU consultants told us they provided out of hours emergency cover for paediatric emergencies. Several of the consultants reported that this reduced their availability to provide cover for the CCU.

## Major incident awareness and training

- The trust had a major incident plan for staff to follow; this covered various injuries and medical requirements that patients may have upon admission in the event of a major incident. This included severe weather responses. This plan was up to date and due for review in 2019. In addition to the plan, briefing cards were available for staff to have a quick view of roles to undertake in an emergency.
- The trust reported that, across the trust, 30% of eligible staff had completed major incident training against a target of 90%. This information was only available at the trust wide level at this time, which was as of March 2017.

- Fire safety training was included within mandatory training, and the trust held a policy on this subject for staff to access. Staff were aware of the processes to follow in the event of a fire; however those we asked were not aware of who the ward fire marshals were. Fire alarm testing was done weekly. However, within the intensive care unit (ICU), we saw oxygen cylinders being used to prop open a door at the time of inspection. This causes risk of fire through potential explosion of cylinders in the event of fire.
- Following significant terrorist attacks within other cities recently, the trust provided staff with information about how to stay safe, and ensured staff were aware they could access extra security support. Staff told us that within CCU, staff names and addresses were requested so that in the event of a similar situation, staff living nearest to the hospital could be called out to help.

## Are critical care services effective?

Requires improvement



We rated effective as requires improvements because:

- We found the critical care unit (CCU) did not provide follow up clinics or appointments after patients were discharged from the CCU. This is a requirement for CCUs as specified in the Core Standards for Intensive Care Units.
- We saw the CCU was underperforming about the number of mix sex breaches (men and women sharing a bay when admitted to the ward).
- Junior doctors were not aware of the National Safety Standards for Invasive Procedures (NatSSIPs, 2015).
- The critical care outreach team staff did not have the opportunity to maintain competencies or to update skills and knowledge.
- We found that although in the main, staff were appropriately assessing patients' mental capacity and applying Deprivation of Liberty Safeguards (DoLS) when required, several patients had bed rails up with no DoLS completed for this restrictive action.

However:

- We saw there was a dedicated pharmacist to support the CCU.



# Critical care

- A specialist nurse for organ donation (SNOD) worked with patients, families and other professionals in order to manage organ donation.
- We saw evidence of good research and audit results on topics such as renal replacement therapy (dialysis) and certain equipment used for this, and involvement of the parent team when managing patients.
- Patients had daily access to rehabilitation via the physiotherapy team, who visited CCU twice daily.
- Results from the Intensive Care Nationals Audit and Research Centre (ICNARC) showed that the CCU achieved scores that were better than expected by chance alone on all relevant measures.
- We saw multidisciplinary ward rounds being conducted, involving consultants, junior doctors, and the pharmacist. Information shared during the ward round enabled effective management of patients.
- We saw that staff had a good understanding of patient consent; and had a clear understanding of when to conduct a mental capacity assessment to identify if a patient was able to consent to an aspect of care or treatment. The only exception to this was about bedrails, as mentioned above.

## Evidence-based care and treatment

- We saw that policies and procedures within the critical care trust (CCU) were written in line with guidelines and standards from the National Institute of Health and Care Excellence (NICE), the Intensive Care Society, the Faculty of Intensive Care Medicine (FICM) and the Nursing and Midwifery Council (NMC).
- We requested data from the trust regarding their adherence to the Core Standards for Intensive Care Units. Data provided from the trust showed variable adherence. The Core Standards identify evidenced based care and best practice for patients within intensive care units.
- The trust told us that they do not collect or monitor information about unplanned re-admissions within 48 hours of discharge to a medical ward.; Readmitting a patient could imply hasty discharge or inadequate care therefore, it is important to monitor this data.
- The trust did not provide follow up medical clinics following a patient's discharge from the intensive care unit (ICU). In line with this, we found adherence to the National Institute of Health and Care Excellence (NICE) clinical guideline 83; 'rehabilitation after critical illness' was not being fully complied with. Critically ill patients have been shown to have complex physical and psychological problems that can last for long time. These patients benefit from the multi-modal approach that an ICU follow-up clinic can deliver. However, we saw that physiotherapists did make effort to provide some ongoing therapy either within the hospital or within the community.
- Assessment of patients' rehabilitation needs within 24 hours of admission was varied. We found this much improved since the last CQC inspection in 2015; however, patient records showed not all patients were receiving the assessment within the time limits set by guidance. We spoke to physiotherapy staff who openly discussed this and reported that due to a reduced staffing level on weekends; focus tended to be on respiratory needs rather than assessments; therefore, assessments were conducted more regularly during the week. However, physiotherapy staff were able to evidence compliance towards guidelines, which recommend patients within the CCU should receive 45 minutes of rehabilitation per day.
- The physiotherapy team continued rehabilitation support with patients who were discharged to a ward within the hospital. For patients that were discharged home from the CCU, advice and guidance was provided as part of a discharge plan around rehabilitation; or if patients were physically fit enough at this point, referrals were made for community physiotherapy.
- We found that since the last CQC inspection, which identified there was no dedicated pharmacy support for critical care, the trust had appointed a unit pharmacist.
- We saw the CCU screened patients for delirium upon admission. This was in line with the Guidelines for the Provision of Intensive Care Services, 2015.
- Data provided from the trust showed results of various audits. For example, audits of the System Of Patient Related Activity (SOPRA), which assesses nursing workloads based on the needs of individual patients, showed that between January 2017 and April 2017 the CCU improved upon this measure. The unit scored 92% in January 2017, 95% in February 2017, 97% in March 2017, and 100% in April 2017.
- Audits of the CCU seven day documentation showed an upward trajectory of compliance between January (85%) and April (100%).
- The CCU care bundle audit showed varied results between January 2017 and April 2017. For example, January and March demonstrated 81% and 88%

# Critical care

compliance respectively. February and April showed 96% and 100% compliance respectively. Care bundles are evidenced based interventions that are grouped together to promote better patient outcomes.

- When speaking with junior doctors working within the department, we noted none were aware of the National Safety Standards for Invasive Procedures (NatSSIPs). These were published in 2015 and outline recommended national standards for procedures carried out in environments outside of the operating room; trusts should use these to develop local standards.
- During January 2017, the West Midlands Critical Care Network conducted a peer review within Walsall Manor CCU. This identified that although the critical care outreach team record data regarding their patient visits; this has never been collated or entered into any database. Therefore, it was not possible to identify the effectiveness of the critical care team as a part of the CCU.
- We saw tracheostomy tubes used within CCU did not include built in ports for subglottic suction; NICE guidelines and the National Resource for Infection Control recommended the use of devices that enable subglottic suction in order to reduce the risk of ventilation-associated pneumonia.

## Pain relief

- We saw there was a pain management nurse that attended the critical care unit five mornings per week to provide support; and that staff were monitoring saw that patients' pain. The pain management team were able to access the critical care unit's (CCU) shared computer drive in order to view updates and communication regarding patients.
- Staff measured pain via the Behavioural Pain Scale (BPS), used with intubated patients, and the Richmond Agitation-Sedation Scale RASS pain measurement tool, which measures the agitation or sedation level of a patient. These help identify if the patient was experiencing pain. For patients that were conscious and able to communicate, staff used a numerical pain scale to clarify pain relief needs.
- We observed staff administer pain relief to patients as per their prescriptions.

## Nutrition and hydration

- We saw that staff used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients.
- Those patients that were able to eat and drink (within HDU mainly) were regularly offered food and beverages. There was a small kitchen area within HDU whereby housekeeping staff could prepare drinks and simple meals such as breakfasts. We saw a menu which patients could choose main meals from; these offered a range of food and were nutritionally appropriate to meet patients need. Pureed or other easy to eat food was available.
- We saw staff supported patients to eat and drink and patient choice regarding food was respected.
- Dietician support was available to the critical care unit to aid with care and advice. However, staff had to specifically request dietician attendance as this was not a dedicated service. The Core Standards for Intensive Care state that dedicated dietician support should be provided to critical care patients.

## Patient outcomes

- The critical care unit (CCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC). This is a national database of critical care outcomes.
- From data submitted between April 2016 to March 2017, we saw that Walsall Manor CCU was performing better than comparators (comparators are a group of other similar sized services within the UK which Walsall Manor CCU figures are compared against to measure performance) on five out of 11 measures; for the remaining six Walsall Manor CCU were performing worse than comparators. Despite this, all applicable measures at Walsall Manor (11 out of 9) were scored as better than expected by chance alone. (The England average was rated as better than this).
- Areas in which the unit were performing better were high-risk admissions from the unit, high-risk sepsis admissions from the ward, unit-acquired infections in blood, out of hours discharges to the ward (not delayed) and non-clinical transfers to another unit.
- Areas in which the unit were performing slightly worse than comparators included delayed discharges of more than eight hours, and delayed discharges of more than 24 hours.

# Critical care

- Other areas in which the unit were performing within the expected range included discharges direct to home, unplanned re-admissions within 48 hours, risk-adjusted acute hospital mortality and risk-adjusted acute hospital mortality – predicted risk is less than 20%.
- We saw evidence that the unit participated in meetings to feedback from audits and research. We saw an audit overview focussing upon renal replacement therapy (dialysis) and effectiveness of filters (technical equipment used in dialysis machines) used. This showed that changes made by the staff ensured dialysis sessions were more economical whilst still being effective as treatment, reducing the risk of filters clogging before they should. We saw evidence that medical staff involved in this audit had been invited to present their findings and to share best practice at establishments outside of the trust.
- Medical staff at the trust had undertaken an audit of parent team reviews within critical care. We saw from this that significant improvements had been made about parent teams both reviewing and documenting reviews of patients.
- The critical care unit (CCU) had a specialist nurse for organ donation (SNOD) who worked with patients, families and other professionals in order to manage organ donation. We also saw information leaflets providing details of donating organs for individuals who followed specific faiths. Staff told us that they had achieved 50% about asking appropriate patients' and relatives about organ donation. This was in line with the NICE clinical guideline 135.
- Nurses within CCU were required to complete two competency booklets; the first was entitled 'step one competencies' and generally took three months to complete on commencement in the CCU. The second booklet incorporated national critical care competencies and nurses were expected to complete this within 12 to 18 months. Following the successful completion of this booklet, nurses were expected to be ready for the post registration critical care qualification.
- Bank staff used for both CCU and the outreach team comprised substantive CCU staff; therefore were appropriately competent to undertake this role.
- The CCU had recently appointed two new practice development nurses (PDNs). We saw significant evidence that the PDNs were proactive and supportive about aiding staff achieve competencies. For example, we spoke to staff who showed us their competency booklets were up to date and ongoing, we observed PDNs give 'on the job' training sessions and we saw plans to continue staffs' professional development in a sustainable way.
- Staff spoke positively of their professional development and reported that they were supported to attend additional training to progress within their role, such as male catheterisation and mentorship training to support more junior colleagues.
- We saw evidence within team meeting minutes that training on different specialities was given to nursing staff. For example, the pharmacist and specialist nurse for organ donation (SNOD) had given talks at meetings.
- The trust provided us with information regarding the management of staff who were not performing to the required standard; PDNs were able to set action plans and monitor progress through additional competencies.
- Nursing staff working within HDU and ICU reported they completed six-month rotations in each ward in order to maintain competencies and skills; this was due to the wards being physically separate to each other at the time of the inspection.
- The critical care outreach team, as stated previously in this report, were not fully integrated within the wider CCU staff group or directorate. The outreach team were part of the medical directorate. This meant that, although there was communication between the outreach team and the CCU nursing staff, the outreach team had no arrangements to access training, development, rotation of work, or supervision or management that the CCU staff had. We observed this

## Competent staff

- Data from the trust showed that as of March 2017, 77% of staff within the critical care unit (CCU) had received an appraisal as compared to the trust target of 90%. This was further broken down by staff group. Seventy five per cent of nursing staff had received an appraisal, and 100% of administrative staff had received an appraisal. All medical staff we spoke to confirmed they had received an appraisal within the last 12 months.
- Fifty four percent of CCU nursing staff had completed a post registration critical care qualification. This met the Core Standard for Intensive Care Units standard 1.2.8. In addition, the CCU had one whole time equivalent (two part time staff) practice development nurses to support the training and education of the staff. This was in line with the Core Standards for Intensive Care.

# Critical care

during our inspection, and data from the trust confirmed this. Furthermore, staff told us that the advanced nurse practitioners (ANPs) staff that covered between 8pm and 8am were not specifically trained in critical care skills; their role covered ten wards within the hospital at night and was not specific to critical care patients. Therefore, we were not assured that the critical care outreach team had or were able to maintain their skills and competencies in order to complete their role due to their isolation from the CCU management structure. Data from the trust post inspection also reported that although the outreach team were invited to participate in critical care operational meetings attendance was infrequent.

- The matron for the surgical care group, under which CCU fell, worked clinical shifts alongside side staff but had not completed the updates and they provided one to one care for patients. The Matron acknowledged that some competencies had lapsed; however, we saw they were certified to practice under Nursing and Midwifery council (NMC) guidelines. The matron had a critical care background.
- We saw from data provided pre inspection, that of all staff approximately 23% were not up-to-date with equipment training.
- We saw the trust had commenced a schedule of three study days for CCU staff including nursing staff and medical staff. Staff from the emergency department (ED) and the ward were also invited. The first study day focussed upon airways and was held in March 2017. The trust provided us with verbal and written feedback following this study day from a range of staff, which was overwhelmingly positive. In addition, other specialist staff throughout the trust were invited to nurse team meetings to provide 'bite-sized' training events.

## Multidisciplinary working

- The pharmacist and junior doctors attended most ward rounds to ensure all immediate teams who were involved within the patients care were represented. We observed that all members of the ward round were included in discussions and clear plans for ongoing patient care were made during the ward round process. A dedicated pharmacist attended both high dependency unit (HDU) and intensive care unit (ICU) ward rounds. Physiotherapists attended the ward round where possible.

- Nursing staff reported good relationships with medical staff; stating they felt they worked well as a team and were listened to.
- Staff told us, and we saw, that the critical care outreach team attended the unit to discuss patients who could be discharged to the ward, and patients being supported on the general medical wards. However, the outreach team did not attend team meetings. The communication was more limited to nursing staff, with the critical care outreach team having limited communication with CCU consultants. Therefore, a multidisciplinary approach to managing acutely ill patients located within medical wards was limited.
- Allied health professionals (AHPs) that regularly attended the CCU included physiotherapists. We saw that these teams had time allocated to CCU; and were fully staffed with capacity to complete their work within CCU. AHPs provided routine cover five days per week (Monday to Friday) and provided on call cover out of hours. We spoke with the physiotherapy team and the staff within CCU who confirmed this was sufficient. AHPs recorded their appointments with patients within patient records.
- We found there to be good working relationships between nursing staff, medical staff, and allied health professionals (AHPs) such as physiotherapists. Both nursing staff and physiotherapists told us they had daily conversations as a minimum to discuss patients; and the nurses could contact the physiotherapy staff at any time to attend the critical care unit (CCU) to provide support.
- Physiotherapy staff told us they were working towards making occupational therapists an integral part of the critical care rehabilitation team in order to support therapy needs.
- Staff told us contact with the speech and language therapists (SALT) was less frequent; staff would have to contact them to attend the unit for swallowing assessments and there was no SALT cover at weekends. In addition, dietitian support was as requested rather than as a full member of the multidisciplinary team. The Core Standards for Intensive Care state a dietician must be part of the CCU multidisciplinary team.
- Regular neurological input was not available within CCU.
- A learning disability nurse specialist worked within the trust and supported patients within the unit who had learning disabilities or difficulties.

# Critical care

## Seven-day services

- The critical care unit ran as a seven-day service.
- Please see 'nurse staffing' and medical staffing' within the safe domain for details of out of hours cover for nursing and medical staff, and allied health professionals cover.
- Microbiology services were available daily at all times; staff reported these services were very good. Staff said that there was a lack of routine endoscopy cover out of hours; which could negatively affect a patient who urgently required this service.

## Access to information

- The trust intranet and email system was available for all staff to use. We saw several computers both within the high dependency unit (HDU) and the intensive care unit (ICU). Therefore, staff were able to keep up to date with changes to policies and procedures; and to find information easily.
- We saw physiotherapy assessments and treatment plans were incorporated into clinical notes and discussed with staff on the unit.
- We observed both nursing and medical handovers; these incorporated a full handover of each patient's status and any additional details. The exchange of information aided effective patient care.
- Ward managers verbally communicated urgent information to staff on shift; and changes to policies and procedures were emailed out to staff.
- Administration staff within CCU contacted patients' GPs to obtain information and to share information from the hospital. This was recorded within patient records.
- We saw within staff areas on both wards within the critical care unit (CCU) folders containing updates and information. The folder on HDU did contain some out of date information; however, within ICU this was well maintained with learning from incidents, policy changes, minutes from meetings and training overviews kept within.
- Nursing staff had access to a communication book on the ward in which quick messages between staff could be communicated.

## Consent and Mental Capacity Act

- The trust reported that as of March 2017, 100% of critical care unit (CCU) staff had completed both Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- We spoke with staff that showed a thorough comprehension of what may affect a patient's mental capacity, how to assess this, and when a best interest decision and or a DoLS may be required. Staff were able to tell us which patients were subject to a DoLS at the time of our inspection.
- During our inspection, we found that staff were completing mental capacity assessments at the time of making decisions about patient care and treatment for those patients where it was suspected they might lack capacity. In addition to this, we saw evidence where DoLS had been implemented for the best interest of patients.
- We saw that some patients within the high dependency unit (HDU) became agitated and restless, sometimes because of confusion, and would attempt to remove medical devices such as intravenous lines. We saw that patients who posed this risk were assessed; and where required were given sedation medication, or provided with items such as hand control mitts. We saw that mental capacity assessments were completed fully in all of these cases at the time of making each decision in order to reduce risk to the patient, with Deprivation of Liberty Safeguard (DoLS) paperwork completed for each patient.
- We observed staff conducting a capacity assessment at the time of a care decision being made. Nursing staff conducted the assessment fully and it was deemed the patient did have capacity to make this particular decision; and therefore consent was sought in the usual way.
- However, we noted that in the vast majority of records we viewed; bed rails assessments had been completed with a decision taken to put the bed rails up as a result; therefore preventing patients from falling out of bed. We noted that no Mental Capacity Act assessments had been undertaken, or DoLS applications conducted for these particular restrictive measures. The Social Care Institute for Excellence (SCIE) cites bedrails as a restrictive measure as it prevents a person from leaving their immediate environment. We spoke with staff about this and staff within CCU acknowledged that DoLS



# Critical care

applications were not made for these particular decisions regarding bed rails and identified that this should be the case, following a mental capacity assessment.

- We observed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms had been filled out appropriately where required; including mental capacity assessments and input from family and carers of the patients' involved. Please see the End of Life Care core service report for further detail.
- We saw that information was provided to relatives about consent, and decisions that may be made in the best interest of the patient.

## Are critical care services caring?

Good



We rated caring as good because:

- All grades of staff were caring and compassionate towards patients. Where appropriate we saw staff explain the care they were giving, to patients.
- We saw that staff within the critical care unit (CCU) had helped facilitate two weddings for patients located within the unit within the last 12 months.
- Spiritual support was available for patients and relatives for a range of faiths.
- We saw staff worked hard to maintain the dignity of patients despite the lack of space and facilities within CCU.

However:

- The lack of space within the unit meant that there were limited facilities to have confidential conversations with patients and relatives.

### Compassionate care

- We saw excellent examples of interaction between staff and patients, which highlighted good levels of kindness, compassion, and respect. Relatives we spoke with reported staff were caring; 'the staff have been brilliant'; and spoke of how staff had ensured relatives were looked after; for example bringing relatives drinks out of café opening hours and supporting relatives who wished to stay overnight.

- We saw staff made an effort to respect patients' privacy where possible such as pulling curtains around the beds whilst providing personal care.
- However, we saw that despite staff effort, the physical environment within the critical care unit (CCU) meant that patient dignity and privacy was compromised. For example, the lack of space around beds in the high dependency unit (HDU) may compromise nurses' ability to remain fully private when caring for individual patients. This issue was raised within the CCU risk register; however, until the new build it would be difficult to resolve fully.
- Staff told us of a recent wedding that had been organised within the unit; the CCU staff worked alongside other departments to ensure the day ran smoothly. Staff reported this is the second wedding to take place within the CCU. Staff spoke very passionately of these events; indicating they genuinely cared about creating the best environment possible for their patients.
- We saw both nursing and medical staff were cheerful and enthusiastic, where appropriate, when working with patients. We saw staff communicated with all patients, despite their level of consciousness. Patient care and comfort were clearly at the core of the CCU; as demonstrated through staff patient interactions, and staff conversations had about patient. For example, we saw a patient requested a light breakfast but then fell asleep. Staff discussed whether to wake the patient or not; decided against, and made fresh food upon the patients' later awakening.
- We observed that staff responded quickly when patients requested their attention.
- We saw that the trust sent bereavement questionnaires to the relatives of patients that had passed away. We viewed four that had been completed in April and May 2017 for patients that had been within CCU during their stay. We saw that all four have very positive responses for questions about the care and support provided to the patient and their family, the professional, helpful and caring attitude of the staff, the privacy provided for family discussions with staff and the privacy and dignity afforded to the patient and their family as the patient passed away.
- The CCU collected Friends and Family Test (FFT) results. These indicate whether patients would recommend the unit to friends and families if they needed to attend a



# Critical care

hospital for this purpose. Within May 2017, the unit received two responses; both reported they would recommend the unit. We also saw positive comments about the care provided by CCU staff were noted.

- Across CCU, we observed numerous thank you cards on display from previous patients and relatives of patients. These all commented upon the care and good level of service provided by staff within the CCU.
- Both nursing and medical handovers were conducted away from clinical areas in order to protect patient confidentiality.

## Understanding and involvement of patients and those close to them

- As highlighted above, the physical environment of the CCU had limited space. This included facilities for relatives, which meant that when staff had to speak to relatives or carers regarding patients to update them on their condition, staff could not always ensure this was done confidentially. We saw that staff did make as much effort as possible to overcome this. For example, we saw that a patient, who was at the end of their life and had later passed away, was moved to the additional space used by the intensive care unit (ICU) as there were no other patients currently occupying that space. This meant the family of the patient could have some time alone, in private, with their deceased relative.
- We spoke with relatives of patients. For the vast majority, relatives and carers reported that staff kept them very well informed of patients' progress, and provided useful information about patient care. However, two relatives we spoke with within ICU informed us they had not been updated on their relative's current condition since the patient had been transferred in from a ward two days ago, despite being the patients' next of kin.
- We saw that staff explained the care they were providing to patients where possible. We saw staff engage with patients and ask questions to ensure the patient was comfortable and included within their care.

## Emotional support

- We observed staff give physical gestures of comfort to patients who were in distress. Staff spoke in calm and soothing tones to aid the reduction of emotional upset. Appropriate language was used to provide emotional support to both family and relatives.

- Guidelines for the Provision of Intensive Care Services (GPICS) 2015 identified that patient diaries can be a useful tool to promote patients' psychological well-being during recovery from intensive care treatment, in addition to being a 'caring intervention'. Staff told us that patient diaries were no longer completed for patients within CCU at Walsall Manor, and there was no plan to reintroduce these at present.
- Chaplaincy services visited the unit at least twice a week to provide spiritual and emotional support for a variety of religions.

## Are critical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There was a lack of appropriate facilities for relatives to stay; within the high dependency unit (HDU), there was one small enclosed room with no washing, toilet, or sleeping areas. The intensive care unit (ICU) had space for one person to stay overnight.
- Bed occupancy was consistently high throughout the reporting period.
- Delayed discharges were worse than other similar sized units. Due to the size of the unit, patients that needed to be stepped down (moved from ICU to HDU) or stepped up (moved from HDU to ICU) were sometimes managed within the unit they were in; with staff moving between the wards to manage the levels of care required.
- Complaints took longer than the trust target of 45 days to be managed.
- We saw a high level of mix sex breaches, particularly within February and March 2017.

However:

- We saw adaptations were available for patients with additional needs. For example, interpreters were requested to interpret for patients who did not speak English.
- Within the reporting period, no patients were transferred out for a non-clinical reason; therefore, all patients that required critical care were managed at the hospital despite the high numbers compared to the available beds.

# Critical care

## Service planning and delivery to meet the needs of local people

- Since the previous CQC inspection in 2015, the trust had made significant steps towards providing a purpose built critical care unit (CCU). Data from the trust reported that this project had been ongoing since prior to 2013. When we inspected on this occasion we saw the trust had recently commenced the building works for the new unit. The trust anticipated the new CCU would be completed by October 2018. We saw the plans for the new unit met the Health Building Notes 04-02, which specify the required standards for intensive care facilities.
- The plans for the new CCU as referenced above also outlined how the needs of patients, including those from the local community and from other areas, would be met. For example, the plan outlines an integrated unit to flex bed utilisation between Level 2 and Level 3 patients, and allow the staffing team to step up or step down immediately a patient's condition changes rather than waiting for an appropriate bed to be available in the correct unit.

## Meeting people's individual needs

- During our inspection, we observed there was provision to support patients and relatives whose first language was not English. For example, we saw access to face-to-face interpreters was swift, and noted leaflets and information in languages other than English. Relatives were also able to access interpretation facilities through the Patient Advice and Liaison Services (PALS).
- We were told about support for patients that had sight and/or vision impairment, in addition to formal interpretation such as using writing to communicate, boards with signs on, and enabling visitors to come and support the patient for general communication needs. Staff told us about a trial of tablets in the department, which 'spoke' aloud to enable people with vision impairment to communicate.
- We saw relatives were supported to stay overnight, and were able to access washing and toilet facilities. However, these facilities were only available in the intensive care unit (ICU); and were limited to one person at a time. In particular, within the high dependency unit (HDU), the relatives' waiting room was small and enclosed. If relatives visiting patients in HDU wished to

- access washing facilities, go to the toilet or stay overnight, they had to re-locate to ICU, which was located in a separate ward. We saw that if required, staff within HDU allowed the use of the staff room area for private conversations.
- We saw there was a drinks machine for relatives use within ICU; however again, no such facilities existed within HDU.
- Relatives and carers were able to access reduced price parking at the hospital and details of this were in relative waiting areas. For any patients that were at the end of their life within CCU, relatives could park free whilst visiting.
- Spiritual support was available for patients and relatives for a range of faiths including Christian, Hindu, Muslim, and Sikh. Staff told us that members of the chaplaincy team attended at least twice weekly to support patients; and were available more regularly if required.
- We saw booklets were available for relatives that provided a range of information for example support options, visiting arrangements, how patients were cared for and what to expect from nursing and medical staff.
- Staff provided examples of how they adapted their approach to working with patients with learning disabilities and dementia. For example, enabling 24-hour community carers to communicate to support the patients as much as possible, and allowing more time to explain care and treatment. Staff would also refer to the trust specialist nurse for patients with learning disabilities; and liaise with family members to gain information about the patient's preferences.
- The CCU had access to bariatric beds and a recliner chair (for heavier patients); however, these had to be requested from the West Midlands Critical Care Network.
- We saw nurses had symbols they could add to patients' bedside areas to alert staff to any additional needs; for example, leaves for patients at risk of falls.
- A television was available for patients to watch in HDU.

## Access and flow

- Data provided prior to our inspection showed that between May 2016 and April 2017, critical care was above the England average for bed occupancy for the majority of this time period. More up to date data showed that bed occupancy was 100% during September, October and December 2016, and January and April 2017.

# Critical care

- There was an escalation process to follow if CCU was approaching full occupancy, or if a mixed sex breach was likely to occur.
- 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 new admissions. Of these, 289 patients were admitted from the ward; of these 16 were categorised by the trust as 'high risk' admissions, which made 5.5%.
- We observed a delayed admission to the intensive care unit (ICU) from a medical ward, which occurred out of hours. We saw the patient waited almost five hours following the decision to admit the patient. The Core Standards for Intensive Care state admission to CCU should be within four hours in order to minimise delays to definitive treatment; this is associated with better outcomes in acutely ill patients.
- Information provided by the trust identified that within the critical care unit (CCU), out of 4745 available bed days in 2016/2017, 6.7% of patients had a delayed discharge of more than eight hours. This was better than 2015/16 whereby 13.5% of occupied bed days had patient discharges delayed by more than eight hours.
- We requested further data from the trust, which highlighted delayed discharges, which were more than four hours. During March 2017, this totalled 45 patients, during April 2017, this was 46, and during May, the number was 47. Reasons provided for these delays included waiting for a speciality bed or a side room.
- We saw that patient flow was looked at regularly within the hospital; for example, bed meetings were held three times daily to assess the needs of patients and availability of beds within the hospital. Staff told us that they informed staff managing patient flow within the trust immediately if they were aware a patient needed to be discharged from or admitted to CCU to enable the team to focus upon ensuring space was available. The critical care outreach team was also involved in these discussions to aid patient flow and to reduce delayed discharges.
- At the CCU in 2016/17, 1.6% of admissions were non-delayed discharges to the ward, out of hours. Out of hours discharges took place between 10.00pm and 6.59am. Compared to other units, this unit was performing slightly worse than others; however still within the expected range.
- During 2016/17, at the CCU there were 865 eligible admissions of which none were transferred to another unit for non-clinical reasons. This is a positive result and corroborates information provided by staff during our inspection. Despite the high bed occupancy, the CCU remained open to patients that required this service.
- We saw there were nine mixed sex breaches in February 2017, and seven in March within the high dependency unit (HDU). For March, the length of breach for each patient was between one and two days. This was considered an under performance against this measure for the trust. Since 2011, NHS guidelines specify that all inpatient accommodation for NHS patients is single sex. A breach of 'mixed sex accommodation' also refers to bathrooms, toilets, and the need for patients to pass through areas for the opposite sex to reach their own facilities.
- Data from the trust reported that between June 2016, to June 2017, 17 elective operations were cancelled due to a lack of critical care beds.
- The trust provided data, which reported approximately 3285 patients, were seen by the critical care outreach service between June 2016 to June 2017.

## Learning from complaints and concerns

- Between April 2016 and March 2017, six complaints were submitted regarding the critical care unit (CCU). The trust took an average of 59 days to investigate and close complaints; this is not in line with their complaints policy, which states complaints should be dealt with within 45 days, dependent on the seriousness of the complaint.
- Three of the complaints related to clinical care, two were about poor communication, and one related to privacy and dignity.
- We saw that as of the time of our inspection, one complaint had been upheld and was resolved, one was partially upheld and resolved; the remaining four were ongoing. Staff told us that if they were involved in care that led to a complaint, they were required to give statements as part of the investigation.
- Data provided regarding these complaints demonstrated that plans were in place to share learning in various ways to different staff groups, for example sharing at team meetings and through anonymised case study learning days. Staff were able to provide examples

# Critical care

of complaints that had been made and identify learning and changes of practice as a result. For example, taping prone patients' eyes shut to avoid eye irritation or infection.

- Advice on how to make a complaint was advertised within waiting areas and within a relatives information booklet. Relatives we spoke with were aware of how to make a complaint if they felt this was necessary.

## Are critical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- We saw senior management did not have an awareness of the day-to-day workings of the CCU; for example, the investigation results of some high profile incidents, and progress since the last CQC inspection in 2015.
- We were not assured that the CCU risk register had captured all risks. For example risks relating to the up to date competency of the out-reach team, and risks regarding specific equipment such as capnography. This was despite all managers being fully aware that these areas were risks to the service.
- The trust was slow to purchase vital safety equipment.
- Critical care outreach staff were isolated from the wider CCU, due to being part of a separate care group. They presented as unsupported, distanced from competency based training and with low morale.

However;

- Staff within the critical care unit (CCU), in the main, spoke extremely positively about the support and guidance provided by local management. Staff told us morale had risen following the start of building the new CCU; this followed on from a period of lower morale in part due to the current environment and a perceived lack of action in this area.
- Staff were aware of the trust vision and values and presented as passionate about working with patients within CCU.
- We saw clinical governance minutes showed a multidisciplinary approach to reviewing the CCU as part of the surgery directorate. A variety of areas were reviewed within these meetings such as audits, incidents, complaints, and service risks (including those on the risk register, and other risks).

## Leadership of service

- The critical care unit (CCU) was part of the surgical care group within the trust. The care group had a triumvirate leadership, which incorporated a matron with a critical care background, a clinical director, and a care group manager. The matron fed information up to the director of nursing. Beneath this triumvirate was a clinical director of intensive care who led the service.
- Below this management, team sat two ward sisters who covered the management of the high dependency unit (HDU) and the intensive care unit (ICU). We saw the practice development nurses managed the training and development of critical care staff, and supported the sisters. Band six nurses were also given supervisory responsibilities such as conducting appraisals for band five and band two staff, and for chairing team meetings. Staff in management positions told us they felt they would get support from the director of nursing if they needed this.
- Staff we spoke with were, for the vast majority, overwhelmingly positive about their local leadership of the ICU and HDU. The band seven staff running the ward were reported to be very supportive to staff, even when discussing and managing difficult situations such as long-term sickness. We also observed these staff to be actively working within the ward, caring for patients by administering medicines, providing bed baths, and generally chatting to patients. It was clear by patient responses that this happened regularly. Staff gave us examples of the flexibility of the ward management, such as adjusting management days to cover clinical duties. We also observed this happening on the days of our inspection visits.
- Administration staff within CCU were managed by a different manager to the band seven staff within CCU. However, staff reported they still felt very much part of the team and involved within the unit.
- We spoke to junior doctors who reported they felt well supported by consultants within the surgical care group.
- During the inspection period, the weather was unseasonably hot. We spoke with staff about managing this; they reported that they submitted incident reports; however, the ward manager had escalated the issue to the health and safety team, which resulted in the provision of fans and portable air conditioning units for the staff and patients.

# Critical care

- We were told of changes from the last CQC inspection in 2015 regarding leadership; these included members of the executive team being more visible and having more contact with staff, drop in sessions held in the hospital's coffee shop and monthly meetings.
- We saw variable evidence regarding the senior managers' full understanding of the issues within CCU. For example, upon speaking a member of the triumvirate management team, they showed a good understanding of some risks to the service such as the issues around lack of capnography equipment. However, was unable to explain some incidents around bolus administration of medication; relating two such incidents to new members of staff. We reviewed these incidents and found that this was not the cause. We were also told that the rehabilitation service had not changed since the last CQC inspection; and until the new build of CCU was complete, there were no plans to improve this as an interim measure. However, during the inspection, we saw that rehabilitation was much improved with physiotherapy in particular having a significant input into patient care.

## Vision and strategy for this service

- Data from the trust showed the strategy for the critical care unit (CCU) from 2017 to 2022. We saw several actions to implement the strategy had already been undertaken such as the new build for the CCU had commenced, and development of the CCU workforce was underway. The new unit would be a combined unit for both high dependency and critical care patients with 18 beds to account for the needs of patients in the local area. Staff we spoke to were aware of the plans for progression for the unit and were positive that this was taking place.
- We saw the trust vision and strategy focussed upon providing safe and specific needs led care at the right time and in the right place.
- Staff told us about the vision and values and spoke about the benefits of working within CCU, which enabled them to live the values, such as spending more time with patients and relatives to provide a high level of patient care.

## Governance, risk management and quality measurement

- The trust held a risk register specific to the critical care unit. As of February 2017, the register contained 14 risks.

These included several risks linked to capacity due to the current structure of CCU. For example, the potential for single sex breaches within CCU reduced essential equipment when the unit was at capacity, and not being able to transfer patients between intensive care unit (ICU) and the high dependency unit (HDU).

- We saw that although critical equipment being short when the CCU was at capacity was on the risk register, there was no specific mention of the lack of provision of capnography to manage all patients that required this. This was despite this issue being raised repeatedly at clinical governance meetings. For example, within the clinical governance meeting minutes for March 2017; we saw new capnography should have been procured by October 2016; this had not yet been done. We were concerned that senior management within the trust had not addressed this concern until it was escalated during the inspection process.
- Other risks included concerns already highlighted within this report such as the current CCU environment having the potential to lead to an increased risk of infection, and poor patient care including a lack of privacy and dignity because of the physical environment.
- We saw risks relating to medical staffing including concerns such as ineffective handovers that did not meet the General Medical Council (GMC) guidance, and a lack of middle grade doctors that led to challenges relating to the development of staff already in post at this grade.
- We also saw that inadequate provision of critical care rehabilitation remained on the risk register. This was identified within the previous CQC inspection in 2015. However with this specific risk, we saw during this inspection the rehabilitation team such as physiotherapists had made significant progress with regards to assessing patients in line with the Core Standards for Intensive Care Units, and had integrated into the CCU as a whole; becoming a strong part of the multidisciplinary team.
- We saw that risks on the risk register had associated actions to mitigate these, although some risks would not be fully resolved until the new CCU had been completed. For example, single sex breaches. However, the trust recognised that every occasion should be logged as an incident so this could be monitored in an ongoing manner.
- Not all risks we identified during the inspection were on the risk register; firstly that of the disassociation of the



# Critical care

critical care outreach team to the CCU team. The critical care management structure were aware of the concerns around this and highlighted they were moving towards integrating the outreach team to be within the surgery directorate; therefore to be integrated within the CCU team as a whole; rather than be in a separate directorate under separate management. It was acknowledged this would be a significant project ensuring the outreach team felt valued and supported to develop competencies and skills up to the levels required of critical care nurses.

- We reviewed three sets of monthly clinical governance meeting minutes between January and March 2017. Within these minutes, we saw that incidents, complaints, audit results, and service risks were reviewed. During these meetings, which were attended by a range of medical staff and unit managers from services within the surgery directorate, which included critical care, we saw learning from incidents was shared and learning and updates were presented such as a trust wide General Medical Council (GMC) presentation. These meeting minutes were available on the intranet for all staff to view.
- The trust provided us with three sets of minutes of monthly ward meetings; these were from March to May 2017. More senior members of the nursing team (band 6 and 7) from the critical care unit attended these meetings. We saw that training and development, including updates to changes in policies and procedures were conducted within these meetings. In addition, concerns, complaints, and incidents were discussed, and monitoring for actions taken was recorded. Attendees also discussed staffing related topics such as staff sickness rates, use of bank and agency, and appraisal completion compliance. We saw individual attendees were allocated areas of speciality such as equipment, tissue viability, and nutrition in order to disseminate learning and training to more junior members of staff. These minutes highlighted that information was cascaded downwards to staff, via team meetings. Regular team meetings had also commenced for band 2 and band 5 staff which were chaired by a band 6 member of staff. We saw minutes for these meetings located in staff areas so any non-attendees could read them. The chair of the meetings also emailed minutes to staff.

- Data from the trust showed that the surgery directorate, including the critical care unit, provided reports, and presentations to the board to ensure information was cascaded upwards.
- During our inspection, we saw that the critical care unit had changed some practice since the last CQC inspection in 2015. For example, multidisciplinary working was much improved and mortality was monitored monthly by a multidisciplinary team; these meetings included discussion and learning from mortalities that had occurred within the critical care unit.
- We saw risks to the unit were recorded on staff room walls; and information was available to encourage learning following incidents and practice updates.
- During the inspection, it was highlighted that one consultant reviewed all relevant patient deaths and incidents within CCU. Whilst this created consistency and ensured continuity with managing these processes, this was a substantial task for one individual to cover in addition to other clinical duties. A more wide reaching review by individuals of different knowledge and experience may also present a more robust, rounded process.

## Culture within the service

- Generally staff within the critical care unit (CCU) reported being happy within their roles. This included nursing staff, administrative staff, and support staff. The vast majority of staff told us that they enjoyed their role within CCU and felt it was a friendly and positive environment.
- We saw within team meeting minutes that CCU nursing staff were able to raise concerns and general issues, which may have affected the team. Action plans were in place to address staff concerns.
- The CCU Consultants reported and demonstrated a collegiate approach to working.
- We were told within documentation provided by the trust, that morale had been lower prior to the inspection; largely in part to the physical environment in which staff had to work; and the lack of visible progress on the new build despite approved plans being in place for some time. Staff based within CCU showed positive reactions towards the start of the new build taking place, and all staff we spoke to presented as eager to be working within the new environment.



# Critical care

- However, we did observe that the outreach team; although in communication with the CCU nursing staff within the wards, were disconnected from the staff in terms of inclusion within team events, training, supervision, management and professional development. The trust said that the outreach team were invited to attend certain team meetings; however, this attendance was infrequent. This lack of attendance may have been due to the isolated nature of the outreach role within the trust. As previously reported the outreach team came under a different care group (medicines) and therefore were not, from a management point of view, part of the CCU. Management had identified this concern, and initial plans were in place to bring the outreach staff back within the surgical care group in which the CCU sat.
- We saw that the critical care outreach team felt unsupported and had fewer opportunities for professional development.

## Public engagement

- Staff within the critical care unit (CCU) sought to gain feedback from patients and patients relatives and carers through the use of the Friends and Family Test (FFT). Due to the nature of the department; the unit received a low response rate. However, 100% patients asked to complete this reported they would recommend the unit to family or friends.
- We saw the trust asked relatives of deceased patients to complete a bereavement questionnaire. Where patients had passed away within the CCU, or had spent time in CCU, relatives were able to comment upon choices they and their family member had been given, and the care

and information provided to both the patient and relatives. We reviewed four completed within April and May 2017. Please see the 'Caring' section for further details.







## Staff engagement

- Senior management highlighted that staff engagement was a relatively new process and was regarded as an ongoing project. We saw plans included full team meetings, bringing the critical care outreach team back within the surgical care group and sharing ideas with the wider critical care team.
- We saw that, with the exception of the critical care outreach team, staff were currently involved in meetings specific to their bands (for example, meetings were held for band 2 and band 5 staff; separate meetings were held for band 6 staff). Staff also had one to one discussions with either the ward manager, or their mentor dependant on grade.

## Innovation, improvement and sustainability

- As previously highlighted throughout the report, the trust were in the process of building a new critical care building which met health building note requirements. This was due to be completed by October 2018. We were told about, and saw that staff were trialling up to date equipment to be used within the new build.
- We saw that new technology (tablets) were available for staff use when capturing patient information. This included the National Early Warning Score (NEWS) to identify deteriorating patients, and for the Friends and Family Test (FFT), to identify patient satisfaction. Anecdotal reports from staff were that this technology was helpful, for example collecting more FFT results than previously.

# Maternity and gynaecology

Safe	Inadequate	
Effective	Requires improvement	
Caring	Requires improvement	
Responsive	Requires improvement	
Well-led	Inadequate	
<b>Overall</b>	<b>Inadequate</b>	

## Information about the service

Walsall Healthcare NHS Trust provides maternity services across both acute and community settings.

Maternity services at the Manor Hospital offer a consultant-led delivery suite which includes one low risk birth room, a fetal assessment unit (FAU), a triage area, an induction of labour area, an outpatient antenatal clinic and an antenatal and postnatal inpatient ward. A standalone midwifery led unit (MLU) is situated a mile away from the main hospital. The unit has three double bedrooms and birthing pools. The community midwifery teams provide maternity services in partnership with general practitioners and health visitors. The community midwives provide antenatal care, home births and postnatal care in children's centres, GP surgeries and in women's own homes. In 2016, the service and stakeholders made the decision to cap the births at Manor Hospital to 4200 annually. This was due to shortfalls in staffing numbers and increased demand for services. 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.

The gynaecology service offers inpatient services, day care, early pregnancy and emergency assessment facilities. Outpatient services include colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists are supported by specialist gynaecology nurses, general nurses and health care assistants.

The inspection was a focused follow up from the inspection in 2015. We rated this service as inadequate overall with safe, effective and well-led rated as inadequate and caring and responsive domains rated as requiring improvement.

Following the inspection we served a Section 29A Warning Notice to the trust regarding the significant concerns identified during the inspection. The four main areas for improvement were:

- The monitoring, recording and escalation of concerns for Cardiotocography (CTG)
- Insufficient midwives with HDU training to ensure that women in HDU were cared for by staff with the appropriate skills
- Safeguarding training was insufficient to protect women and babies on the unit who may be at risk
- There were insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards.

We visited all of the main hospital wards and departments relevant to the service. We visited the stand alone midwifery led birthing centre but did not inspect any of the community midwifery services. We spoke with 21 women and relatives, and 50 members of staff, including doctors, anaesthetists, midwives, nurses, support workers, administrators and student midwives. We looked at 40 sets of medical records.

# Maternity and gynaecology

## Summary of findings

During the last inspection in September 2015, we rated Maternity and Gynaecology services as Inadequate for safe, effective and well led with caring and responsive rated as requires improvement. This meant the service was rated inadequate overall. All of the concerns raised in the previous inspection related purely to maternity services and not gynaecology.

This was because in 2015;

- Staffing levels were insufficient to meet the needs of women and their babies.
- Midwives without specialist training cared for high-risk women.
- Medicines were not stored correctly and confidential information was not kept secure in maternity and gynaecology services.
- Outlier patients on the gynaecology ward caused delays in elective gynaecology operations.
- Audit and plans to improve the service were limited.
- There was a lack of any credible vision and values.
- Forward planning of the service was focused on refurbishment. It did not consider how the number of births would be managed in future.
- Some areas of the maternity and gynaecology service we visited were not clean or well maintained.
- Upper management were not visible at ward level. The management style was top down and directive.
- The maternity dashboard showed several risks that had been evident for two years and governance arrangements were poor.

Following this inspection we rated the service as Inadequate again. All of the concerns raised in this inspection related purely to maternity services and not gynaecology. Although we saw some of the concerns from the previous inspection had been addressed in maternity services we had significant concerns about other areas which had not, this is because;

- Serious incident action plans were not always monitored or completed.

- There was poor evidence of learning from maternity incidents.
- Most staff we spoke with across maternity services could not explain duty of candour and were unable to tell us in detail about the process involved.
- Prescription charts were not fully completed.
- Medical and maternity records were not kept securely in all areas and were not easy to navigate through.
- Staff had not completed safeguarding training in accordance with the trust's target.
- Midwifery staffing was not at the agreed level and with high rates of vacancy and sickness staff were under constant pressure.
- Maternity staff did not always complete the venous thromboembolism risk assessment.
- Maternity staff we spoke with knew a major incident plan existed but nobody could be specific and explain their role within the major incident plan.
- Staff did not always plan care and treatment that was in line with current evidence-based guidance, standards and best practice.
- Audits and plans to improve maternity services were limited.
- Most women we spoke with following birth felt that their pain control had not been well managed.
- There was out-of-date information displayed or in folders for staff to refer to.
- There were many guidelines that remained out-of-date following our last inspection.
- Medical staff within maternity did not always explain the risks to women before a procedure.
- The milk fridges were not locked which meant breast milk could be tampered with.
- Instrumental births and caesarean section rates continued to be higher than the national average.
- Some staff did not have the right qualifications, skills, knowledge and experience to do all aspects of the care they provided to women who used maternity services.
- Handovers were not always focused and in an effective environment.

# Maternity and gynaecology

- Women did not have access to the midwifery led unit due to staffing issues.
- Staff morale across maternity was low due to high levels of stress and work overload. Staff did not feel respected and valued.
- The maternity dashboard showed several risks that had continued to be evident without improvement.
- Due to the challenges facing the maternity service the senior team was focused on managing the daily strains it faced with little innovation evident.
- Women did not always receive compassionate care. Maternity service staff were trying to provide a caring and compassionate service in challenging circumstances.
- There was no consistency of how maternity meetings were held and minutes recorded.
- The senior leadership team was in its infancy and there had been little strategic oversight of governance and incidents at a senior level.
- Maternity staff did not feel involved with the decisions made about the service at a senior level.

However:

- Medicines were stored in locked cupboards, and disposed of safely.
- Adult resuscitation equipment was checked daily in all areas.
- Maternity and Gynaecology staff completed early warnings scores.
- Gynaecology documentation was good.
- Medical staffing on the delivery suite was in line with RCOG Safer Childbirth recommendations.
- Multi-disciplinary team (MDT) working was in the maternity and gynaecology service.
- Women on the gynaecology ward we spoke with told us that they had received pain relief when requested in a timely manner.
- Areas we visited were mostly visibly clean.
- Hand hygiene audits carried out in January 2017 and February 2017 showed 100% compliance with recommended practice in all areas of the service.
- Fluid balance charts we observed were used and correctly calculated and up-to-date.

- Community midwives had good engagement with each other in the primary care setting.
- Gynaecology nurses had an understanding of the MCA, and could explain the process to us.
- There was an active maternity services liaison committee (MSLC), which meant that service user views were considered.
- Management was visible and approachable.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Inadequate



We rated safe as inadequate because:

- Serious incident actions were not always monitored or completed.
- There was poor evidence of learning from incidents.
- Most staff we spoke with could not explain duty of candour and were unable to tell us in detail about the process involved.
- There had not been an audit of surgical site infections within the maternity or gynaecology department.
- Prescription charts were not fully completed.
- Medical records in maternity were not kept securely in all areas and were not easy to navigate through.
- Staff had not completed safeguarding training in accordance with the trust's target.
- Midwifery staffing was not at the agreed level and with high rates of vacancy and sickness, staff were under constant pressure.
- Maternity medical records were difficult to navigate, and to identify contemporaneous documentation.
- Maternity staff did not always complete the venous thromboembolism risk assessment.
- Midwives were acting as a scrub nurse for planned caesarean sections and emergency caesarean sections, which removed them from midwifery specific duties depleting the staffing levels further.
- Staff we spoke with knew a major incident plan existed but nobody could be specific and explain their role within the major incident plan.

However:

- Medicines were stored in locked cupboards, and disposed of safely.
- Adult resuscitation equipment was checked daily in all areas.
- Maternity and Gynaecology staff completed early warnings scores fully which meant that they would recognise a deterioration of a condition.
- Gynaecology medical records were easy to navigate and were mostly fully completed.
- Medical staffing on the delivery suite was in line with RCOG Safer Childbirth recommendations.

- Gynaecology nurses had an understanding of the MCA, and could explain the process to us.
- Hand hygiene audits carried out in January 2017 and February 2017 showed 100% compliance with recommended practice in all areas of the service.
- Areas we visited were mostly visibly clean.

### Incidents

- Staff were confident in using the trust's electronic reporting system and gave examples of incidents that they had reported, for example, not having enough staff on a shift. However, not all staff felt confident to raise concerns, record safety incidents, concerns and near misses and to report them.
- In accordance with the Serious Incident Framework 2015, between April 2016 and March 2017 the trust reported 11 serious incidents (SIs) in maternity, which included the MLU, which met the reporting criteria set by NHS England. There were no serious incidents reported for gynaecology. This included six "baby only" maternity incidents, three maternity incidents involving the mother, one screening issue and one instance of treatment being given without consent.
- Between April 2016 and March 2017, the trust reported no never events for maternity and gynaecology. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Three serious incidents that we reviewed had undergone investigations. However, not all questions raised in two of the three were answered: the action plans were not updated and timescales in one had not been achieved. We observed letters of duty of candour to the women for all three serious incidents which included a written apology.
- There was poor evidence of learning from incidents. The majority of staff could not give an example of learning from an incident. Managers said they gave feedback to staff via a newsletter and staff gave this information at handovers, however we attended four handovers where lessons learned were not discussed.
- At the time of our inspection, the service had 184 open incidents, categorised as no harm or low harm. Out of

# Maternity and gynaecology

these 147 were under review and 37 had not been reviewed. The trust told us that the divisional governance team reviewed all incidents on every working day.

- We examined some low risk incidents which were not correctly categorised and we highlighted this to staff who agreed. For example, a full term baby transferred to the neonatal unit was categorised as no harm.
- The service held monthly multidisciplinary perinatal mortality and morbidity meetings. Babies that had difficult births, became ill after the birth, or had a poor outcome were discussed and actions and recommendations made.
- Most staff we spoke with could not explain duty of candour and were unable to tell us in detail about the process involved. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations came into force in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

## Maternity safety thermometer

- The service submitted monthly data to the maternity safety thermometer, which is a national tool, designed to measure commonly occurring harms within maternity care. Data was collected on a single day each month to indicate performance in key safety areas. These areas included perineal (area between the vagina and anus) and/or abdominal trauma, post-partum bleeding, infection, separation from baby and women's perception of safety.
- The maternity thermometer was displayed on a board in the main corridor. However the graph was too small to read the information and the trust were unable to send us information when requested.
- For the period May 2016 to May 2017, data submitted to the safety thermometer showed there were no pressure ulcers, falls or urine infections for maternity and gynaecology services.

## Cleanliness, infection control and hygiene

- Areas we visited were mostly visibly clean. The antenatal clinic and early pregnancy unit were not clean as we saw 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. We escalated to service leads regarding the areas, which were not clean. During our inspection, the performance manager spoke with us to establish the areas we had concerns about to enable the team to clean them. We returned to the areas and saw this had been carried out.

- Cleaning checklists for bathrooms were not fully completed, this meant it was difficult to ascertain if they had been checked which posed a risk of infection.
- We observed blood on an entonox (gas used for pain relief) hand set which was escalated to staff who arranged for it to be cleaned.
- The Monthly Matron Infection Prevention Audit scores we reviewed for the delivery suite between April 2016 to February 2017 showed one month where no data was submitted, six months of green rag rating of 85% compliance or more, three amber rag ratings of between 75-84% compliance and one month, February 2017, of red rag rating at 72%, against a trust target of 85%.
- Waste disposal was managed appropriately with different types of waste and laundry separated. Sharps boxes for the disposal of needles were assembled and dated.
- Taps which were not in constant use had a flushing schedule to prevent infection thriving such as legionella. A system was in place to ensure that this was completed.
- Staff had completed the majority of temperature checks each day for the fridges we checked. These were all within safe limits for storage of items.
- Personal protective equipment was available for staff to use in all areas we visited. We saw staff used hand gel, which was available at each entrance to the clinical areas. Equipment was cleaned with clinical detergent wet wipes between use.
- There were no MRSA or C. difficile cases reported in the maternity services from January 2016 to November 2016. MRSA is a bacterium responsible for several difficult-to-treat infections and clostridium difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- There had not been an audit of surgical site infections within the maternity or gynaecology department. This meant there was a lack of awareness about how many women may have had surgical site infections in this speciality.



# Maternity and gynaecology

- In the all areas, we observed staff had ‘arms bare below the elbow’ in accordance with the trust’s infection, prevention and control policy.
- Hand hygiene audits carried out between September 2016 and February 2017 showed 100% compliance across all areas, apart from no submission of data for ward 27 in December 2017 and 95% compliance for ward 21 in February 2017.
- We observed equipment and rooms that were cleaned displayed ‘I am clean’ stickers. We observed one piece of equipment with a sticker on that was unclean; we raised this with staff who arranged for it to be cleaned immediately.
- Cardiotocography (CTG) belts were given to women if they required a CTG and they were told to keep them throughout their pregnancy to use again if needed, to prevent cross infection.
- All pregnant women were offered the influenza (flu) vaccination and pertussis (whooping cough) vaccination during their antenatal appointments after 20 weeks gestation. We saw posters displayed in the antenatal clinic explaining the importance of the vaccines.

## Environment and equipment

- We identified during our last inspection in 2015 that the delivery suite had one obstetric theatre and recovery area. The second theatre was a converted high dependency room. The room was not fit for purpose as the sink was inappropriate for staff to wash their hands as water splashed onto the floor causing a risk of slipping to the staff. A member of staff had to hold the soap dispenser for the person washing their hands and only one person could use the sink at a time; in an emergency situation could take up valuable time. This was added to the service’s risk register in June 2013 and an action plan referred to the services refurbishment plan. The staff told us that money had been secured to build an extension, which would include a second theatre scheduled to start in September 2017. We saw interim actions had been put in place to mitigate the risks, and a monitoring system was in place. We spoke with senior management who described that previous concerns in 2015 would be fully addressed with the new build.
- Adult resuscitation equipment was checked daily in all areas including gynaecology, the delivery suite, midwife-led unit (MLU), antenatal clinic, and antenatal and postnatal wards in accordance with the trust’s policy. The neonatal resuscitation equipment was checked in all of the delivery rooms. The resuscitaires used as a warming therapy platforms along with the components for clinical emergency and resuscitation on both of the maternity wards were checked daily.
- The fetal blood-sampling machine on the delivery suite had been defective on one day in June 2017. This was reported twice during that time, however it was still not working in the evening. The trust reported that staff had access to the equipment on the neonatal unit, however due high levels of use for babies on that unit, this caused delays in fetal blood monitoring in one baby and affected the ability to perform cord gases at the time of delivery in other patients
- All equipment apart from two items of electrical equipment had up-to-date safety testing demonstrated by stickers on the item, meaning it was safe for use.
- There were three breast pumps within the service which was not sufficient to meet the needs of the women who wanted to breast feed their babies. We escalated this and on our unannounced inspection, we were informed that the trust had ordered more pumps but had not yet been delivered. Following the inspection the trust received one more pump, meaning there was a total of four within the hospital (Two on ward 21 and two on the neonatal unit).
- The service had received new birthing beds on the delivery suite, which enabled staff to have readily available equipment for instrumental procedures.
- An intercom and buzzer system was used to gain entry to the delivery suite and the maternity ward to identify visitors and staff so that women and their babies were kept safe.
- Cardiotocography (CTG) machines were available for women whose babies needed monitoring in labour. These were three telemetry (wireless) CTG machines which enabled women to be mobile available at the time of our visit.
- The MLU had three birth pools, which were clean and well maintained, and there were evacuation nets to evacuate a woman from the pool in an emergency. We looked at the birthing pool on the delivery suite and found it to be well maintained. Staff we spoke with could describe the pool-cleaning regime in detail.
- The antenatal clinic outpatient’s service had a waiting area and a designated room was available for sensitive discussions.

# Maternity and gynaecology

- The triage and fetal assessment unit (FAU) area was spacious and airy. Beds were only separated by curtains; however, there was provision of a single room for intimate examinations.
- The general decoration of both the Foxglove and Primrose Wards were in need of repair; paintwork on the doorframes was scuffed and damaged.
- The environmental audit for the delivery suite in February 2017 was red at 69%, the gynaecology ward and Primrose ward were amber at 87% and 85%, and the Foxglove ward was green at 94% the trust target was 90%.
- The midwife-led unit was visibly clean however; the waste was only collected twice a week, which meant that waste was left lying around for long periods. We observed and staff confirmed that placentas were bagged and collected once a week causing offensive smells in the surrounding areas where they were stored. On our unannounced visit, we were informed that estates had reviewed the odorous smell, which they determined was from the drains which was resolved and the placentas were also stored in a freezer until collection.

## Medicines

- Medicines were stored in locked cupboards, and disposed of safely.
- Controlled drugs were checked across maternity and gynaecology services according to trust policy in all areas. Staff referred to their medicines policy, the up-to-date British National Formulary (BNF), or they asked for pharmacy support if necessary.
- Fridges were checked daily in all areas with very good compliance however, we were only able to review checks from the 9 June 2017. On one of the wards, the fridge was not locked and this was escalated to the midwife in charge who arranged to lock it.
- We reviewed 12 prescription charts for maternity, which were all dated and signed. However, none had the women's weight recorded, four had illegible signatures, and three did not have documentation in the allergies section. We reviewed five charts for women in gynaecology, three were fully completed and two had illegible signatures and no patient details on any of the pages.

- Intravenous fluids were not stored securely on the emergency trolley on the Primrose Ward. We escalated this to staff. On our unannounced inspection, the fluids were stored safely.
- Treatment to prevent VTEs was not always prescribed and eight of the nine charts we checked had not documented the woman had compression stockings.
- Medical gases were stored safely in a vented room. There were local microbiology protocols for the administration of antibiotics we reviewed charts that showed they were followed by prescribers.

## Records

- Medical records were kept securely in gynaecology, however, they were not kept securely across maternity services. We observed medical records in maternity stored in a lockable trolley which had the key left in the lock. Staff told us that the key remained there because the desk always had someone present. However, the administration clerk was not employed 24 hours a day on the maternity wards. We observed secure storage of records on the gynaecology wards and at the midwife-led unit.
- Antenatal records were paper format and recorded on the electronic system. Midwives gave mothers their records to keep with them and bring to every appointment. During birth and postnatal records were recorded on an electronic system.
- Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.
- We reviewed 42 sets of maternity records across maternity wards, delivery suite and the MLU those that we reviewed on the electronic system were difficult to navigate to review records. We found predictive text was used within the electronic system and in one example a sentence documented did not make sense. It was difficult to have an overview of an entire patient record, 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 service was not able to recall or evidence contemporaneous record keeping when reviewing records for complaints, incidents, or litigation.

# Maternity and gynaecology

- We reviewed eight sets of gynaecology records; all were clear and easy to navigate. Risk assessments were completed and easy to locate and reasons for admission and care plans were evident.
- There was no general documentation audit carried out within the maternity services. This meant we were not assured all the other assessments were being used as intended.
- There was out-of-date information displayed or in folders for staff to refer to. For example, on one ward the obstetric emergency folder documentation within it related to 2009 and 2013.

## Safeguarding

- All staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse.
- There was a named safeguarding midwife who provided support and supervision. Midwives told us they were able to raise concerns and knew how to report a safeguarding incident. If there were any known safeguarding issues, there was a green coloured sheet to identify this in the medical records and an alert on the electronic system to alert staff.
- We reviewed the adult safeguarding training data provided. Level one safeguarding training data showed 100% of staff had completed the training. However for level two adult safeguarding data showed 75.5% of staff had completed it and for level three only 56.5 % of staff completed the training. This did not meet the trust target of 90%.
- The children's safeguarding training data we reviewed showed that for level one 100% of staff completed the training. However for level two 58% and for level three 53% this meant that babies and children were not protected from harm.
- The number of gynaecology staff who had completed level 2 children's safeguarding training was 83%, level 2 safeguarding adults 92% and level 3 safeguarding adults 100% against the trust target of 90%.
- Staff were aware of the female genital mutilation (FGM) guidance. They knew the process of notification to the safeguarding midwife and the Department of Health (DH). This was in line with national guidance. Child sexual exploitation was included in the training and staff were aware to escalate concerns to the safeguarding lead.

- All babies wore an electronic safety tag. Staff were aware of the trust's abduction policy and all ward doors were locked. We observed a woman returning to the ward because the midwife had not escorted her out and security would not let the woman leave the hospital without a midwife. This demonstrated a good example of the trust's abduction policy.

## Mandatory training

- All maternity, gynaecology and medical staff told us they were supported to attend mandatory training.
- Midwives and medical staff attended an annual midwives update study day. The day included maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant woman including sepsis, manual handling, epidural update, suturing update, perinatal mental health and safeguarding updates, physical examination of the new-born, infant feeding, and bereavement. The service compliance across maternity which included the MLU for the update training day from April 2016 to March 2017 was 95%, which was better than the target of 90%. Staff also completed a number of e-learning packages and 96% of staff had completed maternal mental health training, 91% of staff had completed GAP training, 100% of staff had completed smoking cessation training and 93% of staff had completed antenatal screening. The content of these sessions altered according to identified areas of learning from incidents and complaints. For example, the team were reviewing fetal monitoring training due to an incident involving poor review and escalation of a cardiotocography (CTG) trace (monitoring of the foetus heartbeat).
- Mandatory training for adult basic life support was 68% against a target of 90%. This included all staff across maternity and gynaecology services. We saw the MLU and one ante-natal clinics exceeded the trust target and achieved 100%.
- Newly appointed qualified midwives had a comprehensive training programme to complete in their preceptorship period. Staff were supernumerary for at least four weeks and this time could be extended if additional needs were identified.

# Maternity and gynaecology

- CTG training was provided using a nationally recognised e-learning training package. Staff were given time to complete the training. From April 2016 to March 2017, compliance was 86% for the service against the trust target of 90%.
- Staff completed an e-learning package annually, and at the end of quarter four 89% of staff had completed the package. The e-learning package included an infant feeding update. An external stakeholder paid for six staff to attend the UNICEF baby friendly three day training course each year.
- A team of four staff had recently attended the Royal College of Obstetricians and Gynaecologists (RCOG) emergency skills training known as 'PROMPT'. The team planned to develop an emergency skills training day in addition to the midwives update training day.
- Live skills training was provided at least four times a year across maternity wards, delivery suite and the MLU for example, an excessive bleeding scenario was completed in February 2017 and neonatal resuscitation in June 2017. Staff practised a baby abduction scenario on four occasions in 2016.
- One hundred percent of gynaecology staff had completed all mandatory training with the exception of fire safety, which 70% of staff had completed.
- Gynaecology staff did not meet the trust target of 90% for adult resuscitation training as 71% had completed this training.
- Data from the Perinatal Institute showed the trust performed significantly higher than the GAP user average for both antenatal referral (GUA 49.2% - Walsall 54.5%) for suspected growth restriction and also in detection of IUGR (GUA 41.4% - Walsall 51.7%) in Q1 2017/18.
- Midwives and obstetricians emphasised to women during each antenatal contact in the clinics the importance of fetal movements in accordance with MBRRACE-UK 2015 and RCOG guidance. We saw posters displaying this information in the antenatal clinic.
- We reviewed five maternity records, two of which the VTE assessment was not completed. The trust supplied information after the inspection, which showed that there was some improvement in VTE assessments. For April 2017 the maternity arrivals lounge achieved 50% and for May and June 2017 they achieved 100%. For April, May and June 2017 the midwife led unit achieved 93%, 100% and 94%. This met the trust target of 85% every month. For the same period (April-June 2017) ward 24 achieved 80%, 86% and 85% respectively. Ward 25 did not achieve the trust target for any of the three months (April- June 2017) with 65%, 83% and 80% respectively. The delivery suite remained constant across the three months, with 90%, therefore achieving the trust target.. This meant women who were patients at the Manor hospital were at less risk over time, however they were at a greater risk of DVT on ward 25 because risk factors not properly assessed.
- Risk assessments were used to help women choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a woman should have midwife or consultant-led care, or be referred to other professionals within the multidisciplinary team. On admission to the hospital women were admitted to triage for assessment and transferred to delivery suite or home.
- Staff at the midwifery-led unit (MLU) and in the community followed the "care of women in labour in a home setting", "maternal transfer by ambulance" policy. In addition, there was also a specific guideline for the MLU. These documents outlined the circumstances in which women should be transferred from home or the MLU into the consultant-led unit, for example if there were concerns about the wellbeing of either the woman or baby. These guidelines were out of date as the review

## Assessing and responding to patient risk

- Senior staff told us the birth cap of 4,200 births at the trust was working well and had been put in place an effective process of reducing risk to women and their babies.
- In maternity, community staff were responsible for carrying out full risk assessments of women at their initial booking visit. These included social, medical and mental health assessment and referral as necessary. Other assessments included tobacco and drug use, family history and previous pregnancies.
- Fetal growth was monitored from 24 weeks by measuring and recording the symphysis fundal height (from the top of the mother's uterus to the top of the mother's pubic bone) at each midwifery appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 guidance. If concerns arose regarding fetal growth, the patient was referred to triage for a full assessment.

# Maternity and gynaecology

date for the MLU guideline was 2015 and 2016 for the other documents. Service leads told us these guidelines would be reviewed when the recently appointed normality lead was in post.

- Following our last visit in 2015, the service had introduced the use of a pressure area tool to assess a woman's risk of having a pressure ulcer. We reviewed four charts of which two were not fully completed.
- Nationally, patients seen and assessed before the end of the twelfth week of pregnancy have better outcomes than those who are seen for the first time later on in pregnancy. Between September 2016 and February 2017, the service had achieved this assessment target against a service target of 90% for three of the months. For the other three months the trust achieved just below the target at between 87% and 89%.
- Maternity staff completed MEOWS (maternity early warning scores) to assess if the woman's condition was at risk of deterioration. We reviewed five charts on the electronic system and all were correctly completed in full. The electronic system would identify women who required additional screening for sepsis.
- In each of the rooms on delivery suite, the documentation for emergency situations was available. This meant good documentation could be started when the incident occurred reducing delays.
- The use of NEWS (nursing early warning scores) was used correctly on the gynaecology ward. This was a tool that allowed nurses to assess a patient's condition, identify indications that the patient may be deteriorating and escalate appropriately.
- The World Health Organisation (WHO) surgical checklist 'Five Steps to Safer Surgery' was in use in maternity and gynaecological theatre within the trust. From April 2016 to March 2017, local audits showed that the tool was used consistently well as one month scored 99% and the other 11 months were 100% completed.
- The RCOG in 2007 recommended all obstetric units to consider early interventional radiology as an important tool in the prevention and management of postpartum (post-delivery) haemorrhage as it can prevent major blood loss, removing the need for a blood transfusion and hysterectomy.
- When we asked staff about women receiving one-to-one care (a qualified midwife is with them throughout established labour) between October 2016 and March 2017 this was achieved. To enable one-to-one care of women in established labour, student midwives told us

that there were many times when they were providing care unsupervised. 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.

- RCOG states it is best practice for medical staff to review high and intermediate risk women on the delivery suite at least once every four hours. We found through observation and from speaking with staff that this was in practice following our last inspection in 2015. Staff told us three ward rounds were performed in 24 hours.
- We did not observe a full handover of a mother and baby transferred from the delivery suite onto the ward. The receiving midwife did not go to the bedside to check the woman or baby on to the ward.
- Women who required increased observation were reviewed by the critical care outreach team daily.

## Midwifery staffing

- Service leaders told us that they used "Birth Rate Plus" a nationally recognised tool for planning maternity staffing levels. It was evident that the senior team were not actively using the acuity tool to review and plan staffing.
- Staffing numbers for each shift were displayed within the ward areas. We did not observe them displayed outside the wards.
- We visited the maternity ward and found that they were short staffed. The expected numbers of qualified staff were four on the early and late shifts and three on the night shift. The actual staffing we observed was two on the early and late shifts and three on the night shift. This meant the maternity ward was understaffed by two staff on both early and late shifts and met the planned staff numbers for the night shift. The midwife in charge of the shift was also looking after the transitional care babies unit despite service leads informing us the transitional care unit had its own staff. However, we observed transitional care staff caring for women on the ward too. The service had set a target of having 11 midwives per shift, and had deemed this figure to meet the requirement of appropriate staffing levels. Data from the maternity dashboard showed from October 2016 to March 2017 safe staffing on the delivery suite of 11 midwives per shift was consistently not achieved as it was between 74% and 90% compliance we could not



# Maternity and gynaecology

assess if this impacted safety because the service was not actively using acuity information. We observed that on 27 out of 28 occasions during May 2017 there were less than 11 midwives on each shift. On a number of occasions, there were either eight or nine midwives on a shift. We interviewed the senior maternity clinical leadership team and were told that if 11 midwives were not on a shift on the delivery suite the service would be unsafe.

- The midwifery led unit (MLU) had a team of core staff to enable low risk women to birth there 24 hours a day, seven days a week. Although following our unannounced inspection, the senior leadership team made the decision to close the MLU to mitigate risks to women and their babies due to problems with meeting safe staffing levels in maternity.
- We reviewed the maternity taskforce minutes of June 2017 prior to our inspection. Staffing was escalated to the executive team the midwife to birth ratio should be 1:28 however the team knew in April 2017 it would not go up as the bank shifts were not filled. The service had two band six midwives joining in July 2017 and 13 band five midwives in August and September with a further 12 vacant posts. We reviewed the Birth rate plus report and recommendations; due to acuity within the region recommended 165.4 WTE midwives and not 150 WTE midwives which equates to one midwife to 25 births. It is not clear in the report when the review was completed. There were no urgent actions noted following the discussions regarding staffing. The recommendations were 'To note the contents of this report and determine next steps'. The service did not have full oversight of the risk and impact this was having on the staff and service.
- We spoke with three members of staff who became visibly upset because staffing so poor.
- As at 31 March 2017, Manor Hospital reported a vacancy rate of 2.4% in maternity and gynaecology. The senior team acknowledged difficulties in recruitment and retention of staff.
- The senior team we spoke with told us they were consistently recruiting. Following our last inspection in 2015, the trust recruited to 150 whole time equivalent (WTE) clinical midwives, which equated to a midwife to birth ratio of 1:28. However during the inspection, the senior team told us of a vacancy of 12 whole time equivalent (WTE) midwives and 17 WTE midwives that were off sick or on maternity leave. This meant the establishment was running with 121 WTE midwives which was a significant shortfall. Midwives working within transitional care on the maternity ward were drawn from the main establishment without further investment to staff this service. However, the service used bank midwives to increase staffing at the time of our inspection the senior team told us the midwife to birth ratio was calculated to be 1:30.
- The service recruited 20 overseas midwives in the summer of 2016 however, the majority did not stay, and staff we spoke with said two remained in the service. We asked staff why so many staff left and we were told they thought it was to work in the capital city.
- The trust had recruited 12 midwives to begin in August and September 2017. These midwives would not be able to work unsupervised for their supernumerary period and therefore this would not be sufficient to fully mitigate the staffing problems in the short term.
- The sickness rate was 5% at the end of March 2017 which was higher than the trust target of 3.39%.
- Staff told us the maternity support workers changed their own off duty without manager oversight. This could result in too many on one shift and none or not enough on another shift.
- One woman we spoke with said she 'Got the impression there were not a lot of staff on'.
- We observed a number of red flags indicating poor staffing in accordance with 'Safe midwifery staffing for maternity settings (2015). For example medication omissions, delays in induction of labour.
- Midwives were acting as a scrub practitioner for planned caesarean sections and emergency caesarean sections, which removed them from midwifery specific duties, which depleted the midwifery staffing levels further. Following the inspection the trust made a plan to increase theatre staff to provide a team to perform this role, releasing midwives to perform midwifery duties.
- Staff we spoke with told us that student midwives provided often one to one care for women in labour.
- On our unannounced inspection, the maternity-led unit (MLU) was closing overnight to support staffing on the delivery suite. Following our inspection, we observed the staffing rota for the first two weeks of August 2017, which was greatly improved to achieve the safe 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.
- At the time of inspection we were not able to review the acuity in relation to staffing numbers. Following the



# Maternity and gynaecology

inspection, the service was actively using the acuity tool. We reviewed the acuity for the delivery suite for the week of the 17 July 2017. This showed there were three red shifts on the delivery suite and one on the staffing wards for this week. The latest data received from the trust for the week commencing 21 August 2017 showed there had been four red rated shifts on the delivery suite and one red shift on the staffing wards. However, weekly data supplied by the trust during the remainder of August and September 2017 showed this position continue to improve.

- We observed midwifery staff being moved from the maternity ward to support the staffing on the delivery suite, which then increased the risk to women and their babies by diverting staff from other duties.
- The delivery suite had an experienced midwife (team leader) available for each shift on the labour ward in accordance with best practice.
- In the community, midwives held an average caseload of one midwife to between 60 and 100 women depending on the needs of the women. This was in line with the national recommendation of one midwife to 100 women.
- In 2016, NHS England published their National Maternity Review, “Better Births” against which the trust had benchmarked their services. This related to women’s choice, staffing and multidisciplinary working. We reviewed the gap analysis produced in June 2017, which used a RAG rating (red, amber, or green) to assess their current compliance. For midwifery staffing, there were three items that were classified as ‘red’, and one that was amber. There were no ‘green’ ratings. An example where staffing affected patients was; the birth rate at Walsall Manor Hospital was capped at 4200 for safer staffing, this reduced women’s choice.

## Medical staffing

- Access to medical support was available seven days a week. Consultants were on site 98 hours per week including a consultant on night duty in the hospital four nights per week and on-call at other times. This was in line with RCOG Safer Childbirth recommendations.
- The lead anaesthetic consultant for obstetrics was available on site for 50 hours per week between 8am and 6pm on weekdays, with on-call cover out of hours. There was other senior anaesthetic cover for the labour ward 24 hours a day.

- As at March 2017, the trust as a whole reported a vacancy rate of 24% in maternity and gynaecology. This risk was on the divisional risk register. There was a maternity patient care improvement plan in place; one action within the plan was to monitor rotas on a weekly basis. Consultants would act down and support in extreme circumstances.
- An obstetrician or gynaecologist was in the hospital either in the operating theatre or in the outpatients department during clinics on weekdays. They were called on for review of inpatients and day case patients, if necessary. Leaders told us that this was under review and job plans would be revised to formalise daily ward rounds for gynaecology patients in early 2017.
- There was no dedicated gynaecology service out-of-hours. However, An obstetric and gynaecology registrar or junior doctor was available to review gynaecology patients on site out of hours.
- Between April 2016 and May 2017, Manor Hospital reported an average bank and locum usage rate of 19.2% in Maternity and Gynaecology services.
- As of January 2017, both the proportion of consultant and junior staff reported to be working at the trust was higher than the England average.
- To achieve safe medical staffing levels the service used four locum obstetricians known to the service.

## Escalation policy

- The service had an escalation pathway to follow when acuity of the women was complex and staffing was poor. We observed this being instigated with a poor response from the manager that was contacted. The Divisional Director of Midwifery, Gynaecology and Sexual Health was subsequently called and came to assess and plan movement of staff to cover the delivery suite. Following the inspection, the service has revised and launched the escalation policy to ensure appropriate responses to the needs of the service.
- On one shift during the inspection we observed the delivery suite was full and included women with complex needs consisting of antenatal, postnatal and women birthing requiring one-to-one care. There was also another woman with complex needs on her way into the delivery suite who required an assessment. There was significant pressure on the staff, therefore the team leader commenced the escalation plan. However, after an initial review by the manager on-call, no

# Maternity and gynaecology

immediate steps were taken to mitigate the risks. This delay in providing extra support could increase the risk to women not having one-to-one care on the delivery suite.

## Major incident awareness and training

- A major incident plan was in place for the trust. However, staff we spoke with knew a plan existed but nobody could be specific and explain their role within the major incident plan.
- The trust set a target of 90% for completion of major incident training. Information provided showed 30% of staff trust wide had completed major incident training as of 31 March 2017.
- This information was not broken down for gynaecology and maternity staff.

## Are maternity and gynaecology services effective?

Requires improvement 

We rated effective as requires improvement because:

- Staff did not always plan care and treatment that was in line with current evidence-based guidance, standards and best practice.
- Audits and plans to improve the service were limited.
- Most women we spoke with following birth felt that their pain control had not been well managed.
- There was out-of-date information displayed or in folders for staff to refer to.
- There were many guidelines that remained out of date following our last inspection.
- Medical staff did not always explain the risks to women before a procedure.
- The milk fridges were not locked which meant that breast milk could be tampered with.
- Instrumental births and caesarean section rates continued to be higher than the national average.
- Staff did not have the right qualifications, skills, knowledge and experience to do all aspects of the care they provided to women.
- Handovers were not always focused and in an effective environment.
- Women were not able to have access to midwifery led unit due to staffing issues.

- Medical records were not always stored safely.
- Midwifery staff we spoke with were only able to give minimal explanations of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

However:

- The stillbirth rate between January to December 2015 was up to 10% lower than other similar trusts.
- Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home birth service.
- We saw good examples of multi-disciplinary team (MDT) working across gynaecology and maternity service. Staff worked collaboratively in the interests of women in maternity and gynaecology services.
- Women on the gynaecology ward we spoke with told us that they had received pain relief when requested in a timely manner.
- Fluid balance charts we observed were used and correctly calculated and up to date.
- Community midwives had good engagement with each other in the primary care setting.
- Gynaecology nurses had a better understanding of the MCA compared to maternity staff and could explain the process to us.

## Evidence-based care and treatment

- We reviewed the documentation of 15 cardiotocography (CTG) results on the paper trace, the medical notes and the electronic system. Two of the electronic notes had a review documented, none of the paper traces were completed fully.. The documentation on the paper trace was not in accordance with NICE guidance - care of the woman in labour 2017.
- We observed of the six CTG machines we checked, four clocks were not correct. When we reviewed CTG paper traces the time and date was not consistently checked which could be significant if records needed to be reviewed for an incident or a complaint.
- Whilst reviewing the electronic records we found a number of practices that were not evidence based. Admission CTG traces and indications for vaginal examinations were not in full, which was not in line with current evidence based practice NICE guidance.
- Staff told us they put every woman on a CTG to assess fetal wellbeing regardless of their risk status. This is not in line with current NICE guidelines (2014). We were told

# Maternity and gynaecology

this was because they had always monitored all women. NICE guideline for Intrapartum care 2014 states “Do not perform cardiotocography on admission for low risk women in suspected or established labour in any birth setting as part of the initial assessment”. This is because continuous CTG during labour for low risk women shows no significant differences in the prevention of cerebral palsy, infant mortality or other standard measures of neonatal well-being. However, continuous CTG was associated with an increase in caesarean sections and instrumental vaginal births.

- We observed 17 guidelines of which 11 were out-of-date. Staff told us it had been difficult to progress in timely manner due to lack of medical engagement. The service had a plan to have renewed all policies by August 2017. However, an updated guideline was launched two weeks prior to our visit and none of the staff we spoke with were aware of it. This could mean that staff and women were at risk because they were unaware of the changes in practice. We asked the senior team how the guidelines had been prioritised in view of a serious incident last October 2016. The two guidelines that related to this incident remained out-of-date and one had been out-of-date since December 2015. They had not been prioritised to be reviewed which meant women could be at risk of further harm.
- A ward meeting folder had minutes from the January 2017 meeting.
- Care was provided to women in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy in all settings that provide routine antenatal care. This includes primary, community and hospital-based care.
- We reviewed eight induction of labour medical records and all had evidence based indications documented for the procedure. However, these medical records showed four women did not have the risks of the procedure explained to them.
- Staff we spoke with told us the consultants were not uploading scans taken in the early pregnancy assessment unit (EPAU). We escalated this to the senior team on inspection. On our unannounced visit, we asked how this was progressing and were told it had not commenced yet. We were told it was discussed at the EPAU meeting the day before and there was no definite start date, but it would be happening in the next couple

of weeks. Nursing staff logged the details of any scans performed out-of-hours as an interim measure. Staff added these scans onto the system the next day because the medical staff had not received training.

- Women were not receiving antenatal care in accordance with NICE guidance ‘Smoking: acute, maternity and mental health services’ (2013). Women who smoked were not routinely assessed or offered carbon monoxide monitoring.
- The service followed best practice and offered women with risk factors of diabetes a glucose tolerance test in the antenatal clinic.
- Women are offered screening for sexually transmitted diseases at booking. Any positive results would be managed by the ante-natal screening midwife who contacted the woman to arrange an appointment for discussion and treatment.

## Pain relief

- In the midwife-led unit (MLU), a birth pool was available in each room to help women with pain relief. Women could also choose to have gas and air and opioids (pain relief by an injection). Alternative pain relief options such as hypnotherapy, aromatherapy and reflexology were also available.
- On the delivery suite, there was one birthing pool available for women to use. Alternatively, women could have opioids or an epidural. Epidurals were available on the delivery suite 24 hours a day.
- Not all women received pain relief in a timely manner. We saw one woman had to ask three times for pain relief; she said staff were lovely but so busy that she had to wait. We observed on three prescription sheets on the Foxglove Ward that three women had not received pain relief when prescribed. One woman was first day post caesarean section who had not received pain relief that was prescribed. Following the inspection the service have commenced a weekly audit of pain relief.
- Pain scores were used in gynaecology and the pain nurse visited the ward often to see post-operative women.
- Women on the gynaecology ward we spoke with told us that they had received pain relief in a timely manner when requested.

## Nutrition and hydration

- The service had not used the UNICEF baby friendly initiative as a minimum standard or the NICE ‘Postnatal

# Maternity and gynaecology

care up to 8 weeks after birth' (2006) guidance. This meant women were not always receiving the correct infant feeding advice. Three women we spoke with told us they did not receive enough support following birth. One parent was given incorrect advice and felt 'the midwives were pushing the formula feeds and saying they need not breast feed for three hours to let the breast fill', which is not good practice.

- There was a team of support workers that could be called to support women having difficulties with feeding. However, one woman told us she had asked staff for help at least twice in 24 hours and nobody came to support her. This meant she was very concerned for some time that she was not feeding her baby correctly. We escalated this to staff who told us they did not have the time to support women with feeding problems.
- Staff we spoke with said the presence of the breast feeding support workers on the ward had reduced but they did not know why.
- Breastfeeding rates for initiation were between 64% and 68%, which had improved from 60% at the time of our previous inspection. The rates were lower than the national average of 75%.
- The milk fridges were not locked which meant breast milk could be tampered with. Some expressed breast milk was named, dated and timed correctly. However, there were some containers of breast milk with names only; this meant that there was no process to identify when the breast milk was out-of-date which posed a risk of infection to babies.
- Women across gynaecology and maternity services were able to choose from a varied menu, to meet nutritional needs. The menu also met their cultural requirements.
- Fluid balance charts we observed were used and correctly calculated and up-to-date across both services

## Patient outcomes

- Staff told us that the trust offered women a choice of where to give birth. Most low risk women preferred to choose the midwifery led unit as opposed to a home birth. Staff told us that there were one or two homebirths a year which is lower than the national average.

- From January 2017 to June 2017, figures provided by the trust showed there was one planned homebirth which was less than the national average. In addition, during this period, there were 20 babies born before arrival at hospital.
- We looked at the dashboard for October 2016 to March 2017. The birth statistics were not shared with women and their families.
- 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. Week commencing 25 September 2017 we saw these figures in both areas had reached 100%, this was evident the service had made significant improvements and appropriate and thorough monitoring of CTG's was achievable.
- The normal vaginal delivery rate (without any assistance) was 57.5% which had improved from our last inspection when it was 52%. This was slightly worse than the England average of 59.7%. The caesarean section (CS) rate was consistently higher than the national average of 25%. Between January and June 2017, the average combined elective and emergency caesarean section rate was 30.24% This has improved since the 2015 inspection which showed the elective caesarean section rate was 35%. However it still remained worse than the national average. The emergency CS rate was also above the national average of 15.4% at between 16% and 20% for the same period.
- A project group was set up by the trust to review all CS to ensure best practice was being followed. The senior team reviewed all the medical records for CS procedures between January and April 2017. The recommendations were shared with colleagues for example increase the size of vaginal birth after caesarean section clinics. However, the tool used to analyse the data had to exclude 101 deliveries due to issues with the electronic system's data.
- The service did not audit the compliance of category one emergency caesarean sections (baby should be

# Maternity and gynaecology

delivered within 30 minutes of the decision), or category two emergency sections (baby should be delivered within 75 minutes of the decision), This meant that they were not aware if babies were at risk due to not being delivered within the recommended time. Following inspection the service audited the month of June 2017 and reported 74% of category one emergency caesarean sections were completed on time and 92% of category two emergency caesarean sections were completed on time.

- Following the inspection, the service did a retrospective audit from January , to June 2017 there were 60 postnatal maternal readmissions, which was 3.2% of the total number of births. This was above the national average of 1.4%.
- In the 2015 National Neonatal Audit , for maternity outcomes, their performance was as follows:
  - There were 38 babies born at less than 32 weeks gestation included in the audit measure and 79% of these babies had their temperature measured within an hour of birth; this was below the national average, where 93% of eligible babies had their temperature measured within an hour of birth.
  - There were 146 eligible mothers identified who gave birth between 24 and 34 weeks. Seventy-seven per cent of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 85% of eligible mothers were given at least one dose of antenatal steroids.
- Interventions during birth had remained high following our last inspection in 2015 and the service have continued to not audit these outcomes, the trust was unable to provide this information when requested.
- The service audited its compliance with the UK National Screening Committee's standards for screening programmes. The antenatal screening outcomes were good, midwives acted as the failsafe officer checking statistics. The last quality assurance visit was in March 2017 and the report they received had no immediate actions. The team had an audit programme in place to audit against compliance with antenatal and newborn screening.
- Antenatal screening documentation on the electronic system and newborn notes were audited. There were areas of improvement with the electronic system for

example, how to document the newborn bloodspots on the system and how to document the anomaly results. However, there were no defined actions assigned to staff with deadlines.

- Third degree or fourth degree tears (injuries to the mother's perineum during delivery of the baby) were recorded and were RAG rated green from September 2016 to February 2017.
- Data from the MBRRACE-UK Perinatal Mortality Surveillance Report, June 2017 for UK Perinatal Deaths for Births from January to December 2015 showed the stillbirth rate was 3.77. This was up to 10% lower than the stillbirth rate for similar trusts. We found discrepancies with the data provided. For example, from January to June 2017, the data provided showed no post-partum hysterectomies (removal of the uterus after birth). However, there was an incident reported on 23 February 2017 where a women had an elective caesarean section and an 8060mls post-partum haemorrhage and hysterectomy. Another example was there were no blood transfusions for women in May 2017; however, there was one case from 22 May 2017 where the major obstetric haemorrhage protocol was initiated. The statistics did not account for a blood transfusion given to a woman during an incident whilst we were on inspection in June 2017 as the data showed a one unit blood transfusion was administered in June 2017.
- There were 58 full term baby admissions (1.5%) to the neonatal intensive care unit (babies that needed one to one care) from April 2016 to March 2017 this was lower than the national average of 5%.
- Gynaecology services carried out three audits in 2016/17, relating to consent and communication,

oncology patient satisfaction questionnaire and colposcopy audit LLETZ and test of cure.

- The consent and communication audit was undertaken to assess whether consent forms were being used as they were intended. Results showed some areas of the consent were not routinely documented such as the consultant under which the patient was cared for or if the consent was confirmed on the day of surgery.
- A leaflet for the procedure was provided in 71% of cases and a copy of the consent form was provided in 77%.



# Maternity and gynaecology

Actions by the trust resulted in the trust instigating a new consent form following the updated trust consent policy. We were advised by the trust the plan is to re-audit in October 2017 to review progress.

- The second audit looked at the oncology patient questionnaire, which was done to evaluate patient experience offered by the Gynae-oncology service. The results showed that 93% of patients rated their care as excellent or very good. However from the audit several improvements for patient outcomes was highlighted; to ensure better provision of written information on the type of cancer, involve families more and give opportunities to ask questions, give better advice over financial information and have a weekend contact number direct to the CNS.
- Lastly, the service carried out a Colposcopy Audit LLETZ (large loop excision of the transformation zone) and test of cure. This audit looked at Loop Excision of Transformation Zone (LLETZ) is one of the recommended surgical treatments for CIN (Cervical intraepithelial neoplasia). Deep loops or repeated loops may increase the risk of preterm labour or second trimester miscarriage. Results showed that the depth of excision being more than 7mm was 81% compared to the national standard of 95%. This was a significant improvement as previous figures were 31% in 2013. There was no obvious difference in test of cure results whether the LLETZ depth is more than 7 mm or 4-7 mm.
- Two patients out of 101 were found to have LLETZ depth less than 4mm and one patient had a positive test of cure. We were advised by the trust that the main action from this audit was the audit project lead emailed the lead histopathologist to include all LLETZ with a depth of less than 4 mm to be discussed at colposcopy MDT.
- However, as this audit was recent the trust was unable to provide minutes of the Colposcopy MDT to support this action.

## Competent staff

- Some maternity staff did not have the right qualifications, skills, knowledge and experience to do their job. For example, some midwives were caring for women who required HDU care but had not completed HDU training.
- Midwives working on the delivery suite regularly cared for women with either a central venous line (advanced method of giving medicines direct into the patient's bloodstream) or an arterial line They were required to

use these to take blood tests and monitor blood pressure. Not all staff had not received high dependency care training. This is not in line with best practice of 'Core Standards for Intensive Care Units' (2013) and 'Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman' (July 2011). We saw that there were staff with those skills who were caring for patients who did not need those additional competencies, whilst at the same time, women who needed staff to have those competencies were cared for by staff without those skills.

- Midwives who worked in MLU regularly rotated onto the maternity wards and delivery suite to maintain their skills and competencies.
- Midwives were regularly required to act as 'scrub practitioners' (assisting in operating theatres) with the majority having been trained a number of years ago when no formal competency programme existed. Training for newly appointed midwives was delivered by band four theatre scrub practitioners; observing one, doing two with a theatre scrub practitioner and then deemed fit to do the next one alone, this did not follow the recommendations of the College of Operating Department Practitioners, the Royal College of Midwives and the Association for Perioperative Practice. Since the inspection a plan to use theatre staff to scrub has been implemented.
- At the end of March 2017, 89% of all staff within maternity and gynaecology had received an appraisal compared to a trust target of 90%.
- Staff told us they were not able to provide adequate preceptorship to junior colleagues due to the staffing levels, which could make staff feel vulnerable and lack confidence.
- Student midwives we spoke with said the consistency of their mentors was good in the community, the Foxglove Ward and the delivery suite.
- Students were often left unsupervised; this had become common practice, which was thought of as a good exposure to leaning. However, this posed a risk to women being looked after by someone not signed off as a fully trained competent midwife. We escalated this to the senior team, this will not be occurring in the future.
- The Nursing and Midwifery Council (NMC) rules and standards for the statutory supervision of midwives ceased in April 2017. The service had not put an



# Maternity and gynaecology

alternative plan in place based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP). This meant there was no arrangements for supervision of midwives.

- The service used registered nurses on the postnatal ward to care for women who had caesarean sections. A competency document was completed and yearly updates were attended as part of study days. They did not perform any midwifery duties these were referred to the midwives to complete.
- Staff said that the senior team had not addressed issues regarding culture since our last inspection. Following the inspection we have been informed that plans are in place to manage any staff who are not performing in line with the trusts values. We have seen evidence of this.

## Multidisciplinary working

- On the delivery suite, we observed good interactions between medical staff and the team leaders.
- We attended an evening handover in all areas. Neither of the maternity wards followed a Situation Background Assessment Review (SBAR) format although all elements were covered.
- The handovers we observed on the delivery suite were held in a very cramped room. SBAR format was followed however there were many interruptions due to staff coming in and out of the room. This disrupted the flow of the handover and there was a risk all of the information may not be given.
- During the postnatal period if a woman's mental health was a concern the midwives would refer to the mental health team. The service had recruited a specialist midwife due to start to support midwives, women and their families.
- Staff we spoke with told us access to medical care from other specialities was straightforward and response to requests for input into a woman's care was usually prompt.
- Community midwives had good engagement with each other in the primary care setting. Staff from the community described effective multidisciplinary teamwork between community midwives, health visitors, general practitioners and social services.
- The Foxglove maternity ward had four beds to provide transitional care to babies. This is a higher level of care for example, babies requiring frequent observations or

antibiotics, Midwives from the core establishment staffed the unit. Staff told us of good working relationships with paediatricians and advance nurse practitioners.

- Community midwives worked over seven days and were able to see patients at the weekends at the midwifery led unit to complete postnatal checks or transfer them to the health visitor. Care was coordinated with the health visiting team to transfer women to their care when the woman and baby were fit for transfer to the health visitor.
- We observed paediatricians responding to assess a baby immediately following a referral from a midwife.
- Women were able to be discharged at times to suit them and their families. High risk women were reviewed by the Obstetric team prior to discharge home.
- Nursing staff on the gynaecology ward told us there was good multi-disciplinary team working. We observed a variety of specialist providing input into the care of the gynaecology patients, including occupational therapists and oncology nurse specialists.

## Seven-day services

- The midwifery led unit (MLU) had a team of core staff to enable low risk women to birth there 24 hours a day, seven days a week. Although following our unannounced inspection, the senior leadership team made the decision to close the MLU to mitigate risks to women and their babies due to problems with meeting safe staffing levels in maternity.
- The home birth service was staffed by the community midwives who were available 24 hours a day, seven days a week.
- The wards carried a stock of the more routine medicines such as painkillers and antibiotics which enabled take home medication to be dispensed out-of-hours. Midwives were proactive in ordering other medications from the pharmacy to avoid delays to women being discharged at weekends.
- Imaging (x-rays and scans) were available 9am until 6pm Monday to Friday. X-ray was only available in the minor injuries unit from 9.30am to 5pm on Saturdays, Sundays and bank holidays.
- A specialist gynaecology physiotherapy visited the ward from Monday to Friday to review patients.
- A palliative care occupational therapist responded to direct referrals.

# Maternity and gynaecology

- Anaesthetists were available on the delivery suite for pain relief and emergencies 24 hours a day.

## Access to information

- In the antenatal period, staff accessed women's paper notes. When in labour and postnatally the electronic system was used.
- Staff within both maternity and gynaecology could access the trust's intranet which enabled them to review their emails and access guides, policies and procedures to assist in their specific role. However, staff within maternity said due to low staffing levels they found it difficult to have time to log onto the system.
- An electronic notification of discharge and summary of care was automatically sent to women's general practitioner on transfer home.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Maternity staff we spoke with were only able to give minimal explanations of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, they were aware they could seek advice from the safeguarding midwife or relevant line managers who dealt with these issues more often.
- The trust reported as of 31 March 2017, Mental Capacity Act (MCA) training had been completed by 51% of nursing staff and 33% of medical staff within maternity and gynaecology. This was below the trust target of 90%.
- Written consent was obtained for caesarean sections. We saw documentation in four sets or records that consent was reviewed prior to surgery in all cases and documented on step two of the World Health Organisation (WHO) safer steps to surgery checklist.
- Gynaecology nurses had a better understanding of the MCA than their maternity colleagues and could explain the process to us.
- An audit of ensuring informed consent for gynaecological procedures was performed where 35 consent forms were reviewed. Medical staff documented patient details, name of procedure, risks, doctors and patient signatures and explained the procedure in all of the forms. The audit results showed the reason for the procedure was explained in 91% of the cases reviewed. None of the forms were completed by the anaesthetist. The results were escalated to the Trust Quality Executive meeting and a robust action plan assigned to staff with

timelines was developed. During the unannounced we reviewed six induction of labour records and the risks of the procedure were still not documented in four records. Service leads told us the 6% relating to side effects referred to those who had specifically documented risks in that section and was not compulsory to complete.

## Are maternity and gynaecology services caring?

Requires improvement



We rated caring as requires improvement because:

- Women did not always receive compassionate care. Maternity service staff were trying to provide a caring and compassionate service in challenging circumstances.
- Partners and families were not always involved in the care and treatment of women.
- Feedback from women was that they felt safe although they would have liked more support.
- A stakeholder survey asked nine women of their overall experiences; six were not positive.
- Maternity Friends and Family Test (ante-natal) performance (percentage recommended) was generally worse than the England average.

However:

- Women received kind thoughtful and compassionate care on the gynaecology ward.

## Compassionate care

- Between April 2016 and March 2017, the trust's Maternity Friends and Family Test (antenatal) performance (percentage recommended) was generally worse than the England average. In the latest month, March 2017 the trust's performance for antenatal was 80% compared to a national average of 96%.
- Between April 2016 and March 2017, the trust's Maternity Friends and Family Test (birth) performance (percentage recommended) was generally similar to the England average. In the latest month, March 2017 the trust's performance for birth was 95% compared to a national average of 97%. Performance over time was slightly below the England average throughout the year.

# Maternity and gynaecology

- Between April and July 2016 and November 2016 to March 2017, the trust's Maternity Friends and Family Test (postnatal community) performance (percentage recommended) was generally similar to the England average. In the latest month March 2017 the trusts performance for postnatal community was 100% compared to a national average of 98%. There were no submissions between July 2016 and October 2016.
- All interactions we observed between staff and patients were respectful, kind and considerate. This included reception staff, nurses, midwives and doctors.
- Women were asked to text their friends and family responses and there were posters inviting them to comment.
- Arrangements were in place in the outpatients clinics for women who had received bad news or were distressed, to allow them privacy and time either alone or with a professional.
- One mother we spoke with recognised the staff shortages but praised staff for their kindness. 'Really impressed with the staff'.
- On the gynaecology ward, some areas were adjacent to the maternity ward and we were told it was sometimes possible to hear babies crying. If women found this distressing, staff moved them immediately.
- A stakeholder survey asked nine women of their overall experiences; six were not positive one woman said "Was okay for me but a new mum with no experience would find it difficult. Staff were not always helpful and it was difficult at times for women to ask for help." Another woman reported "I wanted an epidural never got it because it took too long to come to her until it was too late."

## Understanding and involvement of patients and those close to them

- We received mixed feedback from women we spoke with. One woman told us they would have liked more support, although they were aware of staff shortages. One woman told us "Midwives are lovely but short staffed".
- Partners and families were not always involved in the care and treatment of women. We spoke to women who said that they were not involved in decisions about their care. For example, one baby was receiving medication and treatment but the parents did not know why.

- However, one woman told us her partner was involved in the decision making for mode of birth.
- Another woman we spoke with said admission was a very slow process and she felt pushed into having to have a vaginal birth after caesarean section (VBAC) because she had needed a caesarean section for her first baby.
- One woman told us how the gynaecology ward enabled her to have a romantic dinner with her husband arranged by staff due to the critical stage of her illness.
- One father told us he felt he and his partner were looked down upon by staff.
- A young woman was being accompanied by her mother as her birthing partner. We spoke with them and were told that they were not made to feel welcome and had to ask for explanations of the plan of care.

## Emotional support

- The service did not have a bereavement midwife; this was identified at our last inspection in 2015. We discussed this with the Divisional Director of Midwifery, Gynaecology and Sexual Health who told us this was the next specialist post the service would be recruiting.
- Women could be referred to the chaplaincy department for support. This service offered care from a variety of religious leaders from the local area.
- Women attending the early pregnancy assessment unit were offered counselling. If the women wanted to continue with counselling, staff referred them to an external counsellor.
- A nurse told us of a long term gynaecology patient who was worried about her garden. The nurse arranged for a picture to be taken to show her that her garden was being cared for in her absence.
- One woman we spoke with told us; "The nurses were lovely" and that she felt listened to. She told us all her worries and questions were answered.

## Are maternity and gynaecology services responsive?

Requires improvement



We rated responsive as requires improvement because:

# Maternity and gynaecology

- During the inspection we saw the maternity service did not fully meet the needs of the local population. However, the service had now appointed some specialist nurses to better support the needs of the local population.
- Bed occupancy for maternity at the hospital was higher than the England average.
- Vaginal birth after caesarean clinics were having difficulty with providing appointments.
- There could be delays in finding medical staff who would agree to consent the women for further treatment when a fetal abnormality was detected.
- Most antenatal clinics ran with a two hour delay.
- There were no displays for women and visitors to give information about how to complain.
- Staff were not able to give examples of learning from complaints. However, there was now evidence of complaints being discussed at meetings with staff.

However:

- The service had displays to promote healthier lifestyles.
- A vulnerable woman midwife had been appointed to support teenage mothers. However, they were not yet in post.
- The service was in the process of appointing a specialist midwife to be responsible for mental health currently women are referred to the mental health team for review and a management plan.
- Gynaecology operated an early pregnancy assessment unit (EPAU) and there was a hyperemesis (severe pregnancy sickness) day clinic which arranged for women to be treated during the day and go home for the night.
- The community midwives offered a range of complimentary therapies to enhance the woman's experience of birth. For example, reflexology, aromatherapy, and hypnobirthing.
- The trust had developed a Health in Pregnancy Programme (HPP) to address the infant mortality rate, which is twice the national average at Walsall Manor. This targeted smoking cessation, alcohol use, diet and obesity for example.

## Service planning and delivery to meet the needs of local people

- The maternity service did not fully meet the needs of the local population, this was a cause for concern during the last inspection in September 2015. For example, at

the time of this inspection there were no dedicated midwives who provided specialist advice for teenage pregnancy, bariatric women or advice and support for Asian or Polish women. However, the service had advertised and appointed some new specialist nurses, including a lead midwife for normality and a specialist midwife for vulnerable families (which would look at teenage pregnancy as part of a wider role) and would now be better placed to meet the needs of the local population.

- At the time of our inspection, the Divisional Director of Midwifery, Gynaecology and Sexual Health did not have any matrons available due to sickness and a vacancy which meant service planning for the future of the delivery of the services was limited. This had been the case for over 3 months.
- Women identified as high risk at booking had their antenatal appointments in the hospital and were cared for by an obstetrician. The antenatal clinic offered appointments Monday to Wednesday, 8am to 6pm, Tuesday and Thursday 8am to 8pm and Saturday 8am to 5pm.
- Women were allocated a named midwife at the first booking appointment with the community midwife.
- The fetal assessment unit was open daily from 9am to 5pm to see women with antenatal complications and operated an appointment system. Women could self-refer or be referred by their GP, emergency department or their community midwife. It was a very busy unit and 20 to 30 women could access it in a day. There was not always a designated doctor as they were often shared with gynaecology, which could cause delays for women to be seen and discharged. Two out of four women we spoke with had a long wait over one hour.
- Gynaecology operated an early pregnancy assessment unit (EPAU). Women who were under 20 weeks pregnant with pregnancy complications and gynaecology emergencies were seen here. Appointments were available from 8am to 8pm Monday to Friday. There was a hyperemesis (severe pregnancy sickness) day clinic to enable women to be treated during the day and go home for the night.
- Gynaecology outpatients offered a range of services and we were informed they ran colposcopy, uro-gynaecology and oncology-gynaecology clinics.

## Access and flow

# Maternity and gynaecology

- Due to the increase in the number of births in 2014 and the shortage of midwives, the service and stakeholders made the decision to cap the births at Manor Hospital to 4200 annually. Women that lived in outlying geographical areas were informed by their community midwife which hospitals they could access, to give birth, to ensure women who needed to access Walsall Manor Hospital were able to do so.
- Elective caesarean section lists ran each day. Staff told us they used to have three women on a list. The third woman was often cancelled and two weeks before our inspection a decision was made to have two on the theatre list to prevent the third being cancelled.
- Bed occupancy for maternity at Walsall Healthcare NHS Trust was higher than the England average between June 2016 and December 2016. We saw bed occupancy was generally higher from 65% to 77% than the England average of 62%. This indicated women were having longer stays in hospital in comparison to the other trusts. We requested information for gynaecology bed occupancy and referral to treatment times, however this information was not provided by the trust.
- A vaginal birth after caesarean (VBAC) was offered to women and run by a midwife and a clinician with 56% success. However, the VBAC clinic was full and there was no available appointments until September 2017.
- Between April 2016 and March 2017, the maternity unit was closed on 10 occasions due to staffing shortages.
- Staff told us there could be delays in finding medical staff who would agree to consent women for further treatment when a fetal abnormality was detected. Staff told us of one occasion where a woman waited three hours in a distressed state.
- The antenatal and postnatal wards had a discharge room for women to wait until all of the paperwork was completed. There were health promotion posters on the benefits of having baby skin to skin and breastfeeding. Women could access a drink whilst waiting.
- The service had displays to promote healthier lifestyles for example, information on smoking in pregnancy and what to do if there was reduced fetal movements.
- We were told most antenatal clinics ran with a two hour delay. However, this was not audited and we were not told of any plans to improve this. We observed waiting delays of 90 minutes which was written on a white board on the wall behind the reception desk.
- The service would provide a chaperone if requested but there were no signs displayed to give women this information.
- Minor gynaecological surgery was undertaken in the day surgery unit situated at the end of the gynaecology ward. Women went home on the day of the procedure unless complications meant they needed to be admitted overnight.

## Meeting people's individual needs

- The community midwives offered a range of complimentary therapies to enhance the woman's experience of birth. For example, reflexology, aromatherapy, and hypnobirthing.
- Interpreters were accessible for staff to use in the hospital and the community for those women who did not speak English as their first language.
- The service had recruited a vulnerable specialist midwife to provide support to staff for teenage pregnancies, alcohol and drug misuse, perinatal mental health, and women with learning disabilities. However at the time of the inspection that person had not come into post.
- The service had a number of leaflets for women however we did not see them in different languages or an easy read version.
- Booklets provided to the women were in English. There was no advice how to get them translated if necessary.
- The service was in the process of appointing a specialist midwife to be responsible for mental health currently women are referred to the mental health team for review and a management plan.
- On the ward areas, if women were in a side room, their birthing partner was able to stay. The wards were in the process of reviewing what women wanted with regard to partners staying. We observed a put up bed in side rooms to accommodate women and their birth partner.
- Women were routinely put in hospital gowns to birth which was not in line with women's choice (Better Births 2015).
- We saw there were pathways for screening for fetal abnormality. High risk women were invited into the clinic for on-going treatment. There was a screening midwife in post who ensured women who had baby's with suspected or confirmed abnormalities were given appropriate care. There were special counselling rooms in the antenatal clinic to enable sensitive discussions to take place in privacy.



# Maternity and gynaecology

- The service had a vaginal birth after caesarean section (VBAC) clinic to promote a vaginal birth when appropriate. Staff told us women were pleased with the service and this was fed back at the maternity services liaison committee in June 2017.
- Access was available for people living with disabilities. All rooms on the delivery suite had en-suite facilities and there was single room accommodation on the postnatal wards.
- The midwifery led unit (MLU) had good facilities to support low risk women in active birth. For example, specialist equipment such as beanbags, mattresses, and birthing balls to provide and promote normal birth and ensure women giving birth were comfortable. However, this facility was not consistently available due to staffing problems. The MLU was open during our announced inspection; however, it had closed overnight during our unannounced inspection.
- The trust ran a diabetes clinic for women to attend an appointment with a specialist diabetes nurse. A specialist consultant ran the clinic as the service did not have specialist midwife for diabetes.. However, there was a midwife with a diabetes special interest that supported the women when she was able but this was not always possible due to staffing constraints. This was highlighted as a suggestion for improvement at our last inspection.
- The delivery suite had two rooms which were used for bereaved parents. These rooms were furnished with double beds and had a homely feel. The rooms were situated away from the main delivery suite so bereaved women and their partners could have privacy and avoid areas where women had just given birth. A cooling cot, which was designed to keep deceased babies at a cooler temperature, was available which meant babies could stay with bereaved parents for longer. Memory boxes were made up for parents. Although there was no specialist bereavement midwife, several midwives took a special interest in this area and cared for these families if they were on duty.
- The trust had a 24 hour a day, seven days a week chaplaincy service provided by Christian chaplains and a partial weekly service by Roman Catholic chaplains. A 24 hour a day, seven days a week service for smaller faith communities was to be reinstated following the Safety and Quality Committee decision in July 2017. The trust had developed a Health in Pregnancy Programme (HPP) which is part of the Healthy Child Programme. The

- health visiting team was commissioned for three antenatal contacts 12, 20 and 28 weeks of pregnancy. This programme was commissioned to address the infant mortality rate, which is twice the national average at Walsall Manor. This will also include national drivers such as Saving Babies Lives (2016) and Better Beginnings. The areas targeted were smoking cessation, alcohol use, diet and obesity, safe sleeping for babies and bonding and attachment.
- The HPP had introduced a parenting class for vulnerable parents and worked closely with the community midwives. They delivered a breastfeeding buddy service to support women with problems to breastfeed.
  - Staff in gynaecology screened women for dementia as part of the nursing assessment. Patients with a formal diagnosis of dementia were identified with a butterfly symbol in the bed space and staff completed a “This is me” document.

## Learning from complaints and concerns

- There were no displays for women and visitors to give information about how to complain. Leaflets were available to inform women how to complain. Three of five women we spoke with did not know how to make a complaint.
- There were 36 complaints about maternity and gynaecology between April 2016 and March 2017. The trust took an average of 45 days to investigate and close complaints; this is in line with their complaints policy, which states complaints should be dealt with within 45 working days. Twenty two complaints related to clinical treatment, five complaints were for communication and there were three complaints each about members of staff attitude, information and diagnosis.
- None of the staff we spoke with were able to give an example of learning from a complaint. However, the trust provided us with evidence to demonstrate complaints were discussed at meetings with staff.

## Are maternity and gynaecology services well-led?

Inadequate



We rated well-led as inadequate because:



# Maternity and gynaecology

- There was a lack of progress and minimal improvement to maternity services since our last inspection two years ago- September 2015.
- Forward planning of the service was focused on monthly planning. It did not consider how the number of births would be managed in future. There was no effective system for identifying, capturing or managing issues with acuity on the delivery suite.
- Maternity staff morale was low due to high levels of stress and work overload. Staff did not feel respected and valued.
- The maternity dashboard showed several risks had continued to be evident without improvement. There was a lack of clarity about how individuals are held to account.
- The senior leadership team was in its infancy and there had been little strategic oversight of governance and incidents at a senior level.
- Due to the challenges facing the service, the senior team was focused on managing the daily strains it faced with little innovation evident.
- There was no consistency of how meetings were held and minutes recorded.
- Staff did not feel involved with the decisions made at a senior level.

However:

- Reviews of maternity by external organisations recognised the service still needed further improvement but they also acknowledged that some progress had been made.
- There was an active maternity services liaison committee (MSLC), which meant that service user views were considered.
- There were good clinical multidisciplinary working relationships. Management was visible and approachable.

## Leadership of service

- There was a lack of progress and minimal improvement to maternity services since our last inspection two years ago- September 2015. Senior leaders and executive members lacked real oversight of the issues in maternity and had not tackled the issues which had been problematic for two years.
- The divisional structure for the women's children's and clinical support services was a team of five professionals. This included a Divisional Director, a

- Director of Operations, and Director of Midwifery, Gynaecology and Sexual Health, a Divisional Director for Paediatrics and Community Paediatrics and a Divisional Director of Clinical Support Services for clinical support. Four care groups sit underneath that; women's, children's and families, clinical support and Therapies and Discharge support. A consultant obstetrician was in the Clinical Director interim position and led the Women's care group which included responsibility for clinical, finance, human resources and quality support.
- Senior leadership in the service had been inconsistent because of changes of people in different roles since our last inspection in 2015. The senior management did not appear to understand the issues of concern within the service or what plans were in place to address them.
- The service was actively recruiting into an available matron's post. At the time of our inspection, the DOM was very new in post and did not have matron support due to vacancy and sickness.
- Staff spoke highly of their new Divisional Director of Midwifery, Gynaecology and Sexual Health staff and said she was visible and supportive. Senior staff we spoke with said the new Director of Nursing (DON) was visible and the Divisional Director had an open door and visited weekly.
- The leaders did not demonstrate a good understanding of the current challenges the service was facing. There were limited work streams due to not prioritising and developing a strategy for staff to follow.
- Generally, staff did not feel confident to raise issues with local and senior leadership as they felt disengaged and not listened to. Some staff felt there was a lack of openness and transparency across the service.
- Gynaecology service local leadership was supportive and staff spoke highly of them. They felt the service was in 'good hands' and staff stated the DoN was visible and fully engaged.

## Vision and strategy for this service

- Staff we spoke with could explain the vision of the trust but were not aware of the service's vision and strategy. The service had a five year annual plan for maternity and one for gynaecology. We did not see this displayed and staff we spoke with were not aware of it.
- We reviewed the annual plans and saw some of the developments planned for the current year were completed. For example, the transitional care unit and the business case developed for expansion of the labour

# Maternity and gynaecology

ward theatre had been agreed for maternity. The business case for a deputy urogynaecology specialist was included in the gynaecology five year annual plan.

- Staff were informed by an email without consultation that an option proposal was to move the midwifery led unit (MLU) to the Manor hospital site. Staff we spoke with were disappointed they had not been involved in any discussions.
- There was a non-executive with responsibility for maternity services. The Divisional Director of Midwifery, Gynaecology and Sexual Health did not have direct access to the trust board. The HOM would meet with the Director of Nursing who had direct access to the trust board.

## Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services. Maternity clinical governance meetings were held monthly. We reviewed three sets of minutes from February, March and April 2017 and saw action logs were monitored and clinical issues, for example, patient experience, investigations and complaints were discussed.
- Monthly oversight meetings were held to monitor the trust's progress against the improvements we told them they must action in the 2015 s29A warning notice. We reviewed the Patient Care Improvement Plan – Progress and Exception Report dated 31 January 2017. This referenced improvements already made in maternity and actions still requiring significant improvement. There was a supporting action plan produced for each monthly meeting which the trust had regularly reviewed. However, during our inspection, we found areas which had not been addressed, despite being raised during our 2015 inspection and outlined in our 2016 report. These included: staffing, low staff morale, high caesarean section rates and staff were unaware of learning from incidents.
- There were weekly safety alert meetings based on incidents and lessons learned. Gynaecology staff described with confidence any lessons learned, however, maternity staff were less confident and could not describe any learning during our inspection.
- Data was collected to measure quality of the service. However, we were not assured local managers had asked for audits in all relevant areas of practice. For example, there were no record keeping audits in place to monitor effectiveness and quality of clinical records or research in place to understand why fewer than expected deliveries were taking place at home.
- The maternity governance team had improved the size of their team and communication with the departments and they had been given support to update the maternity guidelines.
- The clinical director told us the temporary theatre on the delivery suite had been on the risk register since June 2013 and funding had been agreed to build a new purpose built second theatre at the end of the delivery suite. Building was due to start in September 2017. The renewal and update of the guidelines to meet national best practice remained ongoing and had been elevated to red risk on the risk register. The service has developed a plan to remain on track to renew all guidelines by August 2017. We were told that once amended they were emailed to all midwives and consultants to ensure no conflict with national guidelines. However, we were informed that the senior team were aware some of the consultants were not engaging in the process and were not attending the ratification meetings.
- A risk management policy and associated register was used across gynaecology and maternity services to identify and manage risk. Recorded risks on the register had review dates and some evidence of progress. The senior team concerns were evident within the risk register, however there was limited progress for some items for example the out-of-date guidelines were an identified risk but there was delay in their review and republication.
- We reviewed minutes of meetings at ward level. The format of the minutes was not consistent some used team connect format whilst other minutes were in a table format. Not all actions were time scaled or assigned to individuals. The delivery suite had actions carried over each month from August 2016 that were not completed.
- We asked the senior team who were the nominated maternity champions to have direct access to the board. There was not a defined member of staff with this responsibility.
- Maternity had a series of reviews undertaken by external organisations including West Midlands Quality Review

# Maternity and gynaecology

Service, Healthwatch Walsall in addition to external expert advice. All of these reviews recognised the need for further improvement but they also acknowledged that some progress had been made.

## Culture within the service

- The maternity ward was often left short staffed. Staff told us some of the co-ordinators on the delivery suite did not understand the demands and rigours of modern postnatal care and the impact being short staffed would have on them. We observed one trained member of staff and one untrained on the ward on a night shift because the second midwife was needed on the delivery suite. Staff told us this was a regular occurrence at least 50% of the week.
- Staff we spoke with on the maternity wards continued to work additional hours and were unable to take the time back. Morale on the wards was low.
- All staff we asked what improvements they would like stated they would like to see more staff. They had become so used to the shortages of staff it had become a normal expectation to arrive on duty and not have enough staff. Staff were working very hard however, did not feel the trust recognised this and valued them.
- We spoke with staff at all levels. There was a clear theme when we asked staff about non evidence based practice for example, all women having an admission cardiotocography (CTG) we were told this is the 'Walsall way'.
- The service had launched an updated fetal monitoring guideline two weeks before our inspection. On inspection, we identified staff did not know about this updated guideline. On our unannounced visit we observed a sign off sheet to monitor when staff had read this guideline which was commenced on 26 June 2017. On 5 July 2017, eight midwives out of 71 had read the new guideline. We did not observe the medical staff listed on the sign off list.
- Staff reported to us that some of the medical staff were set in their ways which inhibited progress. We discussed the development of guidelines and there was not a medical lead designated to the group.
- We were told some medical staff would not follow nationally recognised best practice because the service "has always done it that way". Staff we spoke with said they felt held back because there was not good

multidisciplinary communication to develop the service and adhere to best practice and there was a hierarchical culture within the service which had devalued the autonomous midwife.

- The model of midwifery care within the Manor Hospital was medicalised and active birth did not appear to be encouraged. The service had recruited a lead midwife for normality who was due to start in the autumn.
- Staff below band seven told us there was a blame culture within the service. Changes were brought about by bullying in many instances, both by medical and nursing leaders within the maternity service.
- Staff recognised the new head of midwifery as being skilled, but felt the new senior leadership team that supported her were blocks to change in culture, and they did not feel that anything had or would change.
- Staff did not feel valued by the organisation and many staff told us that the service ran on the good will of staff.
- Not all staff felt comfortable raising concerns about disrespectful, discriminatory or abusive behaviour or attitudes. This was because they were concerned at the response they would receive from some of the team leaders.
- Gynaecology staff felt they were listened to and did receive individual feedback from issues they raised.
- Gynaecology staff were happy with the time they had to care for each patient and felt that they were provided with the correct facilities and equipment to do this.

## Public engagement

- The trust performed the same as other trusts for 17 out of 19 questions and worse than other trusts for two of the 19 questions in the CQC Maternity survey 2015. The questions were: During your labour, were you able to move around and choose the position that made you most comfortable? Did the staff treating and examining you introduce themselves? The trust performed about the same as other trusts for all other questions. (Source: CQC Survey of Women's Experiences of Maternity Services 2015).
- Between April 2016 and March 2017, the trust's Maternity Friends and Family Test (antenatal) performance (% recommended) was generally worse than the England average. In the latest month of March 2017, the trust's performance for antenatal was 80% compared to a national average of 96%. Between April 2016 and March 2017 the trust's Maternity Friends and Family Test (birth) performance (% recommended) was generally similar to

# Maternity and gynaecology

the England average. In the latest month March 2017, the trust's performance for birth was 95% compared to a national average of 97%. Performance over time has been slightly below the England average throughout the year. Between April 2016 and March 2017 the trust's Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average, however trust performance fell in 2017. In the latest month March 2017 the trust's performance for the postnatal ward was 77% compared to a national average of 94%. Feedback was also received through thank you cards, which were displayed in the ward areas.

- There were maternity services liaison committee meetings every four months. These meetings provided an opportunity for service users and other interested stakeholders to have their views and ideas heard. We reviewed minutes from November 2016, February 2017 and April 2017. There was good attendance and minutes reflected discussions and actions were recorded.

## Staff engagement







- Non-qualified staff did not feel supported. They told us they felt this was because the service had so many other problems they were low in priority.

- There was a service suggestion box however, staff told us that there was no feedback or action from suggestions made.
- 'Listening into action' groups had been introduced across gynaecology and maternity services to allow staff to work with senior managers to improve their service.

## Innovation, improvement and sustainability

- The service secured £48,000 for training which was used to send staff on a number of external training courses for example; CTG master classes, PROMPT training to develop the service's emergency drills study day and human factors study days.
- Plans were in place to build a new obstetric theatre to provide better facilities within maternity.
- There were three freedom to speak up guardians for the trust and one of them was a midwife.
- The gynaecology service had improved the services provided to enable women to have a one-stop service which meant they could have all of the investigations and treatment in one visit.
- The service had won a network award for transitional care.

# Services for children and young people

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Children's services at Walsall Health NHS Trust are provided at the Manor Hospital where 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.

During our inspection, we visited the children's wards, the neonatal unit, the outpatients' areas, an operating theatre used for children's surgery and children's recovery area. We also attended a neonatal support group following the inspection and spoke with parents of babies who had recently been discharged.

In total, we spoke with 21 children and/or their parents and 30 members of staff, including consultants, middle grade and junior doctors, senior and junior nurses, health care support workers, a play specialist, and other members of the multi-disciplinary team. We also reviewed performance data and other information provided by the trust.

At our last inspection in September 2015, we rated services for children and young people as requires improvement overall. We raised concerns about the safety of care and

leadership of the service. During this inspection we saw significant improvements across all five domains, however the trust was aware there was more work for further improvement.

# Services for children and young people

## Summary of findings

During the last inspection in September 2015, we rated Children and young people services as requires improvement for safe and well led and good for effective, caring and responsive. This meant the service was rated requires improvement overall.

This was because;

- We had concerns about the robustness of incident investigations and review process.
- The neonatal unit was cramped and posed a potential safety risk when the capacity was increased above 15 patients.
- There were problems with the availability and content of patient's notes in the children's outpatients department.
- Although the trust was working in collaboration with other stakeholders, we had concerns about the trust's ability to access specialist child and adolescent mental health services (CAMHS) in a timely way and the management of patients requiring these services in the interim.

Following this inspection we saw significant improvements across all areas and we rated the service good overall. This is because;

- Systems were in place to ensure there were adequate numbers of suitably trained and qualified staff to provide safe and effective care.
- There was good clinical leadership and staff felt well supported by their managers and the senior leadership team.
- Processes were in place to identify when a patient's condition deteriorated and escalation to medical staff resulted in a prompt response.
- There was a positive approach to incident reporting and the review of incidents to identify learning, was improving.

- The trust participated in national audits and assessed their adherence to national guidance and best practice through a range of clinical audits. We saw an improving picture of performance in relation to these.
- Collaboration with other agencies and providers of care had improved the safety, responsiveness and effectiveness of care for specific groups of patients; in particular those with mental health needs.
- Staff were kind and caring in their approach and there was good emotional support for children and their parents.
- Governance processes had been strengthened and improved. Staff demonstrated a commitment to providing quality care and an enthusiasm for further improvement.

However:

- The environment within the fracture clinic was unsuitable for children and the trust did not provide any separate waiting area for children in this department.
- Although the individual needs of some specific groups of patients were recognised and addressed, systems and processes were not in place to identify those with a learning disability and ensure adjustments were made to cater for their special needs.
- Delays to discharge sometimes occurred due to a delay in the provision of medicines to take home.
- A significant number of local clinical guidelines were out of date.



# Services for children and young people

## Are services for children and young people safe?

Good



We rated safe as good because:

- There was a good culture of incident reporting and staff awareness of incidents and learning from them, was generally good. Safety huddles took place on a daily basis on each of the children's wards between the nurse in charge of the ward and the on call consultant.
- A paediatric early warning score (PEWS) was used consistently on the children's ward and the paediatric assessment unit (PAU), to ensure signs of patient deterioration were identified promptly and escalated to medical staff.
- Nurse and medical staffing levels were reviewed and adjusted to meet the needs of patients. Steps had been taken to improve senior medical cover out-of- hours.
- Cleanliness of the clinical areas was good and we saw staff adhered to safe hand hygiene practice.
- At our last inspection, we found reviews of incidents were not always robust and opportunities for learning were sometimes missed. At this inspection, we found more recent examples of incidents we reviewed indicated improvements had occurred, although a more in depth analysis of an earlier incident in April 2016 was required.

However:

- The trust policy for safeguarding children did not reflect the most up to date national guidance. Trust processes for recording staff completion of safeguarding training were not reliable.

### Incidents

- Between April 2016 and March 2017, the trust reported no incidents which were classified as never events for children's services. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported no serious incidents (SIs) in children's services which met the reporting criteria set by NHS

England in the same period. A total of 471 incidents were reported in children's services between April 2016 and March 2017. Of these, the severity was graded as major for three incidents and moderate for 51 incidents.

- The range of incidents reported, suggested there was a good incident reporting culture. When we reviewed the incidents, we identified three incidents in particular, which may have warranted classification as serious incidents. We examined these in more detail and found evidence of an analysis of two of the incidents using a 'table top' review approach and learning points were identified from these. In relation to one of these incidents, an independent opinion was sought from a neighbouring trust providing specialist children's services as to whether the incident should be classified as a serious incident. Therefore we concluded the trust had taken an appropriate approach to the management of these incidents.
- However, we identified one incident, which had been downgraded to minor severity following the initial report and for which limited analysis had been completed by the trust. We reviewed the incident report and the patient's records and concluded a more robust investigation was required and opportunities for learning were missed. We discussed this incident with senior clinicians and the governance lead after the inspection and we identified there had been full disclosure to the parents at the time. They agreed that, on reflection, the incident should not have been downgraded. The incident occurred in April 2016 and training in root cause analysis and incident investigation was completed by consultants and other senior staff from June 2016. They told us they were confident if a similar incident occurred now, it would be graded appropriately and fully investigated.
- Staff knew how to report incidents and several staff gave us examples of incidents they had reported. They said they received feedback about the actions taken as a result of incidents. Medical staff said key learning points were fed back at the weekly 'grand rounds.' A grand round is a dedicated multi-disciplinary and evidence based educational session where current patients are discussed and key learning from events such as audits and incidents are shared.

# Services for children and young people

- Staff reported incidents on an electronic incident reporting system. All staff had access to the system except for students and agency staff. They told us that if they needed to report an incident, they would do it alongside a permanent member of staff.
- Staff gave us examples of lessons learned from incidents and changes which had occurred to reduce the risk of recurrence. For example, a patient suffered complications following emergency surgery. As a result of the review of the incident, work was undertaken to develop a shared care approach between surgeons and the paediatricians, for children requiring unplanned surgery. Paediatricians would not previously have been involved in the care of this group of children.
- Senior sisters and the matron were knowledgeable about themes from incidents within the service and it was clear they were involved in identifying changes and driving forward improvements.
- On each of the wards in children's services, safety huddles took place on a daily basis between the nurse in charge of the ward and the on call consultant. Each patient was discussed and any problems and safety issues identified.
- Staff attended monthly mortality and morbidity review meetings; we saw there was discussion of individual cases and learning points were identified along with good practice. Feedback from staff who attended these meetings suggested that there was a willingness to challenge colleagues in children's services, however challenge of colleagues from other services such as the obstetricians was not always as robust.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duty of candour and gave us examples of how the duty had been applied.
- We also saw an example of when the duty of candour was applied. We saw the documentation in the care record which indicated the incident was discussed with the parents and an apology given.
- Most parents we spoke with said they felt staff had been open and honest with them, although one set of parents of a baby on the neonatal unit said they felt staff had "played down" an issue and it was only when they

persisted in their queries that staff arranged for a doctor to talk with them. However, the doctor was honest and gave them a full explanation when they met to discuss it.

## Cleanliness, infection control and hygiene

- No MRSA bacteraemia (blood stream infections) or C.Difficile infections were reported in children's services between April 2016 and March 2017.
- The environment in all areas of children's services appeared visibly clean during the inspection. We spoke with some housekeeping staff who were clear about their duties and followed a daily and weekly cleaning schedule. The cleaning schedules we reviewed were completed consistently.
- Staff completed monthly environmental audits to assess cleanliness of the clinical areas. The results from the audits showed results ranged from 80% to 100% between October 2016 and March 2017 against a trust target of 90%.
- A ward manager told us that when their scores had fallen, they met with the housekeeping supervisor and reviewed the deep cleaning process. Following this, changes were made and the frequency of the audits was increased. The ward manager said the scores were now improving and we saw this was the case.
- The trust completed monthly hand hygiene audits to assess staff compliance with hand hygiene procedures. Results from these audits showed 100% compliance on Ward 21, neonatal unit (NNU) and PAU each month between October 2016 and March 2017.
- During the inspection we observed staff using personal protective clothing and equipment (PPE) correctly and observing good hand hygiene practice. Staff were bare below the elbows.
- Parents were generally very positive about the cleanliness of the environment and told us they saw staff using hand gel and washing their hands before attending to their child. However, one family said that when an emergency occurred on NNU and staff had to move from one baby to another, the nurses changed their gloves but did not wash their hands or use hand gel.
- In the CQC children's survey 2014, the trust scored 8.66 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

# Services for children and young people

- Staff checked for signs of infection at the sites of intravenous (IV) cannulas daily and recorded this (VIP scores). Staff completed monthly audits to assess how well these were completed; we found all the clinical areas met the trust target for compliance and recorded scores of between 86% and 97% between October 2016 and March 2017.

## Environment and equipment

- PAU, Ward 21 and the NNU were accessed and exited via an electronic swipe in/out system. Visitors and non-paediatric unit staff were required to 'buzz' to gain entry and exit to enable staff to monitor people entering and leaving the units.
- The trust had placed a security camera at the entrance to NNU and we noted that when this was not working for a period of several months, the issue was placed on the risk register. At the time of the inspection, this had been rectified and was in full working order.
- The children's ward and the PAU were spacious, well maintained and appropriate for their purpose. They comprised a mix of single rooms and four bedded bays. There was sufficient room for a parent to stay with their child overnight in both the single rooms and bay areas, and fold up beds were provided for this purpose.
- Children and young people with mental health needs were cared for on PAU and the children's ward for short periods. A single room on each ward was adapted to maintain the safety of patients who might be at risk of self-harm. For example, in these rooms the ligature risks had been assessed and reduced.
- The NNU normally cared for up to 15 babies and this was divided into two intensive care beds, two high dependency beds and 11 special care beds. The accommodation comprised a mix of single and double side rooms and larger bays. However, on occasions when the number of babies exceeded the planned capacity, additional incubators and cots were used in the intensive care and high dependency areas.
- At the previous inspection we identified that bed spaces were small and cramped, particularly when parents were in attendance. Although additional incubators were removed from the rooms, when these were needed to accommodate additional babies the space would have been further reduced. The trust told us it recognised the risks imposed by the lack of space and had plans for expansion of the unit.

- At this inspection we saw that the same environmental constraints existed although the trust had taken steps to reduce the number of babies requiring admission and there were fewer instances when the bed numbers were increased. The plans for expansion of the unit had been progressed and work was due to start in September 2017.
- A parent commented on the lack of suitable chairs for parents to sit in when they were holding their babies to provide 'Kangaroo' care (skin-to-skin contact).
- The children's OPD was tidy and uncluttered. However, the assessment room in the OPD (where children were weighed and measured) contained scissors and other sharp instruments in an open cupboard and trolley. This presented a risk to children. We spoke with staff about this although they did not suggest any action they could take to address the issue. The assessment room was not locked when not in use.
- The Starfish suite used for child protection assessments was secure, tidy and no safety issues were identified.
- Emergency resuscitation trolleys were available in each of the children's wards. They were appropriately stocked and checked daily. Other emergency equipment was also checked daily.
- Equipment such as monitors and electrical equipment had been checked in line with their testing requirements.

## Medicines

- Medicines were stored safely and in line with trust policy and national guidance. Controlled medicines were checked twice daily at the shift change. We noted there had been previous issues with the secure storage of intravenous (IV) fluids, however these had been resolved prior to the inspection.
- We observed medicines were administered safely and children and their parents told us staff always checked their identity prior to administering their medicines.
- A parent told us their child's medicines were not always administered on time and they sometimes had to remind staff they were due. We checked the child's medicine administration chart and we saw one occasion when their medicine was given 90 minutes late, although there was no indication that the other medicine mentioned by the parent was given late.
- We checked another child's medicine administration chart and saw they were receiving two IV (intravenous) antibiotics. There was a record of these being given late

# Services for children and young people

over a period of two days. Staff told us there had been problems with IV access which had resulted in the late administration of the antibiotics on one occasion and subsequent doses had been delayed to ensure appropriate gaps between the doses. However, this did not adequately account for the discrepancies.

- Medicines charts were completed consistently and the person prescribing the medicines was clearly identified as required. Allergies were clearly documented and children's weights recorded.

## Records

- Care records were stored securely in locked trolleys on ward 21, the NNU and PAU.
- Separate nursing and medical records were kept on ward 21 however, in the neonatal unit and PAU a multi-disciplinary approach was taken to record keeping.
- Records were generally legible, and the entries, dated, timed, signed and the designation of the person making the entry was identified. However, a small number of the pages were not headed with the patient's identity details on both sides of the page.
- Nursing records on ward 21 contained an assessment of children's care needs in relation to the activities of daily living and a range of care plans. However, all of the care plans we reviewed were standardised and not tailored to the needs of the individual child. For example, a child's vital signs care plan did not indicate the frequency of the observations required.
- Staff completed a daily record of care contemporaneously and we saw medical records contained a clear plan for the patient.
- Vital signs observation charts showed the frequency of observations required and they had been completed consistently.

## Safeguarding

- The trust set a target of 90% for completion of safeguarding training. National guidance states that all professional staff working with children should be trained to level 3 in safeguarding children. Therefore the trust policy did not reflect national guidance.
- Trust processes for recording staff completion of safeguarding training were not reliable. From data initially supplied by the trust, compliance for

completion of safeguarding courses as of 31 March 2017 for staff in children's services, indicated that the trust's targets were not being met for any of the children's or adults safeguarding training for medical staff.

- The data indicated only one member of nursing staff required level 3 children's safeguarding training and only two medical staff required level 3 children's safeguarding training. This is not in line with national guidance which states that all clinical staff working directly with children should complete level 3 training.
- We discussed this with the senior leadership team and we were told staff had received level 3 training and they had identified problems with the recording of attendance data on the electronic staff record.
- They agreed to rectify this and re-send the data. When they did this some problems remained. However, a third set of data supplied by the trust after the inspection indicated the trust target was being met.
  - 91% of staff on the children's wards and 96% of staff on the NNU had completed children's safeguarding training at level 3 (the highest level).
  - 98% of consultant medical staff had completed level 3 training. The percentage of non-consultant medical staff who had completed level 3 children's safeguarding training was reported as being 67%, and did not meet the trust target, although the number of staff in this group was small (12 in total).
- All the staff we spoke with told us they had completed level 3 children's safeguarding training. They were aware of the signs of abuse and how to raise concerns.
- Staff told us the safeguarding team were not based on site but were contactable when needed.
- Staff said when a multi-agency referral form was completed the individual making the referral received an email to inform them of the outcome of the referral.
- On admission, a record was completed of any potential safeguarding concerns. When safeguarding issues were identified, the documentation relating to this was placed at the front on the care record for ease of access.
- The trust had a separate female genital mutilation policy for safeguarding children at risk of female genital mutilation dated February 2016.
- Children were chaperoned by parents or nursing staff.

## Mandatory training

- A mandatory training programme was in place and the trust had set a target for 90% of staff to attend training.

# Services for children and young people

- The overall compliance with attendance at mandatory training in children's services was 85% as of 31 March 2017. Nursing staff achieved 92% compliance, administrative and clerical staff achieved 83% compliance and additional clinical services, 92%. However, the overall compliance for medical staff was 69%. This was being addressed through personal development reviews.
- The highest levels of compliance overall were for equality and diversity training (98%), patient moving and handling (95%), conflict resolution (94%), and infection control (94%).
- Lowest rates of attendance were for fire training (67%).
- Nurses completed a one day mandatory training update annually which also included medicines management, PEWS, documentation, fluid balance, VIP scoring, and sepsis.
- Paediatric basic life support was provided as a topic within the nurses' mandatory training day and there was 95% compliance with attendance. All qualified nurses also undertook paediatric immediate life support (PILS) as a minimum annually.
- When patients required surgery, we saw pre-operative safety checklists were completed on the ward and in the anaesthetic room. The WHO '5 steps to safer surgery' checklist was also completed to reduce the risks associated with surgery.
- We reviewed the results of monthly audits, which were completed to monitor the use of the WHO checklist in the paediatric theatre and saw 100% compliance was achieved every month between May 2016 and April 2017.
- The children's ward regularly cared for children and young people who had self-harmed or with other mental health issues. A risk assessment tool suitable for use by non-mental health providers was used to assess the risk of individual children and adolescents with mental health needs and to indicate the supervision they required. Care support workers who had experience and training in caring for children and young people with mental health needs provided one to one care where necessary.

## Assessing and responding to patient risk

- The paediatric ward and paediatric assessment unit used a paediatric early warning score (PEWS) to identify patients whose condition was deteriorating. This was completed with every set of vital signs observations.
- Records we reviewed showed the PEWS were completed consistently. The trust conducted monthly audits of the use of PEWS and we saw appropriate escalation when the score rose. The results showed at least 95% compliance between January 2017 and April 2017.
- Staff on the neonatal unit told us they had trialled the use of several scores for use in babies, but they had not proved useful for neonates on the unit.
- The children's care group had started to use the 'Sepsis 6 care bundle' to ensure a systematic approach to the management of patients who had possible sepsis (blood stream infection). There was no prompt about sepsis on the initial admission documents for PAU. However, staff told us the documentation had been reviewed and was being updated to include a prompt to think about sepsis.
- Staff told us they had received sepsis training and showed a good level of awareness of the issue.
- A nationally recognised tool was used to help inform nurse staffing requirements on the children's ward and PAU. The tool had been used for three months and indicated staffing levels were reflective of the care needs of the patients on the children's ward. Staff told us they were planning to use the tool through the winter months to assess staffing requirements at a time when patient needs might be different.
- The trust based the nurse staffing levels of the NNU on guidelines produced by the British association of perinatal medicine (BAPM). Staff told us the staffing establishment provided adequate staffing for 17 beds to allow flexibility if the dependency of patients increased or the number of patients exceeded the 15 patients normally accommodated.
- Staff told us there were generally enough staff on duty to meet the needs of the patients. We noted staff reported incidents on the neonatal unit when staffing levels did not meet BAPM guidelines. We discussed this with staff and they told us this sometimes happened when there were an increased number of babies with high dependency needs.
- At the last inspection, we observed the number of babies cared for on the unit regularly exceeded the number planned for and this caused additional pressures on nurse staffing requirements. However, we



# Services for children and young people

saw the actions taken by the trust in the interim to reduce the number of births at the hospital, enabled the NNU to work within their planned capacity for a greater proportion of the time.

- As of 31st March 2017, the trust reported a 0% vacancy rate for children's services and during the inspection staff confirmed they had no vacancies.
- The sickness rate reported for children's services was 2.8% and temporary staff usage was reported as low at 3% at the 31st March 2017.
- Handovers took place at the start of each shift to ensure staff had the information they needed to care for patients safely. A recognised 'SBAR' (Situation, Background, Assessment, Recommendation) tool was used to ensure a structured approach to information provided at handover.

## Medical staffing

- The number of consultants for paediatrics and neonatal services had been increased since the last inspection and some acute care consultants appointed. The acute care consultants were also able to work as part of the middle grade medical rota.
- As a result of the increase in the number of consultants, the rota was changed from January 2017, and two senior decision makers were available out-of-hours and at weekends. Prior to this, one consultant provided cover for paediatrics and neonates. We noted that prior to the introduction of a second consultant there were a number of incidents reported where the consultant was busy with a sick baby on the neonatal unit but was required in paediatrics as well, although no adverse outcome was reported.
- A consultant was on site from 9am to 7pm every day and there were two consultants available out-of-hours.
- Senior medical staff were supported by middle grade and junior doctors, advanced nurse practitioners and advanced neonatal nurse practitioners.
- In January 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1 and 2) staff was also higher.
- A junior doctor said, "The rota is much better now and well-staffed." Another member of staff said, "Medical cover used to be difficult at times but now we have the acute care consultants in place, it's much better. I can't remember when last we were not covered."

- Junior doctors told us they received good support from their seniors and felt able to approach them for advice.
- As at March 2017, the trust reported a sickness rate of 3.1% in children's services for medical staff and an average bank and agency usage of 23%.
- There was a lead anaesthetist for paediatrics. Elective paediatric surgery was shared by all anaesthetists to ensure they maintained competency in paediatric anaesthesiology.
- We observed a medical handover and found it was well attended. A consultant led all three handovers each day during the week. The handover was well organised, timely and robust. Trainees reported it was very good with opportunities for learning, however, from the handover we observed more participation by the trainees in the discussions would have encouraged further learning.

## Major incident awareness and training

- A major incident plan was in place for the trust and was reviewed and updated in April 2016.
- Staff had attended recent training for major incidents and special consideration had been given to the management of children involved in a major incident in light of the recent incident involving children in Manchester.
- Staff we talked with were aware of the major incident plan and understood their role. They told us a decision had been made to take children and adults to an identified ward initially for triage to avoid separating children from parents. Paediatric staff and paediatric equipment would be deployed to the ward to support.

## Are services for children and young people effective?

Good



We rated effective as good because:

- The trust participated in national audits to assess the effectiveness of care and the results showed improving performance.
- Performance in the latest national audit of childhood diabetes was better than the national average for most measures.



# Services for children and young people

- The unit promoted skin to skin contact for new born babies and results showed this had reduced the number of neonatal admissions for low temperature by around 35%
- Local audits were completed to assess compliance with best practice guidance. The trust was working towards baby friendly accreditation with UNICEF.
- In both paediatrics and the neonatal unit, consultants were on site and reviewed patients seven days a week.
- Staff had access to training and development appropriate to their needs. Annual appraisals were undertaken which staff described as meaningful and constructive.
- We found evidence of good multi-disciplinary team working and links with other services such as CAMHS, maternity services and the emergency department.

However:

- Some local clinical guidelines were out of date by as much as four years and required review.
- There was a lack of a systematic approach to assessing patient's nutritional and hydration risks.

## Evidence-based care and treatment

- Clinical guidelines were available to staff on the trust intranet. However, some guidelines were out-of-date and were not robust. For example, 13 guidelines we reviewed were past their review date by over a year and as much as four years.
  - The trust had developed care pathways for the management of children presenting at the trust with specific conditions. This was to ensure a consistent approach was taken to their management in line with national guidance. We saw examples of these for children and young people with diabetes and those with wheeze/asthma.
  - The service completed a range of audits to assess compliance with national guidelines and best practice. Examples of these included an audit of compliance with the sepsis pathway, childhood obesity assessment, the management and follow up of children with nephrotic syndrome and prolonged jaundice screening.
  - There was an ongoing programme of local audits and we noted an audit of the management of diabetic ketoacidosis in children was planned.
  - When audits were completed action plans to address issues identified and improvement needed were developed.
- The trust was working towards the UNICEF UK Baby Friendly accreditation for neonatal units. They were due to submit evidence for stage three by the end of the year.
  - The unit promoted skin to skin contact for new born babies and as a result of issues identified in babies reaching the NNU with low body temperatures, a 'Listening into action' event was initiated in January 2017. Early results indicated that the percentage of admissions to the neonatal unit and transitional care with a low temperature was reduced from 25% in 2016 to 16% between January and April 2017.

## Pain relief

- When children attended PAU or were admitted to the children's ward, staff completed an assessment of their pain. Patients' initial assessment documentation contained a record of this.
- Staff completed monthly pain management audits to assess whether children's pain was assessed and managed effectively. The results from these were reported on the paediatric and neonatal dashboard and monitored through governance committees. Between December 2016 and May 2017, the scores from the children's ward increased from 50% to 83% and the score for PAU ranged from 80% to 93%.
- Staff told us by conducting the audits, they had identified issues on the children's ward with the documentation of re-assessments of pain, following the administration of pain relief. They raised awareness of staff to the issue and had included pain management in the paediatric mandatory training updates. They also developed a new care plan and pain guideline for staff.
- We asked a young person and their parent whether staff asked them about any pain they might have. They told us staff had asked them about their pain levels and gave them medicine for their pain. The parent explained that the young person had difficulty in using the number scale for pain and so staff used pictures of sad and happy faces, to help the child describe their level of pain.
- Another child said they didn't like needles, however, staff put some cream on their skin and they did not remember the cannula being put in.
- The NNU were in the process of launching a new pain chart for use in neonates. The advanced neonatal nurse practitioner had completed a review of the research to identify a suitable assessment tool.

# Services for children and young people

## Nutrition and hydration

- Patients were weighed and their height recorded on admission to the service, however there were no formal assessments of patients' nutritional status in the care records we reviewed. Following the inspection, the trust told us they were in the process of introducing a tool for the assessment of malnutrition in paediatrics.
- We saw a patient with a raised temperature and possible viral infection did not have a fluid balance chart in place. We discussed this with the ward manager who agreed they would have expected this patient's fluid intake and output to be monitored. The ward manager took remedial action to address this. We asked about decisions on when to use a fluid balance chart and they told us a judgment was made for each individual patient.
- Patients and their parents told us the food was good. One person said their child, "Thoroughly enjoyed it." They went on to say, "I think they try to put well known favourites on the menu." However, another parent said there wasn't much healthy food on the menu and a lack of fruit and vegetables. Another parent said the food was very repetitive and there could be more variety.
- They said staff encouraged the children to drink plenty of fluids.
- Two paediatric dietitians were available for children's services and staff said they could bleep them or complete a referral form, if a patient needed a review. They said the dietitians responded promptly and often saw the patient on the same day as the referral was made.

## Patient outcomes

- The trust participated in the national paediatric diabetes audit in 2014/15 and 2016. Results from the 2016 audit showed the trust performed better than the England and Wales average for most measures, which was an improvement from the previous year. HbA1c levels are an indicator of how well a person's blood glucose (sugar) levels are controlled over time.
- The NICE Quality Standard QS6 indicates that a personalised HbA1c target should be agreed, usually between 48mmol/mol and 58mmol/mol. In the 2014/2015 audit, the trust performed similar to the England and Wales average. Trust data for the 2016 national

audit indicated the average HbA1c level was better than the England and Wales average and more people received educational and psychological support than the England and Wales average.

- In the neonatal national audit programme (NNAP) (2015), the unit performed below the national average in relation to the percentage of patients who were screened on time for retinopathy of prematurity (screening for eye problems). Fewer parents had a documented consultation with a senior clinician within 24 hours of birth than the national average. However, survival rates, as measured by the percentage of babies receiving a two year health assessment, were higher than the national average.
- National results for the 2016 NNAP audit were not available, however data for the third quarter of 2016 supplied by the trust, indicated that the trust scored about the same as other trusts in relation to timely screening for retinopathy of prematurity and better than the national average for a consultation with a senior clinician within 24 hours of birth. Other measures reported on included better than average performance in relation to babies having their temperature taken within an hour of birth and 100% mothers who delivered babies between 24 and 34 weeks gestation inclusive were given antenatal steroids as compared with the national average.
- The Epilepsy 12 national audit had not been carried out since the last inspection however an action plan to address issues identified in the audit had been developed following the inspection.
- Data from the national paediatric pneumonia audit for the third quarter of 2016 indicated the trust compared favourably or similar to other trusts in relation to the initial patient investigations carried out, management and follow up of patients.
- Between December 2015 and November 2016 a similar percentage of under one- year olds were re-admitted within two days of discharge following an elective admission, compared to the England average and a similar percentage of patients aged between one and 17 years old were re-admitted following an elective admission compared to the England average. Between January 2016 and December 2016 the trust performed worse than the England average for the percentage of patients under the age of one who had multiple re-admissions for asthma and epilepsy. In February 2016 the RCPCH (Royal College of Paediatrics and Child

# Services for children and young people

health) were invited by the trust to review and write a report relating to a number of historical paediatric cases, together with an opinion on the operation of the neonatal unit. This was to provide the trust with an opportunity to address a number of issues and concerns raised and offer a definitive opinion and recommendations for a way forward.

- The terms of reference were quite specific, looking at the management of paediatric complaints and operation of the neonatal unit, but although these have been met, the Review team extended the scope in order to address more systemic issues around medical staffing, and the pathways through ED.
- Overall the Review team found an extremely busy unit with a number of serious concerns although these were starting to be addressed. The medical staffing for the neonatal unit was insufficient both in numbers and expertise, particularly given additional pressure due to recent local reconfigurations. Staffing was strengthened by a lead neonatologist appointment and a 0.5 WTE tertiary part time neonatologist cover and it was the opinion of the review team that it would be some months before the unit was deemed to be robust. The review also found there was an inappropriate reliance on Advanced Nurse Practitioners to manage the neonatal unit and although across both neonates and paediatrics the review team found excellent nursing leadership, recent restructuring had left the nursing rotas with insufficient experienced staff nurses.
- The trust responded with a comprehensive action plan to address these concerns. During this inspection we reviewed the action plan in full to look at whether the action points had been addressed and we found they had.

## Competent staff

- As at 31 March 2017, 94% of staff within children's services at the trust had received an appraisal compared to a trust target of 90%. When broken down by staff group, nursing and medical staff and those from other clinical services exceeded the trust target. Administrative and clerical staff were below the trust target with 83% of staff having received an appraisal within the previous year.
- Staff said they found appraisals constructive and they had the opportunity to discuss their development needs.

- The trust provided staff with access to education and training relevant to their roles. This included clinical updates by specialist nurses such as in diabetes.
- Paediatric simulation sessions were provided monthly for the multi-disciplinary team in order to improve the management of patients with specific clinical conditions, for example patients with a cardiac condition. Staff told us they received feedback regarding their performance after the sessions.
- Medical staff told us that peer support was effective and had improved over the last two years. Junior doctors felt able to approach their seniors and reported they had a good volume of supervised learning events. They were also encouraged to participate in neonatal network activities.
- Newly qualified nursing staff were allocated a mentor and staff told us they were able to work with their mentor on a regular basis. They were also allocated a buddy and were completing a competency framework, which was well in-bedded for all staff. One nurse we spoke with said they had commenced a foundation course in neonatal care.
- A part time practice educator was available within the neonatal unit and staff told us they were supportive and identified training opportunities for them.
- Nursing staff had undertaken training in assessing children and young people with mental health needs. Care support workers with a remit to care for children with mental health needs had been appointed and in addition to the training provided to all clinical support workers, they had received training from the community child and adolescent mental health team (CAMHS).
- Nurses at band 6 and above had access to leadership and management courses and the ward managers we spoke with were completing a variety of these. They told us the courses had made them more confident in dealing with staff issues such as sickness absence management.

## Multidisciplinary working

- Staff told us there were good multi-disciplinary (MDT) working relationships within children's services. One person said, "The MDT is easy and open. There are fewer barriers and less red tape than elsewhere."

# Services for children and young people

- Staff reported closer working with the emergency department (ED) and they said that since the appointment of paediatric nurses in ED, there was more combined working and the transfer of children between ED and children's services was much smoother.
- There were good links with community children's services. Staff told us of joint working to develop clinical protocols across community and acute services. We also saw that community children's nurses attended the medical handover twice a day.
- We saw evidence of joint working between maternity services and children's services to address issues of babies being cool when they arrived in NNU. A 'Listening into action' group was developed.
- The neonatal unit had an outreach sister who was the link between NNU and the health visitors. The outreach sister attended the ward rounds, and planned discharge. They talked to the parents before discharge and supported them after discharge.
- There were transition clinics for young people with asthma, epilepsy and those with diabetes with clear criteria for the transfer of patients to the adult service.

## Seven-day services

- Consultants were on site and reviewed patients seven days a week in both paediatrics and the neonatal unit.
- There was support from diagnostic and support services such as radiology, CT scanning and physiotherapy seven days a week.
- Two paediatric physiotherapists covered children's services weekdays. Out-of-hours and at weekends the adult team provided care for new patients.
- There were two paediatric dieticians available Monday to Friday.
- A phlebotomy clinic provided blood tests until 7pm one day a week to enable patients to attend without missing school.

## Access to information

- Staff used a combination of paper based records and electronic records. We did not receive any complaints about difficulties in accessing information, or results from investigations.
- Paediatricians were available to provide advice to GPs and to ensure patients were directed through the most appropriate route for review.

- Pathways for transition to adult services were in place to ensure information about patients' ongoing care was available to adult clinicians.
- We talked with a parent of a child who was receiving joint care with a local specialist hospital and they were very positive about the shared care arrangements and felt there was good communication between the teams.
- On discharge from the children's ward, a summary of the care received was sent to the GP and a copy filed in the child's record. On the neonatal unit, an electronic system was in place and the GP was sent a copy on discharge.

## Consent

- The trust had a consent to examination or treatment policy dated February 2017. This provided clear guidance to staff on consent procedures for children, young people aged 16 and 17 years of age and those without the mental capacity to consent to their or their child's care and treatment.
- Staff were knowledgeable about the need to assess the competency of the child or young person to give consent themselves to ensure informed consent was obtained from the appropriate person. They were familiar with the 'Gillick' competencies and 'Fraser' guidelines which provide a framework for assessing competency.
- A parent we spoke with said staff talked to their child about the operation and made sure they understood. They said they signed the consent form prior to admission and staff checked with them again when they were admitted.
- We reviewed the care records of two patients who had surgery and we saw the consent forms were completed with a full record of the risks and the forms were signed appropriately.

## Are services for children and young people caring?

Good



We rated caring as good because:

- Children and their parents told us they received compassionate care and we observed this during the inspection.

# Services for children and young people

- The majority of children and their parents felt they were fully informed and involved in decisions about their care and treatment.
- Emotional support was provided when appropriate. Parents of babies on the neonatal unit (NNU) had access to follow up support and a neonatal support group.

However:

- A small proportion of parents of babies on the neonatal unit said that they were not able to be present during the doctor's daily ward round. Therefore, they did not regularly see the medical staff to receive updates on their baby's progress. They had to make a specific request to see a consultant.

## Compassionate care

- Children's services participated in the national Friends and Family test (FFT). The FFT asks how likely patients are to recommend the ward to their family and friends.
- Between September 2016 and February 2017, the percentage of respondents recommending the children's ward ranged from 87% to 100%. Scores for the NNU ranged from 80% to 100% and scores for paediatric assessment unit (PAU) ranged from 83% to 100% in the same period. The national average is 94%.
- The trust performed about the same as other trusts for all of the 14 questions in the CQC children's survey (2014) relating to compassionate care.
- Parents used adjectives such as, "Fantastic," "Brilliant," and "Very friendly" to describe staff.
- All the patients and parents we spoke with told us staff were kind and caring in their approach. A patient told us staff stayed and chatted with them when their parent wasn't there.
- A parent said their child normally would not talk to strangers and found it difficult to trust adults, however, staff had built a good relationship with them and one member of staff in particular, related very well to them and the child was starting to open up to them.
- We accompanied a child to theatre and observed staff interacting well with the child and their parent.

## Understanding and involvement of patients and those close to them

- Children told us they knew what was going to happen and that staff explained their care and treatment to them.

- Parents on the children's ward said the doctors went through everything with their child and made sure their child understood. One parent said they were kept informed and the doctor adapted the way they gave information, to ensure their child was able to understand. They said, "It is good that they speak directly to [the child]."
- A child was due to be discharged and their parent said a community nurse would visit them after discharge. They said the nurse had come into the hospital, introduced themselves and told them what would happen at home and what to expect.
- A parent of a child on the PAU said the doctors and nurses answered their questions and explained the treatment plan for their child.
- On the NNU, parents were generally positive about the information they were given and said staff encouraged them to be involved in the care of their baby. Two sets of parents compared the approach to other units where their baby had received care. They felt it was more personal and they were able to participate more in their baby's care in this unit. However, one set of parents said staff tended to provide the care for their baby and didn't show mums how to do things.
- One parent was taught to give their baby's nasogastric feeds. They told us the training was good and were surprised how easy it was to learn.
- Two parents said they did not receive regular updates on their baby's progress from the medical staff. They were not sure who their consultant was and if they had met them. They commented that doctors did their rounds at about 9.30am and although they visited daily for several hours, they did not arrive until after the ward rounds had finished and therefore did not see the doctors. One parent said, "Unless you specifically go out of your way to ask something you don't get told." Another parent said they were not sure about their baby's progress and that it would be nice to have an update from the doctors. These parents acknowledged they could ask to see a consultant.
- Other parents told us they were kept well informed. For example, one parent said, "As soon as we went into the room, they told me what was happening and the next step. We saw the doctors every morning and even in the afternoon they always came to tell me what was



# Services for children and young people

happening.” Another parent said, “When the doctors came round they would initially talk between themselves and then they would explain to us. They would break it down so we understood.”

- We reviewed three patients’ care records for babies who had spent at least seven days on the NNU and could not find any evidence of communication with parents in one. However, the other two contained coloured sheets for documenting communication with parents and we found evidence of contact when key events had occurred.

## Emotional support

- Parents on the NNU said staff were very supportive and they recognised when parents were anxious and helped them talk through their anxieties. One set of parents said, “The nurses are excellent, some of them in particular pick you up when you have down days.” They told us that on Father’s day a member of staff made them a card with their baby’s footprint on the card.
- A parent said staff explained there might be times when their baby would seem to take a few steps forward and then a step back but that was normal. They said this meant that when their baby had a set-back they were not as worried as they otherwise would have been.
- A neonatal outreach nurse provided care and support to babies and their parents after discharge. A neonatal support group was held monthly and was supported by nursing staff and the breastfeeding buddies. We saw this was well attended and parents told us they found it very supportive.
- Parents on the children’s ward also told us staff were understanding and supportive. One parent explained their child had a needle phobia and the parent felt staff had dealt with it very well.
- An epilepsy nurse specialist and an asthma nurse specialist were available and provided support to children with these long-term conditions.
- A multi-faith chaplaincy service was available and information about this was displayed in the PAU.

- The service worked with external agencies and other internal departments to provide consistent and coordinated care.
- The environment was generally suitable for the needs of children and a range of age appropriate resources were available.
- There was good access to the service. GPs had direct access to the service and patients could be seen in the paediatric assessment unit (PAU) or in a rapid access clinic when this was necessary. Patients presenting at the emergency department (ED) had access to a paediatrician and could be transferred to the PAU.

However:

- The environment within the fracture clinic was unsuitable for children and the trust did not provide any separate waiting area for children.
- Systems and processes were not in place to identify those with a learning disability and ensure adjustments were made to cater for their special needs.
- Delays to discharge sometimes occurred due to a delay in the provision of medicines to take home. This was particularly pronounced during the winter period when patients could wait all day.

## Service planning and delivery to meet the needs of local people

- Staff had developed clinical pathways for two common ambulatory conditions (diarrhoea and vomiting and bronchiolitis in children and were in the process of developing a further four pathways.. This was to ensure consistency of care whether the patient presented in the community or hospital setting. Meetings with local GP practices were planned to discuss these.
- The neonatal support group was set up in response to an identified need amongst parents of premature and low birth weight babies for peer support and ongoing contact with the service following discharge.
- The leadership team told us they were working with Public Health England in developing an infant mortality strategy, as there was a high infant mortality rate in the area.
- Most children attending outpatients were seen in a dedicated children’s outpatients department (OPD). However, children with broken bones attended the fracture clinic in the main outpatients department.

## Are services for children and young people responsive?

Good



We rated responsive as good because:



# Services for children and young people

There were no separate waiting facilities for children and the environment was not adapted to meet the needs of children. It was crowded and there was nothing for children to play with or to distract them.

- The children's ward, paediatric assessment unit and the children's outpatient department provided an age appropriate environment for children.
- The environment and facilities within the children's ward and the paediatric assessment unit were excellent. There was space in the rooms for parents to have a bed. The children's ward had a bathroom with a height adjustable bath and a toilet suitable for use by those with physical disabilities.
- There was an area for adolescents and older children, equipped with activities suitable for the age group, such as table football and games consoles.
- There was a sensory room for children with complex needs. An outside play area was available with seating for parents and older children.
- Paediatric theatre lists were carried out every weekday and an allocated theatre was normally used. There was a separate recovery area for children.
- Parents of children on the children's ward and the NNU said they had access to kitchen facilities and they were able to stay with their child if they wished.
- There were separate areas for parents and relatives on both wards and on the children's ward, the relatives room was also used as a prayer room.
- Parents on the NNU said they were provided with a free parking permit whilst their baby was on the unit. However, they said there were no concessions for food and food in the hospital was very expensive.
- As a result of feedback from families, visiting times were identified as an issue and the visiting times for grandparents and for family and friends were changed. Staff said they were working with surrounding hospitals to achieve consistency about visiting times as babies were sometimes transferred between units.

## Access and flow

- Patients accessed children's services through ED, by referral from their GP, or by transfer from maternity services. A middle grade doctor and junior doctor were based on the PAU and GPs making a telephone referral were advised of the most appropriate pathway.
- Patients were seen within 15 minutes of arrival by a nurse for triage and initial assessment on the PAU. They were then reviewed by a junior doctor or advanced

nurse practitioner (ANP). A plan was then developed and a middle grade doctor saw the patient and a decision made as to whether the patient required hospital admission, hospital at home or could go home. Consultants were available for advice as required.

- Planned children's theatre sessions were scheduled each weekday and children were normally admitted for planned surgery on the day of their operation. Most planned surgery was carried out on a day case basis.
- At the last inspection, we identified demand and capacity concerns in relation to the NNU. At that time, bed occupancy was between 109% and 123% and additional incubators and cots were placed in the bays to accommodate additional babies.
- From March 2016, the maternity unit capped the number of births and this had started to impact on the number of babies requiring admission to the NNU. We were told additional beds had to be opened less frequently and we saw bed occupancy ranged from 84% and 101% between May 2016 and March 2017.
- Staff had worked with their commissioners and the child and adolescent mental health service (CAMHS) to improve the care and management of children and young people with mental health issues. We were told that the number of admissions to the children's ward had decreased and additional provision in the community meant that patients were discharged more quickly. In addition, there was a reduced requirement for the transfer of patients to specialist mental health beds.
- Data supplied by the trust indicated that during 2015/2016, 34% of CAMHS patients were discharged within one day of admission, whereas between January and April 2017 this had risen to 89%. Between May 2016 and April 2017 there were a total of 134 admissions and the numbers of patients ranged between eight and 25 patients per month.
- A patient's care record we reviewed showed a patient was assessed by the CAMHS team on the day of admission, was re-assessed the following day and was seen by a psychiatrist within two days.
- Patients sometimes experienced delays in discharge due to waits for medicines they required to take home. Staff told us they were able to access some medicines on the ward however, when medicines were required from pharmacy the wait was generally three to four

# Services for children and young people

hours and during the winter period they could wait all day. Several staff told us that children's services were not considered as high a priority as adult services, due to discharge and capacity issues in adults.

- Staff did not monitor and record waiting times in the children's OPD. Staff and patients told us that the waiting time was short. Staff said the clinics often over ran and from the times given it would appear that waiting times of an hour were not unusual at the end of a day.
- Parents we spoke with said they normally did not wait long to be seen in OPD.

## Meeting people's individual needs

- Interpreting and translation services were available for people whose first language was not English and for those using sign language.
- We saw information about how to access interpreters was easily accessible on PAU. Staff told us it was easy to access translation services and they were booked in advance for a planned attendance.
- The trust had access to a web based service to provide information leaflets for patients in a full range of other languages and staff told us they would utilise this as required.
- There was no system to flag those patients with complex needs such as children with a learning disability and staff told us they would only be aware, if a parent rang them in advance.
- Staff told us they did not have any special arrangements for supporting children with a learning disability and they did not use any additional documentation. However, they told us they treated all patients as individuals and would respond to their needs.
- A parent told us their child required one to one support when they were not present, as the child had expressed intentions of self-harm. They told us staff had developed a good relationship with the child and they were confident staff provided the necessary support.
- Two play specialists were available and provided cover seven days a week.
- Staff on the NNU had introduced "Octobuddies" which were knitted/crocheted octopus which were placed with the baby to provide sensory stimulation. The baby was encouraged to grasp the soft octopus tentacles instead of grasping the tubes attached to their body. Staff said they were the second trust in the country to launch the initiative.

- The NNU also had a quiet hour and used music therapy which was shown to have a calming effect on babies and reduce stress.

## Learning from complaints and concerns

- Between April 2016 and March 2017 there were seven complaints about children's services. Five complaints related to clinical treatment, one related to communication and the other complaint related to discharge.
- We reviewed a complaint which the trust recorded as an incident when it was identified. A full investigation was completed and changes to practice introduced.
- The trust took an average of 49 days to investigate and close complaints. This is not in line with their complaints policy which states complaints should be dealt with within 45 days dependent on severity.
- The trust provided information leaflets entitled, "Got something to say? Make sure you tell us," which provided information on how to raise a concern or make a complaint. We did not see these in languages other than English, or in accessible formats.
- No information was provided in a format that was easy to understand for children.

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

Good



We rated well-led as good because:

- Changes to the management structure and governance processes had provided clarity in relation to roles and responsibilities and a more robust framework of governance. There was increased accountability and ownership of issues.
- Nursing leadership was strong and staff felt well supported.
- Staff showed commitment to continuous improvement and a range of initiatives demonstrated a willingness to work with others to achieve continuity of care.
- A five year clinical strategy had been developed for children's services. This identified broad aims for the service and a breakdown of developments on an annual basis.

## Leadership of service

# Services for children and young people

- Children's services sat within the division of women's, children's, and clinical support services. This was divided into four care groups and children's services sat within the children, families and neonates care group.
- The care group covered integrated children's services in the acute and community. The care group was led by a clinical director, matron (paediatrics and neonates), a care group manager for acute paediatrics, and a care group manager for community paediatrics, professional lead for school nursing and a professional lead for health visiting. The trust had also introduced a senior nurse role (Divisional Director of Nursing for Children, Young People and Neonates) that spanned across both the acute and community children's services.
- Staff told us the new structure was good and staff roles and remit were clear.
- Nursing leadership was good. Staff spoke very positively about the leadership shown by the ward managers and ward managers told us of the support, enthusiasm and positive leadership shown by the matron and the divisional director of nursing.
- The management of the neonatal unit (NNU) had moved to the care group approximately nine months previously and the ward manager told us that following this, support had improved. The matron and divisional director of nursing were very knowledgeable about the service. They said they provided more guidance and they had worked together to improve recruitment and to develop a workforce plan.
- In hours cover at band 7 is provided between the hours of 7.30am and 7.30pm, 7 days per week. A member of staff said, "The support is there if you need it."
- Staff meetings were held on each ward on a monthly basis and staff told us they were constructive and consistently run. Minutes of the meetings were sent by email to staff and were placed in the information folders on each ward.
- Medical staff told us of changes since the last inspection. They said the service was more clinically led and there was more ownership of developments in the department.
- Staff said cross divisional working was good and it was easier to get things done.

## Vision and strategy for this service

- A clinical strategy for 2017 to 2022 was in place for children's, families and neonatal services. This provided

some broad aims for the five-year period and a breakdown of planned developments on a yearly basis. The quality and safety of care was clearly identified as a priority.

- We reviewed the strategy and saw some of the developments planned for the current year to support achievement of the strategy were underway. For example, the recruitment of acute care consultants.
- A summary of the strategy was displayed in some clinical areas. Staff were aware of the key elements of the strategy.

## Governance, risk management and quality measurement

- Governance and care group management meetings were held monthly. Consultants, senior nurses and the governance lead attended these.
- Minutes from these meetings showed there was good attendance at the meetings. Incidents, complaints, the risk register, clinical audit results, infection control and Friends and Family Test results were discussed.
- Divisional safety huddles were held weekly to discuss incidents, root cause analyses and actions from incidents. In addition, action from complaints and the risk register were discussed. The senior leadership team told us there were smaller weekly huddles to discuss incidents and a daily safety briefing prior to, or after, the ward rounds at ward level.
- A central team provided governance support. The matron and divisional director of nursing told us the team now coordinated table top exercises and root cause analysis meetings along with preparing chronologies of incidents. This enabled them to focus on their own role and improve their visibility at ward level.
- Staff told us training was provided for consultants and other senior staff on root cause analysis. Root cause analysis meetings were now usually chaired by someone external to the division to provide greater independence. Staff said the process felt more robust and they felt secure to challenge each other. Action plans arising from root cause analyses were allocated to a named individual.
- A children's and neonatal dashboard provided information on monthly performance against key quality indicators. Staff spoke about the monthly

# Services for children and young people

monitoring and action they had taken when performance was lower than the target set. For example, they spoke about issues with pain assessment and the recording of this, and the action taken to improve.

- The risk register identified the key risks and actions were being progressed to reduce and control the risks.

## Culture within the service

- Staff told us the culture in the trust and within the service had changed since the last inspection. They said the medical staff were more involved and there was more ownership and joint working to drive forward improvements to the service. One person commented on how much easier it was to get things done and the passion and drive of staff to improve care treatment and outcomes for children.
- Another member of staff commented that nurses were listened to more and everyone worked better together as a team.
- Staff told us they were not aware of any bullying or discrimination within their service.
- All the staff we spoke with were proud to work in the service and wanted to provide the best possible care.
- Staff were aware of the duty of candour and gave us examples from practice when it had been applied.

## Public engagement

- We saw a range of information for teenagers on a display board in the adolescent room on the children's ward. The play specialist had worked with representatives of the Princes Trust to identify the topics covered and the information provided.
- Workshops were planned to discuss the transition between children's and adult services with young people currently using the service. They were being held in the local leisure centre and steps were being taken to make the session attractive to young people.
- The service used "Tops and Pants" displays to obtain feedback from children and young people about their experiences. The display contained a range of feedback from patients however, there was no information about recent actions in response to the feedback.
- A group had been set up to examine and develop services for diabetes in children and the membership included patient representatives.

## Staff engagement

- Staff we spoke with said that communication had improved since the last inspection and they were aware of the plans for the re-development of the NNU.
- The Chief Executive held a monthly update session which any member of staff could attend. Staff at band 7 and above, were expected to attend and two sessions were held to make them more accessible for staff.
- There was an enthusiasm for improvement and staff said they felt many of the barriers previously experienced to improvement had now been removed.

## Innovation, improvement and sustainability




- At the previous inspection, we identified safety concerns in relation to the care and management of children and young people with mental health issues. The trust worked closely with the local commissioners and the child and adolescent mental health service (CAMHS) to improve care for this group of patients. Services external to the trust were enhanced, which reduced the length of stay in an inpatient bed. A small number of staff were appointed and provided with specific skills to care for these patients and adjustments were made to the environment.
- We saw evidence of a range of improvement initiatives which were being put into place. For example, rapid access clinics had been developed to ensure an urgent senior paediatric review/opinion for children who need urgent review and could not wait for a routine outpatient consultation.
- Children's services had a weekly referral panel where all acute referrals into the service were discussed. There was multidisciplinary attendance with nursing, medical and community input. The panel redirected 336 referral over a 6 month period to more appropriate professionals. The innovation won the responsiveness award at the annual trust awards in 2016.
- Sleep studies were reviewed and a standard operating procedure was developed to improve the referral process and reduce waiting times.
- Actions were taken to improve the timeliness of provision of discharge summaries for GPs. As a result of the initiative, the percentage of discharge summaries reaching the GP within 48 hours of the patients discharge from the paediatric assessment unit (PAU) increased from 50% to 100%.
- Listening into action events were held to problem solve specific issues and bring about improvement. This approach was used in conjunction with maternity

## Services for children and young people

services to reduce the number of babies who were cold on admission to the NNU and also in relation to the timely administration of intravenous antibiotics to infants with suspected neonatal sepsis.

- A portfolio of research was displayed on the children's ward. This included research carried out by a consultant at the trust on neuroimaging in children with chronic headache, information about the prolonged jaundice pathway, and an audit of diabetic ketoacidosis.

# End of life care

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

## Information about the service

End of Life Care is delivered at Walsall Healthcare NHS Trust by a Specialist Palliative Care Team.

End of life care encompasses all care given to patients who are approaching the end of their life and following their death. End of life care includes palliative care. If an illness cannot be cured, palliative care makes a patient as comfortable as possible, by managing pain and other distressing symptoms. It also involves psychological, social and spiritual support for the patient and family or carers. Patients with palliative or end of life care needs are nursed on general wards throughout the hospital.

The trust provides a consultant led Specialist Palliative Care Team with support from the bereavement officer, mortuary and chaplaincy services, along with the 'Integrated Discharge Team' who assured patients were being discharged home rapidly.

The trust has a specialist palliative care team (SPCT). This is an integrated team between the hospital and the community. The end of life care and palliative care team have two separate teams; one for the community and one for the hospital that provide the day-to-day care. The SPCT in the hospital consists of a palliative care consultant, specialist palliative care nurses, and occupational therapists.

Walsall Healthcare NHS Trust provides acute hospital and community an integrated Specialist Palliative Care Team' service for the population of around 270,000.

The service has a strategic plan that includes the development of the integrated team to identify further developments for the team.

The trust had 1,112 deaths between February 2016 and January 2017.

The mortuary department is based at the main Walsall Manor Hospital site with a body store of 69 places (56 body places plus 6 wide, 4 infection risk and 3 deep freeze body places). There was an isolation body store (3 deep freeze), a wide body store (including racking for 8) an annex body store (36 places), and a new annexe body store (36) installed 12 months ago.

Walsall Healthcare NHS Trust has an on-site chaplaincy service and multi-faith chapel for people who wish to pray. Since the last inspection in 2015, the trust has appointed a new bereavement officer who is based on site. The lead arranged the medical cause of death certificates and provided practical support such as registering deaths and contacting the funeral director. The bereavement officer works closely with the mortuary team to book appointments for family to view their deceased relative and friends, to ensure there is a smooth service for the bereaved.

During the inspection, we met with three patients, spoke with relatives, and reviewed 16 patient care records. We spoke with over 20 staff who were delivering end of life care. This included staff from the Specialist Palliative Care Team service, ward staff, accident and emergency staff, a discharge co-ordinator on the wards and the integrated



# End of life care

discharge team (IDT). We also spoke with the bereavement officer, porters and mortuary staff. We observed staff providing care to end of life care patients and supporting their families.

Additionally we looked at the trust's performance data around the Specialist Palliative Care Team at Walsall Healthcare NHS Trust before, during and following our inspection.

## Summary of findings

During the last inspection in September 2015 we rated this service as 'requires improvement' for Effective, Responsive and Well led and 'good' for safe and caring. This meant the service was rated requires improvement overall.

This was because;

- DNACPR forms were not completed fully and mental capacity assessments (MCA) were not completed.
- Patients did not always achieve their preferred place of care for their end of life care.
- Side rooms were not always available for patients in their last days/hours of life and there were limited facilities to allow relatives.
- Spiritual needs of patients were not always addressed and anticipatory medicines for the five key symptoms in the dying phase were not consistently prescribed.
- < >here was no dedicated bereavement service in place within the hospital.  
End of life care followed national practice but there was no comprehensive guidance for staff to follow.

Following this inspection June 2017, we rated all domains as good except for effective which was rated requires improvement. This meant the service was rated as good overall, because:

- Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for end of life care.
- The trust reported no serious incidents (SIs) for end of life care that met the reporting criteria set by NHS England between April 2016 and March 2017.
- There had been no end of life care incidents, which required duty of candour (DoC) investigation in the palliative, and end of life care service.
- The service monitored patient outcomes through national and local audits; these were fed back to the board and end of life care dashboard along with the trust's quality report.

# End of life care

- Multi-Disciplinary Team (MDT) working was effective within the end of life care service. The team worked as a one integrated team across the acute and community sites.
- DNACPR forms were filed correctly in the front of patient records so that staff could locate them quickly. Since the last inspection 2015, the trust has improved significantly around the DNACPR documentation.
- Staff cared for patients in a compassionate, dignified and respectful manner.
- We saw in one of the viewing rooms at the mortuary that there were facilities for washing the body for religious and cultural reasons. We saw this as an understanding and respect for patients' cultural and religious needs.
- The trust had a 24 hour a day, seven days a week chaplaincy service provided by Christian chaplains and a partial weekly service by Roman Catholic chaplains. A 24 hour a day, seven days a week service for smaller faith communities was to be reinstated following the Safety and Quality Committee decision in July 2017. Patient discharge, including moving patients between acute and community care settings, followed patient-centred care best practice.
- The SPCT worked closely with commissioners and other providers to ensure patients' needs were met.
- The Specialist Palliative Care Team ensured patients who required end of life care and palliative care were seen promptly and were identified in a timely way, that deceased bodies were cared for, and that religious and spiritual beliefs were respected and dignified.
- The professional lead for Specialist Palliative Care Team chaired a multi-professional group. Membership included the acute and community palliative care team, and representation from the clinical commissioning group (CCG) as well as the director of nursing.

- The Specialist Palliative Care Team service leaders had a clear direction of the service. Their aim was for an effective integrated service to ensure patients were provided with quality end of life care.
- Staff of all levels felt supported from the end of life and palliative care team.
- We saw the end of life strategy plan for 2015-2017, "Becoming your partners for first-class integrated care". This Strategy has been in development for over a year with extensive engagement and input from the board and operational care groups.

However:

- We spoke with the hospital porters around incidents and learning from incidents, they told us they did not have access to a computer or IT access. The porters told us they received no feedback or actions in relation to incidents.
- Ward staff knowledge and awareness of when to use individualised care plans when caring for end of life care patients varied from ward to ward.
- Porters we spoke with during our unannounced visit on 6 July 2017 informed us that they were never informed if a patient had an infection, especially when transporting patients from one department to another.
- The trust set out a target of 90% for completion of safeguarding training; as at 31 March 2017 nursing staff for end of life care services failed to meet training targets.
- There was a low completion rate for major incident training at Manor Hospital. As at 31 March 2017, only 56 out of 188 eligible staff (30%) had completed this training.
- The trust had the amber care bundle on some wards as part of a phased roll out programme from the Transform Programme. This was being introduced in the last inspection in 2015 but this had still not been fully embedded throughout the wards.
- We saw nutritional assessments were being carried out, but was not always documented as part of the individualised care plan.

# End of life care

- Documented evidence of completed advance care plan (ACP) was only noted in 63 patients and these were predominantly within the community setting, only five patients in the acute setting had an ACP in place.
- Combined results across both sites (community and acute) demonstrated that the use of the individualised end of life care plan was 20% (45 patients in acute setting).
- Registered nurses on the wards had received training to enable them to safely administer medications through the T34s McKinley infusion pumps; however this was not consistent, some staff were not trained or did not know which syringe drivers were being used.
- Porters we spoke with said they had not received any specific end of life care training; they told us that newly appointed staff learnt from and shadowed porters that were more senior.
- Ward staff told us that it was difficult at times to support relatives during an emotional time, as there were no specific rooms to speak with relatives in private.
- The trust did not have any dedicated beds for end of life care patients, they were cared for on general wards throughout the hospital.
- The route that people had to walk to the mortuary for the general office was long and poorly signposted.

## Are end of life care services safe?

Good



We rated safe as good because:

- Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for end of life care.
- The trust reported no serious incidents (SIs) for end of life care that met the reporting criteria set by NHS England between April 2016 and March 2017.
- There had been no end of life care incidents, which required duty of candour (DoC) investigation in the Specialist Palliative Care Team service.
- We saw that all staff involved in any clinical and decontamination procedures were arms bare below the elbows and had short, clean nails that were free from nail extensions and varnish.
- Staff told us they had suitable equipment to meet end of life care patients' needs, for example they had profiling air mattresses and syringe drivers.
- 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).
- Staff handovers were effective at identifying and managing patient risk.
- The trust recently employed a dedicated officer for the bereavement service who worked Monday to Friday.

However:

- Hospital porters we spoke with told us they did not have access to a computer or IT access for incidents. They told us they received no feedback or actions in relation to incidents.
- Ward staff knowledge and awareness of when to use the individualised care plan when caring for end of life care patients varied from ward to ward.
- Porters we spoke with during our unannounced visit on 6 July 2017 informed us that they were never informed if a patient had an infection, especially when transporting patients from one department to another.
- The trust set out a target of 90% for completion of safeguarding training; as at 31 March 2017 nursing staff for the end of life care service failed to meet training targets.

# End of life care

- There was a low completion rate for major incident training at Manor hospital. As at 31 March 2017, only 56 out of 188 eligible staff (30%) had completed this training.
- We were not assured ward staff were fully confident in completing the relevant end of life care documentations.

## Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for end of life care.
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) for end of life care that met the reporting criteria set by NHS England between April 2016 and March 2017.
- Between March 2016 and March 2017, the Specialist Palliative Care Team reported 179 incidents relating to the acute and community care settings. There were 98 'no harm' incidents, two 'low harm', 73 'minor' incidents, five 'moderate' and one 'major'. The major incident, reported in March 2017, concerned a delay in communication and a lack of understanding around the booking of transport from the external transport provider. The end of life care patient had needed to be transferred from the hospital to their preferred place of death.
- Between April 2016 and March 2017, the mortuary team reported five incidents. Four 'no harm' incidents and one 'minor' incident, mainly around mortuary passport document not being filled out correctly by ward staff.
- All staff we spoke with knew how to report incidents via the trust's electronic reporting system. The palliative care team told us that they reviewed all incidents to identify themes and trends regarding concerns.
- There had been no end of life care incidents, which required duty of candour (DoC) investigation in the palliative, and end of life care service. Duty of candour is a regulatory duty that is related to openness and transparency that requires providers of health and social care services to notify patients (or relevant person) of 'certain notifiable safety incident' and provide reasonable support to the person.

- We asked ward staff, end of life and palliative staff about DoC, all staff were aware of the term duty of candour to be open, honest and transparent with patients in their care. Staff told us there had been no incidents that triggered DoC relating to end of life care patients.
- The SPCT told us they would raise incidents on specific wards; examples given were around syringe driver issues or medication errors. Staff went on to say they received feedback from ward managers, along with any outcomes. They felt this was a good learning opportunity and that it was useful as it identified any specific training needs when caring for the patients'.

## Cleanliness, infection control and hygiene

- We saw the trust's infection, prevention and control (IPC) procedures for deceased patients were in date at the time of our inspection and were due for a review in July 2017.
- Staff we spoke with knew how to access policies and procedures that were relevant to their role. This information was readily available in folders on the wards.
- Hand gels were readily available to staff and visitors. We saw that staff gelled and washed their hands regularly.
- We saw senior staff had completed an audit and action plan around infection control, cleanliness and hygiene in the mortuary dated February 2017. The results from the audit included staff training, which showed 100% of staff had completed their infection control training. The check for cleanliness was 92%, which was due to flooring wear and tear; the flooring has since been replaced. Cleanliness scores for the main post-mortem room were 87%, this was due to taps having heavy lime scale deposits despite regular cleaning, and the need for regular maintenance for traps in the dissection sinks.
- The audit showed that the decontamination room scored 95% for cleanliness, infection control and hygiene. This was due to staff not undertaking manual cleaning and checking the temperature of water with a thermometer. Other results included 92% for hand hygiene due to a seal on the sink in the changing area and the sink being loose from the wall, 90% for safe storage of sharps, which were currently stored on worktops and sharps being carried across the rooms at times, and 100% for clinical waste and linen.

# End of life care

- We saw that all staff involved in any clinical and decontamination procedures were arms bare below the elbows and had short, clean nails that were free from nail extensions and varnish.
- We saw some areas we visited using infection prevention yellow hand stickers to inform staff of the importance of infection control when entering a potentially infected room or site. We saw these were also used in patient records and had been newly implemented.
- Porters we spoke with during our unannounced visit on 6 July 2017 informed us that they were never informed if a patient had an infection, especially when transporting patients from one department to another.
- Porters knew how to access personal protective equipment (PPE) and the requirements for the mortuary.
- Mortuary staff and porters could tell us about the procedures they followed and the equipment they used when transporting and moving the deceased. This assured us that staff could recognise, assess and manage associated risks.
- Porters told us that the trolleys they used to transport patients (including the deceased) were not being cleaned on a regular basis.
- We viewed the trolley covers and found they were unclean and not fit for purpose. This was because they had holes in the fabric and were very old. We also noted that the trolley breaks and sidebars were not in working order. We asked the porters who was responsible for the trolleys but no one was able to answer our question.
- Porters told us due to the poor condition of the trolleys, they felt that deceased patients were not being treated with respect or dignity and they felt embarrassed when relatives were on the ward and saw the trolleys. We raised our concerns with the trust, when we visited unannounced on 6 July 2017. Management told us they were aware of the trolley issues and our IPC concerns; however, this information had not been disseminated or communicated to the porters.
- We visited the mortuary department and the viewing area and found them to be clean, tidy, well presented and well ventilated.
- There were sufficient handwashing facilities, clinical waste and general bins both on the wards and in the mortuary.
- Mortuary technician staff were responsible for cleaning all dirty allocated areas of the mortuary such as trays,

fridges and the equipment within. Hospital domestic cleaning staff were responsible for cleaning the clean allocated area such as public toilets, staff changing room and waiting area room.

- We saw that the mortuary staff kept a red folder for the cleaning regime; this included a tick chart of the areas that required cleaning and regular checks. We saw mortuary staff checked the ventilation fan in the mortuary 10 times an hour or more often if required.
- Ward staff we spoke with were aware of the 'last offices', the 'last offices' refer to the care given to a body shortly after death. This included informing the mortuary staff of a suspected or confirmed contagious or infectious disease.
- In the mortuary, we saw they had specific fridges for body storage for those patients with infectious diseases. This was easily identified with the use of signs on fridges and colour coded magnetic stamps on their notice board to inform staff how many bodies were stored in the fridge, and of any new deceased bodies transferred overnight.

## Environment and Equipment

- The trust used the T34 McKinley syringe pumps for patients who required continuous infusion of medication and we saw the policy relating to the use of these.
- The trust had over 50 T34 McKinley syringe drivers in use, these were shared across the acute, and community care settings mainly due to patients being transferred from the acute to the community setting and not all devices being returned, despite them having a 'Walsall Healthcare acute trust' sticker in place.
- Training records showed that Specialist Palliative Care Team staff had conducted training sessions on syringe drivers for ward staff. Ward staff needed to be assessed and pass their competencies before they were able to administer medication to patients via a syringe driver.
- Staff told us they had suitable equipment to meet end of life care patients' needs, for example they had profiling air mattresses and syringe drivers.
- We visited the equipment base for medical equipment (EBME), also known as the medical device library where staff told us they obtained syringe drivers. Medical device staff told us that some wards locked unused syringe drivers in storage on the wards and at times, they did not return them.

# End of life care

- Medical device staff also informed us there were issues around device servicing; this was because the syringe drivers were not always returned in time despite the device team visiting all of the wards Monday to Friday to collect them. We saw there were 13 of 50 pumps either out of date and waiting to be serviced, or unaccounted for and lost. These were recorded electronically.
- Nursing staff told us they could access syringe drivers out-of-hours from the EBME by contacting the night porters who had access.
- Ward staff told us and we saw that they tried to provide side rooms for patients receiving end of life care. This was to ensure a quieter environment, privacy, and dignity for the patients' family and friends.
- The mortuary could store up to 69 deceased bodies. There were 56 body places of which six were wide, four for infection risk and three deep freeze body places. There was an isolation body store (three of which were deep freeze), a wide body store (including racking for eight) an annex body store for 36 places and a new annexe with 36 body store.
- The fridges in the mortuary automatically alerted estates if they malfunctioned out-of-hours. The trust also had a generator in place in case of any electrical faults.
- We saw the mortuary was equipped with two lifted-hoists to lift deceased bodies from the trolley to the fridge. We saw these had been serviced and were visibly clean.
- Porters also told us about the poor maintenance of the mortuary trolleys and that the covers were not of a high standard, they felt this was below a standard that relatives should expect to see.
- We saw a log for temperature checks for the fridges and these were done four hourly or more often if there were issues.
- There was a newly appointed bereavement officer on site who arranged for the medical cause of death certificate to be released and provided practical support for relatives, such as registering the death and contacting the funeral directors; they also worked closely with the mortuary staff.
- When we spoke with the mortuary staff, they said there has been a positive change since the bereavement officer had come in post. The extra support ensured relatives of the deceased had a smooth and supported service. This was an improvement from the last inspection when the trust had no bereavement service.

## 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).
- The pharmacist visited medical wards on a weekly basis to check and replenish stock and to check dates on medications.
- Records we reviewed showed patients referred to the SPCT had their medicines reviewed regularly by the team. This was done in consultation with other medical staff involved in patients' care; we saw this was clearly documented in patient records.
- We observed discussions that took place regarding symptom control and medicine management between nurses and the palliative care consultant, with additional input from occupational therapist to help plan for discharge.
- We saw on the wards and observed staff using the resource folders on end of life care management including symptom control, and a newly designed anticipatory medicine guideline card; a systematic guide on administering anticipatory medicines that all doctors we spoke with had close to hand.
- Ward staff told us they would seek advice on medication from the pharmacy and the SPCT. One member of nursing staff told us that at times there had been delays around certain medications. One example she gave us was around anticipatory medication for preventing a dry mouth, which took over 36-hours to be available and meant patients had to wait to have their symptom controlled. Staff had recorded this as an incident.
- 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.

## Records

- Since the national removal of the Liverpool Care Pathway (LCP) in July 2014, the trust developed a personalised end of life care pathway called the individualised end of life care plan (IEOLCP). Walsall Healthcare NHS Trust introduced the IEOLCP in January 2016. The document was developed following the recommendations of the 'One Chance to Get it Right' report (June 2014).



# End of life care

- The palliative care team told us that staff on the wards knew when to use the individualised care plan when caring for the end of life patients'. However, this varied from ward to ward, some were in use with minimal information documented, some were easily available, in use, and placed in patient records, and others were left blank but were in patient records. When we raised this with the staff on the ward, they said they were short staffed and did not have the time to complete all of the information; other staff stated they were not entirely sure how to use the care plan.
- The trust also had an advance care plan page (ACP) for end of life care patients, which allowed staff to support patients to have access to individualised care tailored to the patients' needs. However, this had not been rolled out to all wards. We spoke with ward staff and some were aware of the ACP but were not confident in using it and felt they needed more training, and some staff were not aware of the ACP. This was an issue during the last inspection in 2015.
- We looked at 16 sets of patient records. Records we reviewed were updated daily with regular patient reviews from the end of life care and palliative care teams. They also contained a detailed plan of care and thorough instructions for all staff to follow.
- On all wards we visited, nursing documentation included care plans, risk assessments, observation charts, and medicine charts. Nursing documentation were kept in a folder at the bottom of each patient's bed. This meant that they were easily accessible for staff providing care.
- We saw that staff in the mortuary had colour coded magnets on a notice board to identify patients that had a pacemaker, patients with the same or similar names and those who had known infections.
- We saw examples of mortuary passport forms where staff would document information about the deceased patient. Information included the deceased's name, jewellery, infection status and any internal devices, such as a pacemaker.
- Mortuary staff told us at times staff on the wards did not always fill the mortuary passport document in correctly. They told us that they rang the wards to inform ward staff members of these errors and to offer them the opportunity to attend drop in learning sessions around documentation. Mortuary staff also told us that this happened on a regular basis and that they recorded this as an incident
- We saw nutritional assessments were being carried out as part of the IEOLCP; however, this was not always documented in the IEOLCP itself. We saw evidence of the information documented in patients main records by the nurses alongside risk assessments. We were assured that nurses were carrying out the nutritional assessments but were not using the IEOLCP effectively.
- We saw that the Specialist Palliative Care Team were supportive of the ward staff, especially around the documentation. We were not assured ward staff were fully confident in completing the relevant end of life care documentations. When we spoke with the ward staff they said they were short staffed on certain wards, this affected caring for the end of life care patient holistically, they also told us that documentation was very 'wordy' and time consuming.

## Safeguarding

- As of the 31 March 2017 for medical staff in end of life care, only 50% of staff had completed level 2 safeguarding children and 0% had completed level 2 safeguarding adult.
- As at 31 March 2017 for nursing staff in end of life care, only 20% had completed level 2 adult safeguarding. None had completed level 3 adult safeguarding and 84% had completed level 2 children safeguarding.
- The trust set an annual target of 90% for completion of safeguarding training. As the end of life care service was an integrated adult and community service, the figures covered the whole team. The trust failed to meet training targets for medical and nursing staff.
- The trust had a training plan in place to ensure all staff to complete training by the end of the year, which included safeguarding children and adults levels 1 to 3. Plans included additional drop in sessions for staff that did not have access to, or were unable to use a computer and ensuring that managers factored in protected learning time to enable completion.
- Staff we spoke with knew whom to contact if they had a safeguarding concern. They told us the lead was easily accessible if they required further guidance. They knew how to access the trust's safeguarding policy (hard copy of the policy was in a folder or on the trust intranet) and of their responsibility to safeguard their patients.
- We reviewed the trust policy for the safeguarding and protection of vulnerable children and adults and found this to be in date with the next review due in April 2018.

# End of life care

## Mandatory training

- The trust set an annual target of 90% for completion of mandatory training.
- As at 31 March 2017 for medical staff in end of life care, training targets were met for fire safety, information governance and patient handling but were not met for conflict resolution, equality and diversity, and infection control.
- As at 31 March 2017 for nursing staff in end of life care, training targets were met for conflict resolution, infection control and patient handling but were not met for equality and diversity (72%), fire safety (48%) and information governance (68%).
- Senior managers were aware of the poor training attendance across the service and advised us they were working hard to ensure these training figures improved.
- The palliative care team participated in all levels of training and support, which was an integrated approach across the acute and the community care settings.
- The team delivered mandatory training on end of life care at all sessions including syringe pump training and the training of students (formal or placement support mentorship). They also had an implementation and engagement plan, which was a two phased approach. In addition to this, the team had fully engaged in the end of life care ward listening into action project and delivered bespoke training on request.

## Assessing and responding to patient risk

- We observed three staff handovers and we found them to be effective at identifying and managing patient risk.
- Patients' records incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw the consultant regularly reviewed patients, which included pain and symptom control reviews.
- Ward staff told us that end of life care patients under the care of the Specialist Palliative Care Team were triaged daily according to their needs. Patients who were dying and in need of a daily review and, or family support were seen by the Specialist Palliative Care Team staff daily, or more often depending on symptomatic management. We saw this was carried out in practice.
- We saw evidence that showed that the service was involved in the 'Transforming End of Life Care in Acute Hospitals' programme and staff were able to describe the programme confidently.

- The ward staff told us they could contact the Specialist Palliative Care Team service to request additional support to respond to patients at risk when required. We saw this during our inspection and observed effective communication between the ward staff and the Specialist Palliative Care Team to ensure patients received appropriate assessment and re-assessments when needed.
- We reviewed nursing records and found they included assessment of risks, such as falls, malnutrition and pressure damage, and that these risks were assessed using nationally recognised tools. For example, we saw staff used the Malnutrition Universal Screening Tool (MUST) to assess malnutrition risk and the Waterlow tool to assess the patients' risk of pressure ulcers.
- We saw that changes had been made following an incident on one ward around effective usage of risk assessments. Staff had implemented "Wound Wednesday" where all patients' skin was checked and discussed in addition to their planned wound care regime. We saw staff took action on the result of risk assessments, for example patients who were at risk of pressure damage were nursed on pressure relieving mattresses.
- We saw on some wards they used 'amber care bundle' stickers on patient records to inform staff that a patient may not improve from their condition post-surgical or medical intervention.
- We saw that the trust had an adult deteriorating patient escalation policy. The policy set out the roles of staff and contained a chart on National Early Warning Scores (NEWS), the frequency of monitoring required in relation to NEWS scores and the clinical response required when a NEWS score was a cause for concern. A red stamp on patient records were also being used on some wards to identify a deteriorating patient.

## Nursing staffing

- We saw there were sufficient and appropriate Specialist Palliative Care Team staff to meet the needs of end of life care patients at Walsall Manor hospital.
- As at 31 March 2017, a vacancy rate of 4.7 was reported in end of life care and nursing staff reported a turnover rate of 5% in end of life care.
- As at 31 March 2017, nursing staff reported a sickness rate of 3.7% in end of life care.

# End of life care

- Between April 2016 and March 2017, end of life care service reported an average bank and agency usage rate of 0.7%.
- We spoke with staff on the wards we visited about end of life care. The majority of staff could name and identify the nurse champions for end of life care on their wards, who they sought advice from if needed when caring for an end of life care patient.

## Medical staffing

- As of 31 March 2017, a vacancy rate of 0% was reported in end of life care amongst medical staff and a turnover rate of 0% was reported in end of life care amongst medical staff.
- As of the 31 March 2017, a sickness rate of 0% was reported in end of life care amongst medical staff.
- Between April 2016 and March 2017, the trust reported a bank and locum usage rate of 0% in end of life care.
- Staff had access to on-site palliative medical advice five days a week. Out-of-hours there was an on-call rota with a local hospice in which Walsall Healthcare palliative medicine consultants participated and worked closely with as part of integrated care.
- Staff on the wards told us that doctors from day shift to night shift used an electronic system handover to inform one another of tasks that required urgent attention, such as bloods and X-Ray reviews.
- Rotas for medical consultants were held electronically, which enabled staff to see who was on on duty or on annual leave.

## Other staffing

- The trust employed two full-time mortuary technicians who staffed the mortuary from 7.30am until 4.30pm Monday to Friday, and Saturday mornings from 8am until 12pm.
- Porters transported deceased patients from the hospital wards to the mortuary. They had out-of-hours access to the mortuary; porters were trained to book the deceased into the storage body fridges.
- The trust employed full time chaplains working alongside faith leaders. The chaplaincy service provided an on-call service, staff; patients and relatives could access chaplains from a number of different faiths 24 hours a day, seven days a week.
- The trust recently employed a dedicated officer for the bereavement service who worked Monday to Friday.

When we spoke with staff, throughout the trust, they told us this was a service that appeared to be highly respected and felt this was a positive change from the trust since the inspection back in 2015.

## Major incident awareness and training

- The trust set an annual target of 90% for completion of major incident training. Currently this had only been provided on a whole trust level. Information provided showed that at Walsall Hospital, 56 out of 188 eligible staff (30%) had completed major incident training as at 31 March 2017.
- We reviewed the trust's major incident plan dated May 2016 and supporting action cards. The plan contained information on roles, duties and contained supporting notes and guidance.
- Staff knew how to find the major incident plan if they needed to access the information.

## Are end of life care services effective?

Requires improvement 

We rated effective as requires improvement because:

- The trust's amber care bundle was still not fully embedded throughout the hospital wards despite being introduced during the 2015 inspection.
- Documented evidence of completed advance care plans (ACP) was only noted in 63 patients out of 240 and these were predominantly within the community care setting. Only five patients in the acute care setting had an ACP in place.
- Combined results across both sites (community and acute) demonstrated that the individualised end of life care plan was not effectively used since January 2016.
- Registered nurses on the wards had received training to enable them to safely administer medications through the T34s McKinley infusion pumps; however this was not consistent and some staff had not received training in the T34s McKinley pumps.
- Nutritional assessments were not always documented as part of the individualised care plan for end of life care patients.

# End of life care

- Porters we spoke with said they had not received any specific end of life care training. They told us that newly appointed staff learnt from and shadowed porters that were more senior.

However:

- We saw that the SPCT and end of life care service cared for patients in accordance with current evidence based practice, standards and legislation.
- Staff discussed pain relief and pain management plans with patients and their relatives.
- The service monitored patient outcomes through national and local audits; these were fed back to the board and end of life care dashboard along with the trust's quality report.
- Multi-Disciplinary Team (MDT) working was effective within the end of life care service, the team worked as one integrated team across acute and community care settings.
- A trust had newly appointed a bereavement officer, which was a vast improvement since 2015 inspection when the trust had no bereavement service.
- DNACPR forms were filed correctly in front of patient records so that staff could locate them quickly. Since the last inspection in 2015, the trust had significantly improved the DNACPR documentation.

## Evidence-based care and treatment

- Since the national removal of the Liverpool Care Pathway (LCP) in July 2014, the trust developed a personalised end of life care pathway called the individualised end of life care plan (IEOLCP). This ensured staff were carrying out evidence based care.
- The ACP is a nationally recognised means of improving care for people nearing the end of life. The plan enabled improved planning and provision of care and support for people to live and die in a place and manner they chose. However, it was not evident that the ACP was embedded with all ward staff despite the SPCT providing training.
- The Community Palliative Care Consultant 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 Specialist Palliative Care Team and support.
- The trust had the amber care bundle on some wards as part of a phased roll out programme from the Transform Programme. The amber care bundle is an approach

used in hospitals when doctors are uncertain whether a patient may recover and are concerned patients may only have a few months left to live. This was being introduced in the last inspection in 2015 but had still not been fully embedded throughout the wards in the hospital.

- During our inspection, we saw that a patient was a suitable candidate for the amber care bundle but that it had not been put into place. When we questioned the nurses about this, they said they were waiting for the surgical team consultant to make this decision, even though they were aware of the deteriorating patient post-surgery.
- We reviewed data around amber care bundles from April 2016 to January 2017 and saw that in March 2017, the trust had 96 deaths and only 29 had the amber care bundle in place.
- End of life care patients were flagged by consultants or nursing staff. Patients were then referred for assessment by the palliative care team, who would decide if the patient met the End of life care criteria.

## Pain relief and symptom control

- We spoke with some patients who were identified as end of life care and we saw they were prescribed anticipatory medicines, which included pain relief. Anticipatory medicines are a small supply of medications for patients to keep at home so they are available when patients need them. They are only to be prescribed by a doctor or a nurse. We saw staff had administered these medicines appropriately in line with best practice guidelines (care of dying adults in the last days of life NICE guideline NG31).
- We saw 'Prescription of Anticipatory Medications in Dying Patients' audit 2015/2016, where 20 patients were selected at random from deaths in December 2015. Medical notes, drug charts, and death certificates were used. The audit showed 50% had all anticipatory prescribed. Generally, good awareness of the range, frequency, route and daily maximum were prescribed.
- We saw ward staff discussed pain relief and pain management plans with patients' and their relatives, we observed this during board and ward rounds. Relatives we spoke with told us staff managed their loved ones pain well.
- We saw that the trust had systems and procedures in place to monitor and manage end of life care patients' pain relief needs.

# End of life care

- The trust had an acute and a chronic pain service. The teams consisted of specialist doctors and nurses who provided advice and support to patients.
- We saw that patients were assessed using a 'midnight to midnight check', which staff explained as "Putting the person being cared for at the heart of care". These checks included comfort, surface, position chart, skin checks, incontinence and nutrition checks. We reviewed these checks and saw all that were in use were signed and up-to-date.

## Nutrition and hydration

- Ward staff we spoke with told us they would refer their patients to the trust's dietitian if necessary and we saw examples of this documented in patient records.
- We observed board and ward rounds, and saw that staff discussed potential nutritional and hydration risks in end of life care patients along with the options available to help assist them. We saw that nutritional and hydration risks were a topic of discussion in their weekly multi-disciplinary team meetings.
- Patients' relatives told us that staff would always ask if they wanted any food or drink, they also told us, "staff are very attentive and never too far away if we need anything".
- We saw that patients and relatives had drinks close by and staff made regular drinks for relatives and patients if needed.
- We saw evidence in patient records that mouth care was part of the nursing assessment when caring for the end of life care patients. We saw this was followed appropriately with anticipatory medication options such as mouth gel if required.

## Patient outcomes

- The trust participated in the National Audit of Dying in Hospital 2016 and performed better than the England average for three of the five clinical indicators. These were recognition of death in good time, discussion of patient concerns and holistic assessment of needs. They performed the same as the England average for one indicator and worse for one indicator, which was discussion of needs of those close to the patient.

- The trust answered yes to seven of the eight organisational indicators. The only indicator where they answered no was the presence of a lay member on the trust board with a responsibility or role for end of life care.
- The end of life care service monitored patient outcomes through national and local audits and these were reported to the board via the palliative care and end of life care dashboard, and the trust's quality report.
- We saw the trust's Specialist Palliative Care Team Annual Report April 2016- March 2017. This report was the first report produced for the organisation with detailed results on 480 patients who had died in the care of Walsall Healthcare NHS Trust across both community and acute care settings. Two-hundred and forty of this cohort of patients died in hospital.
- The most common age range for deaths in both the acute and community care settings was from 60 to 89 years of age.
- The most common disease group most frequently seen in the cohort of 480 patients were neoplasm (196) followed by circulatory disease (125) and respiratory diseases (64). The age ranges of deaths most frequently occurring were 70-79 and 80-89 years of age. The exceptions to this were deaths from cancer, which also occurred in reasonable numbers in the age range 50-59 (33) and 60-69 years of age (66). Approximately 19% of patients in the cohort of 480 had dementia as a secondary diagnosis.
- Within the priority for dying, the results of the trust's latest National Audit of Dying in an Acute Hospital indicated that 30% of patients in the audit cohort had been admitted to hospital and died within 24-36 hours. There after this was included in the acute site audit, the results from these 240 patients had not been upheld with only an average two patients per month of those audited dying within 24-hours of admission.
- From the data records we received, we saw that 68 patients at the acute site had a clear management plan, 95 patients had evidence of a preferred place of care documented and 137 patients had evidence of multidisciplinary team (MDT) discussion and recognition of the possibility that patient may die.
- Documented evidence of completed ACP was only noted in 63 patients and these were predominantly within the community setting. In the audit we received we saw there were only five patients in the acute care setting that had an ACP in place.



# End of life care

- Seventy eight percent of a patient's nominated person had opportunities to discuss concerns as they arose.
- Sixty six percent of patients had their religious and spiritual requirements documented in the acute care setting.
- Data we received from the trust for 2016 showed that 20 (71%) of the individual care plans within the acute care setting were completed and 8 (29%) were incomplete. When broken down by core service, the data showed that 3 (7%) were all completed very well and were on the ITU, 2 (7%) were partially completed and were on surgical wards, 8 (29%) were partially and poorly completed and were on elderly care wards, and 15 (57%) had variable levels of information recorded and were on medicine wards. The data tells us that 82% of records had not been completed correctly.
- The trust's results from reviewing patient records showed that 115 had evidence of on-going reviews, 109 had evidence of MDT discussion in relation to artificial hydration and 126 had evidence of, none-essential medication discontinuation and anticipatory medication prescription.
- The trust no longer carried out a mortuary passport audit. Staff informed us that all mortuary passport inaccuracies were raised as clinical incidents on the electronic reporting system instead.
- We saw evidence of the trust contributed data about Specialist Palliative Care Team to the National Minimum Data Set (MDS). The National Council collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set.
- We saw the trust had an end of life care training plan and staff confirmed they were able to access information on end of life care, such as the IPC, anticipatory medicines and using the newly implemented end of life care tool kit.
- Staff we spoke with said they had received training on end of life care on the mandatory clinical update day. We saw evidence that registered nurses on the wards had received training to enable them to safely administer medications through the T34s McKinley infusion pumps; however this was not consistent, some staff were not trained or did not know which syringe drivers were being used. We saw the competency-training matrix held by the Specialist Palliative Care Team . From January 2016 to April 2017, we saw there was only one registered staff nurse from ward 18/19 (HDU & ITU) that had completed updated training (August 2016) and one registered staff nurse from ward 5/6 - Acute Medical Unit (March 2017).
- We saw evidence provided by the EBME team (medical devices department) that showed staff had undertaken practical sessions on how to use McKinley T34s syringe drivers. We saw that over 200 staff from 21 wards had attended but dates of completion varied from 2013 to 2015.
- Porters we spoke with said they had not received any specific end of life care training. They told us that newly appointed staff learnt from and shadowed porters that were more senior.
- Porters received training from the mortuary staff to gain information about how to respectfully move bodies.
- The palliative care consultants across both acute and community care settings provided education to the local GPs, which included areas specifically around the Gold Standard Framework.
- As at 31 March 2017, 100% of staff within end of life care at the trust had received an appraisal compared to a trust target of 90%.

## Competent staff

- The palliative care team provided a variety of end of life care training for all clinical staff. Some of the examples included the palliative care programme, advance care planning and syringe driver training. We saw an example of training that had been delivered to doctors that was carried out by the palliative care consultant.
- We spoke with the SPCT consultant who told us they were in the process of developing a formal in-house training programme covering specific communication skills for staff when caring for end of life patients.

## Multidisciplinary working

- The palliative care team were a multi-disciplinary team (MDT), consisting of consultants, doctors, nurses and occupational therapists.
- Staff delivered care in a co-ordinated and efficient manner with all staff being involved in patient care.
- The acute and community palliative care team had a strong link with the local GP's, hospices and nursing homes. Staff told us that the service aimed to improve



# End of life care

the care that was provided for patients when they were moved between providers and patients care/treatment wishes were transferred with them from acute to community for continuity of care.

- We saw evidence of good MDT working documented in-patient records involving the speech and language team (SALT), dietitians, occupational therapists (OT), physiotherapists, nurses and doctors.
- When we spoke with the newly appointed bereavement officer, mortuary staff and the chaplain staff, they told us that they felt part of the whole SPCT..
- We spoke with staff within the Specialist Palliative Care Team and they told us that multi-disciplinary team meetings occurred weekly and included the hospital palliative care team, the community staff and the local hospice. Staff also told us this was where patients with complex needs were discussed as well as providing an opportunity to develop communication and relationships with the community.
- The Chaplain and the bereavement team told us they had a good relationship with the mortuary and the SPCT, as this ensured that patients and relatives had a smooth empathic journey.
- Porters we spoke with told us they had a good relationship with the mortuary staff and that they could easily access support from the team if needed.
- Medical staff told us they would send a discharge summary letter to the patient's GP. GP had access to the trust's electronic programme where they could access further information about their patient whilst they were in hospital.
- On the wards we visited, we saw there was a discharge coordinator who worked closely with the integrated discharge team (IDT). The IDT worked closely with the local hospices, GPs, nursing homes, the CCG, physiotherapists, occupational therapists and the Specialist Palliative Care Team , to ensure that the end of life care patients were discharged with a full individual care package at their preferred place to die.

## Seven-day services

- The specialist hospital palliative care team operated a seven-day nursing service between the hours of 9am to 5pm. There was on-site access to palliative medical advice five days per week and out-of-hour's advice via an on-call rota.

- The bereaved were able to view their deceased loved ones by appointment between the hours of 9am to 4pm on weekdays and from 9am to 11.30am on Saturdays. During these times, viewing was at the convenience of the bereaved whenever practicable.
- Ward staff knew how to contact out-of-hours support from the Specialist Palliative Care Team . Ward staff also knew how to contact the porters out-of-hours if they required a deceased patient to be transferred to the mortuary or if they required any additional equipment from EBME.
- The trust had a 24 hour a day, seven days a week chaplaincy service provided by Christian chaplains and a partial weekly service by Roman Catholic chaplains. A 24 hour a day, seven days a week service for smaller faith communities was to be reinstated following the Safety and Quality Committee decision in July 2017. The bereavement officer was available Monday to Friday 9am to 5pm.
- The mortuary operated a 24-hours a day, seven days a week service to provide cover for the hospital. The mortuary staff would also be available per rota to cover on-call service with support from the night duty porters.

## Access to information

- All staff we spoke with could access policies either on the intranet or in the information folders based on each wards.
- We saw the amended version and the award winning 'Palliative and End of Life Care tool kit'. The design was in a pocket sized hand held note pad and had all the relevant contact numbers with on-call information, such as ACP guidelines, amber care bundle information guidelines, important decision making around the Mental Capacity Act (MCA), end of life care decision making, symptom management and dementia, there were also references and resource information available for further reading.
- The SPCT across the acute and community care settings ensured information was shared to ensure care and treatment was accessed in a timely manner.
- We saw many leaflets were available across the hospital around end of life care and dying matters with relevant information for staff, patients and relatives.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

# End of life care

- All staff working within end of life care had completed MCA and Deprivation of Liberty Safeguards (DoLs) training between April 2016 and March 2017.
- We saw staff gained verbal consent from patients prior to providing care and reassured their relatives.
- We saw on ward 10 they had an MCA champion trophy on the ward, which was on display to identify they had a champion for extra support if required.
- All Do Not Attempt Cardio Pulmonary Resuscitation forms were easily identifiable with a red border. Forms showed that best interest discussions with family and the patient had taken place as well as evidence of MDT discussions. Forms had been signed by consultants.
- Data we received from the trust for the end of life care service showed that 272 patients had discussions around DNACPR with a nominated person or with a patient, 151 patients had a discussion around dying and 226 patients had a DNACPR in place.
- Sixty-four out of 73 DNACPR forms (88%) were fully completed within the acute care setting.
- We reviewed 16 DNACPR forms and we found they were all in line with the national guidance published by the General Medical Council.
- DNACPR forms were filed correctly in front of patient records so that staff could locate them quickly. Since the last inspection 2015, the trust has improved significantly around the DNACPR documentation.

## Are end of life care services caring?

Good



We rated caring as good because:

- Staff were passionate and very committed within their role to maintain a high quality service for their patients.
- Staff cared for patients in a compassionate, dignified and respectful manner.
- The Chaplain Service offered spiritual support to patients' 24-hours a day, seven days a week.
- Mortuary staff transferred deceased patients in a respectful and dignified manner.
- Porters told us they showed respect and maintained the dignity of the deceased by ensuring all curtains were closed when transferring them through the wards.

- We saw in one of the viewing rooms at the mortuary that there were facilities for washing the deceased for religious and cultural reasons. We saw this as an understanding and respect for patients' cultural and religious needs.

However:

- Ward staff told us that it was difficult at times to support relatives during an emotional time, as there were no specific rooms to speak with relatives in private.

### Compassionate care

- Staff were passionate and very committed within their role to maintain a high quality service for their patients.
- We saw that staff respected patient's privacy and dignity by ensuring they closed any curtains and doors.
- Staff cared for patients in a compassionate, dignified and respectful manner.
- Porters told us they showed respect and maintained the dignity of the deceased by ensuring all curtains were closed when transferring them through the wards.
- We saw mortuary staff transferring deceased patients in a respectful and dignified manner.
- When we spoke with the mortuary staff, they spoke highly of the bereavement officer. The bereavement officer would meet the family of the deceased and walk them to the viewing area, which ensured they received a respectful and dignified service.
- 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 within 24-hours for a burial.

### Understanding and involvement of patients and those close to them

- A communication skills, education and prioritisation matrix tool was implemented for all staff to complete communication training, to ensure staff understood care of the patients in the last hours or days of life.
- We observed staff consoling a bereaved relative. The staff member showed empathy and respect and allowed the relative time to talk in the matron office.
- Ward staff told us that it was difficult to support relatives during an emotional time, as there were no specific rooms to speak with relatives in private.

# End of life care

- Senior staff told us that if families wished to come on to the ward at mealtimes to offer support to their relatives this was encouraged.
- We observed ward staff speaking with patients in a kind and respectful manner.
- We observed consultants and nurses communicating about an end of life care patient in a respectful and sensitive manner and allowing their relative time to ask questions.
- We saw in one of the viewing rooms at the mortuary, that there were facilities for washing the deceased for religious and cultural reasons. We saw this as an understanding and respect for patients' cultural and religious needs.
- There was a comment box in the mortuary where visitors could leave feedback and staff reviewed these comments on regular basis. We saw numerous positive comments were given, feedback was also displayed throughout the hospital for the public to see.

## Emotional support

- Since the last inspection in 2015, the trust had employed a dedicated officer for the bereavement service. Staff and relatives of the deceased told us this service provided a practical and informative service along with the emotional support needed when loss had occurred.
- We spoke with a staff member who went on to say how important a patients' final wish was, they said between the ward staff, bereavement officer and support from the trust, a patient's final wish had been fulfilled, by allowing the patient's cat to visit them whilst they were at their finals days of life. This bought comfort and emotional strength to the patient and their family.
- We spoke with the SPCT and they told us they provided regular supervision for staff to ensure staff were able to debrief and reflect.
- The Specialist Palliative Care Team provided emotional support to both patients and relatives. Relatives were given opportunities to speak in private if they needed to raise any concerns. However, this took place in a staff room or in the sister's office as there was not a dedicated room for relatives. This issue was raised on numerous occasions when we spoke with patients and their relatives.
- The chaplain service offered spiritual support to patients 24-hours a day, seven days a week and the service catered for different faiths such Christianity,

Muslim, Sikh, and Roman Catholic. We saw an example of the trust's monthly spiritual and religious assessment audit. Between January and March 2017, trust mortality figures were 324 of which 61 had chaplaincy support for end of life patients and, or their families with 11 thank you's for this service. We saw numerous thank you cards and comments on display throughout the hospital for all the public to see.

- Posters advertising the chaplaincy services were clearly displayed on all ward entrances and leaflets about the service were on most ward areas. Ward staff told us that the chaplains visited the wards most days.

## Are end of life care services responsive?

Good



We rated responsive as good because:

- The chapel and prayer room contained Christian religious articles; a separate part of the room could be screened off for the non-Christian worshippers.
- Patient discharge and moving patients between the acute and community care settings followed best practice around patient-centred care.
- The specialist palliative (SPCT) team worked closely with commissioners and other providers to ensure patients' needs were met.
- The specialist Palliative Care Team ensured patients who required end of life care and palliative care were seen promptly and were identified in a timely way, that the deceased were cared for, and that religious and spiritual beliefs were respected and dignified.
- Relatives could visit their loved ones who were end of life any time of day.
- Staff within the SPCT (hospital & community) had access to fast track funding authorised by the Walsall CCG Team. The integrated discharge team had a staff member responsible for out of area discharges to South Staffordshire.
- Between April 2016 and March 2017 there were no complaints about end of life care.

However:

- The trust did not have any dedicated beds for end of life care patients, they were cared for on general wards throughout the hospital.

# End of life care

The route that people had to walk to the mortuary for the general office was long and poorly signposted.

## Service planning and delivery to meet the needs of local people

- Data from April 2015 to March 2016 that the trust provided showed that the number of deaths of those patients referred to the Specialist Palliative Care Team within the acute service was 427. Since April 2016 and March 2017, the number of deaths of those patients referred to SPCT had increased to 526. This means more patients were receiving support from the SPCT.
- During the period of April 2016 and March 2017, 445 (51%) of non-cancer patients were referred to the palliative care team and 421 (49%) of cancer diagnosis patients were referred to the palliative team. This means that patients with a non-cancer diagnosis were receiving support just the same as those with cancer.
- The trust did not have any dedicated beds for end of life care patients, they were cared for on general wards throughout the hospital. Staff told us they would always try to arrange a private side room for those patients in the last few days or hours of life, but this was not always possible as side rooms were mainly used for patients with infections.
- In the last inspection in 2015, the trust did not have a dedicated bereavement service; however, since then, the trust now has a dedicated lead for the bereavement suite. Staff told us there were good procedures in place to ensure death certificates were issued in a timely fashion and since the set-up of the bereavement service, it had reduced the emotional distress of relatives waiting in the general area. Relatives were being cared for exceptionally well from the dedicated bereaved service lead.
- The route that people had to walk to the mortuary for the general office was long and poorly signposted.

## Meeting people's individual needs

- We visited the chapel, prayer room and the multi-faith prayer room. The chapel and prayer room contained Christian religious articles and a separate part of the room could be screened off for the non-Christian worshippers. Prayer mats and holy books were also available. Signposts for the chapel were easy to follow for all staff, patients and members of the public.

- Staff told us they had a chaplaincy 'contact form'. This was left at the patient's bedside and the chaplain would record any contacts made on this form.
- Staff on the wards told us they provided the bereaved with a bereavement booklet when a loved one passed away, which explained the grieving process. The bereavement booklet was available on most of the wards. Staff also provided a booklet describing what to do following a death. The booklet gave practical advice, such as collecting death certificates and contactable details for support. This booklet was also readily available on the wards. The bereavement officer would provide face-to-face support to staff and patient.
- The Specialist Palliative Care Team ensured patients who required end of life care and palliative care were seen promptly and were identified in a timely way, that deceased bodies were cared for, and that religious and spiritual beliefs were respected and dignified. This adhered to the NICE guideline QS13: End of Life care for adults 2011. However, during our inspection we found that ward staff were not always confident in challenging consultants when they felt patients' were reaching the end of their life and this, at times delayed the process of ensuring patients died in their preferred place, documents such as the ACP and IEOLCP were not always completed in a timely manner.
- Patients must be 18 years and above to meet the criteria for commencing IEOLCP at Walsall Manor hospital. The patient must also be cared for in the Walsall Manor Hospital and MDT recognition and discussion that the patient was approaching end of life must have happened.
- The IDT told us they had been able to source a care package over the weekends and the bank holiday weekend to allow an end of life care patient to be discharged home to their preferred place. We were told the hard work of the nursing team ensured this was made possible. Staff had regular discussions with patients' and relatives around the logistics of enabling end of life care patients' to be discharged rapidly.
- Ward staff gave us an example of arranging a discharge of a patient to a preferred place of death within four hours. Staff arranged for oxygen to be delivered at home, a hospital bed to be delivered and a care package to commence in the community. This patient

# End of life care

passed away a few hours after discharge in their own preferred place, which meant that their final wish was fulfilled by dedicated staff at the hospital and responsiveness of the team.

- Relatives could visit their loved ones who were end of life any time of day. Relatives and patients told us they were kept up to date via phone or face-to-face around any changes in care.
- Mortuary staff told us they could rapidly release a deceased patient for certain faiths that required a same day burial. This was supported by having a washroom in one of the viewing rooms at the mortuary to accommodate this.
- Interpreter services were available on the phone or face-to-face and were easily accessible for those patients and relatives that did not speak English as their first language.
- In the Cancer Patient Experience Survey 2014/15, the trust was in the top 20% of trusts for five of the 34 questions, in the middle 60% for 19 questions and in the bottom 20% for 10 questions. Good performing scores, related to communication about free prescriptions, clear communication to patients about treatments, privacy during treatment and when discussing treatments.

## Access and flow

- For urgent palliative reviews, patients could be seen within hours to one working day once a referral had been sent.
- We saw evidence of data that 1,789 referrals, an average of 96% of patients were seen on the day of referral or the following day.
- Staff told us that having an occupational therapist within the palliative care teams speeded the discharge process up. The palliative care team consultant gave us specific examples of rapid discharges of patients to the local hospice or a nursing home in order to achieve their preferred place of death.
- The trust had a bed scheme funded by the local clinical commissioning group (CCG). This consisted of three beds in a local nursing home with the opportunity to extend to six at a local nursing home that were reserved for patients in the last few weeks of life. The beds provided an alternative place of care for those who wanted to be cared for at home but could not. There was a standard operating procedure (SOP) for this

scheme, which clearly identified the patients that were suitable for referral and the procedure to follow. This was always checked prior to the transfer of the patient to ensure the agreement of the nursing home and CCG.

- The acute hospital team updated and shared a daily caseload report that was accessed by pharmacy, chaplaincy and the community specialist services.
- The trusts Rapid Discharge Home to Die Policy highlighted the process and the teams involved to support this process. The SPCT consisted of a clinical nurse specialist (CNS), occupational therapist (OT), a consultant and a specialist nurse practitioner. The SPCT across the hospital site worked closely with the integrated discharge team.
- The Integrated Discharge Team had two staff members responsible for out of area discharges to South Staffordshire and for the local area. Trust target for rapid discharge was four hours.
- The trust reported 177 Fast Track discharges within the four-hour target in 2016/17 of which the community team facilitated 82 (46%) and the acute team facilitated 95 (54%). This was audited by the palliative care team to ensure patients were being discharged in a timely manner, however when we spoke to the IDT they said this was not always achievable if social care in the community did not have capacity. We saw the trust were prioritising in maintaining the four-hour discharge in their 2015 to 2017 end of life strategy documentation. Further support was provided to all staff by the pharmacy to ensure that all drugs were available in a timely manner, that pharmacy staff checked anticipatory drugs and the syringe pump directives. Both the DNACPR forms and the individualised end of life care plan documentation had been developed to follow the patient into any care setting.

## Learning from complaints and concerns

- Between April 2016 and March 2017 there were no complaints about end of life care.
- We reviewed the trust's policy on the handling of complaints and saw this was in date; staff had access to a paper format copy of the policy in folders on the wards and was easily accessible on the intranet.
- Staff told us they would report complaints to their manager and redirect patients to the hospital patient advice and liaison team.



# End of life care

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

Good



We rated well-led as good because:

- The professional lead for Specialist Palliative Care Team chaired a multi-professional group.
- The Specialist Palliative Care Team service leaders had a clear direction for the service with the aim for an effective integrated service to ensure patients were provided with quality end of life care.
- Staff on the wards of all levels felt supported from the end of life and palliative care team.
- We saw the end of life strategy plan for 2015-2017 “Becoming your partners for first-class integrated care”.
- The trust’s values were displayed throughout the hospital.
- The trust was participating in the Black Country Sustainability and Transformation Plan (STP).
- Quality and risks were managed through a monthly specialist quality group for Specialist Palliative Care Team
- We saw that staff were committed in providing a high standard of care and the culture of teamwork ensuring quality of care was provided.

### Leadership of service

- The Specialist Palliative Care Team service was a consultant led service. Staff we spoke with spoke highly of the leaders within Specialist Palliative Care Team , and they were highly respected throughout the trust.
- The Specialist Palliative Care Team service leaders had a clear direction for the service with an aim to achieve an effective integrated service ensuring patients were provided with quality end of life care.
- The trust had a Specialist Palliative Care Team strategic delivery group, chaired by the director of nursing and the care group manager/professional lead of Specialist Palliative Care Team that provided leadership for end of life care.
- The professional lead for Specialist Palliative Care Team chaired a multi-professional group. Membership included the acute and community the Specialist Palliative Care Team and representation from the CCG

as well as the director of nursing. Minutes from this meeting demonstrated wide ranges of issues were discussed, for example results of the National Care of the Dying Audit.

- When we previously inspected this service back in September 2015, it was noted there was no representative for the end of life care service at board level, this position has now been occupied (2017).
- Staff on the wards of all levels felt supported from the end of life care and palliative care team.
- When we spoke with ward staff and everyone knew who the Specialist Palliative Care Team members were by their full names.
- All staff we spoke with throughout the inspection praised the Specialist Palliative Care Team . One member of staff said, “They are always available when you need them.” Many went on to tell us how approachable and responsive they were. They were also proactive and provided clear plans for patients.
- Staff from the mortuary, bereavement suite, porters, chaplaincy and ward staff including occupational therapists, physiotherapists, dietitians, the SALTs and members from the IDT felt they were supported and were able to deliver high quality care for the dying patient and able to support their loved ones.

### Vision and strategy for this service

- We saw the end of life strategy plan for 2015-2017, “Becoming your partners for first-class integrated care”. This Strategy has been in development for over a year with extensive engagement and input from the board and operational care groups.
- We saw a discussion had taken place around the trust’s aim to remain the prime provider of all palliative and end of life care across the borough, working with primary care to increase the uptake of the amber care bundle and improving planning for end of life care. Early identification of patients at the end of life care and a closer alignment of social care, mental health and use of specialist care beds for respite will result in patients experiencing a more integrated approach to their care.
- The trust’s values were displayed throughout the hospital and staff knew what the values were.
- The trust was participating in the Black Country Sustainability and Transformation Plan (STP). The plan was to bring together 10 healthcare providers, numerous local authorities and four CCGs to create an



# End of life care

ambitious local blueprint for accelerating the implementation of The NHS Forward View, for the period October 2016 to March 2021. Specialist end of life care was part of this strategy.

- The vision for the trust to “Care at Home” services is to move to a true single point of access including co-location of the various team members from mental health, social care, and Walsall Healthcare and be able to coordinate patient care in a more holistic way. For patients requiring palliative and end of life care this would involve development of networks of services over a geography, integrating different organisations and services around the patients.
- Staff we spoke with told us that end of life care provision was a high priority for the trust and understood the importance of providing a high quality standard of care that met their patients individual needs.

## Governance, risk management and quality measurement

- Quality and risks were managed through a monthly specialist quality group for Specialist Palliative Care. Minutes from these meetings showed a wide range of issues were covered including reviews of incidents and risks.
- The consultants within the team told us they regularly attended trust clinical governance meetings to discuss key developments, such as audits in relation to the end of life care services. We saw minutes from these meetings.
- The service produced an annual report called “Achievement of 6 key priorities for End of Life Care” for acute and community services for the period April 2016 to March 2017. This report brought together governance, quality and outcomes.
- We saw that the end of life care service identified risks to the service and was seen to be up to date, including review dates for the risks, and an allocated responsible lead person for the risks and completion of any actions.
- There was a risk register for palliative care and end of life care. This was integrated with the community service. One area of concern was finance and the provision of cancer and non-cancer patients.
- We reviewed the risk register for end of life care services and saw that the organisation had no electronic coordination system (EPPaC's) for the storage and sharing of essential information for those patients at the

end of their life. The trusts plan was to engage with the work stream to develop new EPPaC's system for Walsall agreed through the CCG commissioning board for a review in 2018.

- We saw there was an increase incident reporting in relation to use and delivery of drugs via the T34 McKinley Syringe Pump showing user error as a recurrent issue and pump availability. This has been reviewed and an updated syringe pump policy for use in palliative care patients had been implemented along with regular audits.
- Included on the risk register was the mortuary additional body store. The store had no security camera coverage or anti intruder barrier. The surrounding fence was secure but the height enabled members of the public to see into the body store from the reservoir road car park. This means the unit did not comply with the human tissue authority (HTA) requirements for a body store and would affect the HTA license approval. This was actioned and completed on 15 February 2017.
- The current practice regarding DNACPR and mental capacity was consistent. Mental capacity assessments were routinely undertaken for the DNACPR decision.
- We saw minutes from the end of life care strategic delivery group and saw discussions had taken place around syringe driver pumps, these continued to be held on wards unnecessarily, which led to a lack of pumps for other wards. The team from the EBME department also raised this. We saw discussions around the use of the amber care bundle, the progress was slow and concerns may have been around confusion with other initiatives taking place, such as a safer bundle and red and green days. This was highlighted when we spoke with staff during the CQC inspection.
- Since the inspection in 2015, staff reported that the mortuary fridges often broke down and although staff had complained to senior managers, there were no plans to replace the 27-year-old fridges. During the June 2017 inspection, mortuary staff told us that there was a plan in place to have new fridges in the upcoming year. Staff went on to tell us that the breaking down of fridges had minimised and the trust had fixed problems as they occurred. We saw that additional body storage fridges had been built with over 36 spaces with additional bariatric fridges with eight-body storage. This allowed

# End of life care

the hospital to help other trusts within the Black Country if they required additional mortuary space. Walsall NHS trust currently has a service level agreement for coronial post mortems.

## Culture within the service

- Staff told us and we saw they were proud to work within the Specialist Palliative Care Team.
- We saw that staff were committed in providing high standard of care and the culture of team work to ensure quality of care was provided.
- Staff felt their voices were heard and were confident in raising any concerns to their managers if necessary and actions would be taken.
- Mortuary staff told us they felt supported by their manager and felt listened to.
- All staff worked with a sense of pride, and worked together to provide the best care possible to patients at their final stages of life. Ward staff we spoke with were clearly committed to providing good quality care to end of life care patients. A sense of good teamwork was evident throughout the end of life care service.

## Public engagement

- The trust had engaged with members of the public through public events designed to obtain the views of the public in developing services for the future.
- The trust undertook an online survey to look at public attitudes to death and dying and attended regular public stands in the community to share information with the public around dying matters.
- The trust collated patients' views through the friends and family test. We saw "you said we did" notice boards where staff had made changes because of public opinion.

## Staff engagement

- Walsall staff designed the trust's promise and established the sets of behaviour the trust expected from their people. They make a commitment to their patients that will make them feel welcomed, cared for, in safe hands and likewise the trust's own staff who should feel part of one team, supported to meet high standards and feel appreciated.
- Staff were involved in listening in action groups where they could share their views and concerns at a trust wide level and turn them into actions.

- Percentage of staff appraised in this service in the last 12 months as of 31 March 2017, was 100% which exceeded the trust target of 90% and the England average of 86%.
- Staff told us and we saw the trust newsletter, which was distributed throughout the hospital. The newsletter updated staff on current issues, new initiatives and future plans for the site.
- All nursing and medical staff had individual trust email accounts and these were used to circulate message and alerts.
- When we spoke with the porters, they said they would seek emotional support from their fellow colleagues. One porter gave us an example when they attended the emergency department to transfer a deceased body to the mortuary; they were not given a handover or provided with information about the condition of the body before arriving at the department. At this particular time, a porter knew the deceased person. They were not offered to debrief or seek counselling for additional support.

## Innovation, improvement and sustainability






- The consultant in palliative medicine was working alongside the surgical orthopaedic team particularly looking at predicted mortality in those patients with a fractured neck of femur and the use of the amber care bundle.
- The trust arranged a range of activities for the 'Dying Matters week'. The planning group worked positively with the local college students and other groups to present a range of interesting events for the week. Walsall Healthcare, Walsall clinical commissioning groups and local hospices also jointly signed the 'Dying Well Charter' for Walsall demonstrating joint commitment to improving end of life care together.
- The trust produced the palliative and end of life care toolkit designed in conjunction with staff within the organisation to produce a quick reference guide for key areas in palliative and end of life care. These key areas included communication, contact numbers and important decision making. This tool was highly used throughout the trust.
- The palliative care combined multi-disciplinary team received a number of awards from national and international bodies. This included a second place award in the 'Team of the Year' category at the International Journal of Palliative Care awards, and a British medical Association Patient Information Awards

## End of life care

for user involvement, 'Thinking About End of Life Care – a supportive guide for those caring for someone dying from a life limiting illnesses'. They also won an International Journal of Palliative Nursing-Palliative Care Team of the Year –for Specialist Palliative Care MDT award and a Royal College of Physicians –Excellence in Patient Care award for their individualised end of life care plan.

- Staff on wards told us that the hospital were piloting a new initiative with pharmacy technicians being trained to complete medication rounds. If successful, it was hoped this would free up some of the nurses time.

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services at Walsall Healthcare NHS Trust were mainly located on the ground floor and served by several reception desks. The trust runs a wide range of specialities and medical conditions clinics including cardiology, neurology, ophthalmic, rheumatology, diabetes, renal, respiratory and

elderly medicine. There were surgical clinics for ear, nose and throat, colorectal, vascular, orthopaedics and trauma including pre-operative assessment clinics. Women's services included family planning and antenatal clinics.

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.

We spoke with 61 staff, including nurses, clinical support workers, doctors, physiotherapists, podiatrists, senior managers, radiographers, radiologist and administrative staff. We spoke with ten patients, a relative and reviewed five patient records and observed two consultations.

## Summary of findings

During the last inspection in September 2015 we rated this service as requires improvement for safe, responsive and well led, effective is not rated and caring was rated good. This meant the service was rated requires improvement overall.

This was because;

- Systems and processes were not always adhered to.
- The trust electronic records system had caused major backlogs with the appointment system and caused loss of data in the appointments system.
- Clinics were overbooked, ran late and caused long waits for patients.
- Between January 2014 and December 2014 10% of patients failed to attend appointments, which was above the England average. The hospital cancelled 6% of appointments
- The capital replacement programme was not in line with the requirements of the imaging department and many devices were overdue replacement.

Following this inspection we saw the service had made significant improvements across many areas and the service was rated good overall. This was because;

- The outpatients and diagnostic departments had a good incident reporting culture and we found evidence of learning from incidents.
- The environment within the main outpatients and diagnostic departments was fit for purpose, and staff had access to specialist equipment as needed.

# Outpatients and diagnostic imaging

- We found medicine management and safety was very good across outpatients and diagnostic imaging.
- Staff delivered care in line with current national guidance and best practice, and staff updated policies and procedures to reflect changes in guidance and best practice.
- Nursing and therapy staff achieved the trust target of 90% for compliance with yearly appraisals.
- Registered staffs knowledge and understanding of the Mental Capacity Act 2005 was good. Staff gained consent in line with best practice and the Mental Capacity Act 2005.
- Staff provided compassionate, kind and respectful care across all clinical areas.
- The service met the majority of operational and national targets in relation to referral to treatment times, including the 'two week GP urgent referral' and '31 days before receiving their first treatment following a diagnosis' targets.
- Both departments had structures in place to meet the individual needs of patients.
- The service had a newly formed senior leadership team, which was in the process of becoming fully embedded across the service.
- Governance processes were in place and staff were encouraged to be involved in the safe running of the service. For example, all registered staff could access and update the risk registers for their areas.
- We found evidence of senior staff encouraging and developing staff across outpatients. Staff told us they felt supported by their manager.

However:

- The implementation of new technology had resulted in some follow up appointments not being booked, with three patients currently identified as suffering harm as a result.
- Medical staff had not met the trust target for compliance with yearly appraisals, achieving 86% against a target of 90%.

- Friends and Family Test results were worse than the national average in outpatients for March to May 2017.
- The fracture clinic environment did not promote privacy, safety or mobility needs of patients and relatives.
- The trust was not meeting the national standard for the 18 week referral pathway.

Staff within outpatients had not undertaken any dementia awareness training .

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- The service had a good incident reporting culture throughout outpatients and diagnostic imaging; with all staff encouraged to report incidents. We found evidence of learning from incidents.
- The service now had clear oversight regarding 'missed to follow up' patients and had implemented measures to prevent reoccurrence.
- The environment within outpatients and diagnostic imaging was fit for purpose, and we found appropriate and serviced equipment throughout the service.
- The majority of areas visited were visibly clean and tidy. We found good waste management processes in place across the service.
- Medicine management was good across outpatients and diagnostic imaging, including the storage, monitoring and use of FP10 prescription pads.
- Staffing was in line with the requirements of the service, with good visibility of senior nurses across outpatients.
- Medical and nursing documentation within medical records was detailed, accurate and up to date.
- Radiation protection supervisors ensured requests for x-rays and other diagnostic procedures were in line with Ionising Radiation (Medical Exposure) Regulations 2000.

However:

- Compliance with mandatory training and safeguarding training was below the trust target of 90%.
- The storage of records during clinics in outpatients was a concern, with staff leaving medical records unattended and unsecure.
- The implementation of a new computer system resulted in some patients being 'lost to follow up', meaning they did not receive a follow up appointment when they should have. One patient suffered 'minor harm', one 'moderate harm' and one 'major harm' due to being 'lost to follow up'.

### Incidents

- Outpatients and diagnostic imaging reported 235 incidents between April 2016 and March 2017. Of these, 232 were categorised as 'no harm', 'low harm' or 'near misses', one as 'moderate harm' and two as 'major harm'.
- The moderate incident and one major harm incident concerned 'lost to follow up appointment', meaning the service did not successfully follow up a patient after a previous appointment or procedure where this was indicated as required. The second major harm incident related to 'failings in clinical care', where staff did not identify a serious medical problem resulting in an admission to intensive care.

### Outpatients

- Between April 2016 and March 2017, the trust reported no incidents that were classified as never events for outpatients.
- 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.
- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients, which met the reporting criteria set by NHS England between April 2016 and March 2017, classified as 'diagnostic incident including delay'.
- A Serious Incident can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- Staff within outpatients understood the requirements of the duty of candour regulation. One nurse told us it concerned admitting when something had gone wrong, telling the patient what had happened and apologising for what had happened.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We requested three root cause analyses (RCA) from the trust to review the investigation processes. However, the trust submitted one of the requested RCAs. We reviewed the RCA for an incident recorded in March 2017. We found the RCA was detailed and reflected the severity of



# Outpatients and diagnostic imaging

the incident. The RCA contained an overview of the incident, a detailed action plan for improvements, a risk assessment before and after the action plan and details of “unrelated practice issues”, which described contributing factors out of the control of the trust.

- The action plan, as described above, was detailed, contained progress updates, accountable persons for each action, a date for completion and evidence of how changes will be monitored for sustainability moving forward.
- We found evidence of lessons learnt from incidents. The trust submitted two ‘lesson learnt’ documents following incidents in 2016. The lessons learnt documents detailed the lessons learnt, changes made and the evidence to support this, such as new policies, information leaflets for patients or retraining of staff.

## Diagnostic Imaging

- The service reported no never events between April 2016 and May 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.
- Staff were aware of their responsibilities to report incidents and used an electronic reporting system.
- Staff discussed learning from incidents at weekly staff meetings. They gave us an example of an incident where a patient had cut their leg. The service developed a new process for staff to complete to help ensure doctors checked all patients following injury within the department.
- The department had four serious untoward incidents. Three related to missed cancer diagnoses and one was a failure to flag an urgent report. Management had commissioned a deep dive investigation into IR(ME)R compliance and staff discussed the recommendations at their quality meetings.
- As required under the IR(ME)R (Administration of Radioactive Substances Advisory Committee) (Ionising Radiation (Medical Exposure Regulations 2000), the service notified CQC of exposures reaching a nationally agreed threshold for external reporting. It then investigated these.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose paper details to patients (or other relevant persons) of

notifiable incidents as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Staff understood the principles of being open and transparent with patients. We saw root cause analysis investigations were done on all serious incidents. The service offered patients the opportunity to meet clinicians and discuss the results of investigations at face-to-face meetings.

## Cleanliness, infection control and hygiene

### Outpatients

- The hospital had multiple infection control policies in place and we observed staff working within these. All areas inspected throughout outpatients were visibly clean and tidy. Cleaning schedules were in place for each consultation and treatment room and we saw these had been completed daily (when the department was open).
- The department had no incidents of MRSA, Escherichia coli or clostridium difficile between April 2016 and May 2017.
- All nursing and clinical support staff wore uniforms, and we saw all staff adhere to ‘arms bare below the elbows’ best practice. This enabled staff to wash their hands efficiently between patients and reduce the risk of cross contamination.
- Hand sanitiser was available at each reception desk and in the main hospital. Each consulting room also had hand sanitiser and a sink for handwashing. We witnessed staff using these and washing their hands between each patient. This was in line with National Institute for Health and Care Excellence (NICE) Quality Statement 61 guidance and the World Health Organisation’s Five Moments of Hand Hygiene.
- The department undertook hand hygiene audits on staff monthly and we reviewed these for the period April to June 2017. Each month, staff observed 15 doctor, 15 registered nurse, 15 student nurse and 15 clinical support workers interactions with patients, and audited against the Five Moments of Hand Hygiene. The audits showed that staff complied with the Five Moments of Hand Hygiene in all 60 patient interactions in all three months.
- Within the dermatology minor procedure theatre room we found a ‘scrub room’, which consisted of a purpose

# Outpatients and diagnostic imaging

built sink and chlorhexidine decontamination hand wash to ensure staff could effectively decontaminate their hands and arms prior to undertaking a surgical procedure.

- Personal protective equipment (PPE) was available in each clinical area, including gloves and aprons. Some areas, such as dentistry and dermatology minor procedure theatre, had additional PPE, for example masks, goggles and sterile gloves and gowns. We witnessed staff using PPE appropriately, and all PPE checked was within its expiry date.
- The outpatient department had biohazard spill kits, used by staff to safely clean up body fluid spills (such as blood and urine).
- The infection prevention and control team undertook a yearly audit within outpatients in July 2016 and found levels of environmental practices to be good. However, the audit found concerns with regards out of date equipment in dressing trolleys and sharps bins not labelled correctly. The audit recommended actions and we found all equipment checked to be in date, all areas visibly clean and equipment stored and labelled correctly.

## Diagnostic Imaging

- All areas within the diagnostics department were visibly clean. We saw staff cleaning equipment. Staff completed daily cleaning logs of equipment and placed, 'I am clean' stickers on equipment.
- Staff were aware of infection control procedures when treating patients with infectious diseases. The service placed patients on the end of the outpatient list and then deep cleaned the rooms to avoid spread of infection.
- Staff had access to disposable gloves, aprons and alcohol hand gel. We saw staff washing their hands before and after contact with patients.

## Environment and equipment

### Outpatients

- The outpatients department consisted of 'clusters', which represented specialities. Each cluster consisted of a combination of consultation rooms, treatment rooms and specialist procedure rooms (for example dermatology minor procedure theatre and orthodontics).

- The atrium surrounding outpatients, the clusters, corridors and treatment areas were well lit, visibly clutter free and well signposted, with each cluster given a unique number. Waiting rooms were spacious and had adequate seating, with complete oversight by the reception desk.
- All clinical areas visited complied with the Department of Health, Health Building Note 00:10, which sets out the standards all NHS providers must meet in regards to the materials used for floors and walls and the position and location of hand washing sinks.
- We checked multiple pieces of equipment, including resuscitation equipment, patient monitors, lighting and computer equipment and found all to be within the required service date. Where required, staff kept equipment plugged in and charging, for example suction and automated external defibrillators on the resuscitation trolley.
- We found specialist equipment was available within certain areas. For example, the department had a purpose built bath and treatment room to undertake psoralen and ultraviolet A therapy (PUVA), a form of photo chemotherapy, dental equipment within the orthodontic department and examination equipment within the ophthalmology department.
- Within the therapies department (including physiotherapy, occupational therapy and speech and language therapy) we found a purpose built gymnasium room for patients to undertake specific and targeted exercise sessions. The gymnasium was bright, spacious and staff told us fit for purpose and easy to utilise the equipment available due to the design.
- The outpatients department had three resuscitation trolleys, consisting of full advanced life support equipment. Staff tagged resuscitation trolleys and checked these daily to ensure they had not been tampered with. Staff did a 'full trolley check' weekly, where all equipment was checked for expiry dates and sterility. We saw records showing staff had completed daily and weekly checks throughout April and May 2017 and up to 20 June 2017 for all three resuscitation trolleys.
- We found sharps disposal bins in use where required within outpatients, including medication rooms, treatment rooms, dermatology minor procedure theatre and orthodontics.
- The hospital had a waste segregation system in place and we found separate bins and bags in place

# Outpatients and diagnostic imaging

throughout outpatients. We found staff and patients disposed of waste correctly and staff followed the trusts policy on waste management. Within the PUVA suite, we found cytotoxic waste bins and sharps bins in place and used appropriately by staff.

## Diagnostic Imaging

- The service had risk assessments for all forms of radiation that addressed occupational safety as well as risks to patients and the public.
- Staff ensured there was ongoing equipment maintenance and they displayed service stickers to show when the next service was due.
- There was clear signage to restrict access to areas where staff used x-rays and computerised tomography (CT).
- Lead aprons to protect staff from radiation were in good condition and a system was in place to check them for cracks and replace if required every six months.
- A CT scanner was eight years old and due for replacement. Staff recorded all times the machine was inactive due to breakdown, with only two occasions recorded within the previous year. The CT scanner replacement was on the risk register and due for replacement by the trust within a year.

## Medicines

### Outpatients

- Staff did not use or store controlled drugs within the outpatient department, except within orthodontics.
- Staff stored non-controlled medicines in line with manufacturer's instructions, either in a fridge or in a locked cupboard at room temperature. We checked fridge temperature records and found these to be within acceptable limits for April and May 2017 and up to 20 June 2017.
- We checked 12 non-controlled drugs (three refrigerated and nine at room temperature) and one controlled drug across outpatients, and found all were within the expiry dates and stored as per manufacturer's guidance. The controlled medicines matched the controlled drug register.
- Prescribers within outpatients had access to internal prescriptions (which could only be dispensed from the hospitals internal pharmacy) and FP10 prescriptions (which patients could take to any pharmacy). We found the storage and use of FP10 prescriptions was good. The

department manager kept all FP10 books in a locked cupboard within a locked room, and staff signed against specific pads and lot numbers at the start and end of each shift.

- Staff we spoke to were aware of the process for obtaining pharmacy advice or reporting medicine concerns. The department manager gave an example of a recent incident when the packaging and medicines sent from pharmacy did not match. The dispensing nurse reported the incident on the hospitals internal reporting system and informed the department manager. The incident was under investigation at the time of the inspection.
- Outpatients did not use any patient group directives (PGD) for dispensing of medicines. A PGD allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. All medicines administered was first prescribed by either a doctor or other healthcare professional with prescribing qualifications.

## Diagnostic Imaging

- The service had an ARSAC (Administration of Radioactive Substances Advisory Committee) licence and followed The MARS (Medicines Administration of Radioactive Substances) Regulations 1978.
- Medicines were stored in locked cupboards and staff used a code to gain entry into the locked rooms.

## Records

### Outpatients

- The hospital had a system of paper records in place and we reviewed five patient records, including medical, nursing and therapy documentation and prescriptions.
- We found records completed in full, with detailed information about the referral, discussions had with patients and their relatives, treatment options and treatment undertaken.
- We found the availability of records during clinics had improved between April 2016 and March 2017. Between April 2016 and September 2016, an average of 86% of patients' medical records were available at the time of their appointment. This had improved between October

# Outpatients and diagnostic imaging

2016 and March 2017 when an average of 99% of patients' medical records were available at the time of their appointment. The trust continued to improve in April 2017, with 100% of records available.

- All patient documentation looked at contained patient identifiable information, such as name, date of birth and hospital or NHS number. This ensured staff filed all paperwork within the right records.
- Within dermatology, we found staff used the World Health Organisation Five Steps to Safer Surgery checklist for all patients undergoing a minor operation within the theatre room.
- During clinics, staff stored records on trolleys within the corridor of outpatients. We found staff left records unattended throughout clinics 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 someone not authorised to do so. The services senior management team were aware of the concerns and this had been added to the departments risk register.

## Diagnostic Imaging

- Radiography results were immediately available electronically to referring clinicians once staff had reported on them.
- Most GPs in the area had access to the hospitals electronic systems to enable them to see results. Secretaries were aware of out of region GPs who did not have access and sent radiography results through the post or by secure fax.

## Safeguarding

- We had concerns in relation to compliance with safeguarding training across outpatients.
- All staff underwent safeguarding training yearly, which consisted of separate adult and child safeguarding modules. Senior staff told us staff that came into contact with children and young people (for example those working within joint adult and child clinics) underwent children's safeguarding level three training, with all other staff completing children's safeguarding level two training.
- The trust monitored compliance with safeguarding training against a target of 90%.

## Outpatients

- As of 31 March 2017, nursing staff had not met the target of 90% in either safeguarding adults or safeguarding children level two, with compliance at 67% (adult) and 89% (children).
- Medical staff had not met the target of 90% in safeguarding children level two, with compliance at 63%. However, medical staff had met the target for safeguarding adults, with compliance at 100%.
- All staff asked understood their responsibilities in relation to safeguarding patients. Staff could explain the process for reporting a safeguarding concern, and knew how to contact the safeguarding nurse specialist for advice and support.

## Diagnostic Imaging

- Safeguarding policies for protection of vulnerable adults and children were easily accessible to staff through the trust intranet.
- Staff were aware of their responsibilities in relation to safeguarding and knew how to contact the safeguarding lead for advice. All staff were trained to level 2 safeguarding vulnerable adults and children and senior staff (band 7 and above) were trained to level 3.

## Mandatory training

- We had concerns in relation to compliance with mandatory training across outpatients.
- All staff underwent mandatory training on a three yearly basis, which consisted of six modules, including conflict resolution, fire safety, infection control and information governance.
- The trust monitored compliance with mandatory training against a target of 90%.

## Outpatients

- As of 31 March 2017, nursing staff within outpatients met the 90% target in two of the six mandatory modules, with an average compliance across all six modules of 82%.
- Medical staff within outpatients met the 90% target in three of the six mandatory modules, with an average compliance across all six modules of 88%.

## Diagnostic Imaging

- A designated training and development lead coordinated and monitored mandatory training in the department. Training records showed that staff met the trust's target of 90% for mandatory training.

# Outpatients and diagnostic imaging

## Assessing and responding to patient risk

### Outpatients

- Between April 2016 and March 2017, the trust reported six 'missed to follow up appointments', where patients did not receive a follow up appointment that should have happened because their details were 'lost' in the electronic booking system. Of these, three resulted in no harm, one in 'minor harm', one in 'moderate harm' and one in 'major harm'. Where required, the trust implemented duty of candour, accepting the mistake and apologising to the patient concerned.
- The trust was aware of the concerns regarding 'missed to follow up' patients. Consultants reviewed patients that were identified as 'missed to follow up' to establish any 'harm' caused. However, senior staff told us they do not know the exact number of patients affected.
- Following the inspection, we reviewed the trust's follow up backlog procedures which included a follow up backlog review the trust had conducted. We saw they now had a robust revalidation of their outpatients list which included keeping patients and their GPs updated. We were assured the trust had clear oversight of any patient waiting longer than they should for their appointments. The service planned to continue to validate the remaining backlog and ensure actions were taken to prevent data quality problems in the future.
- Staff assessed patients undergoing minor procedures within dermatology using an early warning score system. Staff reviewed patients before, during and after procedures to ensure no adverse effects from the local anaesthetic or other medication used during the procedure.
- Staff had access to resuscitation trolleys within the department and all staff were trained in basic life support. If a patient deteriorated within the department, staff telephoned the emergency '2222' number and the hospital wide cardiac arrest team would respond.
- Each consulting room, treatment room and accessible toilet had a call bell allowing staff to summon help or patients to alert staff they needed assistance.

### Diagnostic Imaging

- The service had access to a radiation protector adviser (who ensured staff complied with IR(ME)R and gave advice about equipment and using the lowest possible doses of radiation to patients) who was on site twice a week and available by phone at all times.
- Radiation protection supervisors allocated to each clinical area ensured requests for x-rays or other radiation diagnostic tests were in accordance with IR(ME)R.
- The service displayed clear signage in waiting areas that informed patients about areas and rooms where radiation exposure took place. Posters informed women to tell staff if they might be pregnant before staff exposed them to any radiation.
- Staff were aware of the policies and procedures to reduce the risks of contact-induced nephropathy (a form of kidney damage in which there has been recent exposure to medical imaging contrast material without another clear cause for the acute kidney injury). This was in line with National Institute for Health and Care Excellence (NICE) acute kidney injury guidelines and the Royal College of Radiography standards for intravascular contrast agent (substance used to enhance the contrast of structures or fluids within the body in medical imaging) administration.
- Staff explained to us the process if patients became unwell in outpatient radiography clinics. Staff would accompany patients to the emergency department if they became unwell and required hospital admission.

## Nursing and imaging staffing

### Outpatients

- As at 31 March 2017, Manor Hospital reported a vacancy rate of 13% in outpatients, a turnover rate of 0% and a sickness rate of 6%.
- Between April 2016 and March 2017, Manor Hospital reported an average bank and agency usage rate of 4% in outpatients.
- Each 'cluster' (or individual clinic) had a staff nurse and a team of support workers each shift. We found the service achieved this consistently throughout April and May 2017 and up to 20 June 2017.
- A sister or senior sister was available each day to coordinate across all outpatient clinics.



# Outpatients and diagnostic imaging

- All bank and agency staff underwent an induction process at the start of their first shift, and subsequently if they moved to another cluster. We did not find any bank or agency staff working in outpatients during the inspection.
- Senior nursing staff routinely evaluated nurse staffing to ensure it met the requirements of the department and specialities. Senior staff did not use a formalised acuity tool; however, included the staff from each cluster in these discussions to ensure they accurately reflected the needs of each area.

## Diagnostic Imaging

- Each week, the service looked at the number of patients and available staff within each area of radiography (for example, ultrasound, x-ray and CT scans) and used agency staff when needed. Staff used an agency induction pack to ensure agency staff were familiar with the department and were aware of local policies and procedures.
- The service had recruited six radiography students who were due to start working in the department in September 2017.
- A radiologist told us they felt the department needed more radiologists to address the reporting requirements within the department. At the time of our inspection, there was one consultant radiologist vacancy. Management had advertised this post and this was on the risk register.

## Medical staffing

### Outpatients

- Between April 2016 and March 2017, Manor Hospital reported a vacancy rate of 18.8% in outpatients. During the same period, Manor Hospital reported zero turnover of medical staff in outpatients and no sickness amongst medical staff.
- Between April 2016 and March 2017, Manor Hospital reported a bank and locum usage rate of 7% in outpatients.
- All medical staff, including those new to the trust and locum staff, underwent an induction, which was signed off by a senior doctor. The induction included the action to take in the event of an emergency, policies around infection control and violence from patients, introduction to the department, and training on the

relevant computer systems in use at the hospital. All locum doctors had to provide evidence on induction of safeguarding adults, safeguarding children and mental capacity training.

## Major incident awareness and training

### Outpatients

- The trust set a target of 90% for completion of major incident training.
- The trust provided information on a whole trust level; therefore, we were unable to establish local compliance with the training.
- Staff asked knew the process in the event of an internal major incident (such as a fire or flood). Staff knew how and where to access policies and information regarding major incidents.
- The service had a business continuity plan in place and the corporate side of the governance structure managed this. The service had appointed a new position to look specifically at business continuity and they were due to submit the first compliance standards in July 2017.
- We found appropriate equipment within outpatients, for example fire extinguishers and fire doors, to support staff in the event of an incident happening.

### Diagnostic Imaging

- There was a major incident box within the department, with cards stating specific roles of staff in the event of a major incident. Radiography staff were not involved with major incident scenarios.

## Are outpatient and diagnostic imaging services effective?

We do not currently rate effective within outpatients and diagnostic imaging. However, we found:

- Policies and procedures within outpatients and imaging departments referenced current best practice. We observed staff following trust policies and best practice guidance.
- We found the facilities throughout outpatients and diagnostic imaging to be very good, with access to the equipment and environment required to effectively treat patients.



# Outpatients and diagnostic imaging

- Nursing, therapy and administrative staff had met the trust target of 90% for having an appraisal within the last year.
- Hernia and knee replacement outcomes from the latest Patient Report Outcome Measures data were better than the national average for the trust.
- The physiotherapy department participated in national research programmes to improve patient's outcomes.
- Staff understood their responsibilities under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).

However:

- The latest patient reported outcomes for hip replacement was worse in two of the three measurement areas than the national average.

## Evidence-based care and treatment

- Outpatients and diagnostic imaging undertook trust wide audits as required, for example infection control and the five steps to safer surgery World Health Organisation Surgical Check List. The department also undertook specific audits, including fracture clinic wait times, pain clinic overrunning times and imaging journey times for accident and emergency CT head requests.
- Trust and department policies were version controlled, and staff routinely reviewed and updated policies and procedures in line with current best practice, guidance and regulation.

Outpatients

- The dermatology team used the World Health Organisation (WHO) Safer Surgery Check List on all patients undergoing minor operations or procedures within outpatients. The WHO Check List ensures the right person undergoes the right procedure and is evidence based in its approach.
- We observed medical staff following the World Health Organisation's hand hygiene best practice, including using sanitising gel after contacting with patients and washing hands in between each patient.
- The trust updated staff on changes to policies, procedure and updates on care through emails, team meetings and handover (or huddles) within each outpatient 'cluster' before clinics started.
- However, we found the trust did not have a policy or standard operating procedure for undertaking PUVA

(psoralen and ultraviolet A therapy, a form of photo chemotherapy). At the time of inspection, the trust provided a draft version of a PUVA policy due for ratification later this year.

Diagnostic Imaging

- Staff followed best practice and guidance including NICE guidelines on chest imaging, chronic obstructive airways disease, lung cancer and stroke pathways.
- The service followed NICE guidelines for head trauma and ensured referrals were justified and authorised by CT radiographers under protocols.
- Staff had a good understanding of IR(ME)R procedures and terminology and knew where to locate guidance.
- There was a process to ensure that staff followed NICE guidelines for acting on an image report/radiologist report. A statistician within the department sent reports to the relevant clinician for discussion at multi-disciplinary meetings.
- The service had local diagnostic reference levels (DRL's) as an aid to optimisation in medical exposure. These levels were better in comparison to national levels. Staff conducted annual DRL audits.
- Local rules were in place for each area and signed by all staff. All healthcare professionals have a legal responsibility to act in the manner that is set out in local written procedures relating to the various radiation regulations.
- The service conducted World Health Organisation surgical safety checklist audits with 97% compliance for breast scans and 100% compliance for imaging in April 2017.

## Pain relief

Outpatients

- We found staff assessed patients' pain as required. For example, pain assessments were included as part of the pre and post dermatology procedure questions.
- We saw examples of medical prescribers prescribing pain relief for patients appropriately.
- However, the outpatient department did not undertake any audits on the assessment, prescribing or evaluation of patient's pain.

## Facilities

Outpatients

# Outpatients and diagnostic imaging

- Throughout the outpatient department, we found very good facilities in relation to the delivery of patient care.
- Due to the main outpatients department being within the newly built and refurbished part of the hospital, all the facilities had been purpose built to ensure patient safety and effectiveness of the patient journey.
- Within dermatology, a mix of consulting rooms, treatment rooms, counselling rooms, theatres and recovery bays allowed staff to deliver care seamlessly in a 'one stop' manner.
- The therapies department had a purpose built gymnasium allowing physiotherapy and occupational therapy staff to undertake one-to-one or group exercise sessions with patients. The therapy department had access to teaching rooms that allowed staff to provide specialist 'self-help' classes, for example in pain management, to groups of patients.
- Within ophthalmology, we found specialised rooms fitted with equipment required to undertake specialist eye examinations.
- Staff monitored the effectiveness of the computerised tomography (CT) stroke pathway: the average time from referral to scan was 21 minutes. This was within the preferred national target of within 30 minutes (national target within one hour.)
- The service conducted regular audits against IR(ME)R procedures and clinical audits in CT and ultrasound that demonstrated they were meeting the necessary requirements.
- The service met report turnaround times for ultrasound with 100% compliance. The service had not met outpatient reporting times and outsourced reporting for plain films and CT to address this.
- The service did not participate in the Imaging Services Accreditation Scheme or Improving Quality and Physiological Services.

## Patient outcomes

### Outpatients

- The trust participated in the Patient Reported Outcome Measures (PROMs) audit. The latest data covering April 2014 to March 2015, and published August 2016, showed that for hernia repairs the trust performed better than the England average for patient reporting an improvement in their condition.
- For primary hip replacements, the trust scored worse than the national average in two of the three measures. However, the trust performed better than the national average in all measurement areas for primary knee replacements.
- The physiotherapy service had participated in national research to understand if pre-radiotherapy exercise helped patients with breast cancer recover full arm movement quicker. The research finished two months prior to the inspection and the results had not been published at the time of the inspection. Staff told us they felt the research was positive and had had a positive impact on patient's recovery.
- The physiotherapy department was also due to participate in further research into the use of exercise programmes prior to colorectal surgical procedures. The research programme was due to start later in 2017.

### Diagnostic Imaging

## Competent staff

- Staff received a yearly appraisal and the trust monitored compliance against a target of 90%. We had concerns regarding the compliance to the target among medical staff.
- We had concerns about the competency assessments for registered nurses within outpatients.

### Outpatients

- As of 31 March 2017, an average of 92% of staff had received an appraisal. We found all nursing staff, 94% of allied health professionals (including physiotherapists and occupational therapists) and 96% of administrative staff had received an appraisal within the last year. However, across the medical staff, 86% had received an appraisal within the last year, missing the trusts 90% target.
- The trust had produced a 23 point action plan to improve the compliance of medical staff with appraisals and the revalidation process. The action plan was detailed and accountable persons allocated to each improvement step. The trust was making good progress with the action plan, with 12 points completed at the time of the inspection and the rest were ongoing.
- Unregistered staff undertook competencies relevant to the area they worked in. This included, aseptic technique, wound care and theatre scrub within dermatology, and urinalysis, bladder scan and blood glucose within urology. We saw evidence within staff files of the completion of these competencies.

# Outpatients and diagnostic imaging

- The department manager told us not all registered nurses undertook competencies due to the staff “knowing” the skills. The department manager could not provide evidence of registered staff competence, and no evidence was present in staff files around competency assessments for registered staff.
- However, we found some registered nurses had undertaken specific training, for example the two nurses undertaking psoralen and ultraviolet A therapy (PUVA) had attended a two day study course.
- During the last inspection, we noted staff within outpatients did not have food hygiene certificates. During this inspection, we found the trust had implemented food hygiene electronic training, and food hygiene and safety face-to-face training. We found all staff required to undertake the food hygiene and safety training had completed it, and 94% of staff required to undertake the electronic training had completed it. The 6% that had not completed the training equated to two members of staff.

## Diagnostic Imaging

- Staff had individual training files that demonstrated their induction was completed and competencies signed off by senior staff including their ability to operate equipment. The training and development coordinator monitored training requirements for all staff within the department.
- Staff who were not formally trained in radiation administration were supervised in line with legislation set out under IR(ME)R.
- There was a radiation management plan that set out who had the necessary certificate from the Administration of Radioactive Substances Advisory Committee.
- Staff delivered training to their peers in lunchtime learning events.
- The diagnostic imaging service had one consultant radiographer (who reported on x-rays) and one consultant sonographer (who undertook ultrasound scans). All staff received annual appraisals. Staff were frustrated that more money was not available for ongoing professional development. However, they understood the financial restraints on the trust.

## Multidisciplinary working

### Outpatients

- We found good multidisciplinary team (MDT) working across outpatients. For example, a range of dermatology staff (including doctors, specialist nurses and psychologists) worked together to plan and implement the patient’s care.
- Within fracture clinic, we found doctors, nurses and podiatrists working together to ensure a streamlined ‘one stop’ service for patients.
- Within outpatients, the trust had seven service level agreements (SLAs) in place. A SLA is an agreement with another organisation to provide services on their behalf. The trust had SLAs in place for plastic surgery, ear, nose and throat, oncology, vascular care, ophthalmology, rheumatology and oral surgery.

### Diagnostic Imaging

- As part of the justification process to carry out exposure to radiation, the radiographers always checked previous images of the same patient requiring the test.
- There were good working relationships between radiology staff, radiologists and other clinicians within the trust. Radiologists attended multidisciplinary meetings within the different specialities.
- The department had a service level agreement (SLA) for another company to deliver their MRI service. The service was rewriting the SLA to address an increase in service provision. Staff told us they had good working relationships with the staff delivering the MRI service and shared learning from complaints and incidents.

## Seven-day services

### Outpatients

- The trust operated clinics Monday to Friday between 9am and 8pm, and Saturday mornings.
- Pharmacy was open and available Monday to Friday 9am to 5pm. Out of hours; staff used external FP10 prescriptions where patients could collect medicines from a pharmacy external to the hospital.

### Diagnostic Imaging

- A seven-day service was available for general x-ray and CT and management were formalising this for sonography. The service operated Monday to Friday 9am to 8pm and Saturday and Sunday 10 am to 4pm. CT staff were available on call between 8 pm and 8am.

## Access to information

# Outpatients and diagnostic imaging

## Outpatients

### Diagnostic Imaging

- Clinicians had electronic access to diagnostic results as soon as staff reported them. Most GPs in the local area also had access to this system. GPs that were outside the region were unable to use the system, so secretaries notified them of results by post or secure fax.

### **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

## Outpatients

- As of 31 March 2017, all staff (medical and nursing) had completed training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards 2010.
- We asked five members of nursing and healthcare support staff about MCA and Deprivation of Liberty Safeguards 2010 and found three of the five had limited or no knowledge of MCA and Deprivation of Liberty Safeguards 2010. One member of staff told us they had not received any training in MCA or Deprivation of Liberty Safeguards 2010 since starting at the trust 11 years ago.
- However, the two members of staff that did have a good knowledge of MCA and Deprivation of Liberty Safeguards 2010 were registered nurses, with one a staff nurse in charge of a 'cluster' and the other a specialist nurse running their own clinic. The three staff that did not have a good knowledge of MCA all stated they would seek advice from a registered nurse or senior member of staff if they had concerns about a patient.
- Medical staff demonstrated good knowledge and understanding of the consent process. We observed medical staff and nurse specialists seeking consent before undertaking a procedure, for example an examination or change of dressing.
- Medical consultants sought written consent from patients undergoing minor operations, for example in dermatology. We found consent forms fully completed, legible, signed and dated.
- We observed all staff seeking consent prior to any intervention, for example taking clinical observations (such as blood pressure), taking blood or disclosing information to relatives.

## Diagnostic imaging

- All staff had received training on consent, Mental Capacity Act and Deprivation of Liberty Safeguards within their mandatory training and understood their responsibilities.

### **Are outpatient and diagnostic imaging services caring?**

Good



We rated caring as good because:

- Staff provided kind, compassionate and respectful care throughout outpatients and imaging services.
- All patients and relatives we spoke to gave positive feedback about the care they had received and the staff delivering the care.
- Patients had access to chaperones in every clinic, and we saw staff actively offered patients this service.
- Staff encouraged patients and their carers to ask questions and be involved in the decision making process concerning their care.

However:

- The national Friends and Family Test results for February to April 2017 were worse than the national average, with 91% of patients recommending outpatients in April 2017, compared to a national average of 93%.
- The environment within fracture clinic did not always promote the privacy and dignity of patients, with visitors, patients and staff able to hear consultations and treatments.

### **Compassionate care**

## Outpatients

- We observed interaction between staff, patients and their relatives to be respectful, compassionate and friendly throughout the inspection and across all clinics visited.
- Staff treated patients with dignity and respect. Consultation rooms had curtains around examination couches to ensure patient's dignity was maintained should someone come in the room during an examination.

# Outpatients and diagnostic imaging

- The dermatology minor procedure unit had changing facilities for patients if they were required to wear a hospital gown during a procedure, promoting their dignity.
- The hospital had a chaperoning policy in place and we observed staff offering patients a chaperone during procedures. A chaperone is a person who acts as a witness for both a patient and a medical practitioner as a safeguard for both parties during medical examinations or procedures.
- We spoke with four patients during the inspection. Patients told us that they were very happy with the care provided within outpatients and they found the staff caring and kind.
- Within the breast care clinic, staff ensured that during an examination by a doctor or other healthcare professional, all women were given a chaperone. Staff ensured that female chaperones were provided to women and male chaperones were available for male patients attending breast clinic.
- In fracture clinic, we found that three cubicles where patients were treated had a curtain to maintain patient's privacy and dignity. However, consultations with patients could be heard within the department due to the confined spaces within fracture clinic and the lack of a wall between the corridor and treatment area.
- The hospital participated in the national Friends and Family Test (FFT). This mandatory test compares care given across NHS providers. It helps hospitals understand whether their patients are satisfied with the service provided, or where improvement is needed.
- The FFT results from February, March and April 2017 showed a worse than national average positive response. In February 2017, 91% of respondents said they would recommend outpatients, in March 2017, 89% would recommend outpatients, and in April 2017, 91% would recommend outpatients. These results were worse than the national average of 93% recommending outpatients.
- The trust was aware the FFT figures for outpatients were below the national average and had implemented a 17 point action plan to improve them. The action plan was detailed, with named individuals allocated to each improvement step. At the time of the inspection, staff had completed 10 of the 17 improvement points, with the remaining on target for completion by the end of September 2017.

## Diagnostic Imaging

- Patients and relatives spoke very highly of the care they received from staff. Comments included, "Superb, very quick and efficient" and "Very kind and professional staff."
- We saw that staff were respectful and maintained patients' dignity during radiography procedures.
- Staff were friendly, approachable and had a good rapport with patients and put them at ease.

## Understanding and involvement of patients and those close to them

### Outpatients

- During the inspection, with the permission of the patients concerned, we observed two consultations between patients and healthcare professionals, for example medical consultants, nurse specialists and nurse consultants.
- We observed the practitioners spoke to patients in a calm and reassuring manner. Consultants and nurses both provided clear, concise information to patients in a format that they could understand.
- Where a follow up appointment was required, we observed staff informed patients of how they would receive this and the length of time until the next appointment. Staff explained the reasons for the further follow up or additional treatment required.
- During each consultation, the practitioner gave both the patient and their relative a chance to ask any questions. The doctor or nurse listened and responded appropriately to the patient and their relative.
- Patients told us they felt listened to by staff and that they had the time to ask questions during consultations. This was in line with the National Institute of Health and Care Excellence (NICE) Quality Statement 15. NICE quality statement 15 is concerned with improving the experience of people using adult NHS service. Quality statement 15 provides guidance in areas such as, supporting patient choice, giving patients opportunity to discuss their health beliefs, concerns and preferences, and asking for a second opinion.

### Diagnostic Imaging

- Patients told us and we saw that staff explained what they were going to do prior to starting any procedures.



# Outpatients and diagnostic imaging

- We saw a member of staff get down to eye-level with a patient in a wheelchair and find out exactly what they were able to do in terms of mobility before starting the x-ray.

## Emotional support

### Outpatients

- We observed all staff within outpatients and imaging services provide support to patients and their relatives, particularly when staff had given patients bad news or a difficult diagnosis.
- The dermatology service offered a 'one stop' clinic for patients with certain conditions, such as those with a diagnosis of cancer. The 'one stop' clinics provided patients and relatives with access to a consultant, nurse specialist and counsellor to provide emotional support.
- Patients had written information provided to them following consultations to further help them understand their condition and treatment plan.

### Diagnostic Imaging

- One patient told us they had to undergo a procedure they were not looking forward to. Staff reassured them by explaining everything in detail and were very supportive. They said, "Never had any issues, friendly, reassuring, always sat with me and reassured me."
- The service had done a patient feedback survey. Comments included, "I was really scared about having my scan the first time, staff made me feel at ease and the exam went well better-than-expected" and "Overall I was looked after wonderfully, everyone was friendly and spoke nice".

## Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated responsive as requires improvement because:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 15: Premises and equipment. We found the waiting room and treatment corridors within fracture clinic cluttered and crowded making access in a wheelchair, or for those patients using crutches, more difficult.

- Within fracture clinic, patients of all ages waited within the same space. We observed adult patients seated next to or near children and young people. The senior management team had not considered the impact of joint adult and child waiting areas on those patients.
- 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.
- The trust answered an average of 67% of calls from patients, about appointments, between November 2016 and March 2017. We found 15 days when the trust answered less than 50% of calls received.

However:

- Staff planned services to meet the needs of the patients attending clinic. For example, specially trained staff were available to assist consultant dermatologists perform minor procedures.
- 'Did not attend' (DNA) rates were higher than the national average of 6.5%; however, the service had implemented a text reminder system, which had seen an improvement in DNA rates.
- The majority of specialities (11 out of 18) were performing better than the England average between October 2016 and March 2017 for referral to treatment times for patients on 'non-admitted pathways'.
- The service was performing better than the operational standard or national benchmark in nearly all areas measured. For example, the service met the 93% operational standard for people seen within two weeks of an urgent GP referral, and was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- Complaints about outpatient care were low, with the service receiving 10 between April 2016 and March 2017.
- Desensitisation visits took place for patients with learning disabilities to reduce their anxiety when they visited the x-ray department.
- The diagnostic service was responsive to patients' individual needs, including those living with learning disabilities or dementia, patients whose first language was not English, and those with mobility problems.

## Service planning and delivery to meet the needs of local people

### Outpatients



# Outpatients and diagnostic imaging

- The trust planned outpatient and diagnostic imaging services to reflect the needs of the specialities offered and population attending. Specialist services had the equipment, staffing and resources available to undertake procedures and clinics as required. For example, the psoralen and ultraviolet A therapy (PUVA) service ensured specialist nurses were available to undertake the procedure, and within dermatology, senior staff ensured scrub trained nursing and support staff were available for minor operations.
- The service worked with neighbouring NHS trusts to provide specialist services, reducing the travel for patient to other centres. For example, each orthopaedic consultant specialised in a different area, allowing consultants to see routine patients and target those patients with specific or complex needs.
- 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 run by external staff.
- Between February 2016 and January 2017, the 'did not attend' (DNA) rates across all sites were between 7% and 12%, which was higher than the England average of around 7%. However, the trust had implemented a text reminder system for patients with the view to reducing the DNA rate.
- Consultants did not offer consultations via means other than face-to-face, for example telephone or video conference consultations. However, evening clinics did run Monday to Friday until 8pm for some specialities.
- Car parking was available at the hospital for patients attending outpatients, with accessible parking close to the main entrance of the hospital for those patients with additional mobility needs.
- Good signposting was in place across the hospital to guide patients. Each 'cluster' within outpatients was clearly signposted, including the specialities covered.
- Patients and visitors had access to toilet facilities (including an accessible toilet with emergency alarm) and access to water in each cluster. Due to the transient nature of outpatients, the department did not routinely offer patients food and hot drinks.
- Senior managers (the directorate lead) held regular meetings with the local commissioners who monitored key performance indicators and discussed service provision.
- The radiography department next to the emergency department (ED) was spacious, bright and welcoming with sufficient seating to accommodate patients and space for wheelchairs. There was a separate children's waiting area with toys to play with.
- Water and magazines were available to patients and their relatives in the main department next to ED.
- The outpatient radiography department did not have a children's waiting area or provide water for patients.
- Patients told us they had few problems parking. Patients received clear instructions in their appointment letters and told us the departments were clearly signposted.

## Access and flow

### Outpatients

- Between April 2016 and March 2017, the trust received 59230 referrals for outpatient care, a decrease from April 2015 to March 2016 when 62233 referrals were made. The trust had an established system for monitoring the waiting times of patients, known as the referral to treatment (RTT) time.
- The trust ran an average of 1688 clinics. On average, the three most run adult clinics were allied health professionals (592), nurse led clinics (190) and general medicine (82). The three least run clinics were cardiothoracic surgery (one), palliative medicine (one) and rehabilitation (one).
- The trust performed around the same or worse than the national average for 18 week referral to treatment pathways. 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 October 2016 and March 2017, the trust's RTT for non-admitted pathways was worse than the England overall performance. The latest figures for March 2017 showed 85% of this group of patients were treated within 18 weeks versus the England average of 90%. Performance at the trust improved slightly each month between October 2016 and March 2017.
- The best three specialities for achieving the 18 week target for non-admitted pathways were neurology (99.3%), geriatric medicine (99%) and general medicine

### Diagnostic Imaging

# Outpatients and diagnostic imaging

(98%). The three worst performing specialties were oral surgery (56%), trauma and orthopaedic (80%) and urology (80%). Seven specialties did not meet the 18 week target for non-admitted pathways.

- Between October 2016 and March 2017, the trust's RTT for incomplete pathways was similar to the England overall performance and worse than the operational standard of 92%. The trust did not supply RTT data between March 2016 and September 2016, we were told they missed this reporting period out.
- The best three specialties for achieving the 18 week target for incomplete pathways were cardiothoracic surgery (100%), gynaecology (97%) and geriatric medicine (97%). The three worst performing specialties were oral surgery (20%), ophthalmology (77%) and urology (80%). Ten specialties did not meet the 18 week target for incomplete pathway referrals.
- The trust was performing better than the 93% operational standard for people seen within two weeks of an urgent GP referral. The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- Between July 2016 and March 2017, the trust performed better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- Between December 2016 and March 2017, the trust cancelled an average of 1.46% of clinics within six weeks of the clinic date. During the same period, the trust cancelled an average of 1.47% of clinics with more than six weeks' notice. The trust did not provide information on the reasons for cancellation.
- During our inspection, the majority of clinics ran smoothly and staff reported no significant delays. However, we found one clinic running two hours late one morning during the inspection. Staff told us this was not unusual for this clinic. Senior staff were aware of the problem and told us they were monitoring the clinic over time. Staff kept patients informed approximately every 15 minutes as to the delay, and reception staff informed patients on arrival of the delay.
- The trust measured clinic utilisation across outpatients and measured this against a target of 85% utilisation. Between April 2016 and March 2017, outpatients saw an

average clinic utilisation rate of 87%, meeting the 85% target. Medicine and long-term conditions had a clinic utilisation of 91% and surgery achieved an average of 90% between April 2016 and March 2017.

- We reviewed call centre data in relation to the number of calls answered against the number made. Between 14 November 2016 and 20 March 2017, the hospital answered an average of 67% of calls made by patients to the hospital.
- During the same period, we found 15 days when less than 50% of calls were answered, with 28 days showing more than 80% of calls answered. The trust did not have a target for the number of calls to be answered.

## Diagnostic Imaging

- Patients told us that it was easy to change their appointment by phone if it was not convenient.
- The service monitored waiting times once patients arrived in the x-ray department. Staff informed patients if there were any delays. Patients told us they rarely waited longer than 30 minutes for their appointment and most appointments were on time.
- The service monitored patients who did not arrive (DNA) for their appointment and displayed the number of DNAs in the waiting area. Staff hoped to encourage patients to inform them if they were unable to attend appointments. They also sent out text messages to remind patients of their appointments.
- Between February 2016 and February 2017, the percentage of patients waiting more than six weeks to see a clinician was almost always lower than the England average (rates rose above the average in October 2016 before falling the month after).

## Meeting people's individual needs

### Outpatients

- Patients had access to information specific to their treatment. Staff offered patients information leaflets and these were available within each waiting room.
- Staff had access to a translation service for those patients whose first language was not spoken English, which included the availability of British sign language (BSL) interpreters. We saw information displayed within each 'cluster' within outpatients informing patients of the service.
- The majority of outpatient clinics had level flooring and easy access. The main outpatient department was

# Outpatients and diagnostic imaging

accessible via stairs, escalators or a lift. Each 'cluster' had wide doors allowing access for wheel chair users. This also facilitated bariatric patients in larger wheel chairs to access clinic and treatment rooms.

- However, we found the waiting room and treatment corridors within fracture clinic cluttered and crowded making access in a wheel chair, or for those patients using crutches, more difficult. We found that outpatients had some specialist equipment to support the treatment of bariatric patients (those with a body mass index of 30 and over). For example, a widened examination couch and weighing scales. Bariatric patient were treated within one 'route' within the outpatients department to facilitate their needs.
- The outpatients department did not have specific alterations in place to assist those patients with specific difficulties navigating around the department, for example a learning disability, dementia or sensory impairment. For example, within the ophthalmology department, information was not readily available in braille or large print signs and directions to assist those patients with impaired vision. However, the hospital did have access to a mobility assistance service that transported patients around the hospital who were less able to walk.
- We requested information on the number of staff that had undertaken training in dementia. The trust did not state that any staff had undertaken dementia training within the outpatient department.
- Within fracture clinic, patients of all ages waited within the same space, adult patients were often seated next to or near children and young people. Staff stated 'several' incidents had occurred with abusive adult patients within fracture clinic in the last year; however, had not considered the impact on other patients within the department.
- The trust informed us of one incident that had been reported by staff involving an aggressive patient. The patient was 'yellow carded' (meaning a warning letter was sent and they could be stopped from entering the hospital should a similar incident happen again) following the incident. The trust told us that staff had not formally reported any other incidents involving violence and aggression towards staff or other patients.
- We observed within dermatology theatres that the pre-procedure waiting room, also used as a post procedure monitoring bay, had two couches with a curtain to separate. This provided limited privacy for

patients when staff were preparing them for a procedure or undertaking observations following a procedure.

Patients had access to one toilet, which did not promote privacy and dignity if staff were caring for patients of the opposite sex or gender at the same time.

- Outpatient staff had recognised that within the community Manor Hospital served, there was low engagement from some sections of the population with health services. Outpatient's staff organised a health promotion day, previously held in the local town centre, and this year held in the hospital entrance, to promote sun safety and skin cancer detection. Throughout the day, staff referred around 10 patients to the dermatology service for further investigation following discussions with patients, visitors and staff walking through the hospital.
- Within the therapies department, we observed specialist 'self-help' clinics, for example for back pain. Physiotherapists ran clinics to support patients with chronic back pain to get more movement through learning about pain and supporting patients to manage their pain at home in different ways.
- During a recent health campaign on staying safe in the sun, staff ran a drop in session for visitors to the hospital to get marks on their skin checked. Staff referred a number of patients for an urgent review by a dermatologist in light of the examination. Specialist nurses were available to talk to patients, support them and explain the importance of attending an appointment to get an in depth review by a consultant.

## Diagnostic Imaging

- The service offered desensitisation visits to the radiography department for patients with learning disabilities. Staff explained how a patient had previously been too frightened to have an x-ray felt reassured by the visit and was able to have their x-ray performed.
- The service had painted murals on the walls within two of the x-ray rooms to make them more appropriate for patients living with dementia. Within the imaging department, five members of staff had undertaken dementia training provided by an external company. A further two members of staff had undertaken in-house dementia training.
- Staff had support from specialist nurses for learning disabilities and dementia within the trust.
- There was appropriate equipment to support bariatric (clinically obese) patients within the department.

# Outpatients and diagnostic imaging

- Staff used translators for patients whose first language was not English. They booked translators in advance to avoid delays during outpatient appointments.

## Learning from complaints and concerns

### Outpatients

- Between April 2016 and March 2017, there were 10 complaints about outpatients. The trust was unable to provide data on the number of outpatient complaints responded to within 45 days, in line with their complaints policy.
- Of the 10 complaints received, seven related to clinical treatment and there was one complaint each for each of diagnosis, information and communication. None of the 10 complaints were referred to the Parliamentary and Health Service Ombudsman for investigation.

### Diagnostic Imaging

- Patient feedback boxes and posters explaining how to make a complaint were accessible in radiography waiting areas.
- Most patients we spoke with knew how to make a complaint but none had needed to.
- Staff explained that they tried to sort out complaints directly with patients before the need to make a written complaint.
- The governance lead for the department monitored all complaints within imaging and radiology and minutes of meetings showed that staff discussed them at monthly quality meetings.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- Governance and oversight of the outpatient and diagnostics service locally was good, despite the local leadership team (senior care group) being newly formed in April 2016.
- We found a leadership team that displayed determination to make improvements, but acknowledged areas where further improvements were required.

- We found a culture of caring and safety orientated staff, who strived for improvement.
- The outpatient and diagnostic departments sought to engage both service users and staff to improve the departments and patient outcomes.

However:

- Senior staff did not update the risk register in line with review dates.
- The quality team meetings, held quarterly, did not consistently review the outpatient service.
- Departmental staff meetings minutes lacked detail and did not evidence shared learning across the service.

## Leadership of service

### Outpatients

- A staff nurse managed each 'cluster' (or individual clinic area) on a day-to-day basis. The staff nurses worked within their specialised area, which allowed them to understand and manage patients and consultant needs effectively. A department manager (senior sister), supported by a sister, managed the outpatients department.
- The trust split the outpatient service between two different directorates. The surgical directorate managed the clinical aspects of the department, and the corporate directorate oversaw the running of clinics, for example the management of medical records and booking processes.
- To ensure complete oversight of the service, the service had implemented a 'senior care group', which consisted of the matron responsible for surgery, corporate lead and a consultant to oversee the medical care provided within outpatients. The senior care group was formed in April 2016 following the previous Care Quality Commission inspection of the trust in November 2015.

### Diagnostic Imaging

- Managers at both modality level (for example sonography, CT and x-ray) and divisional level were highly motivated, driven and passionate about their service.
- Staff told us and we saw that managers were supportive and visible within the department. The staff felt valued and appreciated.

# Outpatients and diagnostic imaging

- There was an open, transparent and positive culture where staff felt able to report incidents in the knowledge that the service used lessons learned to improve the quality of service delivered.

## Vision and strategy for this service

### Outpatients

- The trust has an overarching vision, strategy and set of values, which the service also adhered to. The trusts vision was “becoming your partners for first-class integrated care.” The strategy to support the vision had five areas of focus, which were: “care for patients at home wherever possible”, “provide safe, high quality care across all our services”, “use resources well to ensure we are sustainable”, “value our colleagues” and “work closely with partners”.
- The trust had a five year plan to achieve the vision and strategy, and had identified strategic themes to support this. Outpatients and diagnostic imaging featured within the themes. For example, one theme was “elective care” that looked at reducing the ‘did not attend’ (DNA) rate within outpatient clinics.
- The trust had assessed its strategic approach to its five year plan and found nine areas that required a specific and targeted improvement approach. One of these areas was outpatients, and included standardising referral pathways and redesigning the booking system to reduce DNA rates.

### Diagnostic and imaging

- At divisional level, there was a clear strategy and vision for improving the service incorporated into a one-page document. A senior manager told us that they had shared this with managers within the department. However, staff we spoke with had a lack of knowledge of this strategy.
- However, staff were clear about developments within their own modalities. For example within CT staff had implemented an 18 month programme of competency-based career progression for staff to progress from band 5 to band 6 to help retain staff.

## Governance, risk management and quality measurement

### Outpatients

- We found a good level of understanding and oversight across outpatients in relation to governance and risk management.
- Locally, the outpatient manager oversaw risk and risk management on a day-to-day basis. Staff nurses within each ‘cluster’ led on risk management for their team. The senior care group took overall responsibility for risk management within the service. The corporate director took responsibility for the corporate risk register and the risk associated with it. Matron had responsibility for department level risks.
- The ‘senior care group’ (SCG) met weekly to discuss the service, and this included a review of all risks. This ensured that the clinical, departmental and corporate strands of the governance structure were aware of all risks across the service. We were unable to verify the content of the SCG meetings as staff did not minute these.
- The SCG escalated risks through either the clinical governance or corporate governance divisional teams, who in turn escalated to the trust board.
- When asked, matron described the top two operational risks in outpatients as patients waiting for an excess of time for ambulance transport and diabetic patients waiting for transport and requiring food. The corporate director told us their top three risks were medical records not being available for consultations, capacity on waiting lists and backlog of patients following problems when a new computerised booking system was introduced.
- The SCG told us that these risks were reducing, as fewer patients arrived by ambulance and the trust had 97% compliance with availability of medical records for outpatient appointments.
- The SCG told us that another risk identified across the department was the computer system does not recognise five week months. The trust has worked with other NHS organisations to learn ways of managing the problem; however, the service was still getting patients on lists that should not have been there and other patients being missed off. The SCG told us this was an ongoing piece of work and staff monitored ‘five week months’ to ensure patients were not missed.
- We reviewed the outpatient risk register and found it contained 11 risks associated with the care of adults within outpatients. All risks were RAG (red amber green)



# Outpatients and diagnostic imaging

rated, contained existing controls, actions needed, risk and divisional owners, and the date to next be reviewed. Of the 11 risks, three were rated 'red' (the highest risk), two amber, five yellow and one green.

- The three 'red' risks concerned the ability to provide sufficient appointments for patients, failure to review patients by their guaranteed access date and a specific piece of equipment within audiology that was not fit for purpose.
- We found the risks, as discussed by the SCG, on the risk register, demonstrated the SCG had a good oversight of the risks associated with the service. We noted medical records were accessible and not stored safely within clinics. The risk register contained an entry detailing the risk of medical records being stored behind the reception desk not in a locked cupboard; however, did not mention medical records stored and unattended in corridors during clinics. Controls had been implemented to reduce the risk, and the risk was due to be reviewed in June 2017.
- However, we found three of the 11 risks had review dates prior to March 2017. Although controls were in place, we were not assured that all risks had been reviewed and updated in a timely manner. The quality team meetings, which review risk registers, also did not routinely review and update the risk registers.
- Matrons, divisional leads and clinical leads from across the surgery directorate attended a monthly quality team meeting (QTM). The QTM discussed multiple topics including capacity, issues for escalation and patient safety reports. We reviewed the minutes from the February, March and April 2017 meetings and found the group did not routinely discuss outpatients. There was no mention of outpatients within the March and April 2017 QTM minutes. Within the February 2017 QTM minutes, outpatients was mentioned in relation to clinical engagement with consultants and orthodontic referral to treatment (RTT) improvements. We were not assured that the QTM reviewed outpatients, and had sufficient oversight of the service, on a routine basis.
- Within the March 2017 QTM minutes, it was documented that risk registers had not be reviewed at previous QTM meetings and this needed to happen. This supports the findings above regarding three risks not updated. Attendees documented that a review of the risk register will happen at each QTM moving forward. We saw evidence of this in the April 2017 meeting minutes.

- All staff could attend the staff meeting held monthly and all staff nurses could attend the 'band five' meetings, also held monthly. We reviewed meeting minutes from both the staff and 'band five' meetings for February, March and April 2017.
- The staff meeting minutes were brief, lacked detail and did not state who had attended. However, they did state who was responsible for any actions. The 'band five' minutes were also brief and lacked detail; however, these did state who had attended and had references to who was responsible for actions.
- Neither meeting had regular agenda items nor an agenda stipulated within them. Neither meeting discussed incidents or complaints, nor evidence of shared learning happening.
- Locally, managers had promoted the inclusion of all staff in the governance and risk management of the department. Outpatients had implemented junior nurse led 'cluster audits', which aimed to provide peer led audits of each 'cluster' (or speciality) within outpatient. We reviewed three 'cluster audits' from June and July 2017 and found staff completed these in full with documentation to support any concerns. Staff had developed, updated and signed off action plans for those areas where improvement was required.

## Diagnostic and imaging

- There was a clear governance and risk structure with effective two-way communication between staff in the department and at board level. Having a radiographer at divisional level who knew what the department needed enhanced this process. For example, the executive team were aware of the need to replace the CT scanner that was due for renewal in the next financial year.
- All staff were able to see the risk register on the trust intranet and those we spoke with were aware of the risks documented. The risk register was reviewed at monthly quality meetings and findings fed down to modality managers to share with their staff. Minutes of meetings confirmed this.
- A weekly 'safety huddle' took place with representatives from radiology, gynaecology, obstetrics, paediatrics, operations manager, divisional lead and trust governance where learning from incidents was discussed to ensure trust wide learning.
- The radiologists, consultant sonographer and radiographer attended an audit and discrepancy meeting monthly to ensure regular quality monitoring.



# Outpatients and diagnostic imaging

## Culture within the service

### Outpatients

- During the previous inspection in November 2015, we found a culture that did not support the development and creativity of staff, and did not promote quality and risk management. We found a greatly improved culture during this inspection, with senior staff encouraging a culture of development, learning and safety amongst all staff members, regardless of seniority.
- All staff asked reported that local and divisional leadership teams were supportive and encouraging of all staff to develop. For example, within outpatient, staff nurses had started auditing each other within different 'clusters' and were then supported to develop action plans for improvement and ensured these were completed. Staff were positive about this as they felt this gave an opportunity for learning and development, but also positive ownership of their areas.
- Staff felt the use of 'peer audits' across outpatients helped drive a culture of change, improvement and sustainability of high standards. Staff also reported that improvements were seen as a team effort within 'clusters' and not left entirely to the staff nurse.

### Diagnostic Imaging

- There was an open, transparent and positive culture where staff felt able to report incidents in the knowledge that the service used lessons learned to improve the quality of service delivered.

## Public engagement

### Outpatients

- The trust sought public feedback through the NHS Friends and Family Test.
- Dermatology and outpatient staff had undertaken a public engagement event in the hospitals foyer to educate the public and staff in sun safety. Staff assessed anyone that was worried and referred 10 people into the dermatology service for further tests.

### Diagnostic Imaging

- The service did their own patient survey to gain feedback for improvements to the service. Staff discussed results of these surveys at team meetings.

- Staff gave an example of improvements following patient feedback. A new hospital gown was used which preserved patients' dignity in comparison to the previous gown that tied up at the back. Patients confirmed that the gowns were a huge improvement.

## Staff engagement

- Staff participated in trust wide staff surveys on a yearly basis, and six monthly 'pulse checks' throughout the year to establish trends and improvements in staff attitudes. However, the trust did not report the pulse check data by department and therefore no specific results were available for outpatients or diagnostic imaging.
- We found all staff asked reflected the increase in positivity reported in the pulse checks undertaken trust wide.

### Outpatients

- Senior staff encouraged all staff to attend unit meetings and feedback positive and negatives about the department.
- Staff within outpatients participated in the national NHS staff survey; however, results were not published by department and therefore no specific data was available regarding outpatients or diagnostic imaging.
- Staff, including the department senior sister, participated in a project called "listening into action", where staff could feedback problems or concerns at a trust wide level and then receive feedback at the following meeting.

### Diagnostic imaging

- Staff felt able to contribute their ideas by their regular team meetings and felt that managers listened to them but some senior staff still felt frustration, although understood, about the lack of funding to replace equipment. The equipment was safe and functional but older technology.

## Innovation, improvement and sustainability

### Outpatients

- The service had launched a project called "confirm and challenge", which looked at the key priorities within outpatients and what can be done to achieve or improve these. The working group associated with the

# Outpatients and diagnostic imaging

project consisted of six members, including a matron, clinical lead and health records representative, with input from finance, estates and procurement as required.

- The programme had identified seven areas, linked to the overall trust five year strategy, to focus on. These included the backlog of follow up appointments, DNA rate reduction and efficiency with medical records.
- This was an ongoing programme at the time of the inspection; however, we saw evidence of improvements during the inspection. For example, the programme had facilitated the introduction of a text message reminder system for all outpatient appointments to reduce the DNA rate. Overall DNA rates fluctuated between 15%

and 18% in January 2017. The service introduced the text message reminder system on 1 February 2017 and the number of patients not attending appointments dropped to 11% on 6 February and further to 11% on 27 February 2017.

## Diagnostic imaging

- The service was planning to commence radiography led discharge in September 2017 and were finalising the clinical governance arrangements around this. Advanced practitioners would be able to discharge patients who had x-rays below the elbow or knee if there was no fracture seen. This would help to increase the speed of discharge of patients.

# 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.

## Areas for improvement

### **Action the hospital MUST take to improve Maternity and Gynaecology, MUST do list below for Maternity and Gynaecology services are in addition to the concerns outlined in the Section 29a warning Notice.**

- Risks are explained when consenting women for procedures.
- 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.

# Outstanding practice and areas for improvement

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

## Action the hospital SHOULD take to improve Maternity and Gynaecology

- There is a consultant obstetrician as the designated guideline development lead.
- Staff read and sign newly launched guidelines in a timely manner.
- Staff opinion is sought when developing the service.
- There are displays to inform the public how to complain.
- There are chaperone signs in outpatient areas.
- Available appointments for women to access the clinic for vaginal birth after caesarean.
- Women do not have long waits to be discharge from the fetal assessment unit.
- Women are informed and involved in the planning of their care.
- Women are supported during their stay.
- Pain relief is given as prescribed or when requested.
- Documentation is completed and audited.
- Handovers follow a Situation Background Assessment Review (SBAR).
- The service had an alternative plan in place based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP).
- Student midwives are not practising unsupervised.
- There is a robust data collection system.
- The stillbirth rate is reviewed and an action plan developed.
- The dashboard data is reviewed and action plans are monitored.
- Ensure the breast milk fridge is locked.
- Women are offered breast feeding support.
- Scans are uploaded to the electronic database.
- All cardiotocography machines have the correct time.
- Staff know their role in a major incident.
- Staff complete major incident training in line with the trust target.

# Outstanding practice and areas for improvement

- Prescription charts are fully completed.
- Ensure the women's antenatal handheld records are fully completed.
- All the areas of the electronic computer system are completed.
- Medical records are stored safely.
- Invasive treatments to babies are performed in a private environment respecting privacy and dignity of the baby.
- The environmental audits improve.
- All areas are appropriately clean.
- Audits of surgical infections are performed.
- An audit programme is developed and presented to the service.
- Low harm incidents are reviewed in a timely manner.
- Gynaecology staff complete the adult resuscitation training.

## Urgent and Emergency Services

- The nominated ED triage nurse is clearly identifiable to ambulance staff.
- Risk assess and re-evaluate its use of a cubicle as an ED review room.
- Reassess its policy for the use of review rooms in ED and ensure all staff are aware of and adhere to the process.
- Take action to ensure no confidential conversations between doctors, patients or their representatives take place in the ED review rooms, if there is a chance they could be overheard by other patients or visitors.
- Raise awareness of its chaplaincy service amongst its ED staff and ensure patients and relatives who may benefit from it are made aware of it.
- ED is able to offer written information to patients in languages other than English.

- Review its decision-making process around using RAT cubicles in ED to accommodate patients in time of increased demand, rather than ring-fencing the cubicles to allow the RAT team to contribute to ED patient flow.
- ED continues to improve its staff appraisal completion rates.

## Critical care

- Review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.
- Provide follow up clinics to patients after discharge from the critical care unit; in line with Core Standards for Intensive Care.
- Consider how to effectively identify and manage all infectious patients in the critical care wards given the lack of appropriate isolation facilities.
- That essential equipment is procured and used with relevant patients; and staff are fully trained and competent to use this equipment. Such as capnographs.
- All risks to the service are included on the risk register.
- Deprivation of Liberty Safeguards are applied in all cases where these are required; for example restricting patients movements by use of bed rails.

## Outpatients and Diagnostic Imaging

- There is a robust system in place for monitoring clinic running times to ensure they are running to time on a consistent basis, and take action where this is not the case.
- Review how staff review, document and update risks and progress against action plans.
- That learning from complaints and incidents is shared effectively with all staff.
- Staff are confident and competent to support a patient, or relative, with dementia.
- All outpatient clinics are suitable for the purpose for which they are being used.

## End of life care

# Outstanding practice and areas for improvement

- All staff must ensure they are up-to-date and aware how to complete EoLC documentation.
- Look for ways to improve privacy on the wards/ department when breaking bad news or consoling bereaved families.
- Ensure staff including porters are clear on who is responsible for cleaning trolleys when transferring patient from one department to another.
- Look for ways to support the porters with equipment such as trolleys that are not always suitable to use but for which there are no other options.

## Medical care

- Medication trolleys are adequate for the amount of medications stored.
- Computers are password protected to protect against unauthorised access and that these are not left unlocked.
- Patients have access to call bells at all times and that all call bells can be heard by staff and used to signify an emergency.
- Review the nursing documentation to ensure it is fit for purpose and that risks, such as falls are regularly reassessed and recorded.
- Staff on wards have sufficient knowledge to care safely for neutropenic patients, including knowledge of neutropenic sepsis.
- Patients' nutritional needs are assessed and reviewed in accordance with current guidance.
- All staff are up-to-date with their appraisals.
- There are sufficient staff trained in administering medication via a PICC line.
- Medical records are kept secure and that information contained within is kept safe.
- The fire exit on ward 29 is alarmed to alert staff if a patient leaves the ward.

## Surgery

- The cleaning rota responsibilities are completed and documented on all wards.

- Razors and COSHH items are stored appropriately, securely and in places where people who use services are not able to access.
- Ensure that it is easy to see what contents should be available in the paediatric difficult intubation trolley in the surgical recovery area.
- Intravenous fluids and other fluid items, such as nutritional drinks, are stored in a locked place and are not accessible to the public on ward 10.
- Fridge and room temperature checks' monthly audits are carried out and recorded consistently across all wards.
- Controlled drug checks' monthly audits are carried out and recorded consistently across all wards.
- Consider streamlining their processes for patient records. There are a number of different formats and systems for one patient record, which can cause confusion and has a potential risk of staff not having all relevant information when treating patients.
- Continue with improvements in performance of patient outcomes.
- Continue with improvements in performance of referral to treatment times and patient flow through the hospital.
- Continue with improvements in managing deteriorating patients.
- Continue with improvement plans for IT software to ensure full compliance with the Accessible Information Standards.
- Continue to do all it can to resolve the issues with recruitment to improve staff morale.
- The hospital should consider reviewing the developmental opportunities available for junior physiotherapists.

## Children and Young People's Services

- Review the system for recording safeguarding training and assure themselves that clinical staff in children's services complete safeguarding children training to level 3.
- Review their safeguarding children policy and ensure it reflects national guidance.



# Outstanding practice and areas for improvement

- Introduce a systematic approach to assessing and monitoring children's nutritional and hydration risks.
- Review the environment within the fracture clinic and make improvements to meet the needs of children using the service.
- Put into place systems and processes to identify those with a learning disability and ensure adjustments are made to cater for their special needs.
- Improve the timeliness of provision of medicines for children to take home.

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)

This section is primarily information for the provider

## Requirement notices

Venous Thromboembolism assessments were not carried out for all patients at risk.

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.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

## Requirement notices

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.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

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

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.

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

Diagnostic and screening procedures

#### Regulation

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

Surgical procedures

#### Regulation

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

**HSCA 2008**



This section is primarily information for the provider

## Enforcement actions

### **(Regulated Activities) Regulations 2014, Regulation 13(2): Safeguarding**

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.