

Walsall Healthcare NHS Trust

Walsall Manor Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate	
Urgent and emergency services	Inadequate	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Requires improvement	
Maternity and gynaecology	Inadequate	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas and the trust serves a population of around 260,000. Acute hospital services are provided from one site, Walsall Manor Hospital which has 606 inpatient beds made up of 536 acute and general beds, 57 maternity beds and 13 critical care adult beds. There is a separate midwifery-led birthing unit and a specialist palliative care centre in the community.

We carried out this announced comprehensive inspection on 8 to 10 September 2015. We held two public listening events in the week preceding the inspection visit and met with individuals and groups of local people and analysed data we already held about the trust to inform our inspection planning. Teams, which included CQC inspectors and clinical experts, visited Walsall Manor Hospital and inspected eight core services: 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. We also inspected three out of four community services: adult services, children, young people and families and end of life care services. We did not inspect community inpatient services as this service was registered with the local authority. We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

We have rated this trust as 'inadequate'. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. 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'.

Our key findings were as follows:

- Maternity services had multiple issues with staffing, delivery of care and treatment and people were at high risk of avoidable harm. The service had limited capacity and staffing resources which impacted negatively on patient experience and compromised patient safety.
- The latest MBRRACE report presented results for still births, neonatal mortality and extended perinatal mortality rates for 2013. Standardised results for Walsall were slightly higher than their comparator group. MBRRACE recommended that Walsall should consider a local review to better understand factors that may contribute to these results. In response to this the trust with its partners in the CCG and Public Health had participated in a detailed local study and agreed an action plan both of which have been shared with the Trust Board in public following our inspection.
- The Emergency Department (ED) triage process was ineffective, there was a shortage of qualified paediatric nurses and no paediatric consultant based in ED. There were regular delays with patient handover from ambulance to ED. The trust had been consistently performing worse (5 to 9 minutes) than the England average (median 3 to 6 minutes) for the time to initial assessment of patients between January 2013 and April 2015.
- The percentage of patients seen within the national four hour target to see, treat and admit or discharge 95%, was worse than the standard or national average for almost all of the period between April 2014 and May 2015. We saw the percentage of emergency hospital admissions waiting four to twelve hours from the decision to admit until being admitted (18 to 50%) was consistently above the England average of 5 to 15% between April 2014 and April 2015.
- Incident reporting, particularly feedback to staff was variable across the trust. There was a mixed approach to incident reporting which differed between services. The trust promoted incident feedback to staff through various methods. However, this was dependent upon individual service managers to disseminate lessons learned and staff's capacity to engage.

Summary of findings

- Previous concerns relating to the trust's management of duty of candour had improved. We looked at several serious incident records which demonstrated the trust had adopted a more open and rigorous approach to the duty of candour regulation and its process.
- Staff were caring and compassionate towards patients and their relatives. We did however see that in both ED and Maternity the excessive workload led to the standards of caring falling below that we would expect. Patient's dignity and privacy was largely ensured and we saw many examples of good care across the trust from staff at all levels.
- Community services for Adults, Children, Young people and Families and End of Life Care, were rated as good overall. Governance structure and risk management were well embedded and general leadership of community teams was supportive and nurturing.
- The trust took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme, where national guidance was audited and local priorities for audit were identified.
- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die. It was recognised that the SHMI for Walsall Manor Hospital had increased over an extended period of time, March 2015 was 107.41, April 2015 was 110.54 and May was 102.64. This represented a risk to patient safety.
- The trust was still seeing the effects of implementation of the new electronic patient administration system nearly 18 months previous. Improvements had been made however, the trust was still struggling with simple tasks, (e.g. making patient appointments) as well as experiencing difficulties in gathering accurate information for decision making and performance management.
- The culture of the trust was described by many staff as poor. Morale was low across many wards and departments and we heard examples of senior managers and in some cases executive members taking a heavy handed approach to problem solving. Despite 'low morale' staff demonstrated a positive approach to patient care and a genuine compassion to deliver the best care possible.
- Divisional and corporate risk registers did not accurately reflect identified risks trust wide.
- The trust had failed to implement the new checks and tests necessary to fulfil the requirement for all directors to be 'fit and proper' persons. This statutory requirement came into effect in November 2014. We saw no checks had been carried out for any directors within the trust and there was no Fit and Proper Person Policy in place. Following the announced inspection, the trust had taken remedial action to satisfy statutory requirements which demonstrated compliance with the Fit and Proper Person Regulation before the inspection period ended.
- The Trust Board was aware that the organisation faced significant quality and performance challenges and had launched an Improvement Plan in June 2015 to seek to address these.
- The Trust described to us a "perfect storm" in 2014 as a result of significant increases in emergency and obstetric activity and problems following the replacement of the patient administration system. The Trust Board recognised that the organisation faced significant quality and performance challenges in 2015 and had launched an Improvement Plan ("Improving for Patients; Improving for Colleagues; Improving for the Long-Term"). The plan included a programme of work to develop the two to five year strategy for the Trust and its services. The plan had been launched in June and as in its early stages at the time of our inspection in September 2015.

Importantly, the trust must:

- Improve the governance of incident reporting systems to ensure that processes are embedded across the trust.
- Improve duty of candour training to ensure staff have a clear understanding of the process.

Summary of findings

- Implement systematic training for complaints investigation, improve the RCA process and dissemination of lessons learned to front line staff and their managers.
- Ensure there are adequate numbers of qualified staff across all services, particularly in: maternity services, emergency department and medical services to meet the needs of patients to protect them from abuse and avoidable harm.
- The trust must ensure there is an adequate supply of equipment in good working order and fit for purpose across all services. Any mitigation to replace equipment must have clear reasons, regular review and an up-to-date action plan clearly demonstrating alternative options and timescales to support actions.
- The trust must ensure equipment is stored appropriately; all fire exits must be kept free without compromising patient and staff safety and staff can access equipment when required.
- Mental Capacity Assessments (MCA), Deprivation of Liberty Safeguards (DoLS) and Do Not Attempt CPR (DNACPR) assessments to be carried out in a timely manner and supported by appropriate documentation.
- Review the patient administration system to minimise problems associated with missed patient appointments. Ensure data is accurate and the system is a reliable resource for staff to use which meets the need of patients using the service.
- Ensure health records are completed appropriately and patient data is confidentially managed. Patient confidentiality is maintained at all times across all service.

After the inspection period ended, the Care Quality Commission issued the trust with a Section 29a warning notice outlining there was significant improvement required. This set out the points of concern and timescales to address this. The trust has responded to this with a detailed plan for remedial action.

Importantly, the trust must:

- ensure there are adequately qualified staff across all services to meet the needs of patients and protect them from abuse and avoidable harm.
- improve the embedding of governance of incident reporting systems trust wide.
- ensure medication is stored, administered and recorded appropriately across all services.
- ensure patient confidentiality is maintained at all times across all services.
- ensure all fire exits are kept clear.
- ensure the birthing pool in maternity services is always accessible and available for use and the birthing pool room is free from clutter and non-essential equipment.
- ensure there is an adequate supply of equipment in good working order and fit for purpose across all services. Any decision not to replace equipment must have clear reasons, regular review and an up to date action plan clearly demonstrating alternative options and timescales to support actions.
- ensure equipment is stored appropriately without compromising patient and staff safety and that staff can access equipment when required.

In addition the trust should:

The Emergency department SHOULD:

- consider redesigning the seating arrangement in the ED general waiting area to provide some personal space between the seats.

Summary of findings

- improve staff annual appraisal rates within the ED.
- ensure all staff can be easily identified by patients and visitors at all times when on duty.
- better inform patients and their relatives/carers about the streaming systems in operation in the ED and how patients are going to be seen.
- review the purpose and use of the ED log sheets.
- consider setting out its overarching vision for the ED.

Medical services SHOULD:

- provide a protected, suitable environment for physiotherapy.
- review its stock of equipment including, but not limited to syringe pumps and weighing scales.
- ensure that feedback is given on all reported incidents.
- ensure that the patient safety dashboards on display in medical wards are maintained with up-to-date and accurate information.
- inspect its physiotherapy equipment to ensure that it complies with infection prevention and control guidelines.
- arrange for a patient group directive to be written for the administration of saline flushes.
- ensure that fluid balance front sheets are consistently completed for any patient having their fluid intake and output monitored.
- review the contents and layout of its nursing assessment documentation booklet.
- reinstate a programme of acute illness management training for nurses working on medical wards.
- review its major incident training and the method of its delivery to improve understanding among staff.
- take action to improve staff understanding of the meaning of the butterfly symbol to indicate patients living with dementia and the purpose of butterfly bays on wards.
- ensure that it consistently reports on its performance against the NHS 18-week referral-to-treatment target.
- ensure that robust translation services are used to communicate with patients who do not understand English.

Surgery services SHOULD:

- review the low uptake of medical devices training across the trust.
- review the environment in recovery for children post-surgery to promote a child safety area.
- ensure operating theatres are deep cleaned on a regular basis and should review how equipment is stored in the theatre environment
- ensure equipment used specifically for children in the operating theatres is up to date
- ensure intravenous fluids are stored in secure environments
- ensure easier access to translation services.
 - review the provision of physiotherapy services to ensure initiatives such as the 'joint school' can be re-established.

Critical care Services SHOULD:

- review its morbidity and mortality review process to ensure all deaths are reviewed.
- review its checking system for fridge temperatures so that if temperatures are out of range, they are rechecked to ensure medicines are stored at the correct temperature.
- review infection control procedures to ensure staff wash their hands after removing gloves and aprons rather than just using sanitising gel.
- review junior medical cover to ensure doctors are available to attend consultant ward rounds in critical care and document contemporaneous patient plans in notes.

Summary of findings

- review multidisciplinary team working in critical care to enable multidisciplinary team ward rounds and effective multidisciplinary team working.
- review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.
- ensure patients have access to patient information leaflets in languages other than English.

Maternity and gynaecology services SHOULD:

- ensure fridges used for the storage of medicines are kept locked and secure from unauthorised access.
- ensure that medicines that look similar are not stored next to each other.
- consider how it enables staff to attend required training and supports staff to gain additional qualifications to support the service.
- consider how it can improve care records to ensure that risk assessment and safeguarding issues are easy to locate.
- consider the use of specialist midwives to improve the experience of families including :bereavement, teenage pregnancy and diabetes,
- consider ways to support and improve active birth.
- consider ways to reduce the induction of labour and caesarean section rates.
- consider ways of improving the sharing of information and improving engagement with midwifery staff, so they are aware of and involved in future developments.
- consider ways to improve breastfeeding support to new mothers.
- consider involving patients fully in care decisions by developing a ward round on delivery suite to incorporate every woman present.
- consider ways to improve relationships between maternity and gynaecology to allow the joint use of the gynaecology theatre.
- evaluate the management of outliers on the gynaecology ward.
- consider NICE and best practise recommendations and ensure guidelines reflect up-to-date guidance.
- consider individual feedback to staff reporting incidents.
- consider the ways to inform patients of the role of Supervisors of Midwives.
- consider the use of an assessment tool for the prevention of pressure ulcers for all maternity patients.
- consider the use of the maternity safety thermometer tool.
- consider a way to identify when a piece of equipment is clean and ready for use.
- improve the cleanliness of the delivery suite and delivery suite theatres.
- consider the use of disposable straps for the CTG machines.
- consider the use of wireless CTG monitoring.
- consider trialling the child abduction policy.
- consider increasing audits to improve practice such as the audit of one to one care in labour.

Summary of findings

- consider the use of a debrief for patients following a caesarean section to discuss suitable mode of birth if they choose to have more children
- consider the need for a policy for transferring women to a tertiary unit.
- consider the need for a transition care ward for babies needing extra care.
- consider a pool evacuation policy and suitable equipment to evacuate patients in all areas where pools are used.
- improve the consistency of checking resuscitation equipment on the delivery suite.
- consider a strategy for capping bookings for the service as the number of births increases.

Children and young people services SHOULD:

- take steps to further improve the safety of, and reduce risks to CAMHS (patients receiving care on the children's ward).
- ensure the neonatal unit is suitable for the service provided and is large enough to accommodate the number of babies using the service at any one time.
- review the scope of root cause analysis investigations and the process used to review mortality and morbidity to ensure all possible contributory factors are considered.
- take action to maintain the standards of hygiene and cleanliness within the Starfish suite along with equipment within the suite, and ensure it is appropriate for the purpose for which it is used.
- ensure patient records and referral documents are available in a timely way for children's outpatient attendances.
- ensure action plans are in place to improve practice in relation to national quality audits and monitor progress against these.

End of Life Care services SHOULD:

- take action to ensure that there are sufficient mortuary fridges in working order.
- ensure that all patients approaching end of life have their spiritual and religious needs assessed and are offered support.
- ensure both amber care bundles and advance care planning are being used consistently.
- consider how the trust provides dedicated bereavement care.
- consistently identify a patient's preferred place of death and support them to achieve this.
- ensure there are appropriate areas for patients in the last days and hours of life that provide privacy and dignity for them and their relatives.

Outpatient and diagnostic imaging services SHOULD:

- have a clear plan to replace ageing equipment in the radiology unit.
- consider improving the post-operative procedure facilities for patients attending the day surgery unit and the endoscopy unit.
- ensure all staff have access to trust policies and procedures.
- ensure receptionists are available to meet and book in patients when they are attending for appointments and procedures.

Summary of findings

- ensure staff handling food for patients have attended basic food hygiene training.
- ensure resuscitation trolleys are checked daily as recommended by the Royal College of Anaesthetists.

In response to these concerns, the Care Quality Commission issues Walsall Healthcare NHS Trust with a section 29a warning notice on 26 October 2015 setting out concerns and significant improvement required.

Since issuing the section 29a warning notice we have seen the trust take significant action to address these issues.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

The incident reporting system was not a firmly fixed part of the routine and patients' records were not always completed. Staff were aware of child protection but further training was required for safeguarding adults from abuse. Triage systems were in place but not always followed by staff when ED became busy, which was often. Patient comfort rounds did not have a structured process however, nursing and medical handovers were well organised and thorough. Nearly 25% of admissions were children and young people, but no paediatric consultant worked in ED, and qualified paediatric nurses were not available 24 hours a day. The ED took part in some local and national audits, but action plans to support audits were not robust. Staff were generally caring but at very busy times patients did not always receive effective pain relief and their hydration and nutritional needs were not always met. There was a strong internal and external multidisciplinary team (MDT) working to discharge patients home. The rights of patients being held under the Mental Health Act were respected by the ED staff. Patient confidentiality was not maintained at all times, as patients and visitors could see people's private information on the large tracker screen that was located where staff could use it easily. Communication between staff and patients needed improvement as some senior staff did not wear name badges and not all patients knew who they were waiting to see or approximate waiting times. The ED was not fit for purpose; twice the number of patients now attended ED, the environment was cramped and some patients had to share a single cubicle with another patient when the ED was busy. It was trust policy to keep patients waiting in ambulances rather than on trolleys in the ED. This meant that people waited longer than the government targets for admission, treatment and discharge. The service risk register did not reflect all risks identified in ED, for example, poor performance relating to pain relief and lack of paediatric-qualified nurses. Patients were encouraged to feed back to improve

Summary of findings

service delivery. The hospital did not have a strategic plan for how ED would develop and improve in the future. Staff were encouraged to attend team meetings but were often too busy to do so and frequently went without breaks. Doctors were more positive about working in the ED. Some new improvements had been introduced, for example, the dementia and learning disability champions and the quick assessment of people by a consultant after they arrived by ambulance. However, they were not a fixed part of the routine at the time of our inspection.

Medical care

Requires improvement



Incident reporting across medical wards was variable, as many staff had little confidence that feedback from incidents would be shared and so staff were reluctant to report. There were staff shortages across several wards including the acute medical unit (AMU), wards 1, 16 and 29. The environment and availability of equipment were not sufficient to keep patients safe. For example, the design of ward 29 made it challenging for staff to observe people living with dementia and staff response time to meet patients' basic needs needed to be improved. Some medical wards did not have an adequate supply of intravenous pumps and weighing scales. There was minimal protected time for staff training and clinical progression was not available, leading to staff leaving and moving to other NHS trusts in pursuit of development opportunities. National data was not always reported and some data within the hospital could not be verified. Nursing staff across medical wards did not feel supported or valued. Staff often worked longer than their designated shift time. Staff told us they felt ignored by senior management and 'put on' and felt the executive team did not have a good grip of risks and challenges across medical wards. Despite staff shortages, patients and relatives told us that they were treated with dignity and respect, and that the hospital staff provided genuine, compassionate care.

Surgery

Requires improvement



There were good systems to report and investigate safety incidents. However, there was poor incident feedback to staff. Concerns were identified with lack of training with medical devices, for example, intravenous pumps. Medical and nursing staffing

Summary of findings

levels were adequate to meet patients' needs across surgery wards and theatres. Medicines management and management of confidential records worked well. Infection prevention and control practice was a firmly fixed part of the routine however, there were concerns relating to the lack of regular night deep clean of theatres, which could compromise infection control processes. We found there was excessive storage of equipment and out-of-date equipment, specifically in children's surgery. Mental capacity assessments, Deprivation of Liberty Safeguards and consent were well managed and understood by staff. Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the duty of candour. Surgery services used national guidance to underpin care delivery. Services took part in local and national audits, showing non-compliance, with some local audits being deferred to the 2015/16 programme. Staff competencies were assessed and signed off appropriately and patients were cared for by an MDT multidisciplinary team working in a co-ordinated way with access to some services seven days a week. Patients' hydration and nutritional needs were met and patients and relatives were very complimentary about staff across all services. There was insufficient bed capacity to meet the needs of patients. This resulted in medical patients being placed on surgical wards, which affected the service. The environment in the recovery area in theatres was not child friendly and had not been furnished with children in mind. Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. However, translation services were not well used by staff and there was a reliance on patients' relatives to translate. Staff felt supported and listened to by line managers. There was a surgery divisional risk register in place, however it did not accurately reflect all risks identified across the division and was not regularly reviewed.

Critical care

Requires improvement



Staff were aware of how to report incidents and an open culture encouraged this. There was no structured, systematic process to review all deaths

Summary of findings

and the morbidity and mortality meeting did not include MDT members. Medicines management needed improvement, for example, fridge checks and recording of temperatures to store medication were inconsistent and staff did not document the administering of bolus intravenous sedatives. Only one member of staff signed the prescription chart when the guidelines clearly stated that two were required to sign. There was no effective multidisciplinary team-working, with individual members working independently rather than as a cohesive team. The majority of staff demonstrated a kind and compassionate approach to patient care. However, there were a few occasions when staff worked in silence and provided minimal engagement with patients. This showed a task-orientated care delivery. Delayed discharges were worse than the England average in comparison with other similar sized units, resulting in 53 single sex breaches since June 2015. There was a lack of patient information leaflets in languages other than English. The trust had recognised the need to build a new critical care unit due to lack of facilities within the high dependency unit (HDU) and a business case for a new integrated 18-bedded critical care unit was awaiting approval by the Department of Health. Some governance arrangements were in place in critical care, including a risk register. However, the register did not accurately reflect all risks, for example, the lack of isolation rooms and shower and toilet facilities. The service took part in local audits, but there was no action plan, review date or responsible person to ensure actions were completed to drive improvements in care. Medical and nursing leadership was evident and staff felt supported.

Maternity and gynaecology

Inadequate



Reporting of incidents was not a fixed part of the routine and it depended on how much time staff had whether an incident was reported or not. The service frequently experienced staff shortages, which had an adverse impact on patient safety. Women assessed as high-risk and requiring one-to-one care did not always receive it. There was no system in place to easily identify a woman at high-risk. Midwife to birth ratio was one to 37 at the time of our inspection, which far exceeded the

Summary of findings

national recommendations of one to 28. Further work was required with infection prevention and control. Cleaning checklists were in place but there were no cleaning regimes for the delivery suite, the antenatal, postnatal or gynaecology wards. Concerns were raised with the use of the second theatre, which had been converted from a high-dependency room and was not fit for purpose. There was a shortage of equipment such as birthing stools and CTGs and the birthing pool area was not used for its purpose but, instead, to store beds. Medication was not always stored appropriately and further work was required to improve the standard of documentation and tighten up patient confidentiality. Staff were caring and compassionate and went above and beyond what was required to deliver care, often by working more than their contracted hours, including their days off. Feedback was generally positive from people who used the service. The service took part in national and local audits but results were not always shared with staff. There were good clinical multidisciplinary working relationships across maternity and gynaecology services. Middle management was visible and approachable. Senior management and the executive team were not supportive or visible and their management style was described as 'dictatorial'. Maternity staff were unaware of the trust's vision and values and were focused on 'getting through the day' with little innovation evident.

Services for children and young people

Requires improvement



There was an open culture of incident reporting but investigations of incidents were not robust and we were not assured lessons were learnt. Staff shortages were evident and the trust had employed overseas nurses to fill vacancies. Cramped conditions in the neonatal unit posed a potential safety risk when the capacity was increased above 15 patients. Bed occupancy on the neonatal unit was 100% and, on occasions, capacity had increased to 21 babies. Plans were in place to expand the unit and work was expected to start within the financial year. Ward 21, the children's ward, was spacious and well equipped. There was good multidisciplinary team-working and some examples of development of services across the

Summary of findings

hospital and community services. There were transition clinics in place for children with long-term conditions such as diabetes and asthma. However, 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. Without exception, parents and children spoke highly of the dedication and care of staff. Children, parents and carers were involved in care planning. Children's and young people's services had strong leadership at unit and ward level but there was no overall vision and strategy for the service. Senior managers and the executive team were not visible or supportive and some governance processes required improvement.

End of life care

Requires improvement



Incident reporting was a fixed part of the routine and lessons learnt were shared. DNACPR forms were not completed appropriately, mental capacity assessments (MCA) were not completed for patients deemed not to have capacity and Deprivation of Liberty Safeguarding (DoLS) assessments were delayed due to the unavailability of medics to complete them in a timely manner. End of life care followed national guidance however, there was no documentation to replace the Liverpool care pathway (a national pathway previously in place for care of the dying patient). The trust had a policy for advanced care planning (a structured discussion with patients and their families or carers about their wishes and thoughts for the future) and had started to implement amber care bundles (a systematic approach to manage the **care** of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months) but these were not used consistently across wards. Patients requiring end-of-life care did not always achieve their preferred place of care. Side rooms were not always available for patients in their last days and hours of life and there were limited facilities to allow relatives to stay. Spiritual needs of patients were not always addressed and anticipatory medicines for the five key symptoms in the dying phase were not consistently prescribed. There was no bereavement service in place and no bereavement lead person. Patients' pain, nutrition

Summary of findings

and hydration needs were met. The service took part in local and national audits to assess the effectiveness of end-of-life care. The specialist palliative care team (SPCT) demonstrated good multidisciplinary working and provided a seven-day service. There was strong and committed leadership within the SPCT and the team were well respected in the trust. Patients who were referred to the SPCT were seen quickly and the team provided care to a high percentage of non-cancer patients. End-of-life services at this trust were caring. Patients and relatives spoke highly about the care they received and patients were treated with compassion, supported and involved in their care. Risks had been identified by service managers, however little action was taken to resolve them. For example, the mortuary fridges were on the mortuary risk register since May 2014 due to repeated breakdowns. This had been reviewed in September 2015, but the only action taken had been to monitor the frequency of the breakdowns. SPCT felt supported by senior management but felt executive team members were not visible.

Outpatients and diagnostic imaging

Requires improvement



Incident reporting across OPD and diagnostic services was generally good and managers shared feedback from incidents to staff across both departments. Staff shortages were experienced across OPD and diagnostics, and a specific shortage of radiologists resulted in a reporting backlog currently at two weeks for routine x-rays. Introduction of a new electronic records system had caused major backlogs with the appointment system and caused loss of data. Clinics had been overbooked and appointments had been cancelled by mistake. Staff were kind and caring and involved patients and their carers in decisions about their care. Many devices were overdue for replacement and required regular attendance to maintain their functionality. This included a gamma camera, which regularly broke down and disrupted care delivery and delayed patients' diagnosis. This had been on the risk register since April 2014 with no firm action plans in place. Local leadership was good in outpatients and imaging. Managers understood their staff and provided an environment where they could develop. OPD and

Summary of findings

diagnostic staff did not feel supported by senior managers and stated some members of the executive team were poor role models with a 'bullish' approach to management and leadership.

Walsall Manor Hospital

Detailed findings

Services we looked at

Urgent and Emergency Care; Medical Care, Surgical Care, Critical Care, Maternity Services, Children's Services, End of Life Care, Outpatients and Diagnostic Imaging.

Detailed findings

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Background to Walsall Manor Hospital

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas, serving a population of 260,000. Walsall ranks 30th out of 326 local authorities for deprivation (with 1st being the most deprived). Deprivation and childhood poverty is worse than the England average. Disease and poor health indicators in Walsall show five out of eight were worse than the national average. Life expectancy and causes of death showed the trust scored worse than the national average for six out of nine indicators.

Acute hospital services are provided from one site, Walsall Manor Hospital, which has 606 inpatient beds made up of 536 acute and general, 57 maternity and 13 critical care adult. There is a separate midwifery-led birthing unit and a specialist palliative care centre in the community.

Between April 2014 and March 2015, there were 116,003 attendances to the emergency department and 69,039 admissions. Emergency admissions amounted to 39,619 and elective admissions were 29,348. Between January and December 2014 there were 358,543 outpatients appointments, of which approximately 136,813 were first attendances and 221,730 were follow up.

The trust also provides care to people in community settings; in patients' own homes and from a number of clinics and health centres, GP surgeries and schools. Acute and community services were formed from a merger of an acute and community trust in 2011. The trust employs 4,370 staff (approximately 380 doctors and 1,150 nurses), nearly 8% of which are bank or agency. The trust has an annual turnover of £239.4m and in 2014/15 saw a deficit of £12.9m.

At the time of the inspection there was a stable trust board, which included a Chairman, six Non-Executive Directors, Chief Executive and Executive Directors. The Chair was appointed in June 2004 and the Chief Executive Officer joined the trust in May 2011.

We carried out this comprehensive inspection in September 2014. We held two public listening events in the week before the inspection visit, met with individuals and groups of local people, and analysed data we already held about the trust to inform our inspection planning. We spoke with staff of all grades, individually and in groups, who worked in acute and community settings. We also carried out three unannounced inspection visits after the announced visit.

Our inspection team

Our inspection team was led by: Chair: Professor Juliet Beale, CQC National Nursing Advisor.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission.

Detailed findings

The inspection team comprised 21 members of CQC staff, 30 specialist advisers and two experts by experience who have experience of, or who care for people using healthcare services. CQC members included a head of hospital inspection, an inspection manager, a pharmacy inspector and 14 inspectors. Our specialist advisers included an NHS chief executive, a director of quality

governance, consultant general surgeon and medical director, specialist nurses, medical consultants, a consultant in intensive care medicine and anaesthesia, a consultant midwife, a specialty doctor in palliative medicine, specialist nurses, allied health professionals and clinical managers.

How we carried out this inspection

To get to the heart of the patient care experience, 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 visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges, and the local

Healthwatch. We carried out an announced inspection visit from 8 to 10 September 2015 and three unannounced visits on 13, 20 and 24 September 2015. We inspected the one location, The Manor Hospital, and three community services; adult, end-of-life care, and children, young people and families. No community inpatient services were registered with the trust. We held focus groups with a range of staff, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually. We talked with patients and staff from support services, ward areas, and outpatient services. We observed how people were being cared for, talked with patients, carers, visitors and relatives, and reviewed patient records of personal care and treatment.

Facts and data about Walsall Manor Hospital

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas, serving a population of 260,000. Acute hospital services are provided from one site, Walsall Manor Hospital, which has 606 inpatient beds made up of 536 acute and general, 57 maternity, and 13 critical care adult. There is a separate midwifery-led birthing unit and a specialist palliative care centre in the community.

During 2014/15 there were 116,003 attendances to the emergency department and 69,039 admissions. Emergency admissions amounted to 39,619 and elective admissions were 29,348.

Between January and December 2014 there were 358,543 outpatient appointments, of which approximately 136,813 were first attendances and 221,730 were follow up. The trust also provides care to people in community settings; patients' own homes and from a number of clinics and health centres, GP surgeries and schools.

Acute and community services were formed from a merger of an acute and community trust in 2011. The trust employs 4,370 staff, with almost 8% being bank or agency. The trust has 380 doctors and 1,150 nurses.

The trust has an annual turnover of £239.4m and in 2014/15 saw a deficit of £12.9m.







Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) was situated within Walsall Manor Hospital. It was a purpose-built facility with a separate ambulance entrance.

Trust data indicated the ED saw approximately 86,000 patients a year with, on average, 250 patients each day.

The data showed child attendances was on average 17000 for 2014/ 2015, paediatric attendances including Urgent Care Centre referrals. Child attendances was on average 11000 for 2014 2015, paediatric attendances for ED only. Both figures are for children up to and including 16 years old.

The ED did not have a segregated area for paediatrics patients. The ED was a trauma unit. A Trauma centres was established in neighbouring NHS trust at the Queen Elizabeth Hospital Birmingham.

We visited the ED on the evening of 8 September 2015 at short notice, and made an announced visit during the daytime on 9 and 10 September 2015. We spoke with approximately 10 patients and their relatives or carers, and 25 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

Overall, we found the emergency department (ED) was inadequate.

We found safety was inadequate.

Not all staff used the reporting system and some checks were not being done properly. Patient's records were often not properly completed. Staff knew about child protection but did not know as much about safeguarding adults from abuse. The arrangements to make sure staff could decide which patients needed medical attention first were unclear. Regular checks on the comfort of patients who were waiting for tests or to be admitted to the ward were not always happening. Nurses and doctors were very good at passing information about patients to each other when they changed shifts. Approximately, 20% of the patients treated at the ED were children but the facilities for children needed to improve. There were not enough qualified nurses for them and sometimes doctors had to come from elsewhere in the hospital to treat them. There was a shortage of permanent doctors and some nurses. There were arrangements in place to report problems and improve when mistakes were made.

We found the effectiveness of the ED was inadequate.

The ED took part in some national audits. In the past few years these included how well it treated people with certain conditions such as children with asthma. The audits demonstrated there was room for improvement. The plans the ED implemented to improve practice were

Urgent and emergency services

not always successful. Patients did not always receive effective pain relief and did not always receive food and drink while they waited to be seen or for test results or to be admitted to a ward. The ED needed more nurses and doctors with the qualifications to look after children. The ED looked at new ways to provide staff due to a shortage of permanent doctors. ED staff worked well with community healthcare workers and therapists to help people go home as quickly as possible. There were good arrangements to ensure staff had access to the right information about patients to help them but some staff did not always complete the records. The rights of patients being held under the Mental Health Act were respected by the ED staff.

We found caring in the ED required improvement.

We saw that all types of staff were friendly to patients when they spoke to them. In a national survey patients said the ED did not help them quickly enough with their pain. They also said staff were sympathetic when they became upset. Some patients had to share a single cubicle with another patient when the ED was busy and so had little privacy. Patients and visitors could see people's private information on the large tracker screen, which was located where staff could use it easily. Some senior staff did not wear name badges so people did not know who they were. Staff gave patients explanations about their treatment. Parents attending with their children did not always understand the reason why they were waiting to be seen.

We found responsiveness of the ED was inadequate.

The ED worked with other health and care services in Walsall to try to provide what people needed. The ED saw many more patients than it was built for and the space was cramped. Managers tried to organise the way that people were seen so that very sick people and children could be seen quickly. However, these arrangements were confusing and did not always work well. Fewer people left without being seen than is the case in other hospitals. Some patients were not asked about pain or get pain relief soon enough. Some staff took on the extra job of being a champion for patients who were vulnerable, such as people with dementia or learning disabilities, but that did not always improve things for these patients because those staff were not always on duty. When the ED was busy, it was the

department's policy to keep patients waiting in an ambulance rather than on trolleys in the ED. This meant that people waited longer than the government targets for admission, treatment and discharge. Patients were encouraged to tell the hospital what they thought about the ED service they received.

We found leadership was inadequate.

The hospital did not have a strategic plan for how the ED would grow and improve in the future. Managers from the ED had contact with senior staff across the trust and board members. Risks such as the lack of space, lack of children's nurses and giving patients pain relief were not being dealt with quickly. Staff were encouraged to get involved in improving patient care but some nurses were too busy to take their breaks. Doctors were more positive about working in the ED. Some improvements that had been implemented were new and did not have time to settle in when we inspected. These included the dementia and learning disability champions and the quick assessment of people by a consultant after they arrived by ambulance.

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Are urgent and emergency services safe?

Inadequate



We found safety was inadequate.

Many record-keeping systems, including patients' records and assessment records including early warning scores, were incomplete.

Child protection systems were in place and informed practice. However, vulnerable adult safeguarding processes were not well developed. Staff mandatory training compliance rates did not meet the trust's target, particularly among nursing staff.

The comfort round system (a regular review by staff on each patient to check their personal needs are met) was not effective and some patients were waiting in cubicles without call bells available to them.

Patients did not always receive pain relief in a timely manner.

There were inadequate plans in place to assess and manage risks associated with anticipated future service demands.

There were systems in place to assess patients and respond to clinical risks. However, we found, that these were disorganised and confusing. Patients were directed to the most appropriate part of the ED service for them when they arrived but this was not always effective and patients did not understand the system. Staff did not assess, monitor or manage risks to people who used the services. Opportunities to prevent or minimise harm were missed. There was a heavy reliance on reception staff to decide which service the patient required and the first point of contact for patients arriving on foot was not a trust employee but the urgent care GP service.

There were systems in place to report, investigate, and learn from incidents, to be open and honest when things went wrong, check safety, control infection and safely manage medication. However, not all staff were committed to using the formal reporting system and some systems such as checking medicine fridge temperatures were not used effectively or consistently.

The Ed data showed child attendances was on average 17,000 for 2014/ 2015, paediatric attendances including Urgent Care Centre referrals. Child attendances was on average 11000 for 2014 2015, paediatric attendances for ED only. Both figures are for children up to and including 16 years old. However, the ED did not have a segregated facility to provide safety from adult patients.

There were few dual qualified nurses and no paediatrics consultant or paediatrics-qualified doctors within the ED. The trust had some arrangements in place to call on resources within the wider hospital to mitigate this risk. There was a commitment to and information available to feed-back learning from incidents and complaints to staff, but this did not always work well.

Triage systems were in place, including for patients arriving by ambulance. Although patients presenting with critical conditions were quickly responded to, others were not always prioritised according to risk. There was no systematic approach to triage. Time to treatment for this trust was broadly in line with the national standard of 60 minutes from Autumn 2014 to Spring 2015.

The handover system between shifts for nurses and doctors was thorough and efficient. However, the handover time between paramedics and ED staff was often delayed.

There was a heavy reliance on locum middle grade doctors and many nursing post were vacant, particularly at band 5 level.

The ED operated the trust system of exclusion cards for aggressive and violent patients and security staff had appropriate training for restraining vulnerable people.

Incidents

- Twelve serious incidents all relating to hospital transfers were reported to the Strategic Executive Information System (STEIS) by the ED between March 2014 and April 2015. STEIS is a patient safety reporting and learning framework.
- The ED does not fully utilise the Safety Thermometer and therefore data was not accurate. For the same period ED reported no falls or catheter urinary tract infections and two pressure ulcers.
- Incidents were reported by ED staff and we followed the progress of some recent reports through the electronic system.

Urgent and emergency services

- Senior local nurses confirmed that staff were encouraged to report issues. Staff we spoke with were clear about the incident reporting process.
- However, senior nursing staff told us that incident reporting was not routinely carried out as many issues became normalised which meant staff may fail to recognise the severity of the incident and lose the opportunity for learning and avoiding repetition.
- One experienced member of nursing staff told us there was 'no point' reporting anything that had not had a serious outcome. Another said they received no feedback from incidents they reported.
- Local leaders told us nursing staff received feedback on their incident reports via e-mail but staff might not always read them.
- We saw an example of feedback to nursing staff via e-mail from the Clinical Director (CD).
- There were systems in place to investigate and learn from incidents and these included local support from the patient safety team.
- However, some staff were not clear of the purpose in learning from incidents. Two senior nurses we spoke with had different experiences of feedback about a recent serious incident that had been investigated and resulted in a care pathway being developed.
- One did not know about the incident and the other had a clear understanding of the new pathway. They also confirmed the CD sent e-mail information from root cause analysis of serious incidents.
- We noted there was no formal process in place for checking that learning from incidents, near misses and complaints had been absorbed.
- We noted key messages to staff on the staffroom corridor noticeboards that were eye-catching and staff found them easy to read. These included the number of complaints received, audits and lessons learnt, recommendations and actions for staff, the top five current risks, and the actions required to address them.
- There was a display in the ED dedicated to Sepsis Six messages (a nationally recognised set of six steps to be started within one hour to reduce the impact of sepsis) and the ED performance in the last audit. Staff we spoke with said they understood the need for improvement in practice.
- The trust have shared additional data with us during the formal inspection period that has been presented to the Mortality Review Group in September 2015. This shows

- improvements in all six areas (from 4% improvement in access to high flow oxygen to 82% improvement in patients with IV started in ED). We have not fully reviewed the source data for this.
- We also noted there was a flow chart to inform staff on the duty of candour process. Staff we spoke with understood the principles of candour.
 - Guided by the patient safety team we tracked two reported incidents through the ED system, one that resulted in severe harm and one in moderate harm. We noted that the system was comprehensive and appropriate to discharge the duty of candour.
 - We saw records of the governance meetings that discussed these investigations and shared lessons learnt from them with the rest of the division.
 - Local leaders told us staff sometimes felt the trust had apologised for something when it should not have. This suggested that staff might not be confident about the duty of candour arrangements.

Cleanliness, infection control and hygiene

- The trust had policies and procedures in place for hygiene and infection prevention.
- Cleaning staff we spoke with were aware of the need for good infection control practice.
- The matron told us environment audits were not carried out.
- The ED appeared clean, tidy and free of clutter.
- Although there were not always hand wash facilities at the point of treatment, there were hand sanitising dispensers around the walls and we noted staff used them.
- There was a hand cleansing tower in the main reception area but we saw no patients use it.
- Staff did generally comply with the trust's policy of 'bare below' the elbow and minimal jewellery in clinical areas. We heard a sister reinforce the policy by reminding a consultant to remove their jacket.

Environment and equipment

- We observed that, although the ED was purpose built, it was operating in a space that was not sufficient in size for the level of its activity. The trust told us the ED had experienced a 23% increase in attendance from January 2014 to the time of our visit. Many staff and local leaders confirmed this was a constant challenge and senior leaders were aware of it.

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- This issue was on the ED risk register and rated as red (high) risk, assessed in September 2011, due for review in May 2015 and escalated up through the trust in July 2015. The risk owners were identified as the Clinical Director and the Matron.
- The Executive Director reported to us during our inspection that the trust had invested £650,000 in expanding the ED during 2013/14 to make best use of existing space. Three new 'majors' cubicles and a plaster room had been added. Local leaders confirmed this.
- The trust told us it intended to improve the ED 'estate' after two other major projects within the hospital were completed but could offer no likely timescale.
- There was no separate paediatrics area and we noted children were offered the 'see and treat' service waiting area. Although decorated in a child-friendly style, this area was shared with adults waiting for either the GP or emergency nurse practitioner (ENP) and might not be a safe or appropriate environment for children.
- Staff told us they had difficulty trying to keep children and adult patients separated at night and had to ask adults to move out of the area. This suggested there was no clear communication with adult patients from reception staff about where they should wait.
- There was one cubicle in the major's area of ED that was decorated in a child-friendly way.
- We saw a resuscitation area with four beds and nine 'majors' cubicles with monitoring equipment in each.
- The ED had its own x-ray facility nearby that functioned between 9am and 5pm on Monday to Friday.
- The general waiting area was small and contained tubular metal seats. Seats were set out in rows and firmly attached to the floor and each other. They were small and allowed no personal space between people.
- Twelve seats had torn covers. We asked the three local leaders about plans to improve or repair the seating.
- We found disagreement about whether the entire arrangement was to be replaced in the very near future with a varied colour scheme to denote where patients should wait to be seen by different ED services, or only the seating covers were to be replaced in this way. This suggested poor communication between some leaders.
- We noted that resuscitation equipment was available around the ED. There was a system in place and in use, for ensuring the right equipment remained in place and evidence of audit.
- The ED had an electronic safe system for storage and dispensing of medicines.
- We noted fluids were securely locked away.
- Controlled drugs were securely and appropriately stored. We noted from records they were checked twice daily and the CD check records were complete.
- There was a system in place for checking fridge temperatures on a daily basis but this was ineffective. Medicines stored outside their safe temperature range can become ineffective.
- The checklist gave no safe parameters for temperature. Nursing staff told us staff had no training or guidance for safe fridge temperatures and it was a ward clerk who did the checks.
- We noted from records that this system was not used consistently, for example, records were missing for 14, 16, 17, 18, 19 and 21 August 2015.

Records

- We looked at 23 sets of patients' records and found most were incomplete. Twenty were in the ED at the time of our visit and three were in wards to which patients had been admitted from the ED.
- We noted that many sets of patient records had a range of risk assessments such as early warning score (EWS) system for identifying deterioration in a patient's condition, pressure area or sepsis that were not completed or incomplete.
- We noted for one paediatric patient staff had used adult records that missed a relevant children's safeguarding flag which may result in staff not being able to protect vulnerable children. We raised this with a sister in charge at the time.

Safeguarding

- The trust had policies and procedures for safeguarding children and vulnerable adults.
- The lack of a dedicated safeguarding nurse for the ED was identified on the risk register. The trust told us it is encouraging staff to take part in a programme of ongoing training provided by the trust lead for safeguarding children and safeguarding adults.
- The trust's 'snapshot audit' of children who presented in ED dated 24 June 2015, found safeguarding documentation at 71% complete. The July edition of the ED 'Connecting staff bulletin' highlighted the need for full documentation around safeguarding concerns.

Medicines

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- The matron told us that a member of the safeguarding children's team visited ED on a daily basis to look at the previous day's records and case notes. We observed this in practice.
- Senior nurses told us they heard about child protection incident reports because messages about required changes in practice due to incidents came to them from the safeguarding lead.
- Child safeguarding alerts were flagged on the ED electronic patient information system.
- Senior local leaders told us that adult safeguarding was an issue and staff needed to improve their knowledge and skill.
- Adult safeguarding training had been delivered to only 50% of ED staff. This meant half of staff may not know what to do to protect vulnerable adults in their care.
- Staff we spoke with said they did not often hear about the outcomes from adults safeguarding issues they had reported.
- Trust data on safeguarding training for the ED across all clinical roles was 100% at level 1 as part of mandatory training. Nursing staff had completed level 2 child protection training.

Mandatory training

- Mandatory training status for the ED was put on display topic by topic to prompt and inform staff compliance.
- Trust data for 2014/15 showed overall compliance for ED consultants was generally 100% with a pattern of 0% for more than one topic for some individuals.
- For 'all' non-consultant medical roles the range of compliance was between 33% and 100%. Four topics: level 2 and level 3 children safeguarding, information governance and clinical update, showed less than 55% compliance.
- For all nursing staff, safeguarding children at levels 1, 2 and 3 showed more than 86% compliance. Other topics were less than 60% compliant with conflict resolution at 57%, clinical update at 41%, equality and diversity at 44.5%, fire safety at 44.4%, information governance at 55.5% and patient handling at 39%. Corporate update and load handling were 100%.
- This meant that a significant proportion of staff in clinical roles had not refreshed and updated their training in mandatory topics. Staff whose mandatory

training was not up-to-date may lack the most recent knowledge in some key areas of clinical practice (for example fire safety, resuscitation, safeguarding vulnerable adults and children).

Assessing and responding to patient risk

- We found initial assessment of patients to be a combination of disorganised systems which was contributed to by environmental constraints.
- Walk-in patients were directed by a sign in the entrance lobby to go straight to reception desk one. However, this desk was open only between 10am and 10pm. This was the urgent care reception desk and it was staffed by an independent GP provider receptionist.
- A reception manager told us this receptionist decided which ED services were most appropriate for patients and directed them to the ED 'see and treat' stream or to the GP urgent care service.
- Any patient the receptionist had doubts or concerns about would be passed along to the next window staffed by the trust ED receptionists. They would decide if the patient needed to be seen by the minor illness triage nurse or taken into the major's emergency area.
- An urgent care receptionist confirmed this arrangement and we saw they had a list detailing presenting conditions and appropriate responses. For example, any child under one year of age with a head injury, or an adult with chest pain or difficulty breathing was passed to the ED receptionist for check in and response. We saw this system was confusing for patients, however this was a system set up by an external provider and not by the trust itself.
- An Emergency Nurse Practitioner (ENP) ran the 'see and treat' service. They told us the minor injuries patients they saw were not triaged. We understood the assumption was they would be seen quickly but as there was only one ENP on duty at a time, some patients did experience delays before they were assessed.
- ENPs told us that patients were often directed to the wrong service area so they may see an ENP who then redirected them to the GP service, so the patient had to go back to reception and re-register to do that or vice versa.
- There was a nurse triage system within the main reception area and they told us they saw patients that were not appropriate for the ENP to treat and were mainly minor illnesses that needed to be seen by ED doctors.

Urgent and emergency services

- We observed the triage nurse working with patients and noted that they followed a type of triage based on the 'Manchester Triage System'.
- This meant that patients could wait some time to see either an ENP or GP without being triaged by a qualified nurse.
- The triage nurse also saw patients that had arrived by ambulance and had been rapidly assessed by consultants when they were operating a Rapid Assessment and Treat system (RAT), but did not need to stay on a trolley in the majors area.
- We saw patient handover information between paramedics and ED staff was often delayed. The target is for patient handover to be completed within 15 minutes of the patient's arrival
- at hospital. However, many patient handover delays were in excess of one hour, with the longest delay being more than two hours. This was due to Walsall ED staff did not have capacity to accept the patient's and take the handover from the paramedics in a timely manner.
- We noted a trust letter to staff in June 2015 proposing the introduction of a RAT system in the ED 'majors' stream where patients were presented by ambulance.
- The letter said RAT aimed, "to provide early senior assessment of undifferentiated 'majors' patients and remove 'triage' and initial junior assessment from the pathway. The first clinician the patient sees is the one who is able to make a competent initial assessment, define a care plan and make a decision whether the patient requires admission or referral to an in-taking specialist team".
- We found the RAT system to be part of an uncertain initial assessment system within the ED.
- We spoke to a lead senior clinician who told us RAT had been attempted in different forms previously in the ED. They said it did not work effectively when the ED became busy and when the RAT experienced consultant was not on duty.
- One example given was when the electronic status board was set to show a patient had been seen by a doctor when in fact they had only had an initial assessment.
- A triage nurse was identified for each shift. Patients were triaged and allocated a triage category.
- However we noted unless staff specifically indicated otherwise to doctors, the patients triage cards were put in time order in a box rather than triage priority order in the major's area. This meant there was no gradation of priority and there was a risk of patients conditions deteriorating while they waited their turn.
- Doctors on duty at the time of our visit confirmed they took the next card in the box unless told otherwise.
- We looked at 20 sets of medical records within the ED and noted no triage category recorded on the card for three patients. We could not therefore judge whether these patients had been triaged at all.
- Two out of the three patients notes we looked at on wards for patients admitted through the ED had no triage score recorded so the scoring system was not being consistently used.
- There was one ENP rostered on duty. They led the 'see and treat' service between 10am to 8pm for minor injury patients.
- Although the ED saw a large number of children, there were few dual qualified nurses available and they were not following the 'Intercollegiate Committee for Standards for Children and Young People in emergency care setting 2012' guidelines.
- The matron told us five nurses were dual qualified and a further five had additional training in emergency care of children. Twelve out of the 16 qualified nurses held the European paediatric life support (EPLS) competence.
- The trust told us 100% of ED consultants and middle grade doctors and 100% of junior doctors had PILS (paediatric intermediate life support) competence.
- The trust assured us there was EPLS/APLS (advanced paediatric life support) trained staff on each shift and gave us an example of a contingency plan identified when that had not been possible for one recent shift.
- None of the ED consultants had a paediatric qualification and no paediatric-trained doctor was rostered to work in the ED.
- The trust gave us the following assurance of arrangements in place to mitigate this risk: a paediatric registrar was on site within the hospital and available to attend the ED 24/7. A Paediatric consultant was available within the hospital Monday to Friday between 09.00 and 17.00hrs. There was a consultant of the week for general paediatrics and neonates available on site within the hospital between 17.00 and 19.00hrs. On Saturday and Sunday between 9am and 3pm, there was a consultant available on site within the hospital but on call thereafter for 24hrs.
- We noted this issue was not on the ED risk register.

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- Local leaders told us if there was a concern about a child, the paediatric ward would send a nurse to ED to assist.
- We observed a young child with a fracture and respiratory symptoms brought in by their family was sent directly to the triage nurse by reception and then seen by an ED and a paediatrics department doctor. This demonstrated that on this occasion the system worked.
- The ED time to treatment performed well from January 2013 to January 2014 (at approximately 30 to 38 minutes) against the standard (60 minutes) and the England average (50 to 58 minutes).
- However, it rose sharply in February 2014 and had exceeded the standard (this means it had got worse) by June 2014, dropped again to just below the England average in the autumn of 2014 and rose to meet the standard again during winter 2015.
- We noted from the ED log sheet during our visit that on 3 September 2015 there was a two hour wait to see an ED doctor in the middle of the day.
- Acute medicine specialists told us they attended the ED when they were alerted to a possible hospital admission by the electronic board system. They said it did not always work as some patients were sent to the ward by the time they arrived.
- A standardised early warning tool (EWS) was in place. However, we noted it was not recorded as being used on the ED cards of three of the four patients for whom it would have been appropriate out of ten records we looked at.
- When we looked at the ED records that had gone with three patients admitted to a ward we found the EWS chart had not been completed by the ED.
- We noted from records a patient identified as requiring end of life care had no EWS taken between 6am and 11am and their notes were incomplete.
- We also noted from records that a patient assessed as having dementia arrived at 08.30 after a fall. No documentation was completed for the comfort chart, no EWS score observation chart was completed and no pressure care assessment had been made by 09.45 when, we escalated this to the nurse in charge.
- We observed a board round with the nurse in charge discussing all patients in the ED with doctors. The reason for admission, diagnosis and treatment plans was discussed. Checks were made against diagnostic tests that had been ordered.
- We saw no evidence of a comfort round taking place to check if a patient needed water, access to the toilet, pain level or repositioning, and the records of nine patients we looked at showed no comfort round evidence for eight of them.
- There was a high dependency cubicle near the nurse's station for close observation.
- There were two 'review' cubicles in an area situated off the main hub of the ED. These were staffed by health care assistants. Local leaders told us they were used for patients waiting to be admitted or waiting for test results.
- We noted these cubicles did not have call bells available to patients. Local leaders told us these patients were 'hand-picked' to occupy those cubicles at that stage of their treatment. By this, we understood that an assessment had been made of their safety to be left without call bells.
- We noted one elderly patient who came to ED after a fall at home was left alone in another cubicle for a few minutes without being given the call bell.
- We observed one elderly patient on a trolley was placed in the room where patients would have eye care, as all cubicles were full. This room did not have a call bell.
- We noted that patient's personal information on the large electronic patient tracking screen at the nurse's station was visible to patients and visitors and this compromised people's privacy, dignity and confidentiality.

Nursing staffing

- The executive reported to us that the trust had invested in ED staff during 2013/14.
- A workforce benchmarking tool plan had been undertaken and local leaders told us recruitment from overseas had resulted in some new nurses due to start with the trust during the week of our visit.
- Local leaders told us nursing posts at Band 5 were unfilled. The ED had a budget for 41.21 posts and only 33.19 were filled at the time of our inspection.
- Senior nurses told us that the ED nursing compliment was ten on duty at a time but it sometimes had to function on only six or seven staff. They estimated that four days each week were not fully staffed.

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- Some nurses told us they did not get their breaks and felt they were responsible for too many patients at one time when the ED became very busy. ENPs told us they did not get enough support managing all minor injuries when they were busy.
- Local leaders told us the qualified nursing compliment was 11 for the early shift, 12 for the late shift and 7 overnight. The matron confirmed on the first day of our visit at 6pm on 8 September 2015 there was only seven qualified nurses on duty plus one health care assistant.
- We looked at the roster for the weeks of 31 August 2015 to 9 September 2015 and noted there were considerable shortages of qualified nurses including six short on both Saturday and Sunday and seven short on the Monday.
- Most were filled by agency or bank staff. Where there were no agency or bank staff available, extra health care assistants had been rostered for example, on Monday three nursing shifts were cover by extra care assistants.
- We observed a nursing handover of the nurse in charge on the day shift handing over to the nurse in charge of the night shift and the nursing team. Named nurses handed over patients details to night staff. Each patient was discussed by the team.
- There were insufficient numbers of nurses qualified in paediatrics to ensure one was rostered on each shift.
- A staffing roster that we looked at for August 2015 showed health care assistants, and non qualified nurses were covering a number of vacant nurse shifts.
- There were 11 middle grade doctors attached to the ED. The ED had a budget for 14 middle grades and had eight vacancies.
- There was no paediatrics-qualified doctor.
- Trust data showed the use of locums within the emergency and acute care services to have been at 13.7% and showed a steady decline from January 2015 when it was 17.9%.
- We asked the trust to send us the consultant's rosters for a sample of weeks in August 2015 and the on call roster for September 2015.
- However, we could make no judgement as it was not clear to us from these documents the exact time in the 24-hour clock that each consultant was working. We could see a pattern of shifts against and across names.
- The rosters inferred that that one consultant was on duty up to 11pm each weekday. The on call roster gave dates and names but no times so we could not be assured by it.

Medical staffing

- Government statistics showed the ED skills mix as a lesser proportion of consultants (19%) than the England average (23%) between September 2004 and September 2014.
- There were considerably greater middle career doctors (22%) than the England average (13%) and fewer registrars (27%) than the England average (39%).
- The percentage of junior doctors was higher (32%) to 24% for the England average.
- This meant the ED medical skill mix had been weighted further toward fewer specialists and reliant on middle career and junior doctors.
- Six ED consultants, in addition to the clinical director (CD), were attached to the ED at the time.
- Local leaders told us the ED was struggling to recruit Emergency Medicine Specialists and were relying on locums.

Major incident awareness and training

- The director of nursing told us the trust had a major incident policy. ED staff told us the policy was in draft form only. We noted no major incident room/hub in or near the ED however.
- ED leaders confirmed the ED had twice-yearly training in the major incident response procedure. The aim was to clear the ED and use the cubicles.
- A major incident table top exercise was carried out in August 2015.
- We saw a considerable amount of appropriate equipment and supplies secured in a shed outside of the ED including a decontamination tent and protective suits.
- Local leaders told us security support to the ED was patchy and personnel did not always stay on as long as they were needed.
- Security personnel were multi-agency public protection arrangements (MAPPA) trained (for dealing with sexual and violent offences) and staff said the local police service did not attend as frequently as they used to.
- The ED operated a system of exclusion (red) and warning (yellow) cards for aggressive and violent patients. Three red cards had been issued 'recently'.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Inadequate



We found the effectiveness of the ED was inadequate.

The re-attendance rate was higher than the England average throughout 2014/15.

Treatment plans were recorded in notes for most but not all patients.

The trust took part in college of emergency medicine national clinical audits and also conducted local audits within the ED.

The ED had a mixed performance in the '2012 fracture neck of femur CEM national audit', performed poorly in the 2013/14 'CEM asthma in children clinical audit' and poorly in the '2013/14 CEM sepsis audit.' A trust re-audit of sepsis practice in 2015 showed improvement.

Recommendations were made by ED leaders for improvement actions following national audits. However, improvement was not always consistently sustained. Even where the pathway was well embedded some aspects of the care 'bundles' were not being used.

Pain relief recording was identified as an issue within some of the CEM audits by the CQC emergency department national survey in 2014 and again by a 'trust snap' audit in May 2015. Pain relief record keeping remained poor at the time of our visit in September 2015.

There was no effective system in place for ensuring patient's had appropriate nutrition and hydration while in the ED.

Although the ED saw in the region of 17,000 children each year, there were only five nursing staff working in the ED that were dual adult/paediatric qualified. A further five had some training in the emergency care of the child. None of the consultants working in the ED were paediatrics trained. 'Standards for Children and Young People in Emergency Care Settings 2012 Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' were not being followed.

There were a number of nurse vacancies and locum doctors in use. Local leaders were exploring ways of broadening the occupational profile within the ED to

extend nursing competencies to take on some medical roles. A practice development nurse was in post and doctors were supported by consultants to use and understand the specific care pathways in place. Staff appraisal rates had declined from their 2013/14 rate of compliance.

Multi-disciplinary working was positive and creative.

There were good systems in place to manage and share information but staff did not always complete the records.

Evidence-based care and treatment

- The ED performed worse than other trusts in two of the three 'CQC 2014 national ED survey questions for effectiveness.'
- We noted there was no evidence of a care/treatment plan for three out of the 20 patient's records we looked at.
- The ED performed poorly in the 'national 2013/14 severe sepsis and septic shock royal college of emergency medicine (RCEM) audit' with scores on most aspects well below the RCEM standard for example, the timeliness of pain relief.
- The trust re-audited ED performance in 2015 and most measures had considerably improved. Three measures had declined.
- We saw a standardised care bundle for sepsis (The Sepsis Six care pathway) was in place in the ED and there was information to staff about its use displayed. Staff we spoke with were aware of it.
- We observed a board round that included identification of sepsis patients.
- We also noted that not all the sepsis six documentation had been properly completed for a number of patients whose records we looked at. The trust 'Snap Shot Sepsis Audit of patients presenting in ED on 22 May 2015' found nine patients presented with a history suggestive of sepsis.
- Patients had a complete set of observations; six patients were prescribed antibiotics; three patients received antibiotics within one hour; one patient received antibiotics within two hours; no time was documented for two patients.
- During our visit on 9 September 2015, we found that although the sepsis bundle was available in patient's records it was not always completed.

Urgent and emergency services

- For example out of seven patients whose notes we looked at in the ED, for whom it may have been applicable, we saw that three patients had no sepsis checklist completed.
- There was a chest pain pathway in place and consultants told us it was effectively carried out including access to specialist advice from another nearby trust.
- Local leaders told us fractured neck of femur pathway documentation had not been put in place in the ED at that time. This meant there was a risk the ED was not consistently providing the most effective and safe care for patients with this type of fracture, many of whom were elderly people.
- The trust did undertake some local audit activity during 2014/15 such as the 'pain relief snap shot' and 'paediatric asthma and smoking in November 2014' and identified where improvement in practice was needed.

Pain relief

- The CQC survey of ED services in 2014 showed the trust performing worse than other trusts on the two questions relating to pain relief.
- A trust audit 22 May 2015 found that 41% of patients who were seen in the main department had a pain score recorded.
- Of the 30 patients who were prescribed analgesia, 20 (66%) patients received it within 30 minutes.
- The time of analgesia prescribed was recorded in only 34% of patients. Only one patient had a post analgesia pain score recorded. No patients who were seen in 'see and treat' or referred to the GP led urgent care service had a pain score recorded. This means ED performance around pain management was variable.
- During our visit on 9 September 2015, we found some variable practice remained around pain relief.
- We saw for most patients whose care we observed, pain relief was offered as part of the RAT in majors.
- However, there were exceptions or errors. For example, we saw one young patient with learning disabilities and who was in pain, wait for over for 25 minutes before staff responded and gave the patient's social care worker the advice she required to administer pain relief safely. We spoke to the sister in charge about this.
- We observed one young child in pain and distress having a support taken from their injured limb and waiting 23 minutes for pain relief. We spoke to the sister in charge about this.

- We noted patients directed to other ED services by the receptionist such as the 'see and treat' or the GP urgent care service had to wait for pain assessment.
- We checked the notes for 20 patients, including five children and found pain assessment was recorded for only seven.

Nutrition and hydration

- We observed that some patients had to ask for or go looking for water and food once they were within the ED.
- We noted that many 'care round' records were incomplete or not completed. This meant that patients were not being asked or not consistently asked if they needed a drink or food around meal times.
- Nursing staff told us 'no one is allocated to do food or drinks, it's the nurses' responsibility and we don't have time'.

Patient outcomes

- The ED had variable rates of unplanned patient re-attendance within seven days compared with the England average. Re-attendance was higher than the England average of 7.5% and the standard of 5% throughout 2014/15.
- The trust actively participated in CEM audits and recommendations were made to the Board for improvement actions. However, improvement was not always consistently sustained.
- We asked nursing staff about a sample of three CEM national audits and their impact on practice in the ED. They told us the sepsis pathway was well embedded. We saw evidence of this in practice although there were gaps in its application.
- Staff told us the sepsis pathway was audited by the ED each month to check compliance however, this had not been done in August 2015.
- The trust performed poorly in the '2013/14 CEM asthma in children clinical audit.'
- Staff told us the asthma in children care pathway 'bundle' had been started within the ED and overseen by an asthma specialist nurse. Any child that presented with breathing difficulties would be treated as per the bundle. We observed this with the triage nurse.
- We noted the ED paper to the Board in December 2014 said in response to the CEM audit results, that completion of the discharge summary was one of the areas that needed to improve.

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- However, staff told us although 80% of staff had training in the asthma bundle, it was not embedded in practice and doctors were not completing the discharge summary.
- The trust had mixed performance in the 2012 CEM fracture neck of femur audit.
- The report to the Board in February 2013 noted the poor results received in relation to pain scoring.
- Not all nursing staff were able to tell us anything about improved care pathways following this audit. Local leaders told us the pathway was to deliver pain relief within one hour, seen by a doctor and x- rayed within one hour but it did not always happen due to bed pressures within the hospital.
- The ED had pressure-relieving mattresses on trolleys for these patients when they had to wait up to 12 hours to be admitted.
- The trust audit on pain relief in May 2015 and our findings of poor pain relief recording on patient's notes indicated that improvements were not embedded.
- The trust wide patient safety team confirmed they supported the ED with regular mortality and morbidity meetings and shared outcomes across the divisions through a quarterly patient safety report. Mortality and morbidity meetings were held to review the care of patients who had complications or an unexpected outcome within the department.

Competent staff

- Standards for Children and Young People in Emergency Care Settings 2012 Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings were not being followed.
- Although the ED saw in the region of 17000 for 2014/2015, there were only five nursing staff working in the ED that were dual adult/paediatric qualified. A further five had some training in the emergency care of the child.
- Local leaders told us no money was available to provide any paediatrics nursing training or qualifications for 2015/16
- There was not a consultant with sub-speciality training in paediatric emergency medicine.
- None of the consultants working in the ED were paediatrics trained. This meant that there was not a specialist experienced doctor to oversee paediatric assessment and treatment in this emergency setting.
- Local leaders told us they were looking at various ways to develop staff roles and broaden the occupational

profile within the ED. For example, by appointing advanced nurse practitioners to take over certain clinical tasks to free up medical time such as within resuscitation.

- A staffing roster that we looked at for August 2015 showed health care assistants, and not qualified nurses were covering a number of vacant nurse shifts.
- Trust data showed for 'all' emergency and acute staff the appraisal rate had fallen during 2014/15 to 76% compliance from 81% compliance in 2013/14. This meant a declining trend in the number of staff receiving the support needed to develop their practice and discuss their performance.
- Local leaders told us there were some induction arrangements in place for temporary staff to familiarise themselves to the trust and the ED. Agency or bank nurses were required to complete an induction work sheet before each shift. Induction of locum doctors was checked off if out of hours by a Band 7 or above nurse.
- We noted during the board round handover we observed that the consultant questioned doctors about care bundles and that meant there was a check on the consistency and awareness of care pathways.
- There was a practice development nurse in post at Band 7 for 23 hours a week. This new process to assess and develop nurse competency was part of the ED improvement plan. They told us that for example, a practice weakness had been observed in junior nurses knowledge of anatomy and practice nurses were exploring ways to address this. Newly qualified nurses told us they received good support from seniors and local leaders.

Multidisciplinary working

- Consultants told us they had been working with colleagues in trauma and orthopaedics to increase the number of patients seen by the minor injury review clinic rather than immediately referring them to the trauma clinic.
- The ED had access to psychiatric services and we saw this in practice during our visit when their response was within 2 hours. However, local leaders said this quick response time was not usual.
- A frail elderly pathway team had been developed working with allied and community professionals to identify patients that required support and intervention to enable effective discharge.

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- We observed a paediatrics doctor and also a surgeon respond to ED requests to see paediatrics patients in ED on two occasions.

Seven-day services

- Consultants told us they received a seven-day service from out of hours CT scanning arrangements for isolated head injury. This gave them fast access to reporting that enabled referrals to local major trauma centres

Access to information

- An electronic 'white board' provided up to date information to all staff about the status of all patients through the ED system.
- We noted the ED 'card' for each patient was designed to cover triage, observations and pain assessment as well as biographical data. Early warning scores and comfort round records were made on a different sheet. Staff told us if patients were admitted this second sheet would go to the ward with them.
- We noted that the comfort round card provided for the recording of a comprehensive set of information about the patient including: skin integrity, drink and food offered and continence support.
- However, none of the 20 sets of patient records we looked at in detail were fully completed.
- The sample of three sets of notes we looked at which accompanied patients from the ED to a ward contained incomplete ED notes, including nursing notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed the treatment pathway of a patient detained under the MHA and noted the ED supported their rights, worked with mental health professionals and enabled family involvement.
- We observed staff asked the consent of patients before examination or giving treatment.
- The trust told us work to implement the mental capacity act was still in progress across the services.
- We saw mental capacity training figures for nursing staff was 96.3% and 30.4% for medics.

Are urgent and emergency services caring?

Requires improvement

We found caring in the ED required improvement.

We observed generally positive and friendly interactions between staff and patients.

The ED scored 'about the same' as other trusts in England for most questions relating to 'caring' in the 'CQC A&E national patient survey' in 2014.

However, it scored 'worse than others' in relation to questions relating to pain relief. We also found issues about pain relief.

There were some systemic issues about privacy and confidentiality. Some single cubicles were double occupied with patients when the ED became busy. Patient information and clinical status on the electronic tracking screen was visible to patients and visitors.

Friends and family test scores have been generally above or very near the England average.

Parents with children in the 'see and treat' area did not always understand who they were waiting to see or how long they would wait.

Compassionate care

- 'The CQC national survey of ED's in 2014' found the ED performed about the same as other England trusts in all the questions relating to 'caring' except for time to pain relief and also pain control which scored 'worse' than other trusts.
- We observed generally positive and friendly interactions between staff and patients. For example, we heard nursing staff including students ask patients if they were warm enough when they had arrived by ambulance, ask about and offer to make contact with a patient's social care provider when a fall had resulted in their admission to the ED.
- The CQC national survey of ED's in 2014 found the ED performed 'about the same' as other England trusts in the questions relating to being given **enough privacy** during examinations and treatment.

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- However, we noted the record showed when patients had been 'doubled up' in cubicles. This happened twice on 3 September 2015, three times on 7 September and six times on 8 September 2015. The log did not indicate how many patients were involved.
- Patients we spoke with did not offer any strong comments either way on how staff behaved toward them. When we specifically asked them, they said that staff were 'Okay' or 'Alright'.
- Most staff wore name badges with their role on them so patients and visitors knew who was dealing with them. However, we noted a number of local leaders and one senior nurse did not.
- Low response rates are common for ED friends and family tests (FFT). The ED had good FFT test performance between September 2014 and January 2015 reaching a peak score of 94% against the England average of 87%. However, performance fell below the England average in February 2015 to 86%. The ED bulletin showed the first week of July 2015 score at 100%.

Understanding and involvement of patients and those close to them

- The CQC national survey of ED's in 2014 found the ED performed about the same as other England trusts in the questions relating to being given **the right amount of information** about their condition or treatment and for being **involved** as much as they wanted to be in **decisions** about their care and treatment.
- Parents attending ED with their children told us they had been given no idea of how long they would have to wait in the 'see and treat' area. They did not know what type of clinician they were waiting to see and this was adding to their anxiety about their child.
- We observed triage nurses explain and discuss possible treatment pathways with parents accompanying their children.

Emotional support

- 'The CQC national survey of ED's in 2014' found the ED performed about the same as other England trusts in the question for feeling **reassured** by staff if **distressed** while in the ED.
- ED patients and their relatives and friends had access to all services provided by the hospital such as the chaplains.

- We noted there was a viewing room for relatives of deceased patients and this meant people had a private space in which to grieve.

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

Inadequate



We found responsiveness of the ED was inadequate.

Arrangements to direct patients to the services within ED most suitable for them were not always clear to patients and this system was not always effective. The ED had a system of identified 'champions' in place to support good care practice for particularly vulnerable patients but we saw some examples of less than good practice for these patients.

The ED saw 116,000 patients in 2014/15 almost 20% of these were children and young teenagers. This number of patients was a severe challenge for the size of the facility. There was no segregated paediatrics area although there was a paediatrics cubicle. Attendances resulting in admission had decreased from 2013/14 and fewer people left the department without being seen than the England average, which was between 2.4% and 3%.

Performance against most of the national targets for responsiveness were poor during 2014/15 including ambulance handover times and meeting the target to see, treat, admit or discharge patients within four hours.

There were triage arrangements in place and a rapid assessment and treat system but these were not always effective especially when the department became busy. The ED policy was not to accept patients from ambulance crew if no cubicles were available within which to assess and treat them. There were therefore no patients waiting on trolleys in corridors but patient flow although carefully monitored through a patient status board, became challenging.

Escalation procedures involved the whole hospital system and arrangements with partner agencies and stakeholders.

Urgent and emergency services

The ED services were actively trying to plan, provide and adapt to respond to the needs of local people and work with partners and stakeholders.

There were Dementia Champions in place, however staff did not have time to fulfil this role appropriately.

There were systems in place to actively seek the views of patient's, investigate, respond to and learn from complaints.

Service planning and delivery to meet the needs of local people

- The ED performed about the same as other trusts in all CQC national ED survey questions related to responsiveness during 2014.
- The ED had the facilities and could deal with a patient presenting with a single trauma issue. For multiple trauma needs it was supported by one major trauma centre.
- Consultants told us the trust had recently developed a trauma team to achieve the trauma unit designation.
- The ED provided a minor injuries review clinic five days a week. The consultant told us they saw up to ten patients an hour on average. This meant it reduced ED attendance impact on orthopaedic services.
- There was a 'see and treat' service that operated from 10 am to 8pm, seven days a week led by emergency nurse practitioners.
- A triage nurse worked from the main reception area and triaged minor illness patients and others who walked in when the 'see and treat service' was not open.
- An urgent care centre ran adjacent to the ED main waiting area and was located beside the 'see and treat' consulting rooms. This was led by GP's and provided by an independent healthcare service.
- We found however that patients waiting for the services were not clear about which professionals they were waiting to see or how long they were going to wait.
- An Acute Medical Unit service had been developed by the trust. This took in acute admissions providing assessment to patients to determine whether they needed to be admitted as an inpatient.
- If a patient needed to be admitted, they would then be moved to an appropriate ward. GP's could refer directly and this meant some patients could bypass the ED. The ED could also send patients directly to this unit.

- Matrons who worked in the community were alerted by ED if their patients were admitted via ED in order to support their discharge back into the community.
- Clinical site co-ordinators told us there was a 'trusted assessor' system in place to discharge patients to local nursing homes and care homes that had signed up and agreed this process through the CCG and the local authority.
- The nursing director confirmed when there had been capacity issues within the ED there were 'system wide' phone calls several times each day between the trust, the CCG and local authorities to establish whether beds could be made available in nursing homes.
- There was a virtual ward system where by nurses could visit and care for patients at home to avoid unnecessary admission.
- There was a rapid response system in place to avoid unnecessary contact with ED and this involved close working relationships between the ED and local NHS Ambulance Trusts.
- The ED 'connecting' bulletin for September 2015 reported a 'high flyers' project to establish multi agency partner links to better manage repeat attenders to the ED.

Meeting people's individual needs

- The Board reported to us that the ED had high rates of alcohol related attendance.
- The ED had access to a translation phone line and staff were aware of this. However, one consultant told us they had always managed by asking the family of the patient to translate. This is not best practice as it may provide inadequate or misleading information for diagnosis.
- The ED had a named learning disability champion. However, we observed that a teenager with a learning disability was put into the paediatrics cubicle, which was decorated for young children.
- The ED worked with a frail elderly team that aimed to support quick and safe return home and avoid unnecessary admissions.
- The ED had a named dementia champion. We observed in the board round handover that patients with dementia were identified. However, the records of one patient identified as having dementia had incomplete physical assessments and we raised this with the nurse in charge.
- We noted from records that a patient identified as requiring end of life care had no comfort round between

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5am and 11am. This meant they may not have been offered use of the toilet, food or drink, a morning wash or checks on their access to the call bell or repositioning for six hours.

- We noted there was a dedicated quiet room for patients with mental ill health to wait for assessment. It was appropriately furnished and had a panic strip and good dual aspect visibility. We observed the room was used.

Access and flow

- The trust had developed an emergency care improvement plan. This incorporated: RAT, patients moved out to appropriate areas, use of ambulatory care, daily board and ward rounds on hospital wards to free beds and improved safeguarding awareness.
- During 2013/14, the trust had expanded the ED to include two further major's cubicles and a plaster room. We observed that ambulance crews still had to wait to 'off load' patients.
- There was a 'streaming' system in operation within ED and this identified and directed patients through a route that was most appropriate for their presenting needs. It comprised the major's service, a 'see and treat' service led by an ENP and an urgent care GP service.
- Patients arriving on foot were directed to the urgent care service receptionist window in the first instance between 10am and 10pm. From there they were directed to a service route.
- There was a triage nurse system from the ED main reception area but this did not operate 24/7.
- From April 2014 to March 2015, the ED saw 116,003 patients. 19.6% of patients were less than seventeen years of age.
- ED attendances resulting in admission was approximately 18.6% in 2014/15, which was better than 20% in 2013/14 and slightly better than the England average of 22.8%.
- The CQC survey of ED patients in 2014 showed the trust was about the same as other trusts for all the questions relating to responsiveness.
- From January 2014 to December 2014, 2,110 people left the department without being seen or having refused treatment. However this was below the England average for between January and March 2015.
- Trust data sent to us showed there were 1,129 handover of patients to ED staff from ambulance crew that exceeded 30 minutes during the winter period of 2014/15.
- The total number of handover delayed by more than one hour between April 2014 and April 2015 was 123.
- There were large increases in the number of these handovers delayed by more than one hour in January 2015 (40) and March 2015 (27). The Ambulance service had written to the trust to complain about the delays in patient handovers. The target is 15 minutes to handover the patient from the ambulance to the ED staff. We saw delays ranging from one hour to one hour 30 minutes and in some cases longer.
- The trust had been consistently performing worse (five to nine minutes) than the England average (median three to six minutes) for the time to initial assessment of patients between January 2013
- The percentage of patients seen within the national four hour target (to see, treat and admit or discharge), was worse than the standard or national average of 95% for almost all of the period between April 2014 and May 2015.
- In January 2015 it dipped to less than 80% then rose, fell and then rose again and settled at just less than 90% for April and May 2015.
- The percentage of ED hospital admissions waiting four to twelve hours from the decision to admit until being admitted (18% to 50%) this was consistently above (worse than) the England average of 5% to 15% between April 2014 and April 2015.
- Total time spent in the ED was much lower than the England average in 2013 and early 2014. There were however big increases up from the average of 89 minutes in May 2014 to an average of 150 minutes in January 2015.
- The ED normal practice was to accept a patient from ambulance handover only when a cubicle was free. No patients spent time in corridors or passageways beyond the ambulance handover point.
- Local leaders confirmed that this meant patients had to stay on ambulances when there was a queue.
- We noted there was an assessment cubicle near to the ambulance handover and this was used for RAT only when the consultant was on duty.
- Eight of out ten records we looked at showed triage had been undertaken mostly within immediate to ten minutes with the exception of one patient who had waited 50 minutes.
- The trust identified internal data quality issues in reporting ED four and 12 hour waits during 2013/14 and again in 2014/15.

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- The trust had a new escalation policy and procedure. There were four levels of escalation, level 4 being the highest escalation. On the morning of our first visit on 8 September 2015, the ED was on level 3 escalation status.
- We noted that a shift co-ordinator kept a log sheet on a an hourly basis of number of patients in the department, the number waiting to be seen, ambulances waiting, time to triage, the walk around and cubicles that were doubled up.
- The log contained the escalation process and escalation triggers to prompt staff.
- We noted the log was not consistently completed on a daily basis and not all issues recorded were followed up or reported on the electronic reporting system as an incident. For example, a record of 'trolley waits on beds' on 8 September 2015 at 07.55 was not actioned as there was 'no progress chaser' on duty.
- Senior nursing staff told us 'The daily log becomes where issues are written up rather than incidents logged'.
- On the evening of Tuesday 8 September 2015, we had observed the capacity/bed state meeting and handover between two clinical site practitioners.
- Clinical site practitioners explained the escalation process and it was clear that it included the whole hospital system to support the ED.
- The meeting briefed the oncoming duty manager on the number of patients waiting in the ED to be admitted to wards and how long they had been waiting including the breaches of national targets. Likely discharges from wards that would provide beds were identified and the duty managers could trigger the undertaking of extra ward rounds by consultants to identify patients ready for discharge.
- This was a detailed assessment and management system to support ED and we noted clinical site practitioners had information on each patient's health status and used their names.
- There was a duty manager and on call director arrangements through the night and we saw the on call director check in with the capacity team for the projected status of the hospital through that night before they left for home.
- We noted from this meeting that on Monday 7 September 2015 the ED had been very busy. The unverified data showed 61 breaches of the four-hour target. This was higher than the predicted number arrived at by using 7 September 2014 data.
- On the morning of 8 September 2015 at 7am the unverified number of eight hour breaches was three.
- The clinical site practitioners were working with 75 breaches by 7pm that evening. They told us 68 ambulances had arrived at the ED already that day; the predicted total for the whole day from last year's data was 74.
- We saw during busy times in ED, which was often, patients had been 'doubled up' in cubicles due to insufficient room. This happened 11 times within a five day period between 3 September 2015 and the 8 September 2015.

Learning from complaints and concerns

- Patients were invited to 'have your say' about services provided on a large poster within the ED main waiting area.
- We noted that the ED received support from the trust wide patient safety team through the governance structure to enable learning from complaints.
- Learning from complaints was shared within care group's governance meetings.
- From 1 September 2014 to 30 August 2015, there had been 41 complaints received. We noted complaints and concerns received in July 2015 appeared in the September 2015 edition 'emergency department connecting staff bulletin' including how to improve practice.
- There were seven complaints in July 2015:
 - two were related to missed diagnosis (hand and deep vein thrombosis), improvement required 'check, check and check again, speak to a senior if you have any queries';
 - two reported poor attitude, 'make every effort to ensure you are dealing with the patient in the most empathetic way';
 - one about poor clinical care of a hand wound, 'ensure a clinic appointment is arranged for any patient with a digital injury';
 - one about lack of communication with relatives, 'talk! talk! talk!, provide clear and accurate information to help the patient and their relatives understand what is happening';
 - one complaint about lack of privacy and dignity, 'ensure you are in a private place when delivering personal information about patients' care or treatment'.

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- We noted two of the six 'concerns' raised were related to poor communication and one was related to poor staff attitude.

Are urgent and emergency services well-led?

Inadequate



We found leadership was inadequate.

The trust had a general vision and set of values but there was no specific vision/strategy for the ED. There was an improvement plan for the ED and work with partner agencies and stakeholders was developing strategies to deal with increasing demands on the service.

Most risks were identified and reviewed but little progress had been made on eliminating some of them. The focus was on controlling risks, such as the limits imposed by the size of the estate at a local level. However, the risk involved in the response to paediatric patients without appropriately qualified staff in the ED and consistently poor performance on pain relief was not identified and managed through the risk register.

Local nursing and medical leaders were committed to quality assurance but barriers remained to achieving and sustaining improvements. These included communicating learning from incidents and complaints to nursing staff, responding to audit findings about clinical practice consistency in some care pathways and effectively implementing rapid senior assessment. Record keeping was a particular problem across the ED.

Local leadership was visible and hands on and escalation was embraced hospital wide when the ED was in difficulty. Staff were encouraged to become involved in improving the quality of the service but some nursing staff felt demoralised by high vacancy levels and low prospects of advancement. Medical staff were more positive about the trust and their work in the ED.

Many improvements were relatively recent and had not had time to embed and their sustainability could not be judged.

Vision and strategy for this service

- The trust had a vision and values statement framed on 'our promises'. We saw a poster of this in the ED main waiting area. We saw no evidence of a specific over-arching vision for the ED services.
- The ED 'connecting' bulletin for September 2015 highlighted a piece on 'our improvement plans for our patients, colleagues and the long term'. This was a list of objectives and measures of success in achieving them.
- Improving for the 'long term' objectives were: 'Increase our use of ambulatory care and extend this to the frail elderly by developing a frailty assessment unit, improve our emergency department performance to ensure patients are assessed, treated and discharged in a timely manner, ensure the effective use of resources within the care group to support the division's financial plans, develop robust information and data sharing within the care group to inform and influence improvements on patient flow and care group targets, integrate further with community services within the urgent care pathway to provide seamless patient care.'
- While these improvements were appropriate they were a little limited in the visionary impact required to overcome the limitations placed by the size of the ED estate on patient experience.
- Senior local leaders told us the trust had an emergency care improvement plan in place. Work was being planned to improve staff skills within the ED and to work with partners and stakeholders to create new pathways to avoid unnecessary admissions or contact with the ED such as the rapid response team, frail or elderly team and 'trusted assessor' system.
- A task group had been meeting monthly since November 2014 to oversee and to develop the organisations vision and strategy for Ambulatory Emergency Care.

Governance, risk management and quality measurement

- We noted that the top five risks had been identified and communicated to staff through a notice board display in the staff room corridor of ED. It was well set out so it could be read quickly and included control measures in place.
- The top risks identified were violence, patient re-attenders, poor data quality and completeness of records, patient transfer and handover provision and lack of dedicated safeguarding nurse.

Urgent and emergency services

- We noted however, the risk involved in the response to paediatric patients without appropriately qualified staff in the ED was not identified and managed through the risk register, neither was the lack of nursing and medical staff.
- The risks related to the ED continued poor performance on pain relief was not identified.
- Local leaders acknowledged that some of the identified risks on the risk register had been there for a number of years and were still active and unresolved.
- This included continuing to see children in ED with no 24/7 paediatrics qualified nursing cover. We saw no evidence of how the trust's mitigation of this risk was being actively monitored.
- Local nursing and medical leaders were committed to quality assurance but told us that finding time for staff to get together; especially nursing staff was extremely difficult.
- Although an ED meeting was held once a month, there was no time built into the nursing shift for the day-to-day learning that they felt needed to be achieved in real time such as reviewing complaints raised in the previous 24 hours.
- Senior nurses confirmed there were attempts at achieving 'huddles' but couldn't tell us when the last one they were involved in had taken place.
- The matron saw all incident reports on a daily basis but acknowledged what one nurse who asked to speak with us said. They were not fully engaged with incident reporting. This could affect learning from previous incidents and near misses and also on the exercise of duty of candour.
- There were designated quality champions. The quality champion for the department was the clinical director.
- Reports in relation to RCEM national clinical audit results were presented to the Board by local leaders and included recommendations for improvement actions. Some improvements however were not effectively sustained.
- The trust produced a regular bulletin to distribute to staff trust wide called 'Learning Lessons. A quality and safety Update'.
- The ED was supported and overseen by a relatively new governance structure that reported up to the executive team through divisional board, divisional quality group and the ED and acute medical unit (AMU) care group.
- The trust wide patient safety team confirmed the ED responded positively to the regular support it offered within the governance structures.
- On-going deficits such as completion of patient and care pathway records and pain relief were identified by national and local audit but improved performance had not been achieved.
- The emergency care improvement plan included the introduction of RAT. However this system became ineffective when the ED became busy. This was because it was the ED policy not to permit further handover of patients from the Ambulance crews when all cubicles were occupied.
- The purpose and effectiveness of the ED shift coordinator's log sheet within the risk management system was not clear.
- Consultants meetings were held weekly to discuss issues and there were systems for board rounds and nursing handovers.
- The divisional care group met one month and discussed incidents and complaints. There was a monthly ED meeting to share actions and learning points from the divisional care group with staff, but senior nurses told us it was poorly attended by nurses.
- The trust capacity and operations managers and clinical site practitioners supported the ED with surveillance of the bed state in the hospital and escalation action on the wards.
- Escalation procedures were trust wide and involved the local stakeholders and partners.

Leadership of service

- The ED was managed by a clinical director, matron and Care Group Support Manage. The ED Management Team reported to the Divisional Management Team who reported to the Trust Board. Staff told us the matron and clinical director were supportive and approachable, but the executive team were less so.
- Managers met monthly across a number of decision-making and quality review work streams including a senior managers meeting and an emergency department care group meeting.
- Other meetings such as the ED team meeting, the friends and family forum and the ED's champions meetings were also held and staff were encouraged to attend, although protected time to do so was not given.
- The trust produced a monthly paper bulletin to communicate ED issues and achievements to staff.

Urgent and emergency services

- Local leaders were focused on new approaches to admission avoidance and new roles within the ED to compensate for the challenge of recruiting experienced medical staff but funding to support initiatives was an issue.
- Local leadership on a day-by-day basis was hands on and visible and there were good professional relationships between nursing and medical staff.
- Staff confirmed there was an emphasis on patient experience but also told us they were challenged by the number of patients that attended.
- The ED carried a number of nurse vacancies and relied heavily on locum middle grade doctors
- We found that management activity was not being effective in improving patient experience. Some systems such as triage and streaming were confused and not consistently followed.
- When the ED became busy, some systems such as RAT collapsed.

Culture within the service

- Local leaders were committed to improving patient experience. Staff understood the need to improve patient experience but felt demoralised by nursing shortages. Some nurses told us they did not get their breaks and there was no opportunity for career advancement. Doctors were more positive but some said they routinely undertook some nursing tasks because a nurse was not available.
- Practice nurses confirmed there was an open culture and poor performance was tackled straight away by leaders and staff were not afraid to speak up to each other.
- Two out of the three nursing staff we spoke with at length, told us they did not feel engaged with the trust. They said shortage of staffing meant they did not get their breaks or the support they needed when the ED was busy. They said there was little career progression available for Band 5 qualified staff in the department to encourage them to stay with the trust.

- The third nursing staff member we spoke with was newly qualified and was very happy about the job and the support and education they received
- Medical staff were positive about the trust and their work. They felt supported and said education was good. However some told us they had to routinely carry out nursing tasks such as inserting cannula's as nurses were not always available and this slowed down patient's treatment.

Public engagement

- There was no direct evidence of public engagement with the ED except for the FFT.





Staff engagement

- We noted the ED produced a regular paper bulletin for staff with updated information on issues and a calendar of governance events and meetings. The September 2015 issue included an invitation for interested staff to become involved in a review of the ED operational policy.
- Staff were encouraged to contribute to improved patient experience by becoming named champions for dementia or learning disability. We saw these displayed on notice boards around the ED.
- Newly qualified nurses had two mentors and support from a practice development nurse.

Innovation, improvement and sustainability

- We saw some evidence of innovation such as the rapid response teamwork with the ambulance trust. Many improvement initiatives, such as the frailty team and the acute medical unit had been put in place recently so we could not judge their sustainability.
- Creating a 'see and treat' service led by ENP's who saw all minor injuries had relieved the major's service of patients. However, there were only two ENP's employed to carry this workload.
- Other changes such as the RAT had been tried before with little success and we could not see how it had been any better supported to succeed on this occasion.

Medical care (including older people's care)

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

Information about the service

Medical care at Walsall Healthcare NHS Trust is provided in 12 wards at The Manor Hospital, Walsall.

Between January and December 2014 The Manor Hospital received 27,836 medical admissions.

We visited wards providing stroke treatment, general medicine, gastroenterology, respiratory medicine, cardiology, diabetes treatment and care of elderly patients including those living with dementia. We also visited the acute medical unit where patients were assessed before being referred to specialties and areas where patients were cared for while waiting to be discharged.

We spoke with 21 patients and relatives and 150 staff including nurses, doctors, consultants, managers, therapists, care support workers and pharmacy staff. We looked at 54 sets of patient notes during our inspection. Before the inspection, we reviewed performance information about the hospital.

Summary of findings

Overall, we judged that medical care services at Walsall Healthcare NHS Trust required improvement.

Staffing levels, the environment and availability of equipment were not sufficient to keep patients safe. The response to incident reporting was inconsistent.

Staff were not allowed time for training and clinical progression was not available, leading to staff leaving and moving to other NHS trusts in pursuit of professional and career development opportunities.

National data was not always reported and some data within the hospital could not be verified.

Staff told us that there was a disconnection between the operational nurses and doctors and senior managers. They did not feel supported or valued. Governance processes were disjointed and inconsistent and senior managers were not aware of some common practices at ward level.

The Endoscopy Suite is a member of the Joint Accreditation Group in gastrointestinal endoscopy (JAG) and carried out routine and urgent procedures. The trust had yet to achieve JAG accreditation. Patients and relatives told us that they were treated with dignity and respect, and that the hospital staff provided genuine, compassionate care.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

Medical Care services required improvement to protect people from avoidable harm.

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.

Not all medicines were kept in secure areas. A type of injectable medicine, 0.9% saline solution, was not always prescribed by a doctor before it was administered to patients.

Many of the ward managers, staff and patients we spoke with told us they were concerned about staffing levels. We looked at records of staff numbers on several wards including the acute medical unit (AMU) and wards 1, 16 and 29. We saw they were frequently short staffed and many shifts were covered by bank or agency staff.

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.

Infection prevention and control processes were found to be effective and all the wards we visited were clean. They had noticeboards clearly displaying their performance against safety targets.

Incidents

- Two therapists told us they had been asked to change the wording of incident reports they had submitted to lessen the impact. This meant that managers might have been more concerned with appearances and statistics than making real improvements.
- On the Swift discharge ward, a sister told us there was a good culture of clinical incident reporting, and gave us an example of the process for reporting suspected pressure ulcers, which included photographs of the affected area of skin being sent electronically to a tissue viability nurse for initial assessment and to allow prioritisation of physical examinations.

- On ward 17, a sister told us that staff sometimes receive feedback on incident reports by email but that this was not consistent and sometimes they did not get any response to incident reports.
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. No never events were reported on medical wards or medical care units at the hospital between April 2014 and August 2015.
- Mortality and morbidity review meetings were held monthly and attended by the medical director, consultants, pharmacy managers and managers from other non-clinical areas. We saw meeting minutes that supported this.
- The associate medical director told us that each speciality reviewed 10 patient records for each meeting, and that staff from intensive care carried out spot checks on another 10 records from medicine to ensure accuracy. Any themes or trends that were identified would be acted upon.
- We were given copies of the minutes of mortality and morbidity meetings from March to August 2015. These recorded discussions about specific patients, the trust's performance relative to the summary hospital-level mortality indicator and hospital standardised mortality ratio, suggestions for improvements in procedures, reviews of equipment and action plans arising from identified areas for improvement.
- All of the staff we spoke with were able to explain their responsibilities under Duty of Candour and the process to be followed.
- Consultants had received training about Duty of Candour including a presentation on the legal perspective from a solicitor. This ensured that they had an understanding of the implications and legislation behind the duty.
- Patient safety incidents were reviewed by the patient safety team to assess whether Duty of Candour needed to be applied and to ensure a consistent approach.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It reports data on pressure ulcers, falls, infections associated with urinary catheters, venous

Medical care (including older people's care)

thromboembolisms (blood clots in veins) and harm free care. Between June 2014 and May 2015, medicine wards reported 151 pressure ulcers and 76 falls to the safety thermometer.

- Numbers of pressure ulcers reported per ward ranged from four on wards 7 and 29 to 24 on ward 15. Fall numbers ranged from two on ward 7 and 12 on ward 16. These figures are affected by the nature and illnesses of patients treated on different wards.
- Each ward we visited had a quality and safety dashboard on display near to the entrance, showing performance on harm-free care, falls, pressure ulcers, infection prevention and control, staffing, staff attendance levels and patient feedback. Safety information was represented by green or red magnets for each day of the month.
- Staff told us that the dashboards were a relatively recent fixture, having been installed in August 2015.

Cleanliness, infection control and hygiene

- On every ward we visited, we found equipment, patient areas, toilets and sluices to be visibly clean however, we did not see any labels on equipment to identify that it had been cleaned and was ready for use.
- We looked at three physiotherapy plinths (large therapy beds) used on the stroke ward. All of them had rips to the corners of the mattress covers from having been moved around the ward while the therapy gym area was being used as a normal nursing bay. This meant that they could not be properly cleaned and could provide a reservoir for bacteria.
- The hospital had been free from hospital acquired MRSA infections for over two years.
- Cases of Clostridium difficile infections in the hospital had fallen by almost 50% from 30 in 2013/14 to 16 in 2014/15. The hospital had exceeded its own performance target, no more than 28 cases in 2014/15, by over 40%.
- We were shown results of audits into use of personal protective equipment (PPE), waste disposal and isolation procedures on medical wards. Most areas in these audits scored 90% or higher for compliance. Areas that scored below 75% were: the availability of eye, face and respiratory protection; display of clinical waste posters; availability, cleanliness and condition of clinical waste bins; correct segregation of household, clinical and hazardous waste; and the placing of clear instructions for staff and visitors regarding patients who

were isolated for infection control. The audit reports were clearly written and actions had been identified to improve performance in all of these areas. Further audits were planned to check whether the action plans had led to improvements in practice.

- In the endoscopy unit decontamination room we observed a blue plastic pipe running into a hand wash sink. We were told by staff that it had been installed to allow regular flushing of water to prevent legionella. This was not compliant with HBN 0009; we pointed this out to staff who told us they would arrange disconnection of the pipe.
- The lowest scoring medical ward on the PPE audit was ward 12 with a result of 64%, and the highest scoring was ward 3, at 100%
- The lowest scoring medical wards on the waste disposal audit were wards one and four with scores of 75%. The highest scoring were the acute medical unit and wards seven, 12 and 15 with scores of 93%.
- In the isolation audit, which looked at the practices and provision for isolation of patients with infections, all medical wards scored over 90% with the Swift discharge ward and wards 1, 3, 4, 7, 12 and 29 all scoring 100%.
- However in the endoscopy unit, we found dust on shelves in a procedure room and dust on two portable fans. An endoscopy is a non-surgical invasive procedure used to examine a person's digestive tract using an endoscope, which is a flexible tube with a light and camera attached to it.
- We were told that PLACE audits did not take place in the day surgery ward. This was not good practice as PLACE audits are a recognised independent assessment of the care environment.
- We found the control of substances hazardous to health (COSHH) cupboard in the endoscopy unit had been left unlocked in an unlocked sluice with chlorine and other cleaning chemicals on show.

Environment and equipment

- In the discharge lounge, we found a corridor with fire doors at either end blocked by physiotherapy equipment and piles of patients' notes. We brought this to the attention of the hospital managers and it was cleared the same day. When we returned for a follow up visit a nurse told us they had been asking for the equipment and notes to be moved for several months but nothing had been done about it until our inspection.

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- Staff on ward 29 told us they were concerned about the ward layout, as it did not provide good visibility and many of their patients were living with dementia and needed to be observed to keep them safe. One member of staff told us that there would often be one care support worker covering two patient bays, and they would have to leave patients who were at risk of falls in one bay to attend to the needs of patients in the other bay.
- Physiotherapy stroke services were provided in a converted six-bed bay on the stroke ward. The physiotherapy staff told us they had only had use of this area for the preceding five weeks because it had been used as an overflow area to provide extra bed space when the trust was experiencing capacity pressures. The physiotherapy staff did not have adequate storage for their equipment in this area and it was stacked in a corner. There was no administration area and the physiotherapy staff were using one of the therapy plinths as a desk.
- We were shown an electronic copy of an incident report regarding the therapy gymnasium being used as an overflow area in August 2015. The situation had been acknowledged and a recommendation made that a procedure be written for the use of the gymnasium as an overflow area. This suggested that the gymnasium would be used as an overflow area again in times of capacity pressure and we were not confident that the physiotherapists would retain sole use of the area for rehabilitation of stroke patients. This would have a negative impact on the quality of care they could provide.
- On the acute medical unit, we saw one patient with intravenous fluid connected, which was meant to be changed every four hours. The bag of fluid had been in place over eight and a half hours and was not flowing. It did not have a pump connected. Staff told us that the equipment library did not always have enough pumps available so they had to prioritise which patients they were used for.
- The swift discharge ward provided a clean, bright, spacious warm environment. The resuscitation trolley on this ward had regular daily checks recorded.
- The endoscopy patient preparation rooms had en suite facilities and private curtained changing areas.
- We did not see a comfortable seating area for walking patients who had undergone their endoscopy procedure.
- On the acute medical unit we checked 10 items of consumable equipment such as syringes, wound dressings, cannulas and mouth care kits at random and found them all to be in date, properly stored and in intact packaging. The equipment cupboard was secured with a combination lock.
- On the ward where patients who had a history of alcohol abuse and other vulnerable patients were frequently treated, all of the emergency pull cords in bathrooms and toilets were of a design that prevented them from being used as a ligature.

Medicines

- Medicines were not always stored appropriately. We saw intravenous fluids stored in a room that was not locked and was in a patient accessible area. We were therefore not confident that suitable arrangements were in place to prevent medicines being tampered with. We have been informed by the trust that this has now been replaced.
- At the time of our visit medicines were stored at suitable temperatures to maintain their quality, but we could not be certain that suitable temperatures were maintained at all times. The refrigerator thermometers had not been re-set after each reading and on one ward the room temperature was regularly above the maximum recommended for the storage of medicines with no measures in place to ensure medicines were fit for use. We raised this issue with the director of pharmacy who told us they were aware of the problem and that thermometers had been provided to all wards just before our visit. They told us they planned to target wards which were persistently warm and either try to reduce the temperature or make sure stock wasn't held there long term. They told us the monthly reports to wards mentioned the importance of fridge temperatures and reminded staff to escalate issues to the pharmacy team. We were not confident that sufficient, timely action was being taken to ensure medicines were stored safely.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. An automated dispensing system was available on some wards so that medicines could be dispensed immediately by authorised staff. Nursing staff told us

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that there could be a delay in the prescription and supply of discharge medicines especially when a compliance aid was required, meaning that people were sometimes kept waiting for their medicines.

- Saline flushes, a type of injectable medicine, were not prescribed by doctors before they were administered.
- Staff on ward 16 told us that doctors did not always prescribe oxygen for patients. Nursing staff were undertaking a compliance audit to feed results back and improve practice.
- We observed good practice on several wards during medicine rounds, where the nurse carrying out the round stayed with each patient until their medicine had been taken. This ensured that patients took the correct dose of medicine and was particularly important in the case of antibiotic treatment to prevent organisms developing resistance.
- We found that the pharmacy team provided a well-established and comprehensive clinical service to ensure people were safe from harm. The pharmacy team visited all wards each weekday, and some wards had a weekend service as well.
- We saw that pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in their safe administration.
- We looked at the prescription and medicine administration records for 25 patients on four wards. Prescription charts had been fully completed and showed that people received their medicines as prescribed. Controlled drugs were stored and recorded appropriately.
- We observed that five times in the month of August the temperature of the drug fridge in the endoscopy unit had not been checked, and that three of these omissions were on consecutive days.

Records

- We looked at 54 sets of notes in total across medical services and in seven sets of nursing notes on ward 16, and found that with some minor exceptions they were properly completed. On three sets of notes urine output had not been recorded (fluid intake was recorded on all seven sets of notes) and there were four instances of missed medication doses that did not have an explanation.

- Care plans in the notes we saw on ward 16 were all properly completed.
- Nursing notes were kept in a 46page 'nursing assessment documentation' booklet. Staff told us that this booklet had been introduced to the trust two months before our inspection. Nursing staff told us the booklet was "unwieldy" and "unstructured", and that important information got lost in its pages. They told us that it contained too much guidance information, took too long to complete and that there was not time to read it all every time a patient was attended to. This meant that important information about patients could be overlooked or missed.
- We looked at 12 sets of nursing notes on the swift discharge ward. In four of them, we found that the patient's fluid monitoring front sheets, where initial assessments and target fluid intake should be recorded, had not been completed. The reverse side of this sheet showed records of patients' fluid intake and output and these were all completed.
- On ward 17 we looked at three sets of nursing notes and in two of them we found that the fluid balance chart was a one-sided photocopy of the back page only. The front page, where assessments and target fluid intake should be recorded, had not been photocopied. This meant that while fluid intake and output was being recorded, staff had no way of checking whether volumes were in line with what the patients needed.
- We were shown copies of the risk registers for the elderly care, long-term conditions and specialty care groups. All showed a comprehensive awareness of a range of risks to the service and monitored actions being taken to mitigate risks. The recorded risks were in line with what managers told us they were concerned about.
- We saw minutes of care group and medicine division management meetings where risk registers were discussed. This showed that managers were aware of the on-going risks and how they were being addressed.
- In the endoscopy unit trolleys were full of medical records in an open room adjacent to the patient waiting area and patient notes were also left unattended in the unlocked consultants' office. This meant that there was the potential for a breach of patient confidentiality if medical records were not secure stored.

Safeguarding

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- Nursing and medical staff knew when and how to make safeguarding referrals, and were able to tell us who the trust's safeguarding lead was.
- We saw records of safeguarding referrals on four wards. These were appropriately completed and had been made within the recommended timeframe.
- Plans were in place to establish safeguarding champions across adult medical ward areas to replicate the champions scheme in children's nursing. Safeguarding champions were members of staff who would actively promote safeguarding issues and training among their colleagues.
- Wards where patients were at risk of falls operated 'continuous sitter' bays, where at least one care support worker was always present.

Mandatory training

- Mandatory training was provided for all staff in the medicine division in the following areas: conflict resolution; corporate update; clinical update; equality and diversity; fire safety; information governance; patient handling; and safeguarding children level one.
- Overall completion of mandatory training stood at 79%.
 - More than 90% of staff had completed the information governance and safeguarding children level one training;
 - more than 80% had completed the corporate update and equality and diversity training;
 - more than 70% had completed conflict resolution, fire safety and patient handling;
 - 67% of staff had had their clinical update.
- Further training dates were scheduled to ensure that mandatory courses were delivered to as many staff as possible.

Assessing and responding to patient risk

- On AMU, we asked three qualified nurses including one sister what should be recorded on the National Early Warning Score (NEWS) chart for fluid balance but they did not know and said they were not sure why it was on the chart. We were told that the charts were new and had not been discussed with staff before they were introduced.
- Nursing staff on medical wards told us they did not receive any training on recognising deterioration and acute illnesses in their patients. Staff told us that they used to undertake the 'Acute Life-threatening Events Recognition and Treatment ('ALERT') training but that

this was no longer available to them due to a lack of funding. This meant that deteriorating patients being nursed on medical wards might not have been identified and escalated quickly.

- We asked for details of acute illness management training that was provided for nurses. The trust provided figures showing that 54% of nurses working on medical wards had not received any such training in the last three years.
- On ward 17, we observed a care support worker with a patient who had become acutely ill. We had to prompt the care support worker to escalate the patient's condition to a qualified nurse then had to prompt the qualified nurse to 'fast bleep' a doctor.
- We visited the endoscopy unit. The endoscopy unit opened 8.40am to 5.30pm, Monday to Friday. Nursing staff provided an on call system at the weekend 8.00am to 9.00pm. Any patients that required an endoscopy after 9pm were transferred to the New Cross Hospital in Wolverhampton.
- We were told that if a patient's condition deteriorated in the endoscopy unit the patient became an emergency admission. The unit used the national early warning score (NEWS) to assess if a patient's condition deteriorated and therefore to take action before it became serious.
- Endoscopy patients who were still requiring a trolley four hours after their procedure were moved to a bed. This was in order to reduce the risk of pressure ulcers. We were told that pressure ulcer risk assessments were not completed due to the short period of time patients were immobile.

Nursing staffing

- Senior staff on three wards told us that nurse staffing numbers were a problem and that they frequently did not have enough staff on their wards to achieve minimum staffing numbers.
- We looked at rotas for nursing staff on ward 29 between 24 August and 9 September 2015 and saw that nurse numbers fell below the minimum level required by the trust on 47% (16 out of 34) of the shifts covering those dates, with bank and agency staff included. Of those, 14 shifts had been graded 'amber' (which meant they were short of one member of staff) and two had been graded

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as 'red' (two or more staff short). This was especially concerning as ward 29 had a high proportion of patients who were living with dementia and needed close observation to ensure they were kept safe.

- A care support worker from ward 29 told us that they were "stretched" due to short staffing and having additional duties delegated to them. They told us that they had still been washing patients after 3pm that day. This task should have been completed during the morning.
- On one ward, the ward manager told us that the day of our inspection was the first time in two months that they had been fully staffed. The ward manager told us they regularly stayed late on the ward and phoned in on weekends due to concerns about staffing numbers.
- Staff on the acute stroke ward told us that on some shifts the ward sister would have to carry three bleeps: stroke, transient ischaemic attack and fire, and would be looking after a bay of patients as well. If called, the sister would have to leave the ward to assess an emergency patient or situation and remaining staff would have to manage an extra bay of patients between them. If more than one bleep sounded at a similar time the sister would be unable to respond to both and would have to prioritise which situation to attend to first. This meant that response to emergency bleeps could be delayed.
- On two wards the sisters told us that staff flexed across wards, and frequently their wards would already be at minimum staffing but staff would be moved to cover other wards whose staff levels were below minimum. The sisters told us they did not feel supported by the nurse bank and never had the number of staff they needed.
- Two specialist nurses told us that they could be taken out of their specialist roles to provide general nursing cover if wards were short staffed, which affected their assigned roles and continuity of care for their patients.
- Administration staff on two wards told us that the nurses were always busy. One ward clerk told us that the nurses "never had a minute to spare".
- We asked for data on nurse staffing numbers on medical wards over the six-month period from March to August 2015. Data we received showed the following:
 - March 2015: 96% of planned qualified nurse shifts covered, 116% of planned care support staff shifts covered (this meant that extra care support staff, over and above the planned number, were rostered to work).
 - April 2015: 98% of planned qualified nurse shifts covered, 118% of planned care support staff shifts covered
 - May 2015: 90% of planned qualified nurse shifts covered, 114% of planned care support staff shifts covered
 - June 2015: 88% of planned qualified nurse shifts covered, 108% of planned care support staff shifts covered
 - July 2015: 87% of planned qualified nurse shifts covered, 109% of planned care support staff shifts covered
 - August 2015: 86% of planned qualified nurse shifts covered, 106% of planned care support staff shifts covered
- These figures represented the total number of nursing staff on duty, and included substantive, bank and agency staff. They showed a significant downward trend in the number of qualified nurses and care support staff working on medical wards, and that the shortfall in qualified nurses was being filled with unqualified support staff.
- Between March 2015 and August 2015 14% of qualified nurse shifts and 37% of care support worker shifts on medical wards were covered by bank or agency staff.
- One ward manager told us that their team included a large proportion of newly qualified nurses who were unable to work unsupervised. This meant that the reported numbers of qualified nurses per shift on the ward did not give an accurate reflection of the workload and capabilities of the staff.
- One ward manager told us that until recently they had had vacancies for 10 qualified nurses, but had just recruited four nurses from overseas and two newly qualified nurses. This left them with four vacancies and meant that they would have six staff who required supervision during their induction period.
- A ward sister told us that they struggled to cover day shifts with bank staff as the rate paid was lower than a normal rostered shift, but that bank staff were normally happy to cover night shifts when the hourly rate was enhanced.

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- The endoscopy unit planned its staffing levels six weeks ahead using the hospitals red, amber, green system. Gaps were filled with bank nurses. The unit did not use agency nurses due to the specialist nature of the work.
- Consultant leave and nurse vacancy /leave meant the endoscopy unit was not running at full capacity. At the time of the visit the unit held three band five nurse vacancies and two band five nurses on long-term sickness. The unit uses bank staff who have previously worked in the endoscopy unit. This meant that some patients were waiting longer than expected for their endoscopy examination. We were told that a recent recruitment campaign to recruit four whole time equivalent vacancies had been unsuccessful and clinics had continued to take place.
- Physiotherapists on the acute stroke ward told us that nurses had asked them not to sit patients out of bed as part of their therapy, because there were not enough nursing staff available to safely assist the patients from their chair back into bed after the physiotherapists had finished duty. This could adversely affect the patients' recovery.
- Five nurses on the acute stroke ward told us they had not been able to give the level of care they wanted to for the last 18 months due to staff shortages, and that some nurses had been off sick with stress due to the workload.
- Nurse staffing levels were displayed on quality and safety boards on each ward, and were represented by magnets of different colours on a grid showing the days of the month. Green indicated staffing at or above minimum safe levels, amber indicated that the ward was short of one qualified nurse or support worker (the trust defined this as below optimum but safe) and red indicated that the ward was short of two or more staff (unsafe). During our inspection, only red and green magnets were used due to a supply problem. The nine days of the month leading up to our inspection were predominantly shown as red for staffing on medical wards. Staff told us these days should have been 'amber' as they were short of one member of staff but due to the lack of amber magnets, they had had to use red. When we returned for a follow up visit later in the month all of the magnets had been removed and the staffing grid was blank. During our visit one member of staff told us that a senior manager had told them to "make the staffing green" for the inspection.
- Use of the 'SBAR' (situation, background, assessment, recommendation) communication tool was encouraged during nursing handovers. Staff told us that they used the system and found that the structure it provided was helpful.
- Nurses used the National Early Warning Score (NEWS) to identify deteriorating patients and to judge when to make referrals to doctors. Apart from the fluid balance box which staff were unclear about we saw that NEWS assessments were carried out whenever patients' observations were checked.

Medical staffing

- Locum doctors' competencies were checked by the site co-ordinator before they were allowed to work in the hospital. We were shown the procedure for checking locum doctors' identities and practising competencies and the induction procedure checklist for new locums. This procedure was comprehensive and ensured that locum doctors worked safely.
- Curriculum vitae for all new locums were approved by a consultant within the division the locum was required to work before they were approved to work in the hospital.
- Photographic ID of locum doctors was checked on their arrival or, if they were due to work out of normal hours, details, including a photograph, were emailed to the nurse in charge of the ward where they were due to work. We were shown the standard operating procedure document for this. This meant that the identity and competencies of locum doctors were assured and patients were prevented from harm.
- Junior doctors on the acute stroke ward told us that there were sufficient medical staff to meet the needs of patients.
- A consultant geriatrician (a senior doctor specialising in care of elderly patients) told us that weekend ward rounds by geriatricians had been stopped two months before our inspection and that locum doctors were now being used at weekends instead. This meant that continuity of care was not maintained and that patients may not have been seen by a geriatrician over the weekend.
- There was a seven day consultant cover on the acute medical unit (8 a.m. to 8.00 p.m.) which was provided by two consultants. Thereafter, there was a consultant on call.

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- The hospital used a locum neurology consultant, who was assisted as required by a neurology consultant who had recently retired from the trust. Support was also provided by the neurology department at University Hospital Birmingham.
- Medical handovers for all wards took place on the acute medical unit. Morning and afternoon handovers were led by acute consultants, and the night handover was led by a middle grade doctor. Records of medical handovers were kept in written format, and we were told that there were plans in place to move to electronic records.
- Night medical cover was provided by one middle grade RMO and two junior doctors and supported by an Advanced Nurse Practitioner.

Major incident awareness and training

- We asked six ward sisters about major incident training. All but two of them told us they had not had training but that if there was a major incident they would do whatever the site co-ordinator told them to. The other two sisters told us that they had had major incident training and it was included in all staff members' mandatory training.
- The trust told us that major incident training was delivered as part of the trust induction package, and then updated on a regular basis through corporate and clinical updates.
- We were told that within the medicine division major incident training compliance stood at 81%.
- The senior management team told us that in the event of significant capacity pressure in the hospital all of the wards would take one extra patient from the emergency department, regardless of bed availability. Ward managers would attend the emergency department and where possible would choose a patient best suited to their ward's specialty. Managers on four wards confirmed this had happened and that if necessary the additional patient would be nursed on a bed in the middle of a bay.

Are medical care services effective?

Requires improvement 

Staff were not allowed protected time for training, and many told us they had to complete training in their own time. Staff did not have opportunities to progress clinically within the trust and as a result many had left to work in other hospitals.

Staffing levels adversely affected the quality of physiotherapy treatment that the team were able to provide and as a result it was not delivered in line with NICE guidelines.

Use of patient outcome and monitoring tools were well embedded and these were used effectively.

Evidence-based care and treatment

- NICE guideline CG162 "Stroke rehabilitation: Long-term rehabilitation after stroke" recommends that physiotherapy for stroke patients should be delivered for 45 minutes, five days a week. The physiotherapy team told us that they were only seeing their patients once a week due to staff shortage in their team. This could adversely affect the patients' recovery following their stroke.
- Every Thursday morning band seven staff took part in peer audits, co-ordinated by the quality matron. Staff told us that they had no idea what they would be auditing until they arrived for the briefing on the day. This meant that audits provided an unprejudiced view of the subjects they assessed.
- We spoke with two band seven staff who were carrying out a peer audit on the acute medical unit during our inspection. They told us that results of the audit were fed back to the local ward managers as it was carried out. Following completion of the audit the quality matron analysed data from all the wards or departments involved and would formally feed results back to allow action plans to be made.
- In accordance with NICE guideline CG92 "Venous thromboembolism in adults admitted to hospital: reducing the risk" and Clots in Legs or Stocking after Stroke (CLOTS) trials the stroke ward were in the process of introducing intermittent pneumatic compression for their patients. Intermittent pneumatic compression is a

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mechanical therapeutic technique that includes an air pump and inflatable sleeves, gloves or boots to improve blood flow in patients' limbs and reduce the risk of venous thromboembolism.

- The stroke and swift discharge wards used a recognised tool, the Barthel Index, to measure how well patients were able to care for themselves and perform in a number of activities of daily living.
- All wards that provided care to elderly patients used the Morse Fall Scale to ensure that assessments of their risk of falling were carried out in a structured manner.
- Use of the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition was well embedded throughout the wards we visited. We saw that there was a pre-printed MUST form in the nursing notes booklet and that assessments were routinely carried out on all patients as long as equipment was available. Patients were re-assessed at appropriate intervals according to their score.
- Joint Advisory Group (JAG) accreditation of the endoscopy unit had been deferred for six months due to staff vacancies affecting capacity. However the endoscopy was still following JAG guidelines and working towards JAG accreditation.
- We saw that clinics were in line with best practice and NICE guidelines in relation to appropriate referral, availability of information and completion of checklists.

Pain relief

- We saw pain recorded as "Yes" on two patients' charts on ward 17 however, no reference was made to the patients' pain in the corresponding nursing notes entries.
- On ward 16 staff told us that they would assess the pain of patients who did not speak English using gestures and by interpreting facial expressions. This was not an effective method of pain assessment and did not comply with the National Institute for Health and Care Excellence (NICE) guideline CG138. This states that healthcare professionals should "ensure that factors such as physical or learning disabilities, sight, speech or hearing problems and difficulties with reading, understanding or speaking English are addressed so that the patient is able to participate as fully as possible in consultations and care."

- Patients we spoke with on all the wards we visited told us they were kept pain-free most of the time, although they sometimes had to wait 20 minutes or more for pain relief when they asked for it because the nurses were so busy.

Equipment

- On the acute medical unit, we were told that MUST assessments were not carried out on all patients because weighing scales were not always available due to equipment shortages.
- On the acute medical unit, we were told that syringe pumps were not always available and that staff had to prioritise which patients needed them most. We have been informed that the trust have since placed an order for additional pumps.

Nutrition and hydration

- The nurse in charge on ward 16 told us that they were aware of issues with completion of fluid balance charts but that they did not feel empowered to audit this themselves nor to make changes to correct the situation.
- We looked at five malnutrition universal screening tool (MUST) assessments on the acute medical unit. Two of them contained errors that led to patients being graded as low risk of malnutrition when they should have been recorded as medium risk. This meant that the patients' nutrition might not have been observed and assessed as closely as needed. We raised this with nursing staff at the time and were assured that both patients would be referred to a dietician.
- Nurses on two wards told us that food was frequently served cold because there were not enough staff to assist patients who needed help eating.
- The 2013 National Inpatient Diabetes Audit reported that only 50.2% of patients with diabetes said that their meals had been served at suitable times. This is worse than the England average of 70.2%, and has shown a decline from 85.2% in 2010, 67.9% in 2011 and 66.8% in 2012. A similar trend was seen in what patients with diabetes said about the suitability of meal choices: in 2013 50.9% of patients said the choice of meals was suitable for them compared to 71.2% in 2010, 63.3% in 2011 and 53.8% in 2012. The England average for 2013 was 63.7%.
- On ward 17 we found two MUST assessments that had been completed incorrectly for patients whose body

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mass index (BMI) was 20. A BMI of 20 is the cut-off point at or below which the patient scores one point, medium risk, on the MUST scale. Both patients had been scored zero, low risk, which meant that their food intake would not be monitored as closely as it should have been. We spoke with staff on the ward and were reassured that this was an administration error due to understanding of the 'greater than' mathematical symbol on the form, rather than poor understanding of the assessment tool.

Patient outcomes

- We were told that results of peer audits were fed back to senior ward staff and where necessary, action plans were put in place to address issues that were identified. We asked for details of all peer audits that had been carried out in the medicine division during the six months leading up to our inspection and any resulting action plans however, we were only provided with data from falls audits, none of which had any action plans attached.
- One senior sister told us that results of audits were fed back to ward managers but that they were not given any support to address issues that were highlighted.
- The hospital had not yet achieved accreditation by the Royal College of Physicians' Joint Advisory Group on GI Endoscopy (JAG). At the time of our inspection, their application was going through the quality assurance process.
- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. We saw for the period January 2014 to December 2014 returning a rate of 110 which was banded level 2 "as expected" though had increased steadily in the last four reporting periods from a low of 0.96 between October 12 and Sept 13. SHMI for the month March 2015 is 107.41, April 2015 is 110.54 and May is 102.64.
- In 2015, SHMI was 107.89. It was recognised that the SHMI for Walsall Manor Hospital had increased over an extended period of time and this represented a risk to patient safety and the Trust.
- The Sentinel Stroke National Audit Programme (SSNAP) measures the effectiveness of care and treatment provided for stroke patients at hospitals in England, Wales and Northern Ireland. The most recent report was published in 2014, and Walsall Manor Hospital had a performance level of 'D' for acute care organisation on the scale used by SSNAP, where 'A' represents the best performance and 'E' the worst. In this domain, three measures are used: provision of seven features of acute stroke treatment; 24-hour; seven-day thrombolysis ('clot busting') treatment; and three or more nurses for every 10 beds on acute stroke units. The hospital was providing six of the seven treatments, and 24-hour, seven-day thrombolysis but had fewer than two nurses for every ten beds so scored only 50 against a national average of 62.5.
- The hospital performed similar to the average for England in the Myocardial Ischaemia National Audit Project (MINAP) report for 2014. MINAP assesses how well hospitals in England and Wales care for patients who are having a heart attack.
- At the time of our inspection, the most recent results available from the National Diabetes Inpatient Audit (NaDIA) were from 2013. Results of the 2013 NaDIA showed that:
 - 19.4% of inpatients at Walsall Manor Hospital had diabetes. This is higher than the England average of 15.7% and placed the hospital in the top 25% for prevalence of diabetes. Only eight per cent of those patients, one and a half per cent of the total number of inpatients, had been admitted for a problem directly connected to their diabetes.
 - Diabetes specialist nurses spent on average 51 minutes per week with each patient, which was lower than the average of one hour and 40 minutes.
 - Dieticians spent an average of 18 minutes per week providing care for each patient with diabetes, which was lower than the England average of 28 minutes.
 - 17.9% of patients with diabetes were given a foot risk assessment within 24 hours of admission, which was lower than the England average of 37.6%.
 - The frequency of blood glucose monitoring at the hospital was in the top 25% for England.
 - The hospital performed better than the England average for medication errors, insulin errors and management errors, and was comparable to the average for prescription errors.
- The average length of stay for medical inpatients was higher than the average for England in all areas other than non-elective cardiology. The length of stay for elective respiratory medicine was particularly high, at

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29.3 days against an average of 3.5. We asked senior managers about this and we were told that they believed the figures to be incorrect, however no new figures were provided.

- Readmission rates following discharge were similar to the average for England, with the exception of non-elective elderly care medicine where the risk was 12% lower than average.
- The trust performed 'as expected' in the April 2014 to March 2015 Summary Hospital-Level Mortality Indicator. This meant that the number of patients who died following hospitalisation at Walsall Manor Hospital was considered to be in line with the number who would be expected to die on the basis of average figures in England.

Competent staff

- Ward managers were trained in advanced life support and qualified nurses were trained in immediate life support. One ward sister told us that several staff members' qualifications were approaching expiry but they had been told there was no funding for them to re-qualify.
- In the 2013 National Diabetes Inpatient Audit only 42.2% of patients with diabetes said that staff at the hospital knew enough about diabetes to meet their needs. This compared to an England average of 67.5% and showed a decline from 72.7% in 2010, 54.3% in 2011 and 55.9% in 2012.
- One ward manager told us that the financial pressures being experienced by the trust meant that they were unable to provide additional training for staff on the ward unless they could find free courses. This meant that morale was adversely affected and caused problems with staff retention. The manager told us that the ward had recently lost two qualified nurses to a neighbouring trust that was able to offer them progression and training.
- Five nurses on the acute stroke ward told us that they were not allowed any protected time for training and had to arrange their own study out of working hours.
- A two-day in-house stroke awareness training programme was delivered to new nurses, care support workers and community staff. The training was facilitated by clinical psychologists, occupational

therapists, speech and language therapists and physiotherapists and provided an awareness and understanding of physical and psychological rehabilitation for stroke patients.

- On ward 17 we saw two sets of nursing notes where the patients' National Early Warning Score (NEWS) had been recorded as four and five respectively, which required further investigation, and a further two sets of notes where the patients' pain had been assessed as "yes" rather than using a pain score. All of these entries had been made by care support workers and none made any reference to the patients being referred to qualified staff as a result of the observations.

Multidisciplinary (MDT) working

- Daily MDT meetings, involving doctors, nurses, allied health professionals and the ward discharge co-ordinator were held during the 8am board round on ward 15.
- MDT meetings were held twice a week on the stroke ward, involving consultants, occupational therapists, speech and language therapists, physiotherapists, nurses and Stroke Association volunteers.
- Specialist oncology nurses attended the acute medical unit whenever patients who required chemotherapy were on the ward, to ensure that they received their medicine in accordance with their treatment plans.

Seven-day services

- Stroke physiotherapy was provided seven days a week however, the physiotherapy team told us that this was maintained through goodwill and a desire to care for their patients. They told us the team only had enough staff to cover five days a week and they had to accrue time off in lieu or work overtime to provide the service.
- Speech and language therapists (SALT) provided a five-day-a-week service. A number of nurses had been trained to carry out a 'swallow screen' assessment for patients who were admitted out of the SALT team's hours of work. This provided an initial assessment of the patients' swallowing ability to allow their nutrition to be safely planned immediately they were admitted to the hospital. More detailed assessments were carried out by SALTs during on-going therapy.
- Specialist doctors worked Monday to Friday and Saturday mornings, and a focussed ward round was carried out by a consultant on Saturday afternoons. However, there was no consultant cover from Saturday

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afternoon until Monday morning. The focussed ward round concentrated on patients who were not medically stable, new admissions and patients who could potentially be discharged. Patients admitted to specialties after Saturday morning were not reviewed by specialists until the following Monday. This may cause a delay in patients receiving appropriate specialist care.

- There was consultant on call cover for cardiology and gastroenterology on Sundays. There was consultant ward rounds on AMU and wards 12 and 14 on Sundays.

Access to information

- Policies and procedures were available on the trust's intranet and as hard copies held in ward offices. Staff were able to access these whenever they needed to.
- Locum doctors who regularly worked at the trust had their own logins to the trust's IT systems. Generic logins were available to be used by locums who worked at the hospital less frequently. None of these logins allowed locums to request diagnostic investigations. If diagnostic tests were needed locums had to be supported by the trust's clinical staff to make requests.
- Stroke Association information packs were given to all stroke patients who were aware of their diagnosis, to provide advice and support through their rehabilitation. If patients were not able to understand their situation, information packs could be given to relatives or carers.
- On ward 16, gastroenterology, we saw a notice board for student nurses, which had information displayed about several methods of endoscopy and other examination techniques, Crohn's disease, ulcerative colitis, different methods of providing nutrition, and inflammatory bowel disease.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw a properly completed Mental Capacity Act (MCA) assessment and Deprivation of Liberty Safeguard (DoLS) application for a patient withdrawing from alcohol on ward 14.
- On ward 4, frail elderly care, we looked at two sets of patient notes and found properly completed MCA assessments and justified DoLS applications.
- Nursing staff on ward 17 told us that there was no standard training for DoLS but they had good support from the safeguarding lead nurse whenever they needed it.

- Nursing staff told us that if an MCA assessment was required for a patient it was carried out by a doctor.
- We saw three patients on ward 29 who required a DoLS, however they had not received a mental capacity assessment as this was carried out by medics and there was a delay in medics attending the ward to conduct the assessment. This was brought to the attention of the ward manager and we saw the following day all three patients had been assessed.

Are medical care services caring?

Good

We rated caring as good.

Patients and relatives told us that staff provided them with genuine compassionate care and that they were always treated with dignity and respect.

Patients felt involved as partners in their own care and were supported to make their own decisions.

Patients' families were encouraged to help in their care and rehabilitation and were consulted and involved in decisions about safe discharges.

Compassionate care

- We spoke with five patients on ward 16 who all told us they were happy with the care they were receiving, and that staff were compassionate and treated them with respect.
- On all the wards we visited, we observed staff interacting with patients in a positive manner and displaying obvious compassion and genuine care.
- On the acute medical unit, we spoke with three patients who all told us they were very happy with the care they were receiving. One patient described the care as "brilliant" and "magic".
- One patient on ward 17 told us they "couldn't fault the nurses".
- On ward 4, frail elderly care, we spoke with relatives of two patients who told us that the patients were receiving a good standard of care and that they had no concerns.

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- Physiotherapists told us that when their therapy gymnasium on the stroke ward was not available due to capacity issues patients who were having mobility rehabilitation treatment had to do so in the ward bays, sometimes in view of other patients and visitors.
- Physiotherapists on the stroke ward told us that the nurses treated their patients as human beings and demonstrated genuine care.
- Friends and Family test results gave an average of 88% positive responses for medical wards for the period March 2014 to February 2015. The highest scoring wards were ward 1 and ward 7, both achieving a 94% positive response. The lowest scoring was ward 12, which scored 85% positive.
- Inpatient surveys were carried out by hospital volunteers and asked patients nine questions about how staff communicated with them, whether they were treated with respect, whether they knew the names of and had confidence in the doctors and nurses treating them, whether there were enough nurses on duty to care for them and for any other comments. Over a 20-week period between April and August 2015, 1,472 patients took part in the survey.
- Results of the survey showed that over 92% of patients were happy with the way doctors and nurses communicated with them, and over 93% had confidence in the doctors and nurses looking after them. Over 87% of doctors and nurses introduced themselves to patients. Patients said that about 24% of nurses and 27% of doctors sometimes talked in front of them as if they were not there and 32% of patients said that there were not enough nurses on duty to care for them.
- Physiotherapists carried out a survey of 99 patients between June and September 2015. More than 98% of the patients said the physiotherapy staff introduced themselves, were polite during the treatment and treated them with respect and dignity.

Understanding and involvement of patients and those close to them

- Families of patients who had suffered a stroke were encouraged to observe and assist with the patients' rehabilitation therapy. Staff told us this helped to motivate the patients and helped their families to cope.
- On the swift discharge ward, we heard a discharge co-ordinator on the telephone to a patient's relative. The conversation centred on how well the patient's

relative would be able to cope when they were discharged home, what extra support they may need and if the relative was happy to continue caring for the patient at home.

- The results of the physiotherapy patient questionnaire showed that 97% of patients felt that their treatment had been explained fully and 94% of patients felt they were involved enough in decisions about their treatment.

Emotional support

- Medical wards used a system of displaying an orange 'nurse in charge' sign above patients' beds if the nurse in charge of the ward needed to speak to visiting relatives or carers. This was explained on a poster at the ward entrance and relatives or carers were asked to speak to the nurse in charge if they found the sign above their relative's bed. This meant that the opportunity to pass on important information would not be missed should the nurse in charge be working in another part of the ward when visitors arrived.
- The stroke ward operated a 'stroke buddy' scheme, where former patients would return to the ward to speak with new patients and their relatives. The former patients were trained and supported by clinical psychologists. This allowed people who had recently suffered a stroke and those close to them to share experiences and get advice and support from people who had been through the same or similar situations.
- A sister on the swift discharge ward told us that they had a great deal of communication with patients' families about safe discharge before patients' went home. The sister told us that the emphasis was on providing holistic emotional support for patients and carers and that the ward staff derived satisfaction from making sure patients were discharged with proper support in place.

Are medical care services responsive?

Requires improvement 

The hospital did not have a dedicated cancer treatment ward and cancer patients were not all treated in the same location.

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The physiotherapy stroke gymnasium was not purpose-built or designed and was not always available for use. Patients sometimes had to have physiotherapy treatment in cubicles onwards.

Mixed sex breaches occurred in the discharge lounge.

Unreliable methods of translation were sometimes used when patients did not speak English.

Information about heart conditions was available in multilingual literature and on audio CDs for patients who did not speak English and did not read their own language.

Service planning and delivery to meet the needs of local people

- When the therapy gym on the stroke ward was being used as an extra nursing bay to ease capacity pressures, physiotherapists had to provide treatment for patients in their bed-spaces. This often involved hoisting the patient out of bed, moving their bed out into the ward corridor, moving other furniture out of the bed-space then bringing the therapy plinth in and hoisting the patient back onto it. The process was reversed at the end of the treatment. This increased the time it took for each patient to be treated and had caused damage to the therapy plinths due to their frequent repositioning and movement around the ward.
- During our inspection, we saw male and female patients in their nightwear and in the discharge lounge at the same time. This breached NHS guidance on same-sex accommodation. We raised this with senior managers at the time. When we returned for a follow up inspection, we spoke with a staff nurse on the discharge lounge who told us that the lounge was now only used for one gender at a time. The nurse told us that there had been one occasion since our initial inspection when bed bureau had insisted on them accepting a patient of a different sex to those already in the lounge. This had been reported as an incident and the matron was investigating it.
- The hospital did not have a dedicated cancer treatment ward. This meant that patients being treated for cancer were spread across a number of medical wards and specialist staff had to assess and treat them in different

locations. This also meant that cancer patients who experienced acute episodes relating to their illness could not access a specialist unit directly and had to go through the emergency department.

- Each bed had its own television additional channels on an adjustable bracket. Audio from the televisions would only play through headphones and these were available if patients did not have their own. This meant that other patients were not disturbed by noise and that each patient could make their own choice rather than using a communal television. There was no charge for patients to use the televisions.

Access and flow

- Between 1 August 2014 and 31 July 2015, the average number of bed moves per patient was 1.1. However, 62% of patients had no bed moves at all. This includes all changes of bed, whether internally within a ward or a move to a bed on another ward.
- For the same period the average number of ward moves per patient was 0.5 and 67% of patients did not move wards during their stay at the hospital.
- A senior manager for the medicine division and ward staff told us that the trust's bed moves policy stipulated that overnight bed moves could not take place unless they were approved by the on-call director. We were provided with a copy of the hospital's transfer of care policy, which stated that transfers would not occur after 8pm unless the director on-call had given the onsite manager or night manager permission to do so. An incident report would be completed, including details of the director authorising the move, if this happened. This meant that patients were not disturbed during the night unless absolutely necessary.
- The swift discharge ward operated as an intermediate care facility for patients who were stable and waiting for appropriate care packages to be put in place at their homes before they could be safely discharged. The ward worked to a target of safely discharging patients within seven days of their arrival on the unit. Between April and September 2015, it had achieved this for only 48% of patients and for the same period, the average length of stay on the ward was 14 days.
- The swift discharge ward was GP-led, but because it was a ward within the trust rather than a community intermediate care facility, patients who deteriorated could be referred direct to other specialties without going through a new admission process.

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- The medicine division management team told us that a multi-disciplinary discharge team, made up of hospital nurses, social workers and community nurses was available seven days a week from 9am to 5pm. This meant that services could be planned and co-ordinated to allow patients to be discharged safely.
- The acute medical unit (AMU) had access to a real-time information screen detailing patients waiting for admission from the emergency department, which allowed them to plan their own patient moves. The screen also allowed AMU staff to indicate when a bed was ready for a patient rather than having to telephone the emergency department.
- The hospital had not reported on its referral to treatment performance against the national 18week target since September 2014.

Meeting people's individual needs

- We saw notices displayed on ward notice boards detailing the trust's in-house link nurse translation facility and the external translation service that was available for staff. Staff told us they did not use an interpreter service for patients who did not speak English, but would use the multilingual link nurses, or family members, sometimes over the telephone. Using family members to translate is not a reliable method and the accuracy of the translation cannot be checked or relied upon and may breach confidentiality.
- We were told about a Polish-speaking patient on one ward whose partner translated for ward staff. A Russian-speaking doctor and physiotherapist were also used to assist with translation. These methods were not reliable and did not meet the patient's needs.
- In addition to printed leaflets in a number of languages, information about coronary heart disease and what patients could do to manage their own condition was supplied in audio form on compact discs. These were available in seven languages: English, Hindi, Punjabi, Bengali, Mirpuri, Gujarati and Urdu. This was done in response to a survey that had been conducted into Asian health and lifestyle in Walsall, which identified that the ability to speak an Asian language did not necessarily imply an ability to read or write it.
- Most wards had 'butterfly bays' to identify patients who may have needed more support because they were living with dementia however, staff we spoke with did not have a good understanding about their meaning. We spoke with one sister, one nurse in charge, two staff

nurses and one care support worker on three wards, all of whom told us the butterfly symbol meant that the patients were at risk of falling. Only one staff nurse told us that the symbol indicated that the patients were living with dementia and other nurses nearby disagreed and insisted it meant they were at risk of falls. When we asked these nurses the difference between the butterfly symbol and the leaf, which did indicate an elevated falls risk, they were unable to explain it and told us both meant the same thing.

- One care support worker told us that the butterfly symbols were around one of the bays for decoration.
- We asked an elderly care specialist pharmacist about reviewing prescription charts on a butterfly bay but they did not know what a butterfly bay was.
- The newly opened ward 29 had been designed as a 'dementia-friendly' environment and had a specially designed garden that was accessible from the ward's dayroom. However, during our visit there were no patients using either the dayroom or the garden.
- The endoscopy unit could not treat bariatric patients as day cases as the trolleys in the unit were not suitable. Bariatric patients were admitted and wheeled through to the endoscopy unit on their beds.

Learning from complaints and concerns

- The medicine division was divided into four care groups: acute and emergency, long term conditions, specialties and elderly care. On receipt, complaints were assessed by the lead nurse who decided which care group or groups they should be assigned to.
- During 2014/15, 144 formal complaints and 613 informal concerns were raised about the medicine division. We were given details of trends in complaints for the whole trust which showed that 60% of formal complaints were about clinical care, assessment and treatment.
- We were told about a number of actions that had been taken as a result of learning from complaints including:
- The introduction of a patient transfer form based on the 'Situation, Background, Assessment, Recommendation (SBAR)' tool to ensure consistent and up-to-date information was passed on when patients were transferred between wards or departments.
- Improved information regarding the role of the Swift discharge suite (SDS) had been published, including a letter that was given to patients and relatives about the SDS and a poster giving information about the unit.

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- The lead dietician had reviewed dietary training for housekeeping and catering staff.
- Learning from investigations and incidents was fed back at care group management meetings and up to directors, and shared across care groups where appropriate.
- Minutes of the monthly medicine divisional quality meetings recorded details about complaints and lessons learnt. Lessons learnt and changes in practice were fed back to care group managers and staff by email, ward communication folders and on the trust's intranet.

Are medical care services well-led?

Requires improvement 

Governance processes were disjointed and inconsistent and senior managers were not aware of some common practices at ward level.

Staff told us that there was a disconnection between the operational nurses and doctors and senior managers, and that senior managers were only ever visible in times of crisis.

Staff told us that they did not feel supported or valued and that senior managers used heavy-handed management tactics.

Staff did not feel that the trust's values added anything to the care they provided for patients.

Vision and strategy for this service

- Nursing staff were aware of the vision and values of the trust, but five nurses told us they thought the values 'welcomed', 'cared for' and 'in safe hands' did not add anything to the care they provided as they merely described basic standards of nursing care.
- Nurses told us that the hospital was 'doing ok' on its pledges to patients but was breaking its promises to staff.

Governance, risk management and quality measurement

- Senior managers from the medicine division told us that agency nurses were not allowed to give intravenous medicines while working at the hospital however, on

four medical wards nurses told us that agency nurses did give intravenous medication. This indicated that the senior managers did not have an understanding or awareness of working practices on the wards in their division.

- We asked how agency nurses' competence to give medicines by this route was checked and we were told that agency nurses had to indicate their own competence by ticking the appropriate box on their induction form. We asked for a copy of the competence checklist for agency staff but we were only given a copy of the 'bank and agency staff induction sheet' which made no reference to individual nurses' competencies. We were not reassured that sufficient checks were made on agency nurses' skills before allowing them to administer intravenous medication.
- We were not confident that the care group quality meetings were supported well enough to provide effective governance. We were told that care group quality meetings were held monthly, followed a week later by medicine division quality meetings, however minutes of the medicine division quality meetings from August, November and December 2014 and January, March, May and July 2015 reported variously that care group meetings had not taken place due to low numbers attending or demand in the hospital.
- We saw minutes of the monthly medicine division quality meetings held over the 12 months leading up to our inspection. The minutes recorded discussions about strategy, divisional performance, incident reports and investigations, claims, duty of candour, clinical audits (including actions and lessons learnt from audits), infection control and complaints.
- Minutes of the medicine division quality meetings also included reports from the care group quality meetings when they were held.
- In the discharge lounge we found a fire escape route blocked by physiotherapy equipment and piles of patients' notes. We brought this to the attention of the hospital managers and it was cleared the same day. When we returned for a follow up visit a nurse told us they had escalated this several months ago to senior management and asked for the equipment and notes to be moved, but no action had been taken until our inspection.

Leadership of service

Medical care (including older people's care)

- Senior ward staff told us they felt unsupported regarding nurse staffing shortfalls. They told us that they felt they were “just supposed to get on with the job” and manage with insufficient staff and that little was done to assist them.
- Some senior ward staff told us they felt supported by matrons but others told us they were not supported. We were told that managers above matron level were not visible on the wards and that staff felt senior managers did not listen to them.
- One ward sister told us that if they spoke out about their concerns they were made to feel as if they were causing trouble or being a nuisance and that matrons and senior managers used heavy handed management tactics.
- One ward sister told us that they attended and listened at the weekly sisters meeting but had little input as when they said anything they were made to feel as if they were being negative and “not toeing the line.”
- Physiotherapy staff on ward one told us that before our inspection a senior manager had told them to keep the door to their therapy gym closed and to try not to let us in during the inspection because of the condition of the equipment.
- We were told that the trust's chief executive had shadowed the stroke physiotherapy team a year earlier and had said that the lack of facilities needed to be rectified regardless of cost. No changes had been made to the facilities since then.

Culture within the service

- Several staff on different wards told us that senior managers did not treat all staff equally and that there was a culture of being looked after if you were in favour with the management.
 - We spoke with sisters on two wards who reported to the same matron. One told us they felt well supported and that the matron was approachable however, the other told us they had no support and that they did not feel able to ask for help from the matron.
 - Staff told us that they were told to escalate concerns to their line managers but when they did so no changes or improvements were made.
 - Generally, across medical wards staff felt ‘put on’ and unsupported, particularly by senior management.
- Staff on the acute medical unit told us that the unit managers were supportive and encouraged a team culture. One agency nurse told us they had worked on several similar units in the area and that Walsall Manor's had the best staff culture and was very well organised.

Public engagement

- The medicine division received feedback from patients and relatives through their patient experience surveys, physiotherapy patient surveys and the NHS friends and family test (FFT).
- Over the period March to August 2015, medical wards had an overall average of 93% positive replies in the FFT. The highest scoring wards were the cardiac intervention suite at 100% and ward seven at 98%. Apart from wards 3 and 12 that scored an average of 88%, all other medical wards had achieved over 90% positive responses during this time. Wards 3 and 12 were performing better than their average score in the most recent figures available, which demonstrated an improving trend.

Staff engagement

- A consultant geriatrician told us that the hospital had set up a frail elderly pathway to avoid unnecessary admissions but that senior managers had not involved the geriatricians in this plan despite them being keen to be involved. They told us that the plan was to use a middle grade medical doctor to assess patients on this pathway rather than consultant geriatricians.
- In the staff room on ward 16 we saw two handwritten ‘thank you’ cards to the staff from the director of nursing. We were told that these had been sent following two challenging incidents that had occurred on the ward.
- Administration staff on the acute medical unit told us they felt well supported by managers up to matron level, but that senior managers were rarely seen on the unit and the executive team were not visible at all.
- The Trust published a bimonthly newsletter for staff, called ‘Trust Connect’. Staff told us that if an issue contained particularly important information copies would be attached to their payslips.

Innovation, improvement and sustainability







- One clinical nurse specialist told us that the respiratory consultants were not taking new treatments and guidelines into account and as a result, patients were

Medical care (including older people's care)

not receiving the same quality of service as those being treated in neighbouring trusts. They told us the consultants were not progressive or innovative and were “doing what they had always done” with no regard for developments in their field of medicine. They said that the clinical nurse specialists were not supported clinically by the consultants and the nurses never had feedback on recommendations they made.

- The swift discharge ward was an innovative in-hospital intermediate care facility, allowing proper plans to be made for patients to be safely discharged while still having acute care available should they become unwell.
- The newly opened ward 29 had been designed as a dementia-friendly environment, following the principles of the King's Fund's 'Enhancing the Healing Environment' programme and the Royal College of Nursing's report, 'Transforming Dementia Care'.

Surgery

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

Information about the service

Surgical services at Walsall Healthcare NHS Trust were managed by the Surgery Division, which included six specific departments: Musculoskeletal, Head & Neck/HSDU, Theatres, Anaesthetics & Critical Care, General Surgery/ Urology, Outpatients/Administration /Breast and Cancer Services.

Total patient admission for this period was 18,591 and during the last financial year from April 2014 to March 2015 there were 5,746 admissions to the inpatients wards. 1,500 children were included in these figures.

The surgical department comprised six surgical wards with 152 beds, a surgical assessment unit (SAU) and 13 operating theatres with associated areas for anaesthetics and recovery. Two of the theatres were not in use, one was closed and the other used for storage of equipment. The highest number of episodes was in general surgery.

Since April 2015, the trust had a surgical assessment unit (SAU) which provided surgical assessment for direct referrals from the Accident & Emergency Department (A&E) and GPs and was staffed on rotation from the other surgical wards.

There were 26 beds for emergency trauma (ward 9), 27 beds for emergency female surgery (ward10), 25 beds for emergency male surgery (ward11), 16 beds elective orthopaedic surgery (20a) 24 elective surgery (20b) 24 elective day surgery (20c).

We spoke with 36 patients and nine relatives, held discussion with 71 staff and reviewed 15 patient records and 30 prescription charts. We also made observations in surgical areas and reviewed information provided to us prior to and during the inspection.

Surgery

Summary of findings

Overall, we found surgical care services at Walsall Healthcare NHS Trust to require improvement.

We found that there were good systems to report and investigate safety incidents. However, there was poor incident feedback to staff.

We also had concerns relating to the lack of regular night deep clean of theatres which may compromise infection control processes. We found there was excessive storage of equipment and out of date equipment specifically in the children's surgery.

We saw surgery services had challenges meeting the 18 week referral to treatment targets for OPD and ophthalmology surgery.

We identified some concerns in relation to training on medical devices such as intravenous pumps. Otherwise, we found medical staffing, nursing staffing, the storage and management of medicines, the management of confidential records and infection control procedures to be good.

Mental capacity assessments were undertaken and consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the Duty of Candour.

The majority of patients were treated based on national guidance and local audits. However, there were some audits based on national guidance showing non-compliance with some local audits being slow to progress and some being deferred to the 2015/16 programme.

We found that there were arrangements to ensure that staff were competent and confident to look after patients. Patients were cared for by a multi-disciplinary team working in a co-ordinated way and had access to some services seven days a week.

The nutritional needs of patients were assessed at the beginning of their care. Patients were supported to eat and drink according to their needs and there was access

to medical or cultural diets were catered for. Staff were trained with respect to mental capacity and deprivation of liberty safeguards although there was variable knowledge amongst some levels of nursing staff. We judged the caring aspects of medical care services were good. All the patients we spoke with were positive about their treatment and care. Patients and relatives said they felt involved in their care. Staff treated their patients with understanding and patience.

We judged that the responsiveness of surgery services as required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in medical patients being placed on surgical wards which affected the service.

Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. However, translation services were not easy to access with some patients relying on their relatives to translate on their behalf.

There was no dedicated strategy for the division. There was a backlog of patients waiting for elective surgery.

The surgical division had not addressed some longstanding risks on the risks register.

We saw examples of good clinical leadership within the surgical and trauma and orthopaedic teams. Relationships within the teams were working well and there were a number of opportunities for developing and supporting junior staff.

Staff told us this was a good place to work and they were kept updated via team meetings and monthly newsletters.

All staff we spoke with were highly complementary about the SAU and saw this initiative as a positive move to addressing the management of surgical patients.

Surgery

Are surgery services safe?

Requires improvement



We found that surgical services required improvement to protect people from avoidable harm.

Staff were aware and familiar with the process for reporting and investigating incidents using the trust's electronic reporting system. The surgical division could demonstrate learning from incidents. However, a number of staff told us they did not report all incidents as it was too time consuming and they received no feedback from reporting an incident.

Mortality outcomes were discussed regularly in order to identify where improvements or changes needed to be made. Where there were concerns these were discussed at the divisional meetings.

The NHS safety thermometer information included information about patient harm and harm free care such as pressure ulcers and patient falls. These were displayed on boards in all areas visited. Wards and theatres were clean and monthly cleanliness audits were undertaken.

There was good access to hand washing facilities and hand sanitising gels. Decontamination of surgical instruments was managed by the trusts internal sterilisation department.

Medical devices were maintained and supplied through the electronic bio-medical engineering team and there was a web based tracker system that would flag up where staff needed further training. However, due to the lack of training for nursing staff there were 150 new intravenous pumps waiting to be utilised.

Medicines were managed and recorded appropriately. Care records showed risk assessments were being appropriately completed for all patients on admission to the hospital and were regularly audited. An early warning scoring system was used for the management of deteriorating patients. Staff practiced the 'Five Steps to Safer Surgery, World Health Organisation (WHO)' and the checklist had been adjusted to make it more appropriate for the trust's needs.

Mental capacity assessments were undertaken and consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of

staff induction. Staff were aware of the safeguarding policies and procedures and had received training. Most staff understood their responsibilities under the Duty of Candour.

Although there were vacancies in some areas, arrangements were in place to ensure staffing numbers and skills mix were appropriate to support the delivery of patient care safely. The trust had recently recruited seven new nurses from Italy to work in the surgical division. Staffing levels in theatres were generally well staffed however, it was recognised that there would be gaps in their staffing levels over the next one to two years due to a high number of staff retiring.

Surgical consultants from all specialities were on call for a 24-hour period.

Incidents

- Incidents were reported using an electronic system and ward staff and medical personnel we spoke with were able to describe examples of incidents they had reported and the investigation process. We saw evidence of shared learning on ward 9 where all incident forms had been printed out, collected in a folder and discussed at ward meetings. Key themes and learning from an incident was disseminated via a 'lessons learned' newsletter.
- However, 10 staff told us they did not report all incidents as it was too time consuming and they received no feedback from reporting an incident.
- Between February 2015 and May 2015, 777 incidents were reported in the surgical division: 341 related to general surgery, 140 head and neck surgery, 161 muscular skeletal surgery, 100 operating theatres and four urology. The remaining 31 incidents were attributed to anaesthetics/critical care.
- There had been no never events reported in the 2014/15 period within the surgical division. Never events are serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2013).
- However, a previous never event which took place relating to the wrong insertion of a prosthesis resulted in a change in practice where staff had a 'down time' prior to implanting the new prosthesis. This allowed time for staff to double check the prosthesis was the correct one for the specific patient.

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- Between April 2014 and June 2015 there were 13 serious incidents reported to StEIS. StEIS is a patient safety reporting and learning framework. These 13 serious incidents were: four episodes of ward closures, two cases of suboptimal care, three delayed diagnosis, one loss to follow up, one surgical error, one fall and one communication issue.
- All three ward closures were due to patients having symptoms of norovirus. Norovirus is sometimes known as the winter vomiting bug and is the most common bug in the UK.
- For April 2015 to June 2015 there were 13 serious incidents reported. We reviewed these incidents and saw that the process included a description of the incident, action taken, lessons learned and approval status based on a traffic light system of red, amber and green.
- Mortality data was presented at the Care Group Quality Team meetings every two months and any concerns would be directed up to the Directorate Quality Team meetings for action. For example, at the March 2015 meeting, the mortality data showed that 70% of the morbidity listed was not morbidity and concerns were raised to how these were coded. This was reported upwards to the division's quality team meeting for further discussion.
- Staff understanding of the Duty of Candour was variable depending on their grade. For example, 12 band 5 theatre staff knew what to do if they made a mistake, although they did not recognise the title of Duty of Candour. There was a good understanding by more senior staff with less junior staff on the wards understanding the Duty of Candour.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person,' within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Duty of Candour training was part of the directorate's clinical update training package with an overall of 69% of staff receiving the training. The urology department had a 100% attendance rate, general surgery and

trauma and orthopaedics had attendance rates of approximately 65%, operating theatres had an attendance rate of 70% and head neck and cancer approximately 74%.

- Staff in the day surgery ward told us about a patient who had suffered due to delayed urinary catheterisation. Urinary catheterisation is often a more acute problem in male patients when they cannot pass urine due to prostate problems. It involves a small tube being passed into the bladder to drain urine from the bladder. Not being able to pass urine is very painful. This was recorded as a clinical incident and a duty of candour letter had been sent to the patient. Learning from the incident was also identified for the staff looking after the gentleman. This involved being more accurate about the recording of fluid intake and output.

Safety thermometer

- The trust participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm free' care.
- Data was collected on a single day each month to indicate performance in key safety areas with respect to hospital acquired pressure ulcers, patient falls and catheter related urinary infections. This data was collected electronically and a report produced for each area. Data presented indicated there had been three patient falls between September 2014 and September 2015. The number of patients admitted who acquired a pressure ulcer for the period was 37, seven patients reported as having a venous thromboembolism (VTE) and 27 patients had a catheter induced urinary tract infection.
- Other information was also collected which included: MRSA, Patient and Friends and Family Test, (FFT) Staff and Friends and Family Test, vacancies, sickness, training, appraisals and discharges.
- This data was collected electronically and a report produced for each area. Data was reviewed for ward areas and this indicated for example that on ward 9 there had been one patient fall and two pressure ulcers in the month up to the date of our visit. Wards 9, 10 and 20a results showed there were no patient falls and no pressure ulcers in the month.
- Within the theatre environment, staff employed the use of devices to minimise risks to patients developing pressure sores, such as warming devices and pressure relief aids.

Surgery

Cleanliness, infection control and hygiene

- There were infection prevention and control (IPC) link nurses on each ward and in theatres. They were responsible for giving training and information and to ensure staff were compliant with infection control best practices.
- According to the data presented to the CQC for the surgical services division, there had not been any infections related to Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile Toxin (CDT) cases over the last six months.
- There were dedicated staff for cleaning ward areas and they had been provided with nationally recognised colour coded cleaning equipment for use in defined areas or under specific circumstances. This helped to reduce the possibility of cross contamination.
- We saw evidence to suggest operating theatres were cleaned daily after use although at times theatres could not be cleaned as they were still in use. For example; for the week ending 30th August 2015, theatre three was not cleaned in the morning for six of the seven days although it was cleaned in the evening. Senior staff told us theatres did not have a regular 'deep clean' at night by contractors in accordance with specific guidelines however, theatres were cleaned after each list. Staff told us they did not feel it was necessary to deep clean at the end of each day.
- We were told by theatre staff that theatres did receive a regular 'deep clean' however they could not say exactly how often and there was no deep clean schedules available to look at.
- In main theatres they had separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the trusts decontamination service.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatre environment. This included skin preparation and management of the post-operative wound. The trauma and orthopaedic theatres had a notice outside the theatre doors stating 'if you are not prepared to wear a mask in this theatre, please do not enter'.
- The decontamination of surgical instrumentation was managed by the trusts internal sterilisation department. Procedures were in place for storage of dirty and clean instrumentation, with equipment items scanned and tracked accordingly. However, the system of working on the principle of a pathway through the theatre suite from 'clean to dirty' did not work in the main theatres. Once instruments and clinical waste were ready for removal from the department, they would go back through the clean areas which might compromise infection control practices.
- Surgical wards and the SAU were found to be visibly clean and patients commented on the general cleanliness of the wards. Theatre areas were clean and generally well maintained although storage of equipment was a problem with one theatre (theatre four) being used solely for storage purposes.
- There was access to personal protective equipment (PPE) including gloves and aprons, in all areas visited and staff used these whilst going about their activities.
- Staff had access to infection and prevention control (IPC) policies and procedures via the trust intranet.
- A personal protection and environment (PPE) audit was carried out in May 2015, which demonstrated an average compliance of 95%. This ranged from 73% on the SAU to 100% on ward 20.
- We were told by staff in the day surgery unit that only patients with a negative methicillin resistant staphylococcus aureus (MRSA) result were accepted for surgery.
- We observed staff in theatres and on wards complying with local infection control policies, such as management of sharps, hand hygiene, the management of bed linen and the management of clinical waste. There was good access to hand washing and drying facilities, as well as hand sanitising gel. Containers of the latter were on patient beds, at entrances to wards and bay areas. However, the SAUs hand sanitizers were out of date and some should have been replaced in 2013.
- The PLACE survey information (2014) showed wards 20a, 20b/c and 10 to have areas needing improvement due to collections of dust on equipment and blocked fire exits.
- The armchairs in the day surgery ward did not look comfortable for patients who had undergone a surgical procedure and they did not recline.
- Infection control audits had been carried out with respect to compliance with environmental and clinical

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practices. The surgical departments compliance with its sharps audit (2015) ranged between 78% (ward 10) and 95% (ward 20b/c). There were action plans to address the shortfalls.

Environment and equipment

- There were 11 main operating theatres of which three had air flow exchange (Laminar flow). This meant that all orthopaedic surgery was taking place in the appropriate surroundings. The recovery area had eight bays, including one used for the post-operative recovery of children. Standard theatre environment was provided with anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- The SAU had 11 trolley spaces with three trolleys for males, four for females, two in side rooms and two that could be used flexibly or as a waiting area. Male and females were segregated and all trolleys had oxygen, suction, call bells and lockable bedside cabinets. The resuscitation trolley was clean and checked daily.
- There was inadequate storage for different types of equipment in theatres with one theatre taken over to store equipment. Emergency equipment in theatres was available and included resuscitation items and emergency intubation. The trusts patient equipment audit carried out in 2014 showed that cleanliness was still a concern with an average compliance 89% ranging between 87% (ward 20b/c) and 94% (ward 9).
- We checked the resuscitation trolley in theatres but some checks had not been completed. Out-of- date equipment was found on the paediatric resuscitation trolley such as; an endotracheal tube dated 2013, a laryngeal mask dated April 2015 and some three ways taps dated 2012. Staff were informed at the time of the inspection and these items were removed and replaced.
- Wards and theatres were accessible to individuals living with a disability and technical equipment was available to support individuals where required. This included operating tables being appropriate for bariatric patients.
- The handling and disposal of waste audit showed an average of 90% compliance ranging from 88% on ward 10 to 93% on ward 9. The environmental audit showed an average 90% compliance ranging from 88% on ward 10 to 94% on ward 20b/c.
- Medical devices were maintained and supplied through the electronic bio-medical engineering team who fed any concerns up through the medical devices group and to the care group quality team.

- There was also a web based training tracker system so staff can access training on medical equipment and will flag up to individuals and managers where further training was required. This showed that several members of staff were not trained to use some medical devices and therefore were not competent to use some devices.
- However, due to the low uptake of training across the trust where 75% of staff need to be trained to use the pumps, there were 120 intravenous pumps waiting to be distributed to the wards. Wards 10 and 11 had still not reached their 75% target. The roll out of the pumps should have been completed by July 2015 with the new timeline for completion being November 2015. This meant that staff across the trust were using out-of- date equipment that could be a risk to patients.
- Current pumps were four years old. They were being replaced due to reliability issues and also due to a National Health Service Litigation Authority (NHSLA) alert on shortage of giving sets from a specific provider.
- Staff in the operating theatres, intensive care unit and high dependency unit achieved the 75% trained rate and the new pumps had been circulated and are being used.

Medicines

- We found that the pharmacy team provided a well-established and comprehensive clinical service to ensure people were safe from harm. The pharmacy team visited all wards each weekday, and some wards had a weekend service as well.
- We saw that pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital. We saw examples of medicines interventions recorded by a pharmacist to guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for 17 patients on two wards. Prescription charts had been fully completed and showed that people received their medicines as prescribed.
- Medicines were not always stored appropriately. We saw intravenous fluids stored in a room that was not locked and was in a patient accessible area. Therefore we were not assured that suitable arrangements were in place to prevent medicines being tampered with. We informed staff at the time of the inspection.

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- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. Nursing staff told us that there could be minor delays in the prescription and supply of discharge medicines, meaning that people were sometimes kept waiting for their medicines.
- For the period between April 2014 to March 2015, an overall combined medicines errors across the surgical division was 73 errors with the most amount of errors (17) experienced on ward 10, (12) on ward 20a and (10) on ward 20b.
- The department used a computerised storage and dispensing system to store medication. This proved beneficial for stock provision and monitoring of medicines. There was a code on the door to access the room and fingerprints were used to check signage of control drugs. The system was automatically temperature controlled and flashed an alert should the temperature rise above the safe storage temperature. There had been no temperature alerts by the system.
- Omnicell (automated healthcare system) only allows staff to access medication once they have entered a password or access code. It requires two appropriate staff to sign in before dispensing medication. Medication can however be dispensed without being assigned to an individual patient. However, controlled drugs must be assigned to an individual patient apart from emergency cases when this can be overridden to give a stat dose.
- We saw the day surgery ward used an electronic system to dispense take home medicines for patients. The Medisave system is a locked, controlled storage facility for prescription only medicines already prepared by pharmacists in packages to take home. Therefore, medicines were available to the ward staff and avoided delays for medicines to be dispensed from the pharmacy. Patients did not have long waits for their prescriptions.
- Procedures for ordering, storage and disposal of medicines on surgical wards and the SAU were carried out safely and in accordance with best practice in most areas. This included temperature checks of fridges used for storing certain medicines.
- Controlled drugs (CDs) were stored in locked cupboards, which were secured to the wall. All CD registers we looked at were completed appropriately
- CDs were checked twice daily in theatres however, the trust had introduced a new process for checking the CD stock balance using an additional CD Check Book. This meant there was an additional document used to double check the CDs. Staff we spoke with did not understand why this additional check had been instigated. The pharmacy department was regularly auditing practice in theatres and at the time of our inspection the pharmacy was delivering the outcome of a CD audit and putting a training package in place to support the better handling of CDs for theatre staff.
- We observed medicines being given to patients by nursing staff on wards. Checks were done in accordance with the prescription prior to administration and staff wore red tabards in order for them not to be disturbed whilst carrying out a medication round.
- We checked 30 patient medication charts and found them all to be signed and dated, all allergies documented where necessary and all entries were legible.
- Antimicrobial protocols were visible and there were reminders in anaesthetic rooms about medicines.
- A trust Self-Administration of Medicines Policy was agreed in April 2015 and ward staff were involved in its development. Ward staff were encouraged to promote patients to self-administer their own medication however nurses were advised they needed to be present when patients took their medication.

Records

- The trust had moved to a new electronic patient administration system (PAS) 18 months prior to the inspection. Staff told us this was slow and resulted in patients having to wait to be admitted whilst staff updated records. There was a paper-based standard surgical booklet used for all surgical procedures, which contained the documentation required for the patient journey from pre-assessment or emergency admission through to discharge. This process was well managed .
- A surgical post take ward round documentation audit was carried out to determine whether specific information was being documented on this round. The results showed a high percentage of patient details being documented. However, investigations requested were not always documented in the notes and the decision making was not always clear. As a result of this audit a new post take ward form was being brought in to improve the documentation. This would then be re-audited to ensure practice had improved.

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- We looked at 15 sets of patient's notes. They were comprehensive, well documented and included: diagnosis and management plans, consent forms, evidence of both multi-disciplinary input and discussions with the patient and families.
- Risk assessments, such as assessment of moving and handling, skin integrity, nutrition, use of bed rails and Venous Thromboembolism (VTE) were recorded in the care records reviewed. Assessments of falls, pressure areas and nutritional status were well documented.
- Theatre staff followed the 'Five Steps to Safer Surgery' which included a team brief, sign in, time out, sign out and a debrief. An audit was regularly carried out, with sets of notes selected randomly every day throughout each month. Theatres were achieving 100% compliance each month.
- The Department of Health requires the WHO checklist to be completed for theatres, maternity theatres, cataract surgery and interventional radiology and any area where sedation or invasive procedures take place, including dermatology and ophthalmology. The trust had developed its own version of the WHO checklist, which incorporated all elements of the original WHO checklist.
- WHO checklist audits were undertaken daily and monthly reports were presented to the Quality Review Group. For example, in May 2015, an audit of 99 patients was reported to the group with operating theatres achieving 100% compliance with the standards.

Safeguarding

- Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Theatre staff had completed appropriate safeguarding training and Paediatric Advanced Life Support (PALS) training.
- The uptake of safeguarding training was:
 - Level 1 - general surgery 91.7%, head and neck 93.4%, theatres 94.6 %, trauma and orthopaedic 92.3% and urology 100%. Training uptake for theatre staff was being addressed through monthly training sessions.
 - Level 2 - general surgery- 80.6%, head and neck 90.7%, theatres 73.9 %, trauma and orthopaedic 88.4% and urology 100%. Overall safeguarding Level 3 training for the surgical division was 90.7%.

Mandatory training

- Mandatory training included equality and diversity, moving and handling, fire, information governance, health and safety and infection control. Adult and child safeguarding was a mandatory subject.
- Overall attendance at mandatory training was 81% with general surgery achieving 74.9%, head and neck 81.2%, trauma and orthopaedics 77.5%, urology 88.1% and theatres/anaesthetics/critical care 77.9%.

Assessing and responding to patient risk

- All surgical wards used the National Early Warning Score Tool (NEWS) demonstrating whether a patient's condition was deteriorating. We saw good practice in escalating a deteriorating patient where a patient's observation showed an episode of tachycardia (increased heart rate), this was appropriately escalated and tests were requested and the NEWS used appropriately.
- Theatre staff had recently introduced 'SMART' roles where at the beginning of a list staff were allocated a specific role if an emergency arose. This meant that staff could respond quicker in an emergency. Anaesthetists were also running regular role play situations for staff to be able to respond in a more timely and knowledgeable manner.
- We found that the day surgery reception area was unattended from 2pm. An information board was used instead to inform patients to take a seat and wait for the nurse. However, this was not on display and patients were not received or attended to effectively.
- The NEWS system was also used in the day surgery ward. We were told that if day surgery patients were not fit to go home then they were admitted as an inpatient.
- We were told that all female patients booked for day surgery who said it was possible they could be pregnant had a second urinalysis and pregnancy test with their consent .
- We were given conflicting information about the use of the day surgery ward overnight. One staff member told us that on occasions, the day surgery unit was used for overnight stays for day surgery patients but additional staffing was arranged to facilitate this. Another staff member told us that the day surgery ward was regularly used as an overflow ward to deal with demand on hospital beds.

Nursing staffing

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- Staffing levels based on planned and actual needs were displayed on wards and in theatre areas. Ward staff worked 12 hour shifts. For example, ward 20b/c had four nurses and four care support workers (CSW) on during the day and two nurses and two CSWs on the night shift.
- The SAU and the elective day surgery ward (20b) were staffed on rotation from the other surgical wards.
- From December 2013 to May 2015 there was an overall sickness rate of 4.9%, which was slightly higher than the trust sickness rate of 4.6%. In general surgery it was 5.2%, operating theatres 6.3%, trauma and orthopaedics 2.2%, urology 3.7% and head and neck 2.1%.
- The average use of agency staff was 18.4%. The highest use of agency staff was in ward 10 having 28.1%, with ward 9 using 7.1% of agency staff, ward 11, 19.4%, ward 20a 17.5% and ward 20b 11%.
- Nursing staff turnover was an average of 19% with the highest in urology at 66.6%, with general surgery experiencing a 7.5% turnover, head & neck 10%, operating theatres 6% and trauma & orthopaedics 8.4%.
- Vacancies across the division were 14.0 % in general surgery, head and neck 1.46%, trauma and orthopaedics 9.1%, and operating theatres 3.2%. Urology had no vacancies.
- Seven new trained staff were due to start in the surgical division at the time of our inspection. Staff were concerned this would be too many new staff to start at one time and were looking to stagger their preceptorships.
- Three staff nurses told us that the use of agency nurses at night caused them concern as many agency nurses could not use the medical devices within the trust. This resulted in increased pressure on the permanent staff to deliver the care.

Surgical staffing

- Medical staffing within the surgical division compared favourably with the overall number nationally. However, data from the national hospital episode statistics (HES) January 2014-January 2015 shows the distribution of grades varied from the national picture: 41 consultant staff, which was the same as the national figures, 23 mid-career staff, which was more than the 11 nationally, 14 registrars compared with 37 nationally and 21 junior doctors compared with 12 nationally.
- Consultants ran a one in seven on call rota that started on a Friday morning and would cover the weekend

through to the next Friday. All emergencies were dealt with during the day by the on call consultant leaving the other consultants to manage elective patients. The evenings during the week were covered by the elective consultants.

- For general surgery there were eight surgeons, where five were colorectal, one was upper gastrointestinal and two vascular surgeons. There were eight middle grade specialist registrars and four associate specialists, six foundation year 2 doctors and seven foundation year 1 doctors.
- There were three breast surgeons who were not part of the on-call rota and three urology surgeons with a fourth consultant due to start in the near future. They had their own separate on-call rota.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. Handovers were well structured and detailed.
- The use of locum staff had decreased in May 2015 for theatre, critical care and anaesthetics use of locum staff was 5.9% as opposed to 10.1% in the previous year. This was due to successful recruitment of staff.
- Trauma & orthopaedics locum use was an average of 3%, for urology 20% and general surgery 6%.
- Revalidation for the 61 surgeons in the division of surgery was in progress with 70.5% of surgeons completing their revalidation.

Major incident awareness and training

- The trust had a business continuity plan in place dated 2014.
- Operating theatre staff told us they would not know what to do if there was a major incident. They felt that they would probably be called in to assist in theatres. Staff had no training in major incident planning. However, senior staff in theatres were aware of the procedure and knew how to access the algorithm for the bronze, silver and gold command.
- An algorithm is a set of instructions that can be performed in a prescribed sequence to achieve a set of end conditions. For example the bronze, silver and gold commands regarding to a major incident relate to the different levels of input into the procedure and ensures all staff at all levels understand their roles if there was a major incident.

Are surgery services effective?

Surgery

Requires improvement



The majority of patients were treated based on national guidance and local audits. However, some audits based on national guidance showing non-compliance with standards and some local audits being slow to progress and some being deferred to the 2015/16 programme.

The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical or cultural diets were catered for.

Staff had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. There was evidence to demonstrate that staff were trained with respect to mental capacity and deprivation of liberty safeguards although there was variable knowledge amongst some levels of nursing staff.

Staff received an annual performance review, which included discussion of learning and development needs.

There was evidence of multi-disciplinary team working both within the trust and externally.

Evidence-based care and treatment

- We were provided with a summary of surgical service audit programme for 2014/15. We saw that there were 72 audits taking place including 11 related to national programmes. These included the emergency laparotomy audit, four that were a trust priority, eight divisional audits and 49 self-supported / local interest audits. We noted comments made with respect to the programme, which included some audits being slow to progress and some being deferred to the 2015/16 programme.
- The trusts results for the National Bowel Cancer Audit for 2014 indicated that all patients in this category were discussed at multi-disciplinary meetings. 77% of patients were seen by a clinical nurse specialist, which was slightly worse than the England average of 87.8%. CT scans were reported on in 95.8% of cases, which was better than the 89.3% England average.
- We saw information, which indicated that patient's treatment and care did not comply with the National

Institute for Health and Care Excellence (NICE) guideline CG124: Hip fractures – The management of hip fractures in adults. The guidance included a fast track flow process for staff to follow in order to ensure the patient was operated on the day of or day after admission and having relevant assessment and interventions.

- Hip fracture audit results for 2014 indicated that the location performed worse on four of the indicators in comparison to the England average. For example, 32.6% of patients were seen by a senior geriatrician within 72 hours of admission, against England average of 51.6% and 20.7% of patients were admitted to orthopaedic care within four hours, against the England average of 48.3%. However, they did perform better on patients developing a pressure ulcer, 0.7% against England average of 3% and patients having a falls assessment 99.3% against England average of 96.8%.
- Adherence to the NICE guidelines, CG124, Hip fracture: The management of hip fracture in adults, 2011 showed 54% compliance with the guidance. This meant that some of the prosthesis used for a fractured neck of femur were not recommended by NICE.
- The surgical division answered 'information was not available' to 17 out of the 28 relevant questions in the National Emergency Laparotomy Audit 2014. Local analysis from this audit highlighted no risk assessments were being completed for patients for the risk of mortality prior to surgery and blood loss was not fully recorded within the case notes. The surgical division also undertook a number of local audits such as: day case laparoscopic cholecystectomies, the management of acute kidney injury in surgical patients and the management of patients with a fractured hip. However, the audit of day case laparoscopic cholecystectomies showed the rate of day cases was 46% compared with the national standard of 60%. However, 28-day readmissions back to the same speciality was very low.
- The audit and re-audit of the management of acute kidney injury in surgical patients showed there was no improvement in the management of these cases. Locally the division acknowledged that more work was needed trust wide to address the documenting of patient care.

Pain relief

- There was access to a pain service if needed.
- Ward managers (band 7) had their own peer review audit programme. Whilst on the inspection ward

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managers were auditing other wards pain management processes. This programme also included infection control practices, nutrition and hydration audits. This peer review system was introduced two years ago. We did not have the results of this audit at the time of the inspection.

- We observed that consideration was given to the different methods of managing patient's pain, including patient controlled analgesia pump. Nurses on the medication ward rounds would ask each patient if they were in any pain and would give prescribed analgesia if necessary.
- A patient on ward 20b told us that nurses came to their aid when they needed extra pain relief, and that this was given quickly and the effect checked by nurses.
- All patients we spoke with told us their pain had been managed very well and staff would regularly check to see if a patient was in any discomfort.

Nutrition and hydration

- Patients could choose from cultural or medical related diets and received three hot meals per day if they wanted. We observed meal times on the wards and found on one ward, a doctor examining a patient while lunches were being served and a medication round in progress throughout the lunch time period. When asked about protected meal times (a national initiative to allow patients to eat their meals without unnecessary interruption and to focus on helping those patients unable to eat independently), nurses told us they had always carried out medication rounds during the lunch time period. This meant patients' needs were not always met relating to protected meal times.
- Meals arrived in hot trolleys and set up as a 'counter' where nurses collected the meals as ordered by the patients and delivered to the patient. Meals were carefully placed so patients could access their food. If a patient needed help with eating this was flagged by the use of a red tray system and was delivered last so the food did not get cold.
- The surgical assessment unit (SAU) provided food such as: cereals, toast, sandwiches and soup. If a patient stayed all day on the unit then a hot meal could be provided.
- Pre-admission assessment included nutritional assessment of patients.

- Patients attending the pre-assessment clinic who were having surgery for cancer or major joint replacement surgery were given nutritional drinks to take before they had surgery.
- Dieticians did not attend the wards daily but would attend when requested. Audits on adherence to using nutritional assessment tools were carried out via the band 7 peer review programme.
- Risks assessments were in place for patient's nutritional needs and these had been reviewed as part of the patient's progress reports.
- Following national guidance, the trust enteral tube feeding policy had been updated and there was now a form in circulation for recording the position of nasogastric tubes.

Patient outcomes

- At the general surgical care group meeting in March 2015 readmission rates were discussed which highlighted that of the 67 readmissions coded only 33 were true readmissions. Concerns relating to how these were coded were discussed and were presented at the Directors meeting for further discussion. However, the top three common reasons for readmissions (pain, bleeding and wound issues) would be addressed in order to improve the overall performance.
- Patient Reported Outcome Measures (PROMS) were collected, which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures at the trust. Patient self-reported health outcomes for groin hernia, hip replacement and knee replacement and varicose vein surgery were better than the England average.
- The average length of stay for elective surgery was 3.3 days which overall was slightly longer than the national average of 3.1 days. The average length of stay for all specialties was longer for example: general surgery was 3.5 days as opposed to 3.1 days nationally, trauma and orthopaedics was 4.2 days, which was 3.1 days nationally and urology was 1.5 days with 2.1 days nationally.
- Non-elective surgery stay was also longer than the national average which was 5.7 bed days as opposed to 5.2 bed days nationally. General Surgery was 4.5 days

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against 4.2 days nationally, trauma and orthopaedics was 10.4 days against 8.5 days nationally. However, urology was 3.7 days was better than the national average of 4.2 days.

- Staff told us the length of stay was increasing for medically fit patients awaiting discharge due to social issues, which meant patients could not be discharged in a timely manner.

Competent staff

- Staff confirmed they had opportunities for a review of their performance and discussion of training and development needs during their appraisal.
- The overall appraisal rate for the surgical division was not disaggregated. The overall (clerical/admin) compliance rates quoted are overall compliance rates for all staff groups within the listed care groups :
 - General Surgery medical 88%, nursing 90% overall (clerical/admin) 88%
 - Head & Neck medical 70%, nursing 81% overall (clerical/admin) 79%
 - Operating theatres medical 85%, nursing 91% overall (clerical/admin) 92%
 - Trauma & orthopaedic medical 75%, nursing 85% overall (clerical /admin) 94%
 - Urology medical 100%, nursing 100% overall (clerical/admin) 100%
- The results from the NHS staff survey 2014 the trust performed better than the national average (38%) for the percentage of staff receiving an appraisal (40%), however, one member of staff told us they did not have a meaningful appraisal and had completed her own objectives.
- Staff were assigned link roles for different areas, such as falls, pressure area management, infection control and dementia although staff did not always have time to enact these roles.
- Operating theatres had two specialist practitioners who were first assistants and were trained to carry out minor surgery such as removal of lumps and bumps and more invasive surgery such as hernia repairs and laparoscopic cholecystectomies.
- Agency staff new to working in theatres had an orientation programme which documented all the competencies needed to work in the theatre environment.

- Junior medical staff had access to three hours formal training per week and told us there was plenty of 'on the job' training.
- There was a lead anaesthetist for paediatrics and elective paediatric surgery was shared by all anaesthetists to ensure they maintained competency in paediatric anaesthesiology. There was a system of "Buddy" training days for paediatrics.
- Only a third of the anaesthetists had completed Advanced Paediatric Life Support (APLS) but internal updates were completed annually. Children under three were cared for by one of five anaesthetists who had a special interest in paediatrics. In an emergency, the paediatric-trained anaesthetists could be contacted for input.

Multidisciplinary working

- Daily trauma multi-disciplinary meetings took place, during which all patients seen by the on-call orthopaedic team were discussed.
- Mini 'super clinics' were held at a weekend to reduce the backlog of patients waiting for orthopaedic surgery, these were attended by medical, nursing, administration and physiotherapy staff.
- Major vascular activity was dealt with at Dudley Group NHS Foundation Trust, which took both elective and emergency from the trust. This service level agreement had been in place since 2013.
- There was also a service level agreement with the City Hospital Birmingham to support one-stop breast clinics.

Seven-day services

- Theatre utilisation overall was 94% which showed improvement with March being 90%, April 82% and May 94%.
- Trauma lists took place every afternoon Monday to Friday, between 10am and 2 pm Saturdays and there was a slot the beginning of the theatre list on a Sunday morning. However, medical staff told us more trauma lists were needed as they were using more elective lists to carry out trauma surgery and filling any gaps in the elective lists with trauma patients.
- Physiotherapists provided a seven-day service from 8am to 8pm but this cover was being provided by two physiotherapists as current vacancies had not been filled. Staff told us that patient care was suffering

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because of the lack of physiotherapists and we were given an example where a patient had to be transferred to another hospital, as they were not receiving the level of physiotherapy needed to sustain improvement.

Access to information

- Staff had access to guidelines and protocols via the trust intranet.
- Risk assessments and care plans were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- Patients had access to written and face-to-face information from the nursing and medical staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall training figures with respect to Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) were approximately 88% with attendance from staff on ward 9 at 91.43%, ward 10 at 93.75%, ward 11 at 81.25%, ward 20a at 95.45% and ward 20b/c at 77.50%.
- Patients told us they had been informed of the risks involved in having surgery before they signed the consent form. Other patients confirmed that staff discussed with them what they were going to do before treatment or care, ensuring they obtained their consent.
- Staff working in theatres had a varied understanding of the mental capacity act, depending on their grade and a limited understanding of DoLS. Senior ward staff had a good understanding of the MCA and DoLS.
- We observed a patients journey through the day surgery unit from the consultation with the anaesthetist and surgeon to transfer to the operating theatre for their operation. We observed consent being given by the patient to their procedure. This was explained in full and included some of the risks to the surgery.

Are surgery services caring?

Good



All the patients we spoke with were positive about their treatment and care. Patients and relatives said they felt involved in their care. Staff treated their patients with understanding and patience.

We heard comments, which demonstrated that staff were understanding, caring and compassionate. We observed staff being mindful of the privacy and dignity of every patient.

Emotional support was provided by staff in their interactions with patients and by clinical nurse specialists, who visited the wards regularly. Communications to patients and families was not always clear where multiple medical staff were overseeing patient treatment and care.

Compassionate care

- Patients told us staff treated them with kindness and compassion and always introduced themselves when entering a room.
- Patients told us staff were very caring and 'would go the extra mile to help'. They also told us 'staff were very happy and cheerful'.
- For the period March 2014 to February 2015 the Friends and Family Test (FFT) average response rates for the trust was 43.2%, with a total of 2,440 responses which was higher than the national average of 37.4%.
- Response rates by wards were: ward 9 53%, ward 10 47%, ward 11 34% ward 20a 60% and ward 20b 53%.
- We spoke with 36 patients on the surgical wards, the SAU and in the day-care unit about their experiences. Patients told us staff were caring and sensitive to their needs. Patients also told us the staff were understanding, compassionate, and professional. They stated with respect to the staff, "they can't do enough for you."

Understanding and involvement of patients and those close to them

- Five patients told us their families had been involved with planning their care and had discussed their discharge with occupational therapists and social services.

Emotional support

- The surgical division had a number of specialist practitioners and nurse consultants who were able to give expert advice and support relating to their specialism. These included a continence specialist nurse practitioner, an oncology nurse consultant, two oncology specialist nurse practitioners, a colorectal nurse consultant, two colorectal clinical nurse specialists, two rheumatology clinical nurse specialists,

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a bariatric clinical nurse specialist, a breast nurse consultant, two breast clinical nurse specialists, a vascular clinical nurse specialist, a head & neck advanced nurse practitioner, two urology clinical nurse specialists and a pain specialist nurse practitioner.

Are surgery services responsive?

Requires improvement



Referral to treatment times were not being met across the surgical division. Theatres were effectively utilised however, emergency trauma was using more of the elective theatre time in order to attempt to meet national targets.

Arrangements for pre-admission and specific treatment pathways were in place.

Patient flow through the surgical services was improving with the opening of the Surgical Assessment Unit allowing better utilisation of beds. However, medical outliers were still having an impact on the service and discharging patients back into the community was still a challenge.

The environment in the recovery area in theatres was not child friendly. Apart from a couple of butterflies painted on the wall, it had not been furnished with children in mind. There were no patterned/child friendly curtains around the bed space.

We saw information leaflets and posters available for patients explaining their procedure and after care arrangements.

Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were not easy to access with some patients relying on their relatives to translate on their behalf.

The complaints process was understood by staff and patients had access to information to support them in raising concerns.

Complaints were handled in line with the trust policy and were discussed at monthly care group meetings. Where complaints were raised, these were investigated and responded to and communicated to staff through a range of methods so staff could share and learn from complaints.

Service planning and delivery to meet the needs of local people

- There were 5,736 admissions to the surgical division in the last financial year with the majority being admitted to the emergency surgical (4,632) and trauma wards (1,002).
- In order to improve the patient experience and meet the needs of local people, a Surgical Assessment Unit SAU (ward 8) was opened at the end of April 2015. The SAU was opened to reduce unnecessary surgical admissions to the surgical wards by providing quicker access to a surgical medical team. This would mean patients with surgical conditions would be either fast tracked through the Accident and Emergency department or had a direct referral by the patients GP.
- In the first instance, this initiative was seen as a pilot so as to determine whether this would produce positive outcomes for patients and improve the flow of patients through the surgical pathway.
- At the time of the inspection, the results of the pilot were due to be presented to the directorate care group for agreement to continue on a more permanent basis. The results of the pilot showed a significant reduction in inappropriate admissions; emergency patients could go to theatre and be discharged home on the same day, better feedback and communication to GPs about their patients care and treatment.
- We were told due to the critical care unit undergoing building work in January 2016 the SAU would need to close and be re-sited for a period of four months in 2016. A decision where the SAU would be sited had not been decided nor had a decision as to funding the SAU been agreed at the time of the inspection.

Access and flow

- Patients would be seen in a pre-assessment clinic prior to surgery and was open Monday to Friday 7.30am until 6pm. However, there were additional clinics on a Saturday to deal with the backlog of patients waiting for orthopaedic/spinal surgery.
- The day surgery ward 20c was open from 8am to 8.30 pm and had no overnight stays.
- The trauma and orthopaedic team had a daily trauma meeting to discuss the management of all patients accessing and using their service. This would include discussing all new patients admitted into their care,

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individual diagnosis, what treatment would be necessary, on-going treatment and planning and post-operative care. Action plans for each patient was discussed and formalised.

- There was detailed discussion about individual patients and treatment options with co-morbidity and risks discussed. There were also opportunities for teaching junior staff about orthopaedic pathologies and treatments.
- We observed one trauma meeting where 26 patients were discussed, five patients who had recently been admitted to the department, nine patients awaiting surgery, nine patients whose care was being planned and updated and three patients having post-operative care.
- This meeting was well attended by senior and junior medical staff and other disciplines such as the discharge coordinator.
- Trauma lists took place every afternoon Monday to Friday, between 10am and 2 pm Saturdays and there was a slot at the beginning of the theatre list on a Sunday morning.
- Elective orthopaedic surgery patients were no longer booked into a 'joint school' whilst awaiting surgery. This was due to the shortage of staff in the physiotherapy department. This service provided individuals with the opportunity to understand the operation, recovery process and range of exercises required to optimise their recovery.
- In May 2015, the standard of 93% of patients waiting no more than two weeks from a GP referral to first appointment for suspected cancer was 92.27% which was not meeting the national standard. For those patients waiting for an appointment with a breast surgeon the performance was 82.93%. The reason for not meeting the target was due to the lack of imaging support for one stop breast clinics. There was a service level agreement in place with City hospital Birmingham to address the increase in demand for the service.
- The standard of 85% of patients waiting no more than 62 days from GP referral to treatment for all cancers was 77.78% which also did not meet the national standard. The trust had plans in place to reduce the number of patients undiagnosed above 62 days to meet the target.
- 91.3% of patients waited no more than six weeks for diagnostic tests and there was a 90% compliance with the 18 week referral to treatment time.

- There were 18,591 patient spells with ENT (92.7%), urology (91.3%) meeting the 18 week referral target. However, general surgery (82.9%), trauma and orthopaedic (73.9%) and ophthalmology (74.9%) did not meet the 18 week referral time.
- Between April 2013 and April 2015 there were only two occasions when a patient's operation was cancelled and they were not treated within 28 days.
- The figures provided in the theatre efficiency dashboard indicated that during August 2015, 61 patient operations were cancelled on the day of surgery. 50% of these were due to the patient cancelling and a further 35% due to cancellation for clinical reasons.
- There were no surgical patients on medical wards across the trust however, between August 2014 and July 2015 there were a total of 735 medical outliers, of these 333 were placed on the trauma and orthopaedic wards and 144 on the surgical wards.
- Junior medical staff told us medical patients were frequently not reviewed by the physicians until late in the day after their admission the previous evening and sometimes nursing staff had to chase physicians to come and see their patients. For example, we saw one patient on 9 September 2015 who had been admitted to the emergency surgical ward (ward 10) on 8 September 2015 and had not been seen on the post take ward round. Therefore, patients were not seen by the appropriate physician in a timely manner.

Meeting individual needs

- Comments made to us by patients on their experiences included "it's been great, excellent care" and treatment has been "very good". Another patient said "the nurses are fantastic."
- One patient told us "nothing is too much for them. They (nurses) have even made me a cup of tea at 3am when I could not sleep."
- Sixteen patients told us "response to call bells were answered quickly but staff could not always deal with them immediately and would ask them to wait if busy." However, no patients had to wait longer than 10 minutes, which patients felt was acceptable if staff were busy.
- Patients living with a learning disability were cared for in accordance with their needs. Family or carers were encouraged to stay with their relatives where possible throughout their surgical pathway. Where a patient living with a learning disability was having surgery they

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would be identified at pre-assessment and the wards would be informed. Theatre lists were planned to operate on them at the beginning of the theatre list and they could be accompanied to the anaesthetic room by a carer/relative and would be present in the recovery area at the end of the operation. Side room facilities were offered where possible.

- There was no formal agreed process in theatres in place to identify patients who had additional needs associated with living with dementia. However, staff acknowledged and respected the individual needs of this particular care group and where closer support was needed, this was provided. Staff could contact the dementia nurse if necessary.
- We observed a 'tea party' taking place in one bay on ward 9 over the afternoon period and staff played a reminiscence video to maintain patient's interest. There was also bunting on the ceiling and pictures of the 1940s era.
- We observed two members of staff speaking with a patient about a folder marked with her name on. The book had been provided by the patient's family and staff used it regularly when speaking to the patient about her past. .
- We were told if there were patients living with dementia on the wards, they would use 'sitters' to look after them and give them more one to one care.
- For patients whose first language was not English, carers and families would have to translate or they had to wait for the translation service. This is not recognised as good practice. There was no access to a telephone service and some patients had to wait several hours for an interpreter.
- We saw two patients on a surgical ward whose first language was not English; we asked staff how they communicated and they told us via their relatives.
- We saw nurses using the electronic system for dispensing take home drugs for patients on the day surgery unit. This reduced the time patients had to wait to be discharged.
- The environment in the recovery area in theatres was not child friendly. Apart from butterflies painted on the wall, it had not been furnished with children in mind. There was nothing on the ceiling for children to look at when they woke up and no patterned/child friendly

curtains around the bed space. In addition, the children's bay was opposite the adult bay and each could have seen the other when the curtains were not around the bed.

- We were told by day surgery staff that sandwiches and hot and cold drinks were available for day surgery patients following their procedures. Hot meals could also be ordered if requested.

Learning from complaints and concerns

- The trust's local targets were to resolve single-issue complaints within 20 working days and within 30 working days for moderate harm or a complex multi-issue complaint.
- The average length of time taken to respond to complaints was 34 days for a single issue complaint and 50 days for moderate harm or a multi-issue complaint. The reason for not meeting the trust target was due to a change in the trusts complaints processes and this was being addressed.
- The surgical division received 140 out of 379 formal complaints during 2015. According to the trust data, communication (8%) and attitude of staff (7%) featured heavily as the subject of complaints with 12% of complaints relating to trauma and orthopaedics.
- Heads of nursing worked with the care group matrons and clinical director to ensure investigations were completed in a timely and effective manner. An initial assessment was also made in conjunction with the patient relations team to determine whether early resolution could be achieved by an early meeting with the complainant. The case manager was then responsible for ensuring a comprehensive investigation was completed.
- Senior staff told us learning was disseminated via the organisation's quality structure; through the care group and divisional quality teams on a formal reporting basis. The patient relations team also contributed to the monthly 'Lessons Learned' bulletin, which was distributed to all wards and departments each month.
- Ward 9 introduced a 'relative's ward round' as a result of a complaint about poor communication. These meant families were kept up to date with their relative's conditions/progress.

Are surgery services well-led?

Surgery

Requires improvement



There was no dedicated strategy for the surgical division. However, as part of the trust's annual plan 2015/16 there were two objectives attributed to the surgical division: to improve theatre utilisation and theatre team productivity and to improve the elective care pathway to ensure patients were treated quickly and the patient administration system (PAS) backlog reduced.

There was a backlog of patients waiting for elective care, which was expected to grow in 2015/16.

The surgical division had not addressed its risks on the divisional risk register; many risks had been recorded for long periods with no update or actions.

The division of surgery held monthly quality team meetings, which were attended by a broad range of clinical and non-clinical staff. There were also area specific quality team meetings with action logs that included; the date the action was added, what action was needed, who was responsible for the action, the status of the concern (red, amber or green), planned completion date, any remedial action needed and the final completion date. These action logs were used across all the specialities. Any issues/concerns from these meetings would be fed up to the divisional meetings for further consideration.

We saw some examples of good clinical leadership within the surgical and trauma and orthopaedic teams. The majority of relationships within the teams were working well and there were a number of opportunities for developing and supporting junior staff. We saw other examples of where teams told us they felt they were micro-managed and felt unsupported by senior managers.

Staff felt the medical director was 'championing' quality and medical staff felt more involved in decision making about their services. Staff told us this was a good place to work.

Staff were kept updated via monthly newsletters and team meetings. At a ward level, staff had monthly meetings and where they did not attend, staff were required to read and sign that they had read the notes.

All staff we spoke with were highly complementary about the SAU and saw this initiative as a positive move to addressing the management of surgical patients.

Vision and strategy for this service

- The trust board had recently reviewed a range of information about its current position across operational performance, clinical quality, financial performance, organisational culture and governance via its Trust Improvement Plan dated 25th June 2015. The plan was based on 10 objectives for improvement of which the surgery division staff participated.
- As part of the trust's annual plan 2015/16 there were two objectives attributed to the surgical division: to improve theatre utilisation and theatre team productivity and to improve the elective care pathway to ensure patients were treated quickly and the PAS backlog reduced.
- Staff were aware of these objectives and were updated on progress through their team meetings.
- There was a backlog of patients waiting for elective care, which was expected to grow in 2015/16. A recovery plan involving waiting list initiatives was in place, supported by the trusts transformation programme.
- However, there was no dedicated strategy for the surgical division. There was a trust improvement plan for elective access improvement dated June 2015 which included how the trust would address its waiting list targets such as; the cancer two week wait to be seen at first appointment, six week wait for a diagnostic test and 18 week wait from referral to treatment. These were all short-term plans with no longer term actions identified.

Governance, risk management and quality measurement

- The division of surgery held monthly quality team meetings. Attendance at these meetings included, clinical leads for each speciality, matrons and senior nursing staff/practitioners, patient safety officer, pharmacist, care group managers, allied health practitioners and risk, audit, patient safety managers.
- Agenda items discussed at these meetings included: complaints and PALS referrals, position update and lessons learned, patient safety report, clinical audit, outcomes, infection control and other operational items.
- There were also area specific quality team meetings with action logs that included: the date the action was added, what action was needed, who was responsible

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for the action, the status of the concern (red, amber or green), planned completion date, any remedial action needed and the final completion date. These action logs were used across all the specialities. Any issues or concerns from these meetings would be fed up to the divisional meetings for further consideration.

- However, the division was not addressing its risks on the risk register. For example, the division had 33 risks on its risk register, general surgery had 9 risks, head and neck 5 risks, muscular skeletal 4 risks, outpatients/ chemotherapy 2 risks, theatre/anaesthetics/ critical care 10 risks and urology 2 risks. Of the 33 risks, 12 had been on the risk register for more than two years with a further four being on the register for nearly five years. For example, medical devices training was added to the risk register in 2011 which remained an area of concern in 2015. Failure to meet best practice tariff for fractured neck of femur was added in 2010. However, additional weekend lists were added to improve the fractured neck of femur target.
- There was also a surgical meeting every Friday lunch time to discuss mortality and morbidity, incidents and other concerns. All medical staff were expected to attend these meetings.

Leadership of service

- We saw examples of good clinical leadership within the surgical and trauma and orthopaedic teams. Relationships within the teams were working well and there were a number of opportunities for developing and supporting junior staff.
- Nursing staff told us that the director of nursing was visible and approachable. All staff we spoke with felt well supported and empowered since the director of nursing had come into post.
- Staff felt the medical director was 'championing' quality and medical staff felt more involved in decision making about their services.
- Staff told us the current trust board was engaging with medical and nursing staff.

Culture within the service

- The trust recognised there was a lack of empowerment amongst operational teams and this was due to micro-management in order to resolve some trust wide issues.
- This resulted in a number of junior staff across the division not feeling supported to do their job and staff told us they were not listened to by their managers.
- Our observation of the culture in theatres was that there was lots of communication, through a range of methods. There were opportunities for staff to raise concerns and staff confirmed they were generally happy.
- Medical staff told us this was a good place to work and they were more engaged reviewing their services.







Public engagement and staff engagement

- Once a fortnight, members of the directorate team visited staff for 30 minutes called 'Quick Comms' giving them the chance to tell the senior team what they were proud of and what was working well.
- Staff were kept updated via monthly newsletters and team meetings. For example, theatre staff met each month at the directorate's audit half day where team meetings and learning sessions were carried out. At a ward level, staff had monthly meetings and where staff did not attend, they were required to read and sign that they had read the notes. Key messages were also left on white boards in the staff rooms.
- In the NHS staff survey 2014, the trust scored better than the national average for good communication with senior management, the trust scored 33% versus 30% nationally.
- However, the trust scored 47% for the question 'How likely are you to recommend this organisation to friends and family as a place to work'.

Innovation, improvement and sustainability

- All staff we spoke with were highly complementary about the SAU and saw this initiative as a positive move to addressing the management of surgical patients. Patients also told us about their positive experiences as a patient using this service. However, funding has yet to be confirmed to ensure this service continues.

Critical care

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

Information about the service

The critical care unit at the Walsall Healthcare NHS trust has 16 beds. It consists of two geographically separate areas, the intensive care unit (ITU) with five funded intensive care beds with three additional bed spaces that were used when the ITU was at full capacity. There was a separate high dependency unit (HDU) with eight high dependency care beds. Patients who have a potentially life-threatening illness can be admitted to an intensive care bed; they receive one-to-one nursing care, or those patients too ill to be cared for on a general ward can be admitted to a high dependency bed. The Intensive Care National Audit and Research Centre (ICNARC) data showed the unit had admitted around 800 patients between April 2014 and April 2015.

The hospital had a critical care outreach team who assisted with the management of critically ill patients on wards and departments across the hospital. The critical care outreach team work between the hours of 8 am to 8:30 pm, 7 days a week. Out of hours cover was provided by the hospital out of hours advanced care practitioner team. A national early warning system (NEWS) was used to manage the deteriorating patient, promoting early detection and intervention.

We spoke with eight patients, five relatives and 33 staff including nurses, physiotherapists, pharmacists, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment and reviewed eight care records. Before and during our inspection, we reviewed performance information about the critical care unit.

Summary of findings

Critical care required improvement.

Checking systems to ensure fridges were maintained at the correct temperature required improvement. Staff were not documenting when they were administering bolus intravenous sedatives and although two staff checked intravenous therapy prior to administration, only one member of staff was signing the prescription charts. Junior doctors were not always available on consultant ward rounds resulting in patient plans not being written up at the time of the round.

Local audits were conducted in critical care but action plans to address required improvements had not been formulated. There was not effective multidisciplinary team working, with individual members working independently rather than as a cohesive team. The intensive care society guidelines were implemented to determine the treatment provided.

Staff cared for patients in a kind and professional manner. Patients and relatives were kept fully informed and staff treated them with kindness. In the main staff were supportive and responsive to patients' individual needs. However, there were a few occasions when there was a lack of interaction between staff and patients and instances where staff could have been more reassuring to patients and their relatives.

The number of delayed discharges was worse than the England average when compared with other similar sized units since April 2014. As a result of this, there had

Critical care

been 53 single sex breaches since June 2015. There was a lack of patient information leaflets in languages other than English. The trust had recognised the need to build a new critical care unit due to lack of facilities within HDU and a business case for a new integrated 18 bedded critical care unit was awaiting approval by the Department of Health.

There were governance structures within critical care. However, the risk register only contained two risks and did not incorporate risks such as the lack of isolation rooms and shower and toilet facilities within critical care. As local audits did not have related action plans, it was unclear how required improvements were being monitored. There was clearly identified nursing and medical leadership within critical care and staff felt well supported by their managers.

Are critical care services safe?

Requires improvement



There was not a structured, systematic process to review all deaths.

In the main, infection control practices were adhered to. However, we observed that staff tended to use the sanitising hand gel rather than washing their hands following removal of gloves and aprons. There were no isolation facilities within HDU or shower and toilet facilities within HDU and ITU. A business case to build a new critical care unit was currently awaiting sign off from the Department of Health.

Improvements were required when staff checked fridge temperatures to ensure that if the temperature was out of range it was re-checked to ensure that medicines were stored at the correct temperature. Staff were not documenting when they were giving intravenous bolus sedatives and although two staff checked controlled drugs and intravenous therapy prior to administration, only one member of staff was signing the prescription chart.

There was a lack of junior medical cover for critical care at night time. During the day, junior doctors were not always present on the consultant ward round due to seeing other patients, resulting in contemporaneous plans for patients not being written in the notes at the time of the ward round.

There were good systems for monitoring the NHS safety thermometer data and effective processes in place to report and learn from incidents.

Incidents

- Staff we spoke with were aware of how to report incidents using the electronic reporting system, but were not confident they would receive feedback from them.
- There had been no 'Never Events' (serious largely preventable safety incidents that should not occur if the available preventative measures have been implemented) reported between May 2014 and April 2015.

Critical care

- There were 163 incidents reported between 3 February 2015 and 19 May 2015. There was one serious incident involving HDU closure due to Norovirus. The main themes of incidents were delayed discharges to the wards and lack of isolation side rooms.
- Incidents were reviewed at monthly quality and safety meetings and learning passed onto the nursing staff in their team meetings. We reviewed minutes of these meetings.
- Following an incident where a patient obtained a pressure ulcer whilst in ITU, new risk assessments had been developed and staff had received additional training.
- There was not a structured, systematic, multidisciplinary process to review all deaths. There was not a specific mortality and morbidity meeting. Consultants told us that some deaths were reviewed at the monthly quality and safety meetings and at the anaesthetic weekly meetings attended only by anaesthetists.
- We were shown an example of an incident that had been investigated and the family of the patient had been involved and were invited in to the hospital to have a meeting to discuss the incident. This demonstrated that staff were aware of their Duty of Candour responsibilities.

Safety thermometer

- The ward assurance performance and safety thermometer (for measuring, monitoring and analysing patient harms and 'harm free care') results were displayed on a noticeboard within ITU and HDU. This included data about the development of new pressure ulcers, incidences of Clostridium difficile (C difficile) and MRSA, falls and safe staffing levels. The information was accessible for relatives and members of the public to see.
- Data reported (via safety thermometer audits) between June 2014 and June 2015 demonstrated that there were no falls and pressure ulcers and only one catheter related urinary tract infection. We noted three pressure ulcers had been reported (via the trust's incident reporting system) between 03/02/2015 and 19/05/2015.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.

- Staff followed the trust policy on infection control. The 'bare arms below the elbow policy' was also adhered to. There were hand washing facilities and protective personal equipment (PPE) such as gloves and aprons available. We observed staff using gloves and aprons and changing these between patients as per policy. We observed staff using hand sanitising gel but not always washing their hands following removal of gloves and aprons. This did not adhere to the trust infection control policy, which recommended washing hands and only using sanitising gel when hand washing facilities were not available.
- Hand sanitising gel was available throughout the unit and signage reminded staff and visitors about hand hygiene. We observed that if necessary, staff also reminded people entering the unit to wash their hands.
- Monthly hand hygiene audits demonstrated good compliance. However, the audit stipulated that 15 observations should be carried out each month and in the last few months an average of only five observations had been completed.
- There were 68% of staff who had completed infection control training against a trust target of 90%. There was no robust process to check staff compliance with training. It was reliant on staff to ensure their compliance was up to date.
- Cleaning schedules had missing parts in both the daily and weekly schedules. Parts of the schedule were missing on 1, 2, 5 and 8 September. All parts were missing on the 3, 4, 6, and 7 September. Within the weekly schedules the areas missed between 1 to 7 September included: storerooms, nurse's station, clean utility, sluice, side room alcove and linen room.
- There had been no incidences of MRSA since August 2014.
- HDU did not have a side room facility to isolate patients with infections. A business case to build a new critical care unit with over 50% side rooms had been agreed with the Trust Development Authority and was currently awaiting approval from the Department of Health.

Environment and equipment

- We found equipment was clean and fit for purpose.
- All equipment we checked was found to be in date for portable appliance testing (PAT) or servicing.
- The resuscitation equipment was checked daily and records were maintained of these checks.

Critical care

- An intercom and buzzer system was used to gain entry to ITU to identify visitors and staff and ensure that patients were kept safe.
- The HDU was cramped with little space between beds. There were no shower or toilet facilities on either HDU or ITU. Staff had to take patients to neighbouring ward's facilities. This meant that patients had to have a commode or wash at the bedside. This was problematic due to the lack of bed space.
- Problems also arose if/when extra staff were required around the bed space to assess and treat a patient; there was insufficient room to accommodate larger pieces of equipment.

Medicines

- Medicines including controlled drugs were safely and securely stored. Records demonstrated that twice-daily stock checks of controlled drugs were maintained.
- There was a process for two members of staff to check all intravenous infusions prior to administration to patients. However, only one member of staff signed the prescription chart. This did not adhere to the trust's medicine policy.
- The medication records we looked at during our inspection were found to accurately reflect the patient's prescribed and administered medicines. However, we noted that when staff gave bolus doses (a bolus dose is an additional dose (from the syringe infusing) administered on top of the prescribed infusion rate); these were not documented on the prescription chart. This was also not documented on fluid charts so there was no way of keeping a check on how much had been administered. Staff told us they told each other but never documented bolus doses.
- Records demonstrated that fridge temperatures should be monitored daily to ensure that medicines were maintained at the recommended temperature. We found several gaps in the daily checks on the 4, 6, 11, 23, 26, 27 August 2015. On three occasions on 1, 22 and 31 August the temperature exceeded the maximum temperature of 8°C. There was no recording of re-checks to ensure the fridge returned to the required temperature. We spoke to staff regarding this who told us they would normally re-check the fridge temperature if it was out of range but there was nowhere to record this on the checking form.

Records

- There was standardised nursing documentation at the end of each bed. Observations were recorded clearly on a daily review chart and demonstrated that patients were being reviewed regularly. Risk assessments were incorporated including pressure ulcer risk, nutrition risk, and coma scale and delirium assessments.
- All medical records were in paper form, followed the same format and were completed by the multidisciplinary team. This meant that information could be found easily.

Safeguarding

- Staff we spoke with demonstrated an understanding of safeguarding procedures and its reporting process. They were able to show us how they could access the safeguarding policies on the trust intranet.
- The trust safeguarding lead was available to staff for advice on safeguarding matters.
- Staff told us they had received training in adult and children's safeguarding. Data confirmed that 100% of staff had completed adult safeguarding and 98% of staff had completed children's safeguarding level 1 and 2. This was against a trust target of 90%.

Mandatory training

- Records demonstrated that several staff were overdue some of their mandatory training such as conflict resolution, equality and diversity and fire safety.
- Staff and the professional development lead received reminders when training was out of date but there was no other system or action taken if non-compliant.
- In May 2015 ITU scored 79% and HDU achieved 91%. In July 2015: ITU scored 80% and HDU achieved 89%, against a trust target of 90%.

Assessing and responding to patient risk

- The national early warning score (NEWS) of acutely unwell adult patients was used to identify patients whose condition had deteriorated. For patients with an aggregate score of seven or more or any red score (individual parameter scoring three) denoting high clinical risk, then staff had to contact the critical care outreach team in addition to the clinical team. However, the outreach team could be called for any adult patients of clinical concern with or without an observation trigger.
- The critical care outreach team consisted of two full-time and one part-time band 7 nurses. The critical

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care outreach team operated between 8am and 8:30pm seven days a week. In addition to responding to new referrals for patients considered to be at risk of clinical deterioration, they also operated an on-going follow up service for those patients considered at risk of deterioration or recently stepped down from critical care areas.

- Overnight, the hospital out-of-hours advanced care practitioner team were responsible for the monitoring and assessment of acutely ill patients throughout the hospital.
- The critical care outreach team was managed by the medical directorate. Staff were concerned that they no longer rotated into critical care to maintain their clinical skills. They told us they had not had access to any specialist courses/study days for continuous development for the past two years.

Nursing staffing

- Critical care had vacancies for one band 5 nurse and additional hours for a band 6 nurse however, they could not confirm exactly how many hours.
- Nursing rosters indicated and staff confirmed that critical care rarely used any registered agency nurses. Shifts were usually covered by their own internal staff working on the nurse bank.
- There were sufficient staff to ensure that one nurse cared for one level 3 (intensive care) and one nurse cared for two level 2 (high dependency) patients. This complied with the National Critical Care Alliance standards on nursing ratios within critical care.
- All shifts in critical care had a supernumerary senior nurse (band 6).
- Nursing handovers occurred twice a day, as a group and individually by the bedside, during which staff communicated any changes to a patient's condition to ensure that actions were undertaken to minimise the risks.

Medical staffing

- The consultant work patterns delivered continuity of care in ITU. In HDU cover was less ideal for providing continuity. It was covered by one of the Intensivists but usually not in blocks of one week. Most of the consultants worked two to three day stints, with only

one working the whole week. This could have been improved upon as it is recognised that longer blocks of care avoiding multiple handovers result in better continuity for patients.

- A consultant in intensive care medicine was present within critical care, as a minimum, from 8am to 6pm Monday to Friday. At the weekend, one consultant covered both ITU and HDU. There were no set hours but they conducted a ward round each day on both HDU and ITU. Out of hours they were available on call and able to attend within 30 minutes. Staff said there were no problems contacting consultants or them arriving on the unit out of hours.
- The consultant to patient ratio was one to eight which met recommended national guidelines.
- The lead consultant for critical care told us that all patients were reviewed by a consultant within 12 hours of admission to ITU and this was supported by review of patient records.
- During the day, there were often just two junior doctors, one registrar-equivalent and one basic level trainee. (On some days, there were three.) At night after 11pm there were just two registrar-equivalent level doctors to cover the whole hospital. Staff told us that they were often stretched at night to cover all the work. Staff reported being unable to cover the correct location and time due to there being two isolated critical care units (ITU and HDU), plus also covering the emergency department and ward referrals. They felt there were too few doctors for the amount of work.
- We observed the medical handover from nightshift to day shift. This was an informative and comprehensive handover involving the night-time and day junior doctors and the ITU and HDU consultants.
- We were told that locums were not used to cover sporadic absence for example, sickness. Shifts were covered with internal staff.

Major incident awareness and training

- The major incident policy was currently under review and the previous policy was not available on the trust intranet for staff to access.
- Staff were able to explain the procedure in the event of the need to evacuate critical care in the event of a fire.
- The matron had recently been on a major incident table top exercise and was able to describe her role in the event of a major incident.

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Are critical care services effective?

Requires improvement 

Critical care was not fully meeting the requirements of the National Institute of Health and Clinical Excellence (NICE) to provide a rehabilitation programme for critical care patients although a business plan was currently being formulated. Local audits were taking place but action plans to address improvements required had not been formulated. There was not effective multidisciplinary team-working, with individual members working independently rather than as a cohesive team.

The intensive care society guidelines were implemented to determine the treatment provided and Intensive Care National Audit & Research Centre (ICNARC) quality outcome results were in line with the England average (apart from delayed discharges) when compared to other similar sized units.

Evidence-based care and treatment

- The Intensive Care Society guidelines were implemented to determine the treatment provided.
- Care pathways and protocols were in use. For example, we observed that staff were following the unit's sedation break protocol.
- Critical care was not fully meeting the requirements of NICE (guidance 83) which identified a need for an individualised, structured rehabilitation programme. Patients were seen by the critical care outreach team within 24 hours of transfer to the wards. However, there was no follow-up clinic following hospital discharge to evaluate their on-going rehabilitation needs. The matron told us that a business plan was currently being formulated to address this. We asked to see a copy, but this was not available.
- ITU had commenced using patient diaries to record patients' time whilst in ITU. However, staff told us that patients were not allowed to take the diaries with them on discharge from ITU to enable the unit to audit them. Staff said they did invite patients to return to the unit to discuss these diaries once discharged home. Only two patients had returned to do this. Patient diaries usually travel with patients on transfer from ITU to enable patients to look back on their time within the unit to aid their recovery.

- Local audits were carried out, for example on critical care bundles, aseptic non-touch technique (ANTT) for IV therapy and completion of critical care notes. Results for the critical care bundle audit were 100% in February, 90% in March and 70% in April 2015. Results for ANTT were 85% in February and 86% in March 2015. Results for completion of critical care notes were 72% in February, 68% in March and 92% in April.
- We asked the matron if action plans were formed in relation to these audits to address improvements required. She told us that no written action plans were completed but the audit results were discussed at the monthly quality and safety meetings. We saw minutes of these meetings where audits were discussed.

Pain relief

- We saw that pain scores were assessed and documented on an hourly basis in the six records we reviewed.
- Patients told us that their pain had been well managed.

Nutrition and hydration

- Patient records showed that staff used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients accurately.
- In the ITU, staff followed the unit protocol for hydration and nutrition of ventilated patients and initiated enteral tube nutrition when necessary. We observed that patients were being treated according to this protocol.
- Dietician support was available Monday to Friday. Several consultants told us that there was not regular daily dietician input to ITU (as recommended by Joint Standards Committee (2013) Core Standards for Intensive Care). Staff told us that the dietician attended the same day when asked.

Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This is a national audit of critical care workload and outcomes. The ICNARC results between July 2014 and July 2015 were in line with other trusts apart from delayed discharges (70-80 per quarter) which were worse than the England average (40-50 per quarter) when compared to other similar sized units.
- ICNARC data demonstrated that mortality was similar to the England average.

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- Unplanned readmissions within 48 hours were similar to the national average (two per quarter).

Competent staff

- All staff received one-to-one supervision and appraisals. These processes covered training, development needs and practices.
- In May 2015, ITU achieved 92% and HDU 93%. In July 2015, ITU achieved 85% and HDU achieved 86%, this was set against a target of 95%. Staff told us that their appraisal had been well conducted and linked to training plans.
- In critical care, 58% of nursing staff had completed a post registration qualification. This complied with national guidance.
- There was a dedicated professional development nurse responsible for coordinating education in critical care. All staff were working towards ITU competencies and were being assessed by a mentor.
- We noted that not all staff were on the equipment training register and that equipment training for high-risk equipment was only three yearly not annually. Staff self-assessed that they were competent to use equipment rather than have their competence checked.
- Trainee doctors told us they were well supervised and consultants were very accessible and supportive. One of the consultants had produced a comprehensive induction booklet as an introduction to ITU for junior medical staff.

Multidisciplinary working

- A multidisciplinary team supported patients and staff in the unit. However, the dieticians, physiotherapists, pharmacist and microbiology staff did not attend the daily consultant ward rounds.
- There was a lack of daily communication between the multidisciplinary team. There was not effective multidisciplinary team-working, with individual members working independently rather than as a cohesive team.
- We observed and were told consultants frequently carried out ward rounds without any junior medical staff present. The registrar-equivalent who had examined the patients earlier in the morning was not present on the ward round to communicate their findings with the consultant. A contemporaneous plan for the patients was not recorded in the multidisciplinary notes at the time of the ward round. Plans were completed on an ITU

daily sheet and notes updated later on in the day. This may result in the multidisciplinary team not having all the required information within the notes if they saw the patients before the multidisciplinary notes were updated.

- The physiotherapists visited patients daily and each patient had a rehabilitation plan whilst in ITU. However, the staff told us and we observed little evidence of communication and team-work between the physiotherapy and medical teams. On discharge from ITU there was no on-going rehabilitation plan, which is recommended by NICE.
- A consultant microbiologist attended the critical care unit each weekday afternoon and provided an on-call out-of-hours service.
- There was not a dedicated critical care pharmacist. One pharmacist covered ITU and another pharmacist HDU. They were only allocated 10 minutes per patient per day as they had other commitments to cover. The pharmacist told us they spent a lot of extra time than their allocated 10 minutes per patient but felt that they could not dedicate enough time to critical care patients. As they were unable to attend the consultant ward round. They would try to speak to a doctor in person and if necessary bleep them. If the registrar and consultant were busy, they would leave them a note. The pharmacist updated the multidisciplinary notes and informed the bedside nurse of any changes. According to Joint Standards Committee (2013) Core standards for Intensive Care, there should be a full-time pharmacist dedicated to critical care of this size.
- The critical care outreach team were not integrated into critical care and rarely attended the medical handover. The consultants felt that there was a disconnection between ITU and the outreach team. They felt that the outreach team operated in isolation and rarely discussed patients with the ITU consultants. A lack of communication between the outreach team and ITU reduces the ability to work together, learn from each other and ensure that patients receive the best possible multidisciplinary care.

Seven-day services

- There was consultant cover for patients in the unit during the day from 8am to 6pm, Monday to Friday and an on-call service out-of-hours and at weekends. There was a consultant ward round on both HDU and ITU at the weekend.

Critical care

- Pharmacy, dietetics and microbiology staff were available Monday to Friday and physiotherapy staff seven days a week. Microbiology and pharmacy staff were available on-call at weekends.
- A critical care outreach team provided support from 8am to 8:30pm, seven days a week, for the management of critically ill patients.
- Overnight the hospital out-of-hours advanced care practitioner team were responsible for the monitoring and assessment of acutely ill patients throughout the hospital.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust and access guides, policies and procedures to assist in their role.
- Radiography and blood results were available electronically for staff to access.
- There was a standard handover on discharge of patients from critical care back to parent teams. This included a written discharge form and a verbal handover. This handover documentation was contained in the multidisciplinary critical care notes and provided an effective method of written handover.

Consent and Mental Capacity Act

- Staff we spoke with were aware of the Mental Capacity Act 2005 and how this related to the patients they cared for.
- Whenever possible, patients were asked for their consent appropriately and correctly. Within critical care, patients were frequently unconscious or unable to communicate or lacked capacity to provide consent. We saw written examples of when doctors and the multidisciplinary team had acted in the patient's best interests when the patient did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately.

Are critical care services caring?

Good



Staff cared for patients in a kind and professional manner. Patients spoke very highly of staff and said they were treated with dignity and respect. Patients and relatives were kept fully informed and staff treated them with kindness.

In the main, staff were supportive and responsive to patients' individual needs. However, there were a few occasions when there was a lack of interaction between staff and patients and instances where staff could have been more reassuring to patients and their relatives.

Compassionate care

- We observed staff caring for patients in a kind and professional manner. We saw patients were treated with respect and dignity. Nurses were attentive and had a good rapport with patients.
- Both patients and relatives told us that staff treated them with dignity and respect.
- Patients and relatives spoke very highly of the staff. One patient said "they are very good, they are lovely." Another patient told us "they are excellent, very helpful and always there for you."
- Critical care used the Friends and Family questionnaires to gain feedback from patients and relatives. There were low response rates of about 12 per month but of those, 100% would recommend critical care to their friends and family.
- Individual comments from the Friends and Family questionnaires included "care was excellent, very professional, attended to everything" and "informative, approachable staff. Inclusion with all aspects of care. Timely responses to patient requests with regard to care, I do not think anything could be improved."

Understanding and involvement of patients and those close to them

- Relatives and patients told us they were kept fully informed and staff explained everything to them. One relative said, "they are brilliant, we're kept informed and they always explain what they are doing."
- We observed the nurses and doctors explaining the plan of care to patients on the ward round.

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- The critical care team had access to the specialist nurses for organ donation (SNOD) at a local hospital. There was no SNOD embedded into the ITU and so the ITU team did not have regular daily contact with a SNOD. They only attended when there was a potential donor. When on-going treatment was considered to be not in the patient's best interests, the relatives were made aware of this and the possibility of organ donation was discussed.

Emotional support

- We observed that in the main staff were supportive and responsive to patient's individual needs. However, there were a few occasions where there was a lack of interaction between staff and patients and one instance where staff could have been more reassuring to patients and their relatives.
- Staff told us they had good access to a psychiatric nurse, to provide additional emotional support and counselling for patients.
- The chaplaincy service also provided emotional support for patients and their relatives and was very responsive, being available 24 hours a day, seven days a week.

Are critical care services responsive?

Requires improvement



ICNARC data showed that the number of delayed discharges was worse than the England average when compared to other similar sized units since April 2014. As a result of this, there had been 53 single sex breaches since June 2015. This was on the critical care risk register and was being regularly discussed with the senior management team.

There was a lack of patient information leaflets in languages other than English. This did not represent the culturally diverse population that the hospital served. Although translators were available, we observed that staff tended to use relatives to translate.

The trust had recognised the need to build a new critical care unit due to lack of facilities on HDU. A business case for a new integrated 18 bedded critical care unit had been

approved by the Trust Development Authority and was currently awaiting approval from the Department of Health. A business case was also being formulated to develop critical care rehabilitation and follow up service.

Service planning and delivery to meet the needs of local people

- The trust had recognised that a new critical care unit was required due to the current HDU not currently fit for purpose. The HDU was geographically separate to the ITU and isolated from both theatres and ITU. There was too little space around each bed and the unit lacked facilities such as showers, toilets and isolation facilities.
- A business plan for a new integrated, 18 bedded critical care unit had been approved by the Trust Development Authority and was currently awaiting approval from the Department of Health. All 18 beds would be able to be flexed to provide level 3 care if required. This unit would incorporate seven isolation beds and two isolation rooms. A sink will be allocated to each bed space.
- A business case was currently being formulated to develop a critical care follow-up service, to include a consultant led follow-up clinic including medical discharge summaries and rehabilitation packages of care.

Meeting people's individual needs

- Lead nurses for dementia and learning disabilities provided support and advice to staff regarding caring for patients living with dementia or patients with a learning disability.
- Translators were accessible to staff for patients whose first language was not English. However, we observed that staff tended to use relatives to translate. This is not recognised as good practice.
- We observed that there were no patient information leaflets available in languages other than English. This was not responsive to the culturally diverse population that the hospital served.
- A relative's room containing a bed and en suite facilities was available to relatives who wished to stay overnight. This also doubled up as a relative's interview room which could be difficult if it was occupied as it left nowhere to have a difficult conversation with another family. A drinks machine was also available in the waiting area for relatives to purchase drinks.

Access and flow

Critical care

- The critical care bed occupancy was above the England average from February 2014 onwards and reported as 100% each month from September 2014 onwards.
- We requested from the trust the percentage of patients admitted within 4 hours of referral. The trust was unable to provide this data as they did not audit this.
- ICNARC data showed that the number of delayed discharges was worse than the England average when compared with other similar sized units since April 2014. This was on the critical care risk register and was regularly being discussed with the senior management team.
- We spoke with one patient who had been delayed for three days in ITU due to lack of bed capacity in the hospital.
- There had been 53 single sex breaches recorded within critical care since June 2015. Staff reported these breaches as incidents if the patient was unable to be transferred after four hours. In ITU staff tried to use the side room or had access to screens to maintain patient's privacy. Within HDU staff tried to maintain single sex bays as far as possible.
- The numbers of patients discharged out of hours (that is patients discharged between 10pm and 7am) was similar to the England average.
- Non-clinical transfers out (that is, patients discharged to a level 3 bed in an adult ITU in another acute hospital) was similar to the England average.
- Between August 2014 and July 2015, 13 elective surgery operations were cancelled due to lack of critical care beds.
- Unplanned readmission to critical care within 48 hours was similar to the England average.

Learning from complaints and concerns

- Patients and relatives told us they would speak to the nurse looking after them if they had any concerns.
- Learning from complaints was discussed at the monthly quality and safety meetings and at staff meetings. We saw minutes of these meetings. Staff were able to give us an example of how they had learnt from a recent complaint regarding a patient developing a pressure ulcer. Staff had received additional training and new risk assessment documentation had been implemented.

Are critical care services well-led?

Requires improvement

There was a governance structure within critical care with regular review of incidents, complaints, audit results and the risk register. However, the risk register only contained two risks and did not incorporate risks such as the lack of isolation rooms in HDU and lack of shower and toilet facilities within ITU and HDU.

Action plans had not been developed in response to local audit results, so it was unclear how required improvements were being monitored. There was not a structured, systematic, multidisciplinary process to review all deaths.

There was clearly identified nursing and medical leadership within critical care and staff felt well supported by their managers. Staff felt engaged and were involved in the development of the new critical care unit.

Vision and strategy for this service

- There was a clear vision for the critical care service, which mainly focused on the rebuild of the critical care unit. Staff understood that vision and were engaged with it. There were also clear plans to develop critical care rehabilitation and follow up service.

Governance, risk management and quality measurement

- There was a governance structure present. Monthly directorate quality and safety and critical care operation meetings took place where incidents, complaints, audit results and the risk register were reviewed. We saw minutes of these meetings. The minutes of these meetings were also available to staff on their intranet.
- There was alignment between the recorded risks on the risk register and what staff expressed was on their 'worry list.' However, the risk register only contained two risks: insufficient outreach for critical care rehabilitation and the inability to discharge level 1 patients due to lack of space on the wards. The risk register did not contain risks relating to the lack of isolation rooms in HDU or the lack of shower and toilet facilities within critical care.
- We saw from minutes of the quality and safety meetings that audits were discussed at these meetings. However, there were no action plans developed in relation to local audits carried out in critical care. Therefore, it was unclear how improvements were monitored.

Critical care

- Learning from incidents and complaints was discussed at monthly staff meetings. Staff were sent minutes of these meetings via e-mail if they were unable to attend.
- Consultant anaesthetists told us and we saw that deaths that occur on the CCU were taken to the care Group Quality Meeting for shared learning and discussion. However, this was not an MDT meeting, it was attended by anaesthetists only.
- The clinical lead suggested the deaths that were significant were discussed, but no further details were supplied. They said simple, 'uncomplicated deaths' were not discussed. It appeared that there was no system by which either all deaths were discussed or there was any systematic process by which deaths were reviewed and a decision made about whether to discuss in more detail.
- Critical care used the Friends and Family questionnaires to gain feedback about the service. There was quite a low response rate but of those who did respond, 100% would recommend critical care to their friends and family.
- Staff within critical care said they felt engaged and were involved in the project plans to develop the new critical care unit. A patient representative was also involved with the project team.

Innovation, improvement and sustainability

- We asked staff what innovative practices had been implemented within critical care. They were proud of the introduction of patient diaries. We observed that these were well completed. However, staff said patients were not allowed to take the diaries with them on discharge from critical care due to audit purposes. Usually patient diaries travel with the patient to enable them to review their time within critical care to aid their recovery. Staff invited patients back to critical care to discuss their diaries but only two had done so in the last six months.
- Critical care had developed an innovative, multidisciplinary care record for patients within critical care. All members of the multidisciplinary team including doctors, nurses, physiotherapists and dieticians wrote in this record. It incorporated nursing care plans and discharge paperwork in one place. This ensured there was easy access to information about each patient on critical care.
- One of the consultants had produced a comprehensive induction booklet as an introduction to critical care for junior medical staff.

Leadership of service







- There was clearly identified nursing and medical leadership within critical care.
- Most of the staff we spoke with said they felt well supported and had good relationships with their managers.
- The matron told us there was good two-way communication between critical care and the board. We were told the director of nursing was supportive and listened to their concerns.

Culture within the service

- An open and supportive culture encouraged staff to report incidents.
- Staff told us morale was variable but that there was good local teamwork within critical care.

Public and staff engagement

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

Information about the service

We rated maternity services as 'Inadequate' overall.

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 community midwifery teams consist of 4 teams. They provide ante natal care, parent education, home births, postnatal care and intrapartum care in children's centres, GPs surgeries, the Midwifery Led Unit and in a woman's own home.

Between April 2014 and March 2015 4,614 babies were born at Walsall Healthcare NHS Trust.

The latest MBRRACE report presents results for still births, neonatal mortality and extended perinatal mortality rates for 2013. Standardised results for Walsall are slightly higher than their comparator group. MBRRACE recommends that Walsall should consider a local review to better understand factors that may contribute to these results.

Specialist maternity services for women with diabetes are provided by a dedicated multi-disciplinary team between obstetrics and medicine.

The gynaecology service offers inpatient services, day care and emergency assessment facilities. Outpatient services include colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment.

The Gynaecologist and Obstetricians are one team, working across both gynaecology and maternity.

We visited all the wards and departments relevant to the service. We spoke with 13 patients and relatives and 39 members of staff including: doctors, anaesthetists, midwives, nurses, operating department assistants, support workers, hearing screeners, and domestic assistants. We looked at 44 sets of patient notes.

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Summary of findings

Overall, we rated maternity services as inadequate. The service had multiple issues and people are at high risk of avoidable harm. The service had limited capacity and staffing resources which impacted negatively on patient experience and compromised patient safety.

Women told us they had little support once their baby had been born on the labour ward due to the midwife having to look after someone else. Staff told us they did not feel they could offer the support and assistance in the immediate post-birth time that they would like to offer. However, staff were trying to provide a caring and compassionate service in difficult circumstances.

The lack of specialist midwives might result in reduced support for women with mental health concerns and bereaved parents. 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. However, there was a plan to cap births at 5,000; this has been agreed strategically with two neighbouring trusts. Some areas of the maternity and gynaecology service we visited were not clean or well maintained.

The Trust had approved a business case for investment in additional midwives as part of the Annual Plan for 2015/2016 which would bring the birth ratio to 1:33. These staff were not in post at the time of the visit.

There were good clinical multidisciplinary working relationships. Middle management was visible and approachable. Upper management were not visible at ward level. The management style was top down and directive.

Cultural differences between services led to lack of facility sharing to ease flow in maternity. The maternity

dashboard showed several risks that had been evident for two years. There was not an active maternity services liaison committee (MSLC), which meant that service user views were limited. The service used other methods of capturing patient feedback including FFT, Twitter, and Maternity services website on the Trust Internet page. The service main focus was on managing the daily strains it faced, with little innovation evident.

Feedback was generally positive from people who used the service and those who were close to them. Women told us that they understood their care and treatment and were able to ask staff if they were not sure about something.

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Are maternity and gynaecology services safe?

Inadequate



We rated this service as inadequate for safety.

Women and babies were at high risk of avoidable harm and there were limited measures to monitor safety performance.

Staff did not always recognise serious incidences. Staff did not monitor or manage risks to woman who used the service and opportunities to prevent or minimise harm were missed

Insufficient staffing put women and babies at avoidable risk. Midwife staffing levels had been reported as a concern for more than four years and in August 2015 the midwife to birth ratio was recorded as 1:37, which is significantly higher than the national average of 1:28. Some women did not receive one to one care in labour. Some areas of the maternity service were not clean or well maintained.

Sixteen serious incidents for maternity were reported to the Strategic Executive Information System (STEIS) between May 2014 and April 2015

One never event, a retained object post procedure, was reported in May 2014. We saw that an investigation had taken place, learning points had been identified and shared and an action plan had been developed.

The named midwife model was in place for community care and women told us they had a named midwife.

The gynaecology service was clean and well maintained with appropriate equipment. Staff demonstrated a good understanding of risk management and incident reporting. Gynaecology was staffed appropriately in accordance to patient need. Records were completed correctly and staff were competent in their roles.

Incidents

- There had been one never event in the 12 months before our inspection. A surgical swab had been left in a patient's body following a caesarean section procedure

and further surgery had been needed to remove it. A risk meeting was held to discuss the outcome of the investigation and action plans were put in place to reduce the chance of it happening again.

- As a result of the incident, the trust had introduced a new pathway for all patients around the time of their surgery. We saw that swab and instrument checks were completed before, during and after operations in all the case notes we reviewed. We also saw records of completion of the majority of pre and post-procedure swab and instrument checks for women requiring perineal repair. The trust introduced whiteboards into each birthing room to record swabs, needles and instrument checks.
- We were not assured best practice was followed concerning cardiotocography, which is the recording of a foetal heartbeat (CTG). We found midwives reviewed CTG recordings on an hourly basis but we could not find evidence of peer 'fresh eyes' reviewing to ensure safety. The National Institute for Health and Care Excellence (NICE) intrapartum guidelines recommend that a second midwife checks a CTG recording of a baby's heart rate hourly to ensure that it is normal. The continuing professional development (CPD) midwife told us that 'fresh eyes' had been introduced approximately 18 months ago but had 'fallen by the wayside'. The CPD midwife acknowledged that 'fresh eyes' reviews were done on an adhoc basis. The need to incorporate peer review of CTGs into everyday practice had been reiterated to band 5 midwives during their student training programme but not to other staff.
- Sixteen serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between May 2014 and April 2015. There were five unexpected admissions to the neonatal unit (NNU), nine intrauterine deaths (deaths inside the womb) and two unplanned maternal admissions to the intensive care unit (ITU).
- All reported incidents were reviewed at monthly risk meetings attended by the senior management team. Lessons learnt were fed back to staff via a quarterly newsletter and shared learning files and notice boards were located in all maternity and gynaecology ward areas.
- Following every reported serious incident an investigation was undertaken and a report was written

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detailing the incident, cause, learning and policies. A root cause analysis (RCA) was also carried out in line with National Patient Safety Agency (NPSA) guidance, to establish the reasons the incident had occurred.

- All the staff we spoke with were aware of how to record safety incidents, raise concerns and near misses, but during the inspection we saw two serious safety incidents that were not reported. We were told repeatedly that feedback was rarely received on an individual basis when incidents were reported.
- During our inspection, we saw a syringe of diamorphine (a controlled drug), which had been left out on the work surface in the anaesthetic room unattended. We raised our concern to the theatre staff who disposed of it immediately. An anaesthetist we spoke with said it had been there since the previous operation three hours before.
- We saw a delay of one hour and 31 minutes for an emergency caesarean section procedure while we were in the department. The recommended time for this procedure to be completed is 30 minutes according to the Royal College of Obstetricians and Gynaecologist guidelines. This means both mother and baby were put at prolonged risk. When we checked the next day neither of the incidents were reported by staff. There was no documentary evidence that duty of candour was followed in this case.
- The continuing practice development (CPD) midwife told us that she had revised the mandatory training programme for midwives to incorporate lessons learnt from incident reports and complaints.
- The CPD midwife also told us that the service had an increase in the number of third degree perineal traumas (a tear extending downwards from the vaginal wall and perineum into the muscle that controls the anus) in July and August 2015. This was rated as red on the maternity dashboard. Investigations had not identified any trend but an update on perineal trauma was planned to be included in mandatory training later in the year.
- The service did not use any tool for the prevention and identification of pressure ulcers in maternity. Staff told us that managers had informed them they felt this was not necessary as most of the women cared for in the unit were fit and healthy. However, in 2010 the National Patient Safety Agency (NPSA) said, due to an increase in maternity pressure ulcers, pressure ulcer prevention

must be a priority across all NHS settings, not just those caring for patients typically at risk. This put patients at risk of developing pressure ulcers that might not be identified and treated.

- Gynaecology staff had a good understanding of incident reporting and received feedback from their managers on incidences reported.

Safety Thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. It allows the proportion of patients that are kept 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE) to be monitored. Safety Thermometer Boards were located at the entrance to the clinical areas. The boards for both Foxglove and Primrose wards were completed but the board for ward 27 (delivery suite) was blank. During our unannounced visit, boards on the delivery suite, antenatal and postnatal ward and gynaecology ward were out of date. The manager for the delivery suite area told us this was because the boards had been erected in a place they did not agree with and they were planning to relocate them.
- Between September 2014 and September 2015, maternity and gynaecology services reported nil for pressure ulcers, falls and catheter-acquired urinary tract infections. However, there were six reported VTEs, but we saw there were no action plans in place to support this figure.
- The maternity safety thermometer allows maternity teams to carry out a 'temperature check' on harm, and records the proportion of mothers who have experienced harm-free care. It also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from perineal and/or abdominal trauma, post-partum (after delivery of the baby) haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar (a score to summarise a baby's health) of less than seven at five minutes after delivery and those who are admitted to a neonatal unit.
- Managers were unaware of the maternity safety thermometer and therefore, the service did not collect information for it.
- Safety thermometers on the gynaecology ward were fully completed and included positive patient feedback.

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Cleanliness, infection control and hygiene

- We saw environmental audits for all areas. The infection prevention and control of equipment audit showed the delivery suite achieved only 69% compliance in 2014 compared to 100% in 2013.
- The antenatal and postnatal wards showed an improvement in the environmental audit scoring 98% and 97% for 2014 compared with 72% and 73% the previous year. The gynaecology ward scored 89% compliance, which was an improvement on 79% the previous year. There was an action plan to improve equipment cleaning, which stated staff were responsible for cleaning their own equipment and cleaning regimes should be set up to ensure cleaning of equipment was not missed. We saw checklists to document each room had been cleaned but no regimes for rooms on the delivery suite or the antenatal, postnatal or gynaecology wards.
- We saw that the antenatal and postnatal wards were visibly clean and well maintained.
- Cleaning checklists were in place on the delivery suite to check each room, but specific cleaning duties for each room were not detailed on the delivery suite or the wards.
- In four of the birthing rooms we inspected there was surface dust on the bed frames.
- In the temporary operating theatre, there was a layer of dust on top of the baby resuscitation equipment and other elevated surfaces.
- In the theatre, there was a piece of equipment used to elevate patients called a Cardiff wedge that was torn. A tear in the material could harbour bacteria and become an infection control hazard.
- We saw the door to the main theatre damaged, with the surface covering torn from multiple trolleys forcing the door open. This posed an infection risk as it was unable to be cleaned well.
- The midwife-led unit was visibly clean and well maintained in all areas.
- Staff told us they assumed responsibility for cleanliness of equipment. There was no system in place to identify equipment was clean and ready for use.
- None of the toilets in the clinical areas had information displayed to indicate the last time the area had been cleaned.
- The service stocked reusable cardiotocograph (CTG) belts (straps which hold the monitor onto the mother's

- abdomen). We were told they were washed between each patient. When we asked what temperature they were washed at the staff member was unsure. The belts can be reused if washed at 60 degrees and not washed more than 20 times. We did not see any record of how many times each belt had been washed, when we asked staff they were unsure. On the wards, staff told us belts are sometimes used for multiple patients without washing. This poses an infection control risk.
- On the postnatal ward, a domestic pram was being used to transport babies to the neonatal unit for their antibiotics. The pram was made from a porous material. When we asked staff what cleaning measures were taken in between each baby that used the pram we were told that they changed the sheet. Porous material cannot be cleaned adequately to prevent the transmission of infection. The babies receiving antibiotics were high-risk and prone to infections due to the nature of them being on antibiotics; this factor, combined with transporting them in an environment that cannot be thoroughly cleaned is an infection control risk. We raised this with the manager who immediately took the pram out of use.
- Women being admitted for elective caesarean section procedures were routinely screened for MRSA. The results were documented in their notes.
- Sluice areas in the delivery suite, antenatal and postnatal wards, gynaecology wards and midwifery-led unit were clean and had appropriate disposal facilities.
- Hand cleaning and use of PPE (personal protective equipment) followed the trust infection prevention and control policy. We saw staff use hand gel, and we were prompted at each access to all wards to gel our hands. We saw protective clothing and adherence to the 'bare below the elbow' policy.
- The gynaecology ward was clean and well maintained with appropriate cleaning regimes. Equipment was clean, well maintained and ready for use.
- Nurses demonstrated a good understanding of appropriate aseptic non touch technique to reduce the risk of infection to patients.

Environment and equipment

- The delivery suite had one obstetric theatre and recovery area. Due to increased capacity issues over the past two years, the service had transformed a former high-dependency room into a second theatre. This room was not fit for purpose as it did not have an

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appropriate sink area for staff to clean their hands. There was a sink but 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, which in an emergency might take up valuable time. When we visited the second theatre it looked like a store room and cardboard was stored on the floor. It had been on the service's risk register since June 2013 and an action plan referred to the services refurbishment plan.

- We found seven pieces of out of date equipment on the airway management trolley in the main obstetric theatre. We were told that the trolley was checked daily by an anaesthetic nurse.
- The water warmer in the main obstetric theatre did not have any temperature checks and the theatre staff did not know what temperature it should be.
- There was a theatre communication book, but nothing had been documented since April 2015.
- Resuscitation equipment was accessible in the delivery suite, MLU antenatal and postnatal wards and the trust's policy required it be checked daily to ensure supplies were complete and within date. Checking of the neonatal resuscitation equipment in all of the delivery rooms which we had access to (seven in total) for August and September 2015, there were two days on average missing from the records. On our unannounced visit, we found an average of two days for the previous week had not been checked on the four resuscitators we looked at. The manager responsible for the area acknowledged the service struggled with compliance of this due to the high activity of the delivery suite. They communicated to shift co-ordinators and midwives to ensure that checking was completed. Adult resuscitation equipment was shared between theatre and delivery suite and it had full compliance in daily checking.
- We found in the temporary obstetric and main obstetric theatre one adult laryngoscope (medical equipment used to obtain a view of the vocal folds and the glottis) and one neonatal laryngoscope that were uncovered and it was unclear if it had been used or it was ready for use. As there was no packaging the cleanliness of the equipment could not be guaranteed and may have presented an infection risk.
- We looked at equipment check records on Foxglove and Primrose wards, the midwifery led unit (MLU) and the gynaecology ward and saw all equipment had been checked appropriately and was ready for use. The fetal blood sampling machine on the delivery suite had been defective for two weeks. During this time, staff had accessed the equipment on the neonatal unit, which was easy to access from the delivery suite. However, during our visit we witnessed staff having to take a sample to the Intensive Care Unit for analysis. This was a significant distance, around four minutes' walk away from the delivery suite, which posed a risk in terms of time delay, accuracy of the results and subsequent care and treatment of babies. Information provided post inspection by the trust supported the fact a new piece of equipment had been ordered. All equipment, apart from two items of electrical equipment, had up-to-date portable appliance testing (PAT) demonstrated by stickers on the item, meaning it was safe for use. We saw two machines for taking patient observations were out-of-date in terms of safety testing.
- Staff told us following a simulated inspection the trust undertook in preparation for our visit, an order had been placed for additional equipment such as patient monitors but these had not been received yet. Midwives also told us they were expecting new birthing beds but these were not evident on the delivery suite. Management did not know if these had been ordered. The midwives struggled on a daily basis in locating special equipment that enabled women to be assisted into a suitable position for instrumental births.
- An intercom and buzzer system was used to gain entry to the delivery suite and the maternity ward to identify visitors and staff so women and their babies were kept safe.
- Cardiotocography (CTG) machines were used for women whose babies needed monitoring in labour. Telemetry (wireless) CTG machines that enabled women to be mobile were not available.
- The MLU had three birth pools that were clean and well maintained. There are two nets available for evacuating women from the pool, these are kept on the resuscitation trolley in the MLU.
- We looked at the birthing pool on the delivery suite and found it to be well maintained. Staff we spoke with knew the pool cleaning regime. There was no pool evacuation policy although there was a net available to do this on delivery suite.
- We observed an effective outpatients clinic service. Comfortable, private rooms were available in the antenatal clinic for sensitive discussions.

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- The triage and fetal assessment unit (FAU) area were cramped. It was a challenge to provide privacy and dignity. Intimate examinations were frequently carried out in a two bedded bay with a curtain to separate beds which compromised womens' dignity. A single room was used when available. On our unannounced follow-up visit the FAU had been relocated. The new location was spacious and airy however beds were only separated by curtains and there was no provision for a single room for intimate examinations.
- Scanning facilities were under strain due to inadequate staffing and equipment resources. This led to delays in scanning appointments, which caused inconvenience and potential risk to women who had to wait for scan appointments. The trust opened evenings and weekend clinics to ease flow.
- A fire door to the kitchen area on Foxglove ward was wedged open. This was addressed and rectified. The décor of both Foxglove and Primrose wards was in need of repair; paintwork on the doorframes was scuffed and damaged.
- The gynaecology ward and early pregnancy assessment unit were spacious, comfortable and fit for purpose.

Medicines

- Controlled drugs are medicines that require additional security. We found a syringe containing a controlled drug left out on the work surface in the anaesthetic room on delivery suite, we immediately reported this to the shift co-ordinator
- Records demonstrated that twice-daily stock checks of controlled drugs were completed in line with trust policy in maternity and gynaecology.
- Intravenous fluids were not stored appropriately. The fluids were in stock rooms without locked doors both in maternity and gynaecology services. This had been on the service's risk register as an amber risk since March 2013. When we raised this with managers on the gynaecology ward, the door was immediately locked.
- Plastic containers of intravenous medicine containing potassium were stored on a trolley alongside other intravenous medicines in similar containers. This caused an avoidable risk of medicine errors.
- Temperatures of refrigerators used to store medicines were monitored daily; this ensured medicines were maintained at the recommended temperature. There were gaps (one to two) in the checking record in all of the four previous weeks of fridge temperatures in the

delivery suite. Staff in the anaesthetic area were unable to explain the procedure for reporting a refrigerator where the temperature was above the designated range. In the anaesthetic room adjacent to the two theatres, the medicines refrigerator and cupboards were unlocked. Both the anaesthetic room and the theatres are accessible from the corridor. We raised this issue with staff and both were immediately locked.

- Suxamethonium and thiopentone (medicines used by anaesthetists) were stored in identical pre-loaded syringes and located next to each other in the refrigerator. The similarity of these syringes may lead to confusion on administration.
- Midwives may supply and administer medicines under a system known as midwives' exemptions. We saw evidence of this on patients' prescription charts. Syntometrine, a medicine that is frequently administered to the mother following birth to promote delivery of the placenta was documented in the maternity notes but rarely on the prescription charts of the notes we looked at.
- Treatment charts in gynaecology were completed correctly in the notes we viewed.
- We saw medicines for home births were kept in boxes on the MLU following being dispensed by pharmacy. They were collected by the community midwives whilst on call to supply and administer. This was good practice and ensured the medicines had been checked for safe administration.
- We saw venous thromboembolism (VTE) risk scores were recorded in women's records and monitored. VTEs are a potentially dangerous type of blood clot. Treatment to prevent VTEs was prescribed and administered in accordance with the trust policy.

Records

- Sensitive confidential information about patients was not kept secure and could be seen by members of the public. The delivery suite activity board which contained patients names, number of pregnancies, progress in labour as well as medical conditions was displayed in a public place; although shutters were available they were not frequently used. Two coordinators of the delivery suite said they were never closed. On all occasions we visited (one announced inspection over two days and two unannounced inspections) the shutters were open. The birth register in the MLU was kept on a cabinet outside the nurses' station. When we raised this issue,

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the register was moved to a secure location. On the gynaecology ward, we saw several communication books with patient details were left unattended on the nurses' station; when we raised this with staff the books were put into a secure place.

- We observed that staff handover on the delivery suite took place in a corridor where the activity board was placed. This meant it was possible to overhear confidential information such as number of pregnancies and progress in labour being discussed amongst clinical staff because of the location of this board and lack of space for a confidential discussion to take place. Furthermore, whilst the activity board was protected when not in use by shutters, during handover it was clearly visible to people accessing the corridor and via an adjacent corridor. The lack of a private area for handover meant patient confidentiality was breached.
- On the maternity unit we saw individualised maternity records being reviewed as part of the women's care and the child health record books were introduced for each new-born. Red books are used nationally to track a baby's growth, vaccinations and development.
- We reviewed 44 sets of maternity records. The antenatal notes were a mixture of hand written documentation and computer printouts that had been stapled in. This made navigating around the antenatal documentation extremely difficult. Midwives told us they also struggled to find information when a woman arrived at the maternity unit. The maternity service used the National Perinatal Institute notes for labour and following birth. Documentation of the labour and postnatal care was greatly improved and easier to navigate. Decision making was poorly documented in 30 sets of notes where the woman had an induction of labour. One set of notes we saw, the midwife had to request the on call doctor to review a woman who had arrived for induction as there was no documentation that this was the plan. Doctors rarely provided evidence that decisions had been discussed with the women and their partners or birth companions. Risk assessments were difficult to locate in the records due to the mix of computer printouts stapled in and hand written records; staff also reported they found risk assessments difficult to locate.
- The operating theatre staff applied the World Health Organization (WHO) surgical safety checklist as part of the 'five steps to safer surgery' procedures at critical time points within a patient's care pathway to ensure their safety. We saw good documentation of this during

our first inspection however, on our unannounced follow up inspection, two of the five sets of notes we reviewed did not have a full completed WHO check list. This meant we were not reassured that use of this checklist and compliance with checks to keep women safe was well embedded in the operating theatre.

- We reviewed eight sets of gynaecology records. Gynaecology records were clear and easy to navigate. Risk assessments were completed and easy to locate. Reasons for admission and care plans were evident.

Safeguarding

- Arrangements were in place to safeguard adults, children and babies from abuse, harm and neglect and reflected up-to-date safeguarding legislation and local policy. Maternity services had a designated safeguarding specialist midwife.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984. Staff were unsure if this policy had ever been tested.
- Clinical areas were protected with camera surveillance and we saw evidence that visitors to the unit were challenged prior to being admitted into the area. Babies on the postnatal wards were kept secure with an electronic tagging system.
- Staff demonstrated an understanding of the trust's safeguarding procedures and reporting process.
- Safeguarding children training compliance for women's, children's and clinical support services was recorded at 96.7% for level one, 90.9% for level two and 92.2% for level three. Management were unsure what the target levels were.
- 96% of midwives were trained to level three in safeguarding children and there was a robust system in place to ensure new starters had this training incorporated into their induction
- Staff told us they received good support from the safeguarding midwife who visited wards regularly to review safeguarding issues, and was available by telephone at other times.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children,

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2015). Community midwives undertook safeguarding supervision where they discussed each safeguarding case with a safeguarding specialist to ensure safety in line with trust policy.

- There was an indicator on the maternity service information system for any woman who had a safeguarding concern. Safeguarding plans were also uploaded to the information system.
- Identifying safeguarding issues in the hand held antenatal records was difficult due to the mixture of hand documented and computer print outs inserted into the notes. Midwives told us they did not rely on the hand held records for safeguarding information and checked the computer system if they had time. If they were too busy there was a danger safeguarding information may be overlooked.
- There was a policy in place to safeguard people at risk of and treat those affected by female genital mutilation (FGM). Staff were aware of their responsibility to safeguard female infants at risk of female genital mutilation.
- We saw all women were asked about domestic abuse in line with NICE guidelines [PH50] 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively' and disclosure was recorded. Staff knew how to make referrals to other agencies in cases of disclosure.

Mandatory training

- The CPD midwife co-ordinated mandatory training for the midwifery and medical staff. Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of haemorrhage after birth, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse (when the umbilical cord comes out of the uterus with or before the presenting part of the fetus). This training did not include scenarios for staff working in the MLU or community setting. The CPD midwife told us that capacity and staffing affected the availability of multidisciplinary staff to attend.
- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling and positive mental health.

- Mandatory training including fire safety, manual handling and safeguarding level one was recorded at 84% for midwives and 70% of medical staff. The target was 90%
- Gynaecology service showed a mandatory training uptake of the following: corporate update 100%, clinical update 96.5%, conflict resolution 87.8%, equality and diversity 93.9%, fire safety 93.4%, information governance 96.9%, patient handling 93.1% and safeguarding children level 1 96.9%.
- Maternity service showed a mandatory training uptake of the delivery suite staff of the following: corporate update 100%, clinical update 70.7%, conflict resolution 95.7%, equality and diversity 80.8%, fire safety 76.6%, information governance 97.8%, patient handling 93.2% and safeguarding children level 1 100%.
- Mandatory training only incorporated basic life support (BLS) for staff. In terms of new-born life support (NLS) training, management confirmed that it was mostly the band seven team leaders who were NLS trained. We established that no midwives working in the stand-alone midwife led unit were NLS trained.
- Specific maternity mandatory training covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, management of sepsis, perinatal (around the time of birth) mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- A cardiotocography (CTG) machine was used by midwives on the delivery suite to measure contractions and baby's heart rates over a period of time. Midwifery CTG training compliance for delivery suite was 90.6% for July to September 2015. The service aims for 100% of midwives to be up to date with this training. There was not an action plan to improve compliance.

Assessing and responding to patient risk

- For women using the maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit in the woman's home. We saw that on-going risk assessments were carried out at subsequent antenatal visits and referrals were made to the obstetric team if risk factors were detected. This ensured that issues presenting risks to unborn children were identified quickly and could be addressed to reduce the chance of harm.

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- Women who had problems in pregnancy were reviewed on the fetal assessment unit (FAU). If necessary, they could be admitted to the ward for short periods to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth, recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans could be made for their pregnancy.
- The weight of babies at birth was correlated with the fetal growth charts data to recognise babies who had not achieved their expected birth weight (intra uterine growth restricted). Appropriate care plans could then be instigated. Maternity services also fed this data (anonymised) back to the publishers of the growth charts to ensure on-going improvements and monitor for efficiency of the system.
- Maternity services utilise both a maternity and neonatal early warning score (MEWS/NEWS) to facilitate escalation of the deteriorating mother or baby. We found that scores on all notes we reviewed had been calculated appropriately and, where necessary, had been escalated. On Foxglove ward, we witnessed a midwife undertaking a NEWS assessment and escalating her concern regarding this infant to the paediatrician.
- Midwives frequently looked after women requiring high dependency unit (HDU) care. There was a specifically designed room for this level of care. Only five midwives out of 141 whole time equivalent (WTE) midwives had received a one-day HDU training course. All other midwives cared for women with central or arterial lines without specific training. A central line is a long, thin, flexible tube used to give medicines, fluids, nutrients, or blood. The catheter is threaded through this vein until it reaches a large vein near the heart. During our inspection, a woman who was known to be high-risk and required HDU care was not allocated a midwife who had undergone HDU training due to the minimum number of midwives that had completed the one day training. None were on duty for that day.
- There were clear guidelines with criteria for the transfer of women from the low risk environment of either the MLU or home birth into the consultant unit.
- Women were routinely risk assessed at booking in and at 36 weeks gestation regarding their choice of place of birth although both the senior leadership and the contact supervisor of midwives told us the uptake of women choosing the MLU as a place of birth did not meet the nationally recognised targets. They felt this was due to the culture of Walsall wanting the reassurance of a doctor being available during a birth.
- We spoke with service users who met the criteria for birth at the MLU but had chosen to give birth in the consultant unit. This was because of their uncertainty about whether the MLU would be open due to capacity or as a result of the midwives having been deployed to support the consultant-led service. They had received this information through other women using the service and from staff.

Nursing and midwifery staffing

- The ratio of midwifery staff to births was worse than the England average of one midwife to 28 women from April 2011 onwards. The ratio during our inspection was 1:37. The recruitment of extra midwives had commenced earlier in the year to improve the ratio to 1:33. These staff were not yet in post at the time of our inspection
- Nursing and midwifery staff were flexible and told us they worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to their immediate managers. The planned and actual staffing levels were displayed at the entrance to each maternity ward during our inspection; however, during our unannounced follow up visit these numbers were not displayed. The staff were unsure why this information was not displayed. We later learned the trust was awaiting the arrival of amber coloured magnetic counters and until such time the staffing level boards would not be updated. This had not been communicated to all staff.
- The minimum staffing levels calculated by the trust for delivery suite were nine midwives and two maternity care assistants (MCA) for each shift and we saw that the required number of staff were on duty during our announced visit. During both our unannounced follow up visits, the staffing was under requirement at eight midwives for both visits. We looked at the staff rota on the delivery suite from 6 August for a four week period. Twenty seven out of 28 days were working at suboptimal staffing levels at some point.

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- Safe staffing levels for the antenatal and postnatal wards were three midwives and two maternity care assistants (MCA's) on the early shift and the same on late shifts and nights. For the maternity wards, we saw that the required and planned staff were on duty during our announced visit. During our unannounced visits we saw that one midwife from each ward had been relocated to delivery suite due to workload.
- Midwives worked eight or 12 hour shifts. The delivery suite required nine midwives per shift. The role of the delivery suite coordinator was to coordinate the activity on the ward. They required constant oversight of the ward so that decisions could be made regarding care and treatment. We saw the band seven delivery suite coordinator was not supernumerary and we were told in times of increased activity, they routinely had to look after women in labour. This could affect the safety of women in labour as the coordinator needed to have an overview of activity at all times in order to manage the delivery suite safely. The Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health joint report 'Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007)' states "to ensure 24hour management cover, each labour ward must have a rota of experienced midwives and labour ward shift coordinators who are supernumerary to the staffing levels required for one-to-one care." The trust was not adhering to this guidance.
- The same guidance recommends that "there should be one whole time equivalent consultant midwife for each midwifery-led birth centre" and the labour ward of a consultant obstetrician-led unit should have two consultant midwives to every 3,000 births per year. The trust did not have any consultant midwives.
- The triage and induction rooms on the delivery suite were staffed by midwives included in the delivery suite numbers. A maternity care assistant (MCA) sometimes supported the midwives. We looked at the triage and combined fetal assessment unit (FAU) activity records and observed that 37 women had attended in one 24hour period and 46 women the next 24hour period in September 2015. This area was sometimes staffed by one midwife per shift with no maternity health care assistant to help. This meant that the midwife would complete all duties required including washing and changing bed linen between patients, which would exacerbate the high workload.
- Safer childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) states that, "The underpinning principle of midwifery care in labour and the foundation of Birthrate Plus is that labouring women receive one-to-one individual care by midwives throughout established labour". We asked the senior leadership about the staffing situation. We were told midwife to birth ratios varied. Birthrate Plus is a nationally recognised tool to assess the individual needs of a maternity service. It looks at several elements such as the women who access the service, peak and falls of activity and skill mix of staff. It ensures a safe, good quality service. Birthrate Plus recommended a ratio of one midwife to 31 births for the numbers and type of patients at The Manor Hospital. We observed a discrepancy in the ratio of midwives to births. There was funding for one midwife per 35 births and at the time of our inspection we were told there was a ratio of one midwife per 37 births. However, the Obstetrics Business case document reported a current ratio of one midwife per 39 births. This is considerably higher than the national average of one midwife per 28 births. The midwife to birth ratio was a RAG rated red risk on the maternity dashboard but the staffing numbers were not shown on the dashboard.
- Senior management told us the vacancy level of midwives was 11.78 WTE and recruitment was in process; the obstetric business case reported midwives vacancy as 17.14 WTE. The department's sickness rate was 6%. According to the NHS sickness and absence rates between April and June 2014 the average sickness absence rate for the NHS in England was 3.92%.
- The maternity wards did not use agency staff and had their own bank of temporary staff. This was made up of permanent staff who undertook extra work to cover shortfalls. In one four week period in August 2015, midwives worked 100 extra hours collectively to provide cover by staying behind at the end of their shift. For 6 to 12 September we saw there were 29 bank shifts available for the maternity service.
- One to one care in labour was not audited routinely and while maternity management told us one to one care was being achieved in 70% of cases, in practice we were told midwives routinely cared for a woman in labour

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alongside a woman with a lesser dependency rating. This meant that one to one care was not being provided. The service did not audit the number of women who received one to one care. Midwives told us, and we saw they were unable to provide one to one care in labour for all women on the delivery suite. Delivery suite midwives often cared for a woman in labour as well as other women. For example, a high risk woman having her labour induced or a woman requiring high dependency care. On our unannounced follow up visit we observed one midwife caring for three women: one being induced for prolonged rupture of membranes, another being induced for reduced fetal movements and another in the HDU who was post caesarean with suspected complications following birth. Women on the MLU did receive one to one care.

- Birthrate Plus identified women who required a syntocinon infusion as being at moderate risk and requiring a ratio of 1.2 midwives each (the 0.2 indicated further support such as a delivery suite co-ordinator). We noted that midwife staff levels had been on the risk register since October 2011. We saw that a business plan had secured an additional £900,000 to recruit midwives and that the recruitment of new midwives was being implemented.
- Community midwives had caseloads of 95-100 for a full time midwife, which was in line with the Royal College of Midwives' recommendation of an average caseload of 96 patients per midwife.
- We saw there was a lone worker policy. Part of this stated midwives should telephone the MLU once they were home from work activities. If they did not call in they were called to ensure they were safe. Midwives were trialling an alert device and satellite location systems that tracked their location if an emergency occurred.
- Maternity services used an acuity tool developed by local heads of midwifery to assess delivery suite activity compared to staffing. Delivery suite shift co-ordinators said the tool was not very helpful as it did not accurately reflect the level of activity on the delivery suite. They said often they did not have time to work out the figures needed for the acuity tool as the shift was too busy.
- The service had an escalation policy when activity on delivery suite required more staff. The escalation policy involved moving midwives onto the delivery suite from wards, the community or the MLU.
- During August 2015, the escalation policy was used on 18 days of the month.
- We reviewed the rota for the delivery suite and saw on 26 out of the 28 days over a four-week period in August 2015 the unit was below minimum safe staffing numbers.
- Relocation of midwives as part of the escalation policy ensured improved safety of the women being cared for on the delivery suite, however as the postnatal wards were the first part of the escalation this had an adverse effect on the care being delivered to women and their babies on both Foxglove and Primrose wards. We saw delays in antibiotics being given to new babies due to a lack of staff available on the wards. Furthermore, midwives told us there was a lack of understanding of the complexity and rigours of contemporary postnatal care amongst some of the delivery suite co-ordinators.
- Incident forms were completed when the escalation policy was used. Staff told us the number of times the escalation policy was used was not currently being audited. It is important this information is collected so management can easily see how often the policy is being used so improvements to the service, such as increasing staffing numbers can be made. When we requested this information, it was provided retrospectively and showed the escalation policy had been used 18 times in August 2015.
- We saw from staffing rotas held on the delivery suite and from what staff told us that the escalation policy was in almost daily use and was no longer an escalation plan but usual practice. As such, it was an unsustainable model for the staffing of maternity services. The heavy reliance on bank staff and good will coupled with staff being moved to work in unfamiliar environments from post/.antenatal wards to labour ward and vice versa could put patients at risk. Staff told us the trust failed to recognise the impact of their policy on staff and the consequent effect on the safety of the service.
- We reviewed the midwifery co-ordinators' hand over sheets for the period of 14 to 24 September. This document provided an overview of the activity and staff on duty for any day or night shift. Over this period the escalation policy was utilised on eight out of the 10 days. We observed documented comments such as 'inductions delayed due to activity,' 'elective caesareans delayed due to activity,' 'patient delay in perineal

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suturing of one and a half hours,' 'no midwives able to have breaks,' 'neonatal unit requesting unit to be closed due to lack of beds' and 'early staff stayed two hours extra'.

- We saw delays to patient care had occurred because staff numbers were not sufficient to safely manage activity levels. We spoke with one woman who had to wait for 18 hours to have her waters broken as part of the induction of labour process. This should have taken place within a few hours to prevent prolonging the induction of labour process. This was reflected in the documentation in her notes. One woman had to have an emergency caesarean because she had an infection and her baby was in distress, and had to wait an hour and thirty one minutes for the procedure which should have been completed within 30 minutes according to Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists (2010) Classification of urgency of caesarean section.
- Due to capacity issues, inductions of labour were staggered throughout the day and start of the procedure could be deferred at times of high demand. The co-ordinator recorded this daily but there was no audit of the information. Elective caesarean section lists were frequently interrupted to accommodate emergency cases. Whilst this ensured the safety of emergency cases, the impact of delayed planned care may lead to poor patient experience. We saw although an incident form was submitted if an elective caesarean section was deferred to the following day, no records were made of other delays to elective caesarean section.
- Staff commented on being unable to care appropriately for new mothers and babies following birth as they often had to attend to other women in labour. We saw evidence of a delay in perineal suturing following birth due to staffing capacity.
- The unit had recently recruited a number of Italian midwives. Clinical midwives and the CPD midwife told us they were concerned any benefits from this recruitment would not be realised for some time due to the extended period it would take the new midwives to become familiar with working in British maternity services
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse for eight patients. We saw a safe staffing board displayed planned and actual staff ratios

for each shift on the gynaecology ward. During our visit, the ward was staffed according to the planned number of staff required. We saw a ratio of 1: 6. The gynaecology ward used bank staff in times of staff shortage.

Medical staffing

- The trust employed 29 whole time equivalent medical staff in maternity services. The level of consultant cover was 41% which was higher than the national average of 34%. There were fewer registrars (38%) which was less than the national average of 51%. The percentage of middle grade doctors was 7% which was similar to the national average of 8%. There were 14% junior grade doctors which was more than the national average of 7%.
- Consultant obstetric cover on the delivery suite was on average 105 resident hours per week at the time of the inspection, which was above the required level of 96 hours detailed in Safer Childbirth. This included resident consultant cover on the delivery suite for four night shifts per week. Outside these times a consultant was on-call.
- There was 24-hour senior anaesthetic cover for the labour ward. A consultant anaesthetist was available from 8am to 6pm for weekdays on the labour ward. Out-of-hours cover was provided by the anaesthetist on call.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with the Safer Childbirth (RCOG 2007) recommendations.
- The gynaecology service was covered by a junior trainee and a registrar from 8.30am to 5pm Monday to Friday and by a dedicated junior trainee and registrar out-of-hours. Emergencies were managed on an emergency list by consultants and/or middle grade staff.
- A ward round did not occur on the delivery suite. Routine ward rounds involving patients is good practice. Women's care was discussed amongst the team but not every high-risk woman was visited and assessed by the multidisciplinary team. This meant that women were not always involved in discussions regarding their care. If the midwives requested a medical review it would be undertaken.

Major Incident Awareness

- We were told the trust had a major incident plan which stated "although particular services and functions

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across the trust may take a visible lead in the response, any and all responses to major incidents are trust wide-affairs that require an increased level of flexibility and activity from all members of staff.”

- Staff were unaware of the role that maternity services would play within that plan. Staff were unable to say if there had ever been a rehearsal for major incident. Two midwives told us they had both been employed at Walsall for over 10 years and had not been involved in or heard about any major incident exercises.

Are maternity and gynaecology services effective?

Inadequate



We rated this service as inadequate for effective.

Women receive care from staff who did not always have the skills or experience required to deliver effective care. The trust did not have specialist midwives for women at increased risk such as diabetes, substance misuse, teenage pregnancy, bereavement and mental health.

Women’s care did not always reflect current evidence based guidelines.

There was no midwife responsible for the oversight of infant feeding. Breast feeding initiation rates were lower than the national average. Normal vaginal birth rates were lower than the national average and induction rates and caesarean section rates were significantly higher than the national average. Audit was limited with no clear action plans. Midwives did not have time to correctly assess women in labour in regard to method of fetal monitoring. Active birth support for women on the labour ward was limited.

Women did not have access to interventional radiotherapy services if required. Foxglove and Primrose wards did not have a formal transitional care facility which is a higher level of care input for babies on antibiotics or frequent observations. Women we spoke with felt that their pain control had been well managed. Epidurals (a specialised type of pain relief) were available 24 hours a day.

Most staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity

service. Staff worked collaboratively to serve the interests of women in the hospital and community settings. 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.

Gynaecology patients had adequate pain relief and access to food and fluids as required. Patients had access to information leaflets. Nurses had support with staff development

Evidence-based care and treatment

- The delivery suite did not have a system in place to provide Cardiotocography (CTG) review known as ‘fresh eyes’. NICE Intrapartum Guidelines recommends that a second midwife checks a CTG recording of a baby’s heart rate hourly to ensure that it is within normal parameters.
- Staff had access to guidance, policies and procedures via the trust intranet.
- There was a lack of support due to staffing levels and a shortage of equipment such as birth stools and telemetry CTG monitoring for women who choose to give birth on the labour ward. Although there was a birthing pool available on the labour ward when we visited, its room was being used to store beds and equipment. Active birth, where women are encouraged to mobilise as much as possible during labour was not encouraged. Staff said this was due to time restraints and old fashion practice. One newly qualified midwife said she was “really enthusiastic about active birth when she first qualified, but it soon wore off once she started working on delivery suite due to how busy it was.” We saw documentation that women frequently gave birth in lithotomy position where a woman’s legs are separated and raised whilst she is lying on the bed. Most women we spoke with said they gave birth in a semi recumbent position on the bed. Having an active birth by adopting upright positions such as standing, supported squatting, kneeling and the ‘all fours’ positions in labour according to research are associated with the following: less pain, fewer episiotomies (where the perineum is cut to aid the birth), fewer extensive perineal tears, less perineal trauma,; fewer women experiencing discomfort, fewer women experiencing intolerable pain and a reduction for the need for instrumental delivery where forceps or a suction cup are needed to assist with the birth. We saw documentation

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that several women had been placed into lithotomy during the second stage of labour to aid descent of the baby into the birth canal. This demonstrated that the midwives did not have a full understanding of the benefits of active birth which might affect the birth experience a woman has and may not be following current best practice.

- The care of women using the maternity services was not in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development and the facilities.
- 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 this was because there was not enough time to assess women properly and one midwife said “at least if they are on the CTG I can get on and assess the next woman.” NICE guidelines for Intrapartum care 2014 state: “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 wellbeing. However, continuous CTG was associated with an increase in caesarean sections and instrumental vaginal births.
- RCOG say 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, speaking with staff and reviewing case notes that medical reviews occurred on an ad hoc basis and were only instigated as a result of midwives escalating a concern to medical staff. This put women and their babies at risk because high-risk labours were not being managed appropriately.
- There was no visual representation of a woman’s individual risk for example, a traffic light system to clearly identify those women at the highest risk on the patient board. This meant that women at high-risk were not easily identifiable. We found from our discussions with women and staff and from observations that care was being provided 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, including primary, community and hospital-based care.

- The trust’s guideline ‘continuous fetal monitoring in labour’ was not in line with the December 2014 update to the NICE Intrapartum Guideline CG190 and still referenced the 2007 guidance. This meant staff were not using best practise guidelines to interpret CTGs which may put women and babies at risk by failing to recognise deterioration in fetal wellbeing.
- We saw from our observation of activity and from reviewing care records the care of women who planned for, or needed a caesarean section was not managed in accordance with NICE Quality Standard 32. Women who have had a caesarean section were not offered a discussion or given written information about the reasons for their caesarean section and birth options for future pregnancies.

Audit

- Examples of presentations on audits included induction of labour and caesarean section. Gynaecology examples included cervical glandular neoplasia (abnormal cells in the cervix) and management of ectopic pregnancy.
- We reviewed the trusts audit into caesarean section rate; there was no clear action plan following this audit, detailing tasks and the person responsible for task completion.
- The contact supervisor of midwives (SoM) told us if an individual midwife’s practice was subject to a supervisory investigation this was done by a Walsall SoM. They were unaware of the recommendations of the Ombudsman Report that best practice was for supervisory reviews to be conducted by an external assessor.
- The continuing professional development (CPD) midwife told us they participated in regular stress (audit) tests, where a number of notes are reviewed to see if they are compliant with guidelines. They told us they had done a stress test following the retained swab ‘never event’ which had occurred in May 2014. The results of the audit confirmed compliance with swab checking and counting standards. The maternity service worked closely with staff from the hospital’s main operating theatres. A verbal update was shared with all

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'scrub practitioners' (staff who work in theatres during operations). The CPD midwife was unaware any form of audit should be registered with the trust's audit department.

- The cervical glandular neoplasia audit did not have a clear conclusion or action plan to follow.

Pain relief

- We saw pain relief was well managed.
- We saw complete documentation of pain scores included on the maternity early warning score chart in all the notes we reviewed.
- Epidurals were available 24 hours a day. Infusions (a type of injection) of opioids and remifentanyl (strong painkilling medicines) were available for those women where an epidural was not an option.
- A birth pool was available on the delivery suite so women could use water immersion for pain relief whilst in labour however, when we visited this room was cramped due to being used to store equipment.
- On the antenatal ward, we saw several pain relief methods available, including baths and entonox (an inhaled pain medicine, sometimes called 'gas and air') for women who were having their labour induced.
- In the midwife-led unit (MLU), a birth pool was available for pain relief alongside entonox and opioids. Alternative pain relief options such as massage, aromatherapy and reflexology were also available.
- The women we spoke with were satisfied with their pain relief options and felt they received them in a timely fashion. They reported pain relief was good. Epidural times were routinely audited with the service regularly achieving the 30 minute (from request to being attended) local and national targets set by The Association of Anaesthetists of Great Britain and Ireland and Obstetric Anaesthetists Association.
- Post operation pain relief was managed well in the gynaecology patients we saw.

Nutrition and hydration

- There was no midwife responsible for the oversight of infant feeding. However, the trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby. Documentation

about discussions relating to methods of feeding was difficult to find in the hand held notes. Peer supporters who are volunteers mostly with experience as breastfeeding mothers, who have undergone training assisted women with breastfeeding practise. Antenatally all recorded discussions were documented within Badger net (maternity IT system). Discussions postnatally are recorded in the Purple Post-natal Baby notes.

- Women told us that the breastfeeding support was limited as midwives were so busy. We saw the initiation of breast feeding rate was 60% in March 2014, which was below the national average of 75%. This was the most recent data provided from the trust when we requested breast feeding rates; the infant feeding midwife had left so no audit on breast feeding rates had been done since she left in 2014.
- Women were able to choose from a varied menu, to meet nutritional needs. The menu also met their cultural requirements on the maternity and gynaecology ward.
- Women told us that food was available outside of set meal times if they did not feel like eating at those times on the maternity and gynaecology ward.

Patient outcomes

- The maternity dashboard was used for recording activity and outcomes. We looked at the dashboard for April to August 2015 and saw that in August, five national indicators were RAG rated red out of the ten indicators assessed according to targets. The caesarean section rate, the induction of labour rate, the number of third degree tears, the midwife to birth ratio (although no numbers were provided), and the prevalence of smoking at access to the service. No indicators were rated amber. Five were green.
- Information on the maternity dashboard demonstrated that in August 2015 the normal vaginal delivery rate (without any assistance) was 52%, which is lower than the royal college of obstetricians and gynaecologists (RCOG) recommendation of 60%. The caesarean section rate was 35%, which is higher than the national average of 25%. Of these, 13% were elective, which was above the national average of 10.7% and 22% were emergency which was above the national average of 14.7%. The induction of labour rate was 30%, which worse than the national average of 22%. When we asked a senior

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manager about these figures, they said the figures were audited but there was no action plan in place with targets to reduce the caesarean section or induction of labour rates.

- Historically, the trust had a high caesarean section rate. We saw this was on-going and the rate for August 2015 was 35%. This is higher than the national rate of 25%. We saw limited attempts to address this, although services were being developed to support women in their choice of mode of birth following a caesarean these services were not yet in place. The antenatal clinic staff said they knew this clinic was going to start but they did not know when or how it was going to work. This may help reduce the caesarean section rate.
- The ventouse (suction cap) and forceps delivery rate was 13% which was the same as the trusts target.
- Third degree or fourth degree tears (injuries to the mother's perineum during delivery of the baby) were recorded in 2.8% of patients. This is higher than the trust's target of 2.5%.
- The rate of stillbirths from April 2015 to August 2015 was 4.3 per 1000 live births which is lower than the 4.6 per 1000 average still birth rate for England.
- 32 women had experienced a postpartum haemorrhage (bleeding after giving birth) of over 1500ml between April and August 2015 which was 1.5% of all births. There was not a trust target reported on the dashboard for this indicator. This would make recognition of increased incidences or improvements in service difficult to recognise and action. All of these haemorrhages were reported as incidents. A consultant reviewed the management of these cases and concluded that guidelines were followed.
- The service did not have access to interventional radiology to control excessive haemorrhage. The RCOG in 2007 urge all obstetric units to consider early radiology as an important tool in the prevention and management of postpartum haemorrhage as it can prevent major blood loss, removing the need for blood transfusion and hysterectomy.
- We saw one woman was admitted to the intensive care unit following complications after giving birth between April and August 2015. This was less than the trusts tolerance target of one or less per month. The notes were reviewed by a consultant and they concluded guidelines had been followed.

- There were three cases of meconium aspiration syndrome (a situation where the baby has faecal matter in its lungs on being born) in neonates in August 2015 compared to the trusts target of 0. These babies were admitted to the neonatal unit.
- Examinations, scans, treatment plans and assessments were carried out in the gynaecology assessment unit during weekdays from 8am to 8pm. A team of midwives, doctors and allied health professionals supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours.
- The trust provided activity data showing that 1,844 gynaecological operations took place between August 2014 and July 2015. Of these operations 1,566 were elective and 278 were non elective operations.
- We were shown an audit of colposcopy services, the purpose of this audit was to compare the service with the national guidelines and to ensure there were no further breeches in waiting times for treatment. The conclusion of the audit was not clear and did not address the purpose of the audit. We were not assured that audit of practice resulted in improvement of service.

Competent staff

- Responsibility for mandatory training and other learning and development within the directorate was managed by the CPD midwife, who co-ordinated requests for external course nominations each year and sent them to the senior leadership for funding approval.
- Staff told us opportunities for development were limited due to rota pressures and the need to focus on operational demands.
- The trust did not have specialist midwives for diabetic care, mental health, bereavement care, teenage pregnancy, infant feeding or substance misuse. This was because management believed having these specialist roles would de-skill the other midwives as they would rely on specialist midwives for patient care. However, specialist midwives have an important role in education and support of their specialism for other midwives as well as a role in development of pathways and guidelines. Specialist midwives also improve continuity and outcomes for women and their babies.

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- Staff told us they felt that their development opportunities were limited due to the lack of specialist roles used in the trust. We were told consultant-led teaching, including case studies and cardiotocograph (CTG) interpretation was about to recommence.
- At the time of our inspection the service was implementing a growth assessment protocol (GAP). This was an individualised growth chart which took maternal, fetal and pregnancy characteristics into consideration when estimating the size of the fetus. The CPD midwife told us that 80% of midwifery staff had accessed and completed GAP training. A senior midwife told us that there is poor compliance amongst medical staff for GAP training. We were told there was not an action plan in place at present to address this.
- Midwives working on delivery suite regularly cared for women with either a central venous line or an arterial line. Both of these are advanced methods of giving medicines direct into the patient's bloodstream. Staff had not received high dependency care training.
- Medical support was available from the critical outreach nurses and the anaesthetist 24 hours a day if required.
- The critical care outreach team had not received training in care of the high-risk woman and were unaware of the physiological changes which occur to pregnant or newly birthed women. This was a breach of the obstetric anaesthetist association Guidelines for Obstetric Anaesthetic Services (2013) which stated that parturient women had the right to the same standards of perioperative care as any other surgical patients. Training must be to the standards defined for the care of the general surgical patient.
- There is an orientation package for midwives commencing allocation within the MLU, this includes training on pool evacuation and emergency situations
- 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 a band 4 theatre scrub practitioner. We saw this practice was against the recommendations of the college of operating department practitioners, the royal college of midwives and the association for perioperative practice. The arrangements put in place to support staff moving from the consultant-led unit to the midwifery-led unit, where staff were required to practice more autonomously, raised concerns. For example, an orientation package was in place but no specific practical training on pool evacuation or managing emergency situations in the MLU took place.
- Midwives had been trained in new-born and infant physical examination and carried out this examination within 72 hours of birth. This enabled women to be discharged home without waiting to see a paediatrician.
- All newly qualified midwives undertook a preceptorship programme prior to obtaining a band 6 position. This meant they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- 89% of staff in maternity and gynaecology had up to date appraisals.
- A detailed and specific program was in place to anticipate the arrival of midwives who had not previously worked in England having commenced employment at the trust.
- The Nursing and Midwifery Council (NMC) sets rules and standards for the statutory supervision of midwives. Supervisors of midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio at Walsall Healthcare was 1 to 14. This reassured us there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives told us they had access to and support from a SoM 24 hours a day, seven days a week and that they knew how to contact the on-call SoM.
- Midwives were competent in examination of the new-born which enhanced the continuity of care for women.
- Gynaecology nurses said they had access to additional training if they required, one nurse discussed the trust supporting her through a nursing degree course.

Multidisciplinary working

- We saw good examples of multi-disciplinary team (MDT) working on the delivery suite.
- We observed staff and medical handovers where patient care was discussed and discharges planned. A multidisciplinary handover involving obstetricians,

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midwives and anaesthetists took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients wherever they were situated in the hospital.

- Handovers were carried out three times during each day on the labour ward. We observed the formal multidisciplinary 8.30am handover which included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover.
- Midwives and medical staff told us that access to medical care from other specialities was straightforward and responses to requests for input into a woman's care was usually prompt.
- The matron for the delivery suite told us that there was no formal escalation policy for high-risk women who required transfer to a tertiary unit that provides specialist care. If this was anticipated the woman would have care booked at the tertiary centre at the beginning of her pregnancy. There was no policy for transfer.
- Electronic communication with the community midwifery team facilitated women's transfer home from hospital. Midwives told us if sensitive information such as safeguarding needed to be communicated to the community team this would be done via a telephone call.
- Each woman had a named midwife and the women we spoke with told us they felt the continuity of care this afforded in the antenatal period was a positive attribute of the service.
- Communication within community maternity teams was efficient. In the community we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services.
- Foxglove and Primrose wards did not have formal transitional care facilities which is a higher level of care input for babies on antibiotics or frequent observations, but midwives provided intermediate care to those babies requiring interventions such as intravenous antibiotics. Midwives told us they were well supported by a team of advanced neonatal nurse practitioners who were very visible on the wards during our visit.
- One of the pressures on the maternity unit at Walsall was the availability of neonatal cots. Transfers of women out of the unit happened frequently (two-three times per week on average) resulting in an added burden on midwifery staffing because women being transferred

needed to be accompanied by a midwife, which left the unit short of staff. The unit had a robust framework to support the safe transit of women requiring transfer before they had given birth.

Seven-day services

- Access to medical support was available seven days a week.
- Consultants were on site 105 hours per week including a consultant on night duty in the hospital four nights per week and on call at other times. This is 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 labour ward 24 hours a day.
- The early pregnancy service ran between 9am and 5pm Monday to Friday. If necessary, early pregnancy scans could be carried out at weekends by the oncall consultant or registrar. At the weekend women accessed care via accident and emergency.
- Community midwives were available 24 hours a day, seven days a week to facilitate home births.
- 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. Any other medicines not stocked relied on the midwives proactively sending charts to pharmacy before the weekend which could delay a woman going home. Midwives were proactive in ordering these medications to avoid delay.

Access to information

- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust and access guides, policies and procedures to assist in their specific role.
- An electronic notification of discharge and summary of care was automatically sent to women's GPs on transfer home. GPs could refer women into the service either via the fetal assessment unit (FAU) but could also access advice and support directly from either the consultant or specialist registrar covering delivery suite.
- Women and their families could access information via their community midwife, through patient information leaflets and the trusts maternity service web page.

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- Gynaecology patients had access to information leaflets on the ward following procedures such as counselling services after a miscarriage.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Midwives had limited understanding of the Mental Capacity Act 2005 (MCA) and the Children's Acts 1989 and 2004 in terms of legislation and guidance relating to consent and decision making. When asked, they did not know what the act involved, but on prompting they said if they had concerns over someone's decision making ability they would seek advice from senior colleagues.
- For clients under the age of 16 years midwives said they would assess their ability to consent using the Gillick guidelines.
- Gynaecology nurses had a better understanding of the MCA and said they would contact the mental health crisis team who were available 24 hours a day if they had any concerns.
- MCA and Deprivation of Liberty Safeguards training was not well established in maternity services. 61% of delivery suite staff and 57.9% of the staff on the antenatal and postnatal wards had attended training. Senior managers reported there was no action plan at present to increase the uptake at present.
- 96.6% of staff on the gynaecology ward had attended MCA training.
- An interpretation policy was in place at the trust which stated that the six most prevalent languages spoken in the local area were catered for by multilingual staff members; these staff members were oncall and could be contacted to translate. A senior manager told us this was on a consultant's request only. When we asked senior management about requests from midwives who did not have access to consultants e.g. in the MLU, they were unsure of the process. During our inspection we found three cases where it was assessed and documented at the booking appointment that the woman required interpretation services.
- Interpretation services were provided at some antenatal appointments. None of these women received interpretation services during their inpatient stay for labour or birth. All of these women gave consent for complex medical procedures: two for a caesarean section and one for a fetal blood sampling. It was not documented how informed consent was achieved. There was no documentation of how the information

was interpreted into their own language. When we asked the senior management about this we were told consent was gained from one woman by a doctor who spoke the same language, although this was not documented.

- The doctor who gained consent from another woman told us they spoke very slowly to her and asked her to repeat back what she had said to ensure understanding. We were told a third woman could understand English. As this woman was still an inpatient we went to speak to her. We found she could not speak or understand English. Her partner was present for the labour and birth and he informed us that he had interpreted for her. We were not reassured that consent was being properly gained from women who could not understand English.
- Consent for episiotomy, a cut made to the perineum to expedite birth and perineal repair, this is the suturing procedure to the perineum after birth, was obtained verbally and documented in patient notes.
- Written consent was obtained for caesarean sections.
- We saw documentation that consent was reviewed prior to surgery in all cases and documented on step two of the WHO check list.

Are maternity and gynaecology services caring?

Requires improvement 

Maternity service staff were trying to provide a caring and compassionate service in difficult circumstances but there are times when women do not feel well supported or cared for.

Peoples' privacy and dignity were sometimes compromised due to environmental constraints.

Feedback was generally positive from people who used the service and those who were close to them. They told us that they felt safe although they would have liked more support.

Women told us that they had little support once their baby had been born on the labour ward due to the midwife having to look after someone else. Staff told us they did not feel that they could offer the support and assistance in the immediate post birth time they would like to offer.

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There was a paternalistic approach to care. Managers told us plans of care were discussed with multidisciplinary teams regarding high-risk pregnancy at the perinatal meeting. The women this care revolved around were not present at these meetings.

People were told about their care rather than being involved with the decision making process.

Women told us they understood their care and treatment and were able to ask staff if they were not sure about something. However, we observed one woman who was told about her induction of labour rather than being involved in the decision making process.

On the postnatal ward, staff responded when people needed help and supported them to meet their own and their babies' personal needs.

The lack of specialist midwives may result in reduced support for women with mental health concerns and for bereaved parents.

Gynaecology patients felt well cared for and listened to. One patient said "she never felt that the nurse was trying to rush her."

Compassionate care

- We observed genuine caring and compassionate interactions between staff and the women and their families that used the service.
- Support and advice for women in the early stages of labour was available via the telephone. We witnessed coordinators speaking to several women accessing support and advice while we were on the delivery suite. The interactions were respectful with the midwife ensuring the advice she had given was acceptable to the woman. A written record of the advice given was filed in the woman's notes.
- We witnessed the midwives and staff working to ensure that women's privacy and dignity were respected in difficult circumstances. The triage area was cramped with limited facilities for physical and intimate care. A single room within the area was used if available but we observed several care episodes involving intimate examinations in which privacy and dignity could be compromised.
- The July 2015 Friends and Family Test (FFT) achieved the following results:

- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? Out of 231 responses, the trust achieved a score of 92% for this question which was below the national average of 95%.
- How likely are you to recommend our delivery suite/ birthing unit to friends and family if they needed similar care or treatment? Out of 38 responses a score of 100% was achieved which is the same as national average of 100%.
- How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? Out of 395 responses, a score of 96% was achieved compared to the national average of 97%.
- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? Out of 15 responses, a score of 100% was achieved compared to the national average of 96%.
- FFT results for gynaecology indicated that 99% of patients would recommend the service.
- The CQC maternity survey of December 2013 surveyed women who gave birth in February 2013. It showed that most outcomes for Walsall Healthcare were similar to the national average.
- We saw that thank you cards were displayed in ward areas indicating appreciation from women and those close to them.
- Gynaecology patients said they felt cared for and well looked after. They felt the nurses always had time to listen to any concerns or questions.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about anything. Partners of pregnant women said they felt informed of events but would have liked the opportunity to support their partner on the postnatal ward but this option was not available to all partners all of the time.
- For women with high-risk babies a plan of care was formulated at the multidisciplinary perinatal meeting and then filed in their notes. The woman or family was not involved with the care planning however, they were informed of the plan at the next appointment.
- We heard of a complaint from a user on the postnatal ward regarding the length of time taken for a baby to

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receive antibiotics on the neonatal unit. The mother told us she had been woken at 3am by a member of staff who told her that her baby required a lumbar puncture, where spinal fluid is collected to screen for infection. The baby did not return to her mother until after 10am. During this time of separation, the mother told us she was not kept informed about where her baby was or what was happening.

- The women that we spoke with on the postnatal ward were all aware of the options for choice of birth.
- The service had an online virtual tour and also offered a tour of the midwife-led unit for those women considering birth there.
- The women we spoke with were unaware of the role of the supervisor of midwives. They should be informed of their role as they can provide guidance and support for women if required. The contact supervisor told us SoMs were involved in supporting women who chose birth outside guidelines and cited one woman who requested a home birth.
- We were told and saw documentation that confirmed women were supported to make a choice about the place they wished to give birth. This decision was made when they were 36 weeks pregnant and information was provided to assist them in making their choice. We saw specific risk factors which needed to be considered and would lead midwives to advise a hospital birth rather than home or the MLU were taken into account.

Emotional support

- Women felt they had good support from their community midwife due to the community model of continuity of midwives. This meant they mostly saw the same midwife at each appointment.
- Women who gave birth on the labour ward reported the midwife was 'in and out' during labour as they were not the only one the midwife was caring for. One woman told us she "felt the midwife was doing her best under the circumstances." Women who gave birth on the midwifery-led unit reported 'fantastic supportive care' and felt that their 'every need was catered for'.
- The service did not have any specialist midwives therefore there was no resource for midwives to access support or advice when caring for women with mental health issues in pregnancy or after the birth or for those

families needing bereavement support. Such women and families could access emotional support, but the professional offering this support did not have any formal counselling qualifications.

- There was no dedicated bereavement midwife to support women who had suffered the loss of a baby. An external review of the service had recommended that a specialist role be created. The midwives on delivery suite stated that there was a small cohort of midwives who had a special interest in caring for bereaved parents and these individuals tended to act as a resource for others. Limited training was in place to support midwives.
- The delivery suite had two rooms which were used for bereaved parents and the service provided a range of mementos to help parents. The chaplaincy department provided support and were available 24 hours per day. The service accommodated the majority of creeds and religions from the local population.
- Staff on the early pregnancy assessment unit (EPAU) offered counselling to women experiencing pregnancy loss. On-going support was provided by self-referral to an external counsellor. We were provided with a contact card for the counsellor. When we called she was easily contacted.

Are maternity and gynaecology services responsive?

Requires improvement 

We rated this service as requires improvement for responsiveness.

The service did not always meet the needs of the people it served.

There was a shortage of scanning facilities. This had a negative effect upon maternity and gynaecology patients because they could not access scans in a timely manner, which could delay their care and treatment.

The service had limited capacity and staffing resources, which had a negative impact on patient experience.

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The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs but sometimes the support was limited due to the lack of specialist midwives.

Translation services within the hospital were limited, this raised concerns around informed consent and confidentiality in maternity and gynaecology.

We saw evidence that 333 outliers (patients who are not being nursed in a specialist area for their particular condition) had been placed on the gynaecology ward between August 2014 and July 2015. Staff told us that this could detract from providing care to women with gynaecological conditions.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

- Visiting on the postnatal wards and gynaecology was carefully monitored. There were no facilities for partners to stay overnight.
- Midwives qualified in ultrasonography were unable to offer scans due to a lack of supervision and support structures. Recruitment of sonographers was in progress to resolve scanning issues of limited capacity for scan appointments.
- The trusts policy on reduced fetal movements recommended performing an ultrasound scan within 48 hours of the second episode of reduced fetal movements. Due to the limited availability of scanning, this was sometimes delayed. A cardiotocography (CTG) was arranged as an interim measure to monitor the baby until a scan was available to reduce risk.
- Compared to a national average of 3.9%, 20% of women who give birth at Walsall Manor were under the age of 20. The maternity service did not provide a specialist midwife to support these women. Care for young mothers fell under the children's and young people's directorate. There was not a clear pathway of communication between the two directorates to allow holistic care of these young people. When we asked the clinical director of services about how these services work together they were unsure.

- The population had a high number of diabetic mothers. Although there was a dedicated doctor for diabetic care there was not a diabetes specialist midwife despite the recommendation by an external review into perinatal outcomes. The review indicated that this would improve outcomes for diabetic mothers and babies.

Access and flow

- The number of births had increased from 3,888 in 2010/2011 to 4,640 in 2013/2014 resulting in capacity issues. A business development plan had identified the service could not cope in terms of staffing and facilities for more than 5,000 births per year. There was a plan to cap births agreed strategically with two neighbouring trusts. The antenatal clinic Midwife manager forwarded the monthly booking numbers to the Head of Midwifery. This information was captured on the Maternity dashboard and shared with the Multidisciplinary team in Maternity services and upwards to a sub group of Trust board via the Quality and Safety Committee
- The delivery suite had very little capacity to react to unforeseen circumstances. The maternity service had closed to admissions three times in the three months preceding our inspection. This meant that women who were booked at the unit had to be diverted to another local unit to be assessed and to give birth.
- An escalation policy was in place and was triggered when the workload on labour ward required extra staffing. An acuity tool developed by a local heads of midwifery was used to assess activity. The escalation policy was used 18 times in August 2015. Although this ensured women on labour ward were safe, it did not take into consideration the workload on the antenatal and postnatal ward from where staff were pulled to support the delivery suite. This compromised patient safety on the antenatal and postnatal wards. When we visited the unit, the antibiotic administration to several babies had been delayed due to staffing issues.
- Women could access the maternity service via their GP or by direct referral. We saw that all women were seen by a midwife by 12 weeks and six days of pregnancy, which was in line with NICE antenatal care guidelines.
- The fetal assessment unit (FAU) provided a 24hour a day assessment service to women. Women could be referred to the FAU by community midwives, GPs, or could self-refer. The FAU and triage areas were situated within the delivery suite. It was cramped and women reported they often had a long time to wait to be seen.

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There was a plan in place to relocate the FAU. Midwives told us they always tried to prioritise women in terms of need and urgency when working in the area but this could be difficult because of the environment and demands made upon them as it was only covered by one midwife.

- The MLU was underutilised and efforts to promote it were limited. In August 2015, only 21 women gave birth on the MLU compared to 443 on the delivery suite. An average of 5% of births took place in the MLU. The Birthplace national prospective cohort study by the national institute for health research, demonstrated that birth in a midwifery-led unit is as safe as birth on a consultant-led labour ward for low risk women. Women who were low risk did not book for birth at the MLU by default; it was a choice offered to them. We were told by the senior leadership and the birth unit manager that the culture among women in Walsall was to give birth in hospital with doctors present and they were finding it difficult to change the perception of the population to encourage normal birth. The manager had recently undertaken an advertisement campaign in local shops to promote the service. It was too early to assess if this promotion had been successful.
- Medical cover on the labour ward was provided by obstetricians from the on call team. Patients and staff told us review by the medical team could sometimes be delayed.
- Bed occupancy for maternity at Walsall Healthcare was higher than the England average for both 2013/2014 and 2014/2015. We saw that bed occupancy for quarter four (January to March) 2014/15 was 73% compared with the England average of 57%. This indicated women were having longer stays in hospital in comparison to the other trusts.
- The early pregnancy assessment unit (EPAU) offered appointments each weekday. Women were normally seen within 24 hours of referral to the service. This nurse-led service was managed by staff from the gynaecology ward and medical team. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and the hospital's emergency department.
- We saw evidence that 333 outliers (patients who are not being nursed in a specialist area for their particular condition) had been placed on the gynaecology ward between August 2014 and July 2015. Staff told us this could detract from providing care to women with

gynaecological conditions. In August 2013 there were four incident reports filed for patients who arrived for elective gynaecology surgery that had to be postponed as there were no beds available due to medical outliers on the gynaecology ward.

- A colposcopy service is run by doctors and a colposcopy nurse. From the services colposcopy audit, they identified that 17% of patients were not seen within the 62day target waiting period. The audit did not show an action plan to address this.
- Minor gynaecological surgery was undertaken in the day surgery unit and women went home on the day of the procedure unless complications meant they needed to be admitted overnight. Women we spoke with told us they had received good care and had been informed about their discharge home.

Meeting people's individual needs

- The service had developed its own hand held antenatal record. The service used a mixture of hand written records and computer printouts. Access to the electronic system was required to view women's needs. We were not able to check individual women's needs were assessed because the electronic summary of the antenatal period was not attached to all of the 44 sets of notes we reviewed. This meant that there was a risk that women's care and treatment may not be provided in a timely manner.
- In the community setting link workers were available to act as translators and were recruited according to their ethnicity to aid engagement in the local population. Translation services could also be booked for appointments.
- We asked maternity managers about interpretation services and were told there were no interpretation services available for inpatients. A manager told us that if a woman could not communicate they would try to find someone who spoke their language amongst staff to try to help. If they could not find anyone they would use a family member, sometimes on the telephone, to translate. This is an inadequate provision of translation services and could affect confidentiality and informed consent for procedures. When we asked senior hospital managers about this they provided us with the hospital's interpretation policy. This indicates that members of staff speak the five most common

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languages in the local area. These staff members are on call and may be contacted on a consultant's authority. The policy indicates friends or family may be used to translate in emergency circumstances.

- We saw there were effective processes 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.
- We saw a range of patient information leaflets, which were available in the majority of languages used by the local community.
- 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.
- Supervisors of midwives (SoMs) were available to help midwives provide safe care for mothers, babies and families. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care delivered met women's needs.
- Women with complex requests or needs for example, requesting home birth when risk factors were present, held discussions with the SoM and a plan was developed.
- The maternity service had a midwifery led unit (MLU) with good facilities to support low risk women in active birth. The midwifery led unit had specialist equipment such as beanbags, mattresses, and birthing balls to provide and promote the comfort of women in labour. There were three birth pools for women who wished to use water immersion for pain relief in labour.
- The trust ran a specific clinic to support women with diabetes through their pregnancy, although a specialist diabetic midwife was not in post. This was highlighted as a suggestion for improvement by an independent review to improve continuity of care for diabetic women.
- The delivery suite had two rooms 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 is designed to keep deceased babies at a cooler

temperature, was available which meant that babies could stay longer with bereaved parents. 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 service provided a range of mementos to help parents such as memory boxes.

- The chaplaincy department provided support and was available 24 hours per day. This service accommodated most religious beliefs practised within the local population including Christian, Muslim, Hindi and Sikh.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was an on-site neonatal unit. However, this was frequently over maximum capacity and babies had to be transferred to other units. Babies requiring additional care such as antibiotics were cared for on the postnatal ward. They had to be taken to the neonatal unit to have their medicine administered which sometimes meant they had to leave their mothers. Due to neonatal unit staffing issues this separation could be prolonged leading to distress for the mother and baby resulting in reduced bonding and interruption of breastfeeding.
- One woman on the postnatal ward told us her transfer to the ward following birth took over six hours. She told us she understood that the midwife was needed to care for another woman but felt let down by the service.
- We saw a variety of patient information leaflets available such as screening choice in pregnancy and following birth for mother and baby.
- There was patient information available on the gynaecology ward with literature visible to visitors.
- A company that provided samples and photography services visited the ward on a daily basis and midwives told us the company representative would not approach any woman without seeking advice regarding women who may be vulnerable or unsuitable to visit.

Learning from complaints and concerns

- Trust data showed there had been 18 formal complaints about maternity and gynaecology services between April and August 2015 and that there were six cases of on-going litigation against the trust. Complaints included- lack of care planning, lack of communication, lack of pain relief, infection, staffing levels and the death of a baby in labour.

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- Complaints were handled in line with trust policy. If a woman or relative wanted to make informal complaints they were directed to the midwife or nurse in charge. Staff directed patients to the trust's Patient Advice and Liaison Service if they were unable to deal with concerns. Patients were advised to make a formal complaint if their concerns were not resolved by either of these processes.
- All of the women we spoke with were aware of how to raise a concern or complain. A leaflet describing the process was readily available on the antenatal and postnatal wards.
- All complaints were initially seen by the senior lead who then distributed them to the relevant department.
- We saw evidence themes from complaints such as poor communication were communicated back to staff via newsletters and communication boards to improve patient experience.
- Staff knew what the duty of candour was and said they would use it. The staff we spoke with had never used the duty of candour. Since their training they had not come across any incident where duty of candour was required.

Are maternity and gynaecology services well-led?

Inadequate 

We rated well-led as inadequate for this service.

Leadership lacked insight into the serious failings of the service.

There was a lack of service vision and values and there was no credible statement of vision and guiding values.

Forward planning of the service was focused on refurbishment. 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 and risks at team, directorate and organisation level.

Cultural differences between services led to lack of facility sharing to ease flow in maternity. The gynaecology theatre had been used on a few occasions to ease the pressure on the obstetric theatre and prevent the use of the temporary

emergency theatre on the delivery suite. However, due to cultural differences between departments, communication had broken down and this arrangement was not currently being used.

Upper management were out of touch with what was happening on the front line. Senior management was not visible at ward level. There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated.

The culture was top down and directive and was not open to challenge and improvement.

The maternity dashboard showed several risks that had been evident for two years. There was a lack of clarity about authority to make decisions and how individuals are held to account. Quality and safety were not the top priority for leadership.

There was no active maternity services liaison committee (MSLC), which meant that service user views were not considered.

The service was focused on managing the daily strains it faced with little innovation evident.

There were good clinical multidisciplinary working relationships within services. Middle management was visible and approachable.

Staff in the gynaecology department were more familiar with the trust vision however, they said it was how they did their job everyday anyway by being caring. 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 they were provided with the correct facilities and equipment to do this.

Vision and strategy for this service

- There was a lack of vision and values. Staff were unable to articulate the vision for the next five years and those staff who could discuss it mainly concentrated on the planned refurbishment and upgrade of the building to accommodate the extra capacity. Births had increased from 3,888 in 2010/2011 to 4,640 in 2013/2014. We were told by the senior lead this was due to the closure of the consultant unit at County Hospital in Stafford and the closure of Sandwell General Hospital's maternity services.

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- When we asked senior managers, we were told there was no maternity service strategy in place.
- We were told by the directorate an investment of £3 million had recently been agreed for the maternity service however, on further questioning of the clinical director we were told the proportion of funding available for maternity had not been decided.
- The MLU had a 15 year lease with a 5 year opt out option. A financial viability study had taken place following the first year's activity.
- We saw the requirement to ensure a high quality service based on the current levels of activity for the women and babies of Walsall in the service business plan for 2015. The aim was to provide 'care that is safe, care that is clinically effective and care that provides as positive an experience for the patient as possible'. Staff knew about the development plans and were looking forward to the positive changes they would bring.
- The business plan identified it would not be possible to extend the service to provide care for more than 5,000 women to give birth. There were 4,640 births in 2013/2014. On discussing this with senior managers we were told they intended to cap the number of women who were able to book at the trust as the numbers increased. Numbers would reach 5000 by 2016-2017. The clinical director said there was no plan in place about how and when booking would be capped or the selection criteria that would be used. There had not been any engagement with other local services to see how this would affect the area as a whole.
- Staff in the gynaecology department were more familiar with the trust vision however, they said it was how they did their job everyday anyway by being caring.

Governance and risk management

- A midwife who was responsible for risk prepared and submitted a monthly report to the women's and children's risk group. There was a monthly women's and children's risk group meeting and a quarterly summary of risks was produced by the group. There was also a quarterly quality report for the division, which reflected the same findings as the risk report. We saw the minutes from these meetings in May 2015; it was discussed that there was difficulty in obtaining scans so daily CTG's were being performed instead. This issue had also been discussed at the consultant meeting in May. There is no consensus or conclusion from the consultant meeting but it was reiterated CTG's should not be requested in

place of scans. It was documented 'scans should be available when needed but this is not happening either'. This discussion was then documented as 'item closed'. We were not assured identified risks were being addressed in an appropriate manner with robust action plans to reduce the risk to patients.

- We did not see any evidence the service was aware of the challenges of governance arrangements. The governance arrangements were not clearly visible and it was not clear how they linked to ward level or fed into the trust board. From the discussions we had with clinical midwives we were not assured they were aware of their role and responsibilities and there was a lack of ownership of governance amongst the clinical midwives.
- Activity was recorded on the maternity dashboard and was reviewed at governance meetings to identify trends and enable service planning. However, the frequency of the use of the escalation policy demonstrated planning was not effective.
- The maternity risk register listed risks that has been of concern for considerable length of time. For example, the number of babies requiring additional care on the postnatal ward from 2009 and maternity and neonatal unit staffing levels from 2010. Little had been done to resolve issues on the risk register. The service development plan was cited as the potential solution to several issues although allocation of exact funding had not been agreed.
- We saw copies of a maternity risk newsletter on notice boards in the department but were not displayed in an area which encouraged staff to read for example, in staff rest rooms.
- There was a clear alignment between the risk register and personal 'worry lists' of senior managers. Staffing numbers was the highest risk cited by staff. Capacity issues were recorded as an amber risk on the risk register but the majority of staff stated they would rank this alongside staffing as a risk to the service.

Leadership of service

- Leadership lacked insight into the serious failings of the service.

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- Senior management did not appear to understand the issues of concern within the service or what plans were in place to address them. A top down and directive management style was observed throughout our inspection.
- Whilst the lead for obstetrics was new to post they did not appear to have a cohesive relationship with all members of the senior midwifery team. The obstetric lead was not aware the caesarean section rate was 35% when we visited. Challenge and development of the service was limited from the obstetric view point.
- Staff reported that not all senior leaders and board members were visible or approachable with the consequence that staff did not always feel valued or respected across maternity services.
- Midwifery staff spoke positively about matrons at departmental level and their support in general.
- The staff on both Foxglove and Primrose wards stated they felt valued by the ward manager. They felt they were approachable and staff felt 'protected' whilst they were on duty. However, when middle managers were not on duty they were often left short staffed in order for the delivery suite to be staffed.
- The postnatal 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. This varied amongst the group of co-ordinators.
- Staff on the delivery suite felt supported by the matron and whilst acknowledging they had not been in post for long they felt that they had the necessary skills to be able to transform and lead maternity inpatient services.
- From speaking to staff at all levels there appeared to be a separation between what was described as 'Walsall trained' and midwives 'from elsewhere'. We were told regardless of individual skills and competencies all midwives had to conform to the 'Walsall way'. Senior leadership told us they had experienced issues with midwives recruited from other trusts because they did not provide the same approach to care as Walsall midwives. When we asked how she would ensure the retention of the staff recruited from abroad we were told they had a two year contract and a detailed induction plan was in place.
- The CPD midwife had developed a robust training and induction programme for the overseas recruits. However, she told us she was concerned that the new preceptorship (students who have completed their training at Walsall, who were also due to commence employment in the near future) would not receive as much support as they needed because of the pressure of supporting the Italian midwives. We saw an action plan was in place to support the new midwives.
- It was evident from observation in the clinical areas staff at all levels worked cohesively and collaboratively to support each other within their own service or department.
- The gynaecology theatre had been used on a few occasions for elective maternity operations which had alleviated the need to use the 'make do' temporary theatre on the delivery suite. However, due to lack of cohesion and communication between theatre, maternity and gynaecology teams this plan was no longer in place. There was recognition by senior management about this issue but there was no plan in place to break down the cultural differences contributing to this lack of teamwork. The theatre risk was amber on the risk register and a plan to work with gynaecology services to address the theatre issues was documented to be in place.
- The clinical director told us the temporary theatre on the delivery suite was on their 'worry list' and when we asked what was being done to address it we were told it had been taken to the board for discussion. It had been on the risk register since June 2013 and apart from the development of the investment plan for services, no action or immediate remedial actions had been taken.
- The clinical director had reported the risk to women in relation to the high caesarean and induction of labour rate to the board. Despite audits into both of these risks there were no actions or timescales in place to actively reduce the number of women undergoing inductions or caesareans. We were told a vaginal birth after caesarean clinic was in place and run by senior managers. This clinic aimed to educate women about mode of birth options following a caesarean in order to increase the number of vaginal births after caesareans. We discussed this with antenatal clinic leads and found management had not yet implemented it. It was documented on the risk meeting minutes to start in July 2015.
- After a very busy shift on the delivery suite the midwives were given postcards from the co-ordinator to thank them for their hard work.
- There was inconsistent management of time owing between the delivery suite and the antenatal and

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postnatal wards. Some staff were owed up to 30-40 hours. On the delivery suite staff got the time back when the unit was quiet although we were told the opportunity for this was rare. However, on the antenatal and postnatal wards there was no system to give staff their time back for extra hours worked. Staff thought this was an extremely unfair and poor management decision.

Culture within the service

- Staff in maternity services felt disengaged with reporting safety incidents as they felt little was ever done about the concerns they raised.
- From our observations and discussions with staff we saw resilience and a determination to do the best they could under the constant pressure they were facing on a daily basis.
- Midwives felt sad they could not provide the level of care they wanted to due to staffing and capacity levels and were exhausted which adversely affected staff's morale. Staff reported a culture of doing things the 'Walsall way' and if individual staff members did not agree with any aspect they felt ostracised. Midwives said they did not dare 'go up against' senior managers with issues they had. They felt they just had to accept the way things were and got on with the job.
- Many of the midwives had trained and worked at the trust for many years; whilst this demonstrated commitment to the trust it also limited the opportunity for development and innovation of the service through outside input.
- Midwives were working with a sense of resigned resilience. Staff told us generally there was good teamwork between wards however, due to the recent strain on staffing resource relations between the delivery suite and the antenatal/postnatal wards had become strained as staff were always being moved to the delivery suite resulting in difficult busy workloads on the wards.

- 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 they were provided with the correct facilities and equipment to do this.
- One gynaecology nurse had relocated from another ward within the hospital and told us she was very happy and felt she had a good relationship with other staff members and managers.







Public and staff engagement

- There were limited opportunities for women's views to be sought. The labour ward forum had a user representative but there was no Maternity Service Liaison Committee (MSLC). A supervisor of midwives (SoM) told us that two SoMs were working on a patient experience questionnaire.
- People's views and experiences were not effectively gathered and acted on to shape and improve the services and culture. Leaders did not prioritise the participation and involvement of patients and staff.
- Junior managers were involved in recruitment interviews of potential new staff. This gave them the opportunity to develop management experience.

Innovation, improvement and sustainability

- There was a lack of innovation and no evidence of sustained, continual improvement across the service.
- When asked about innovation senior leadership told us they felt proud as they were the best unit in the Midlands area at detecting intrauterine growth restriction, a condition where a baby's growth slows or ceases when it is in the uterus. This detection rate was 50%, compared to the average for the west midlands being 36%.

Services for children and young people

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

Information about the service

The children's and young people's service at Walsall Manor Hospital cared for children and young people up to and including the age 16 years and young people under the Child and Adolescent Mental Health Service (CAMHS) up to and including age 17 years. The service includes a children's ward (Ward 21), a paediatric assessment unit (PAU) and a level 2 neonatal unit (NNU) where babies who needed extra support following birth were cared for. There was a children's outpatient department, orthoptic department, and audiology department. In addition, the Starfish suite provided a dedicated area for child protection assessments. The service was part of the women's, children's and clinical support services division. During 2014, the service cared for just under 2500 inpatient, 94% of which were emergency admissions.

During the inspection, in order to make our judgements we visited inpatient and outpatient areas. We talked with 12 patients and/or their parents, and over 35 staff including nurses, doctors, physiotherapists, a play specialist, support staff and managers. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. In addition, we reviewed care records, other documentation supplied by the trust and performance information.

Summary of findings

We found children's and young people's services required improvement overall.

There was an open culture of incident reporting but we had concerns about the robustness of the investigation and review process. This meant learning opportunities could have been missed which may have prevented similar incidents occurring in the future.

The neonatal unit was cramped and posed a potential safety risk when the capacity was increased above 15 patients. This was recognised as a risk by the trust and there were plans in place for the expansion of the unit.

There were problems with the availability and content of patient's notes in the children's outpatients department. Therefore, decision making could be compromised as vital information may not have been available to staff seeing the patient.

There was good multi-disciplinary team working and some examples of development of services across the hospital and community services. There were transition clinics in place for children with long-term conditions such as diabetes and asthma.

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.

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Parents and children without exception praised the staff for the care they provided and said staff ensured they were involved in all aspects of their care and treatment.

Children's and young people's services had strong leadership at ward and team level but there was no overall vision and strategy for the service and some governance processes required improvement.

Are services for children and young people safe?

Requires improvement 

There was an open culture of incident reporting and appropriate systems were in place to investigate and review incidents. However, the review process was not always as robust as it could have been and opportunities for learning were sometimes missed.

Regular audits of infection prevention and control ensured standards were maintained.

The environment in most parts of the children's and young people's services was generally good; this included the paediatric assessment unit, the children's ward and the outpatients department. We found the treatment room was not secure.

The neonatal unit was cramped and posed a potential safety risk when the bed capacity was increased above 15 patients. This was recognised as a risk by the trust and there were plans in place for the expansion of the unit. Cleaning of the Starfish suite was not completed regularly and during the inspection we found cleanliness issues and disposable items that were out of date.

Staff were clear about their responsibilities in relation to safeguarding and they felt confident to report concerns.

Although considerable work had been undertaken to improve the care and safety of children and young people with mental health needs who posed a risk to themselves and others, risks were higher than in a specialist service catering specifically for their needs. We had concerns about the trust's ability to access specialist services in a timely manner and the length of time these patients were on the unit prior to transfer to a more appropriate service.

Incidents

- There were no never events reported for children's and young people's services between May 2014 and April 2015.
- Four serious incidents were reported over the same period. Three of these related to the safeguarding of a vulnerable child. All were investigated by the trust and

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root cause analysis was undertaken with multi-agency involvement. Actions were identified for all agencies as a result of the reviews and learning was shared with staff to help prevent further incidents.

- Staff told us they were encouraged to report incidents and they knew the reporting procedure. They told us they received feedback about learning from incidents through emails and verbal feedback from the ward managers.
- Staff were able to identify changes that had taken place to practice as a result of learning from incidents. These included installation of anti-ligature cord light switches in bathrooms on the children's ward, an intravenous checklist and 24 hour digital clock to reduce errors in intravenous medicines administration. A video-laryngoscope (to look down someone's throat) was also being bought to increase effectiveness of intubation of new-born babies.
- Arrangements were in place to ensure mortality and morbidity meetings were held monthly.
- However, we had some concerns about the robustness of root cause analyses and mortality reviews. An independent review of 16 neonatal deaths occurring between 2010 and 2014 carried out by the Perinatal Institute of Maternal and Child Health, was published in June 2015. It found while "all cases had under gone 'in house' review and discussion at joint obstetrics and gynaecology and neonatal mortality meetings, in many instances important additional information became apparent and many key learning points were missed." In addition, following a more recent serious incident, the trust's review of the incident did not identify an issue which should have been explored during the review.
- Staff were aware of the requirements in relation to the 'Duty of Candour'. There were arrangements in place for ensuring that children and their family were kept informed of incidents which had occurred and were provided with the necessary support as well as being kept informed of any investigations and their outcomes.

Cleanliness, infection control and hygiene

- We observed staff adhering to the 'Bare below the Elbows' requirements and cleaning their hands before and after patient contact. Hand washing facilities were readily available in all the clinical areas within the service. Staff wore personal protective clothing and equipment in line with recommendations.

- The environment within children's and young people's services appeared visibly clean and we saw cleaning schedules were in place to ensure a systematic approach to cleaning.
- There was a clear allocation of responsibilities for cleaning and there were records of the cleaning of clinical equipment and other aspects of cleaning which were cleaned by nursing staff. Specific aspects of risk relevant to the care of neonates and babies, such as the milk kitchen and equipment used in high dependency care were inspected and we found they were visibly clean at the inspection and cleaning had been undertaken daily.
- In the neonatal unit, incubators which were not being used were stored in the corridor but were covered with plastic sheeting to protect them from dust.
- Arrangements were in place for the cleaning and decontamination of toys and play equipment between uses.
- The clinical assessment room in the Starfish suite was cluttered and untidy and the floor was not clean. The cleaning schedule indicated the shower room had been cleaned on 21 out of 32 occasions. Surfaces were dusty and some disposables were out of date. For example, some swabs had an expiry date of December 2012, some skin care cream was labelled as best before 2009 and hand wash 2013.
- A range of audits had been carried out by the infection prevention and control team to assess compliance with best practice and all areas within children and young people's services had scored highly in these audits.
- All areas within children's and young people's services had scored 100% in recent hand hygiene audits.
- All babies admitted to the neonatal unit from other hospitals were cared for in a single room and screening swabs were taken to identify infection or colonisation of organisms such as MRSA.
- Parents we talked with said they found the environment to be clean however, one set of parents said the cot linen used on the neonatal unit was frequently stained when it came from the laundry.

Environment and equipment

- There was secure access to the children's ward and the neonatal unit. However, we were able to enter the areas without staff being aware. On three occasions we were able to enter the area unannounced by waiting for other visitors to enter or leave and taking advantage of the

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door being opened. On the children's ward visitors had to bleep the nurses' station in order to exit the ward, but on the neonatal unit there was a green button to press for exit and therefore monitoring of those exiting the unit was difficult.

- All resuscitation equipment we looked at was checked regularly and stocked appropriately. Other equipment for emergency use was also checked daily.
- Equipment such as monitors and electrical equipment had been checked in line with their testing requirements.
- Staff expressed concerns that the Communications and Media department was situated centrally in the children's outpatients department; members of the media and other visitors passed through frequently, reducing the security of the area and creating the possibility of inappropriate observations of the children in the unit.
- There was a dedicated area for child protection assessments called the Starfish Suite. During the inspection we visited the area but did not see it in use. Equipment such as proctoscopes had been left out in the clinical assessment room, which may have been frightening for children and young people who were not familiar with medical equipment.
- The neonatal unit was equipped and staffed to be used for up to 15 babies and during the inspection there were 15 babies on the unit. However, we were told there were frequently up to 19 babies and on occasions 21 babies on the unit. We saw from the occupancy figures we were given the unit was over 100% occupancy for April, May and June 2015. We saw the bed spaces were small and cramped particularly when parents were in attendance. Additional incubators had been removed from the rooms and when these were needed to accommodate additional babies the space would have been further reduced. Spare incubators were stored in the corridor reducing access and space. The trust acknowledged the bed spaces did not meet the health building notes requirements and had recognised the risks associated with the environment. There were plans for the expansion of the unit to provide additional space and the work for this was expected to start within the financial year.
- The environment on the children's ward was spacious and suitable for the needs of the patients and their parents. There was a parent's sitting room on the

children's ward with a hot water machine for making drinks. This presented a safety risk as the door was open during the inspection and could be accessed by children and young people.

- The door to the treatment room on the ward was kept closed but not locked. Storage cupboards were labelled with their contents and were not locked. They contained sharps such as needles. This was a particular risk to children and young people who may wish to self-harm. We raised this with the manager and they told us they would address it by requesting a lock for the door to the room. In the meantime, the door would be kept closed.

Medicines

- Medicines were mostly stored safely and in line with requirements on the children's ward and the neonatal unit, except that we found one of the refrigerators used to store medicines on the neonatal unit was unlocked when our inspectors arrived on the unit. It was checked five minutes later and on another two occasions later in the day and was locked on each occasion. We made the ward manager aware and she expressed surprise, saying stating it was normally kept locked. Refrigerator temperatures were recorded daily and were within acceptable limits in both the children's ward and the neonatal unit.
- Systems were in place for the safe management of controlled medicines.
- We saw staff wore red tabards when administering medicines with directions not to disturb the wearer. Staff said: "we do still get disturbed by some parents, but we explain and respond if we can."
- We looked at the medicines administration record for six patients and saw they were completed consistently and there were no gaps to indicate medicines had been missed.
- An intravenous checklist had been introduced on the neonatal unit as a result of learning from a medicines error. This had been shared and recognised as good practice at the local neonatal network.

Records

- Medical records were stored in closed trolleys by the nurses' station and nursing records were kept by the bedside on the children's ward. Records were multi-disciplinary on the neonatal unit and were stored in closed trolleys.

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- We looked at 12 sets of records and found they were legible, timed, dated and signed, with the exception of the initial nursing assessment of the activities of daily living on the children's ward which did not have a space for the nurse's name, signature or designation.
- An initial nursing and medical assessment had been completed for all patients in the care records we reviewed on the children's ward and an assessment of their needs in relation to the activities of daily living had been completed. However, these were very brief and care plans had not been completed for such aspects of care such as nutrition and personal care, resulting in a lack of clarity in the documentation as to the needs and preferences of each child. There was a daily record of care that was completed contemporaneously and contained a good description of the care provided and the progress of the patient. There were also some inconsistencies in the quality of the case notes in the paediatric assessment unit.
- We were told there were problems with the availability of medical records in the children's outpatients department and we saw incident forms had been completed in relation to this issue. Medical records arrived late and at times, arrived during the clinic. This caused delays to the clinic and as a result, notes could not be prepared properly and referral letters were not always included in the notes. This meant decision making could be compromised as vital information may not have been available to the staff seeing the patient.

Safeguarding

- A children's safeguarding policy was in place which had been reviewed in January 2015. There was also a document that provided information on identifying a concern with the process for referral.
 - There were named staff in place with responsibilities for safeguarding children.
 - Staff we talked with said they had completed training in safeguarding children to the required level and mandatory training records indicated 98% of staff in children's and young people's services had completed safeguarding children level 2 training and 95% had completed level 3 training.
 - Staff including junior and senior medical staff, nurses and care support workers, were clear about the action required if they had a concern and the process for making a referral.
- We were told the trust safeguarding team was very supportive and would come to the clinical area to provide help and advice. On the neonatal unit, the safeguarding team attended a ward round on a weekly basis.
 - Systems were in place to check whether a child was subject to a child protection plan when they were admitted to the service.
 - There was space on the initial multi-disciplinary patient assessment for safeguarding information but this had not been completed in two of twelve records we reviewed. We were told and saw green paper was used within the care records for safeguarding documentation to ensure it was easily identifiable within the record.

Mandatory training

- Overall, mandatory training compliance for the Children's and Family Care Group was 93.05% in May 2015 and attendance by all individual staff groups was over 85%.
- Mandatory training for nursing staff working in children's and young people's services had been tailored to ensure it was relevant to the patient group. Staff completed the first day of the trust programme and a second day specific to paediatrics, delivered within the service. Safeguarding training and Paediatric Advanced Life Support training was provided in addition to this.

Assessing and responding to patient risk

- A paediatric early warning score (PEWS) was in use on the paediatric assessment unit and the children's ward to aid the identification of patients whose condition was deteriorating. An escalation plan was provided on the back of the observation chart.
- We saw PEWS was completed at every set of vital signs observations. No escalation was needed in the sets of observations we checked, so we could not assess whether escalation was undertaken in line guidance. However, staff understood escalation requirements and described when and how they would escalate.
- There was no risk-scoring tool in use for recognising deterioration in neonatal patients. A nurse told us, "we just have an inkling that baby is deteriorating and then bleep the doctor straight away." They told us medical staff were normally available on the unit.
- The children's ward regularly admitted children who had self-harmed or had other mental health issues. The trust had been working with the Child and Adolescent

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Mental Health Service (CAMHS) and the clinical commissioning group to improve the care of this group of patients and were part of a Black Country regional group looking at tier 4 CAMHS provision. Agreement had been reached regarding the timely review of patients by the CAMHS team and we were told this had been very beneficial in improving the management of some patients. However, there was no access to CAMHS medical staff out of normal working hours and the service had experienced delays in obtaining a bed in specialist services for patients at the higher level of risk. As a result, these patients had had to stay on the children's ward for several days on some occasions.

- A risk assessment tool suitable for use by non-mental health providers had been introduced to assess the risk of individual children and adolescents with mental health needs and the supervision they required, following a number of incidents on the ward. Where necessary, one to one care was provided and a registered mental health nurse (RMN) was requested to provide care. The trust found it difficult to secure an RMN at short notice and the skills of some of the temporary staff in caring for children and adolescents had been questioned. As a result, the trust was planning to recruit a number of care support workers who would be provided with additional training by CAMHS. However, even more senior nursing staff on the ward who were experienced in caring for these patients had experienced some challenging situations in managing individual CAMHS patients. The inability to transfer patients to a more suitable service in a timely manner and the limited skills of the staff gave us concerns about the safe management of these children and adolescents.
- Anti-ligature cord pull light switches had been installed on the children's ward following an incident with a CAMHS patient, but no other steps had been taken to identify and reduce ligature risks.

Nursing staffing

- The service did not use a formal dependency tool to assess nurse staffing requirements but we were told they were looking at the possibility of using a tool in the future. Currently, the requirements were based on national recommendations.
- The ward manager on the children's ward identified that staffing levels were below national recommendations. However, the trust was addressing this and actively

recruiting new staff. Nurses from overseas were arriving in the trust during the week of the inspection. In the interim, the ward had the authorisation to use temporary staff to address shortfalls in the staffing levels. We were told the ward utilised a small number of temporary staff who were familiar with the ward and we saw this was the case when we examined the staff roster. We saw the agreed staffing levels had been achieved on most shifts over the previous month.

- Non-compliance with neonatal staffing levels for Level 2 new-born babies and over occupancy of the neonatal unit were identified on the risk register for the Women's Children's and Support Services. Additional staffing had been agreed for the unit. There was a vacancy level of approximately 5% on the neonatal unit. The unit was staffed to accommodate two new-born babies requiring level intensive care, two new-born babies requiring high dependency care and eleven special care babies. The trust were actively working with the local Neonatal Network to manage capacity, but a lack of capacity in other neonatal units in the area resulted in up to 20 babies being cared for on the unit on frequent occasions. Staff on the unit told us they were authorised to utilise additional temporary staff when they exceeded their capacity and as with the children's ward, they used staff known to the unit wherever possible.
- Handovers took place at the start of each shift to ensure staff had the information they needed to care for the patients safely. A recognised 'SBAR' (Situation, Background, Assessment, recommendation) tool was used to ensure a structured approach to information provided at handover.

Medical staffing

- There were sufficient middle and junior grade doctors on duty to provide safe and effective care. The mix of junior, middle grade and consultants was broadly in line with the England average.
- There was a separate rota for new-born babies and paediatrics, providing a registrar and junior doctor for each area. Medical staff told us they appreciated the additional level of support this created out-of-hours as they could work together to help each other when busy.
- There is a separate Consultant allocated each week for new-born babies, in effect providing dedicated 9-5 Consultant cover for the neonatal unit of Consultant Paediatrician's with additional training in neonatal medicine.

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- Medical staffing in the neonatal unit did not fully meet the Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' recommendations. The RCPCH recommended a team of ten consultants. There were 3.5WTE neonatal consultants and 5.5WTE paediatric consultants in post. As a result, some out-of-hours cover for new-born babies was provided by the paediatric consultants.
- A Consultant was on site from 8am to 7pm weekdays and 9am to 3pm at weekends.
- There was a lead anaesthetist for paediatrics and elective paediatric surgery was shared by all anaesthetists to ensure they maintained competency in paediatric anaesthesiology. Children under three years were cared for by one of five anaesthetists who had a special interest in paediatrics.
- We observed part of a handover and morning ward round and found them to be effective in delivering key information about the patients' progress.

Major incident awareness and training

- There was no major incident plan. Staff at ward level had not received any major incident training. There was a Trust Business Continuity Policy and service level Business Continuity Plans.
- A clinical emergency patient simulation exercise was held monthly and coordinated by a Consultant and the Divisional Nurse and Matron. This was communicated via the emergency bleep with a message saying it was a simulation and staff attended as they would in an actual emergency. Feedback was provided following the scenario to all those who participated. As a result of learning from the exercises, changes had been made to the location of emergency drugs to enable easier access.

Are services for children and young people effective?

Good 

We found services for children and young people to be effective. There was a multi-disciplinary approach to care and some examples of good practice in the development of packages of care across hospital and community services. The service was a member of the Staffordshire, Shropshire

and the Black Country Neonatal Network and worked collaboratively with other members of the network to improve the safety and effectiveness of care and patient outcomes.

Staff had access to an annual appraisal and felt well supported in their roles. They were provided with opportunities for further development.

The service participated in national audits for which it was eligible. Performance in these audits was variable but actions plans were in place to improve for most audits. However, there was a lack of coordinated action for epilepsy and senior managers did not have knowledge of the issues.

There were no nutritional assessments or nutritional care plans for children and young people on the children's ward. This meant it was possible that children would not receive nutrition tailored to their needs. However, staff were knowledgeable about each child's needs and preferences and we did not see an effect on the children whose care we reviewed.

Evidence-based care and treatment

- Policies were based on NICE guidance and this was clearly indicated in the documents. For example, we reviewed the local guideline for head injury in paediatrics and this was clearly linked to the NICE guidance on this subject.
- We saw the results of audits which had been completed to assess compliance with national guidance and re-audits following the implementation of action plans to improve compliance.
- Local Neonatal Network (Staffordshire, Shropshire and the Black Country) guidelines were also used and were easily accessible on the trust intranet. We saw staff were able to access policies and guidance as required. A member of staff said: "I always follow policies. I understand it's important to follow policies to keep patients safe."
- Care pathways were in place for some conditions such as diabetic ketoacidosis and asthma. The asthma care pathway was in place across acute and community services which ensured that patients received consistent treatment if they moved between community and hospital based services.

Services for children and young people

- There was evidence of some local audits to assess compliance with best practice and an audit forward plan for 2015-2016, although the number of audits was limited.
- The trust did not participate in any accreditation schemes such as 'Your Welcome' or 'Baby friendly.'

Pain relief

- We found there was a space on the initial assessment documentation to record a pain score; the documentation was used in the children's ward and the paediatric assessment unit. A child friendly score was used. The score had been completed in 10 of the twelve records we reviewed.
- The neonatal unit did not use a pain score but staff told us they monitored the baby closely to identify any symptoms of pain and responded accordingly.

Nutrition and hydration

- We did not see evidence of any formal nutritional assessments within the care records we reviewed. The care plans we reviewed on the children's ward did not include a care plan for nutrition or hydration for a patient admitted with gastroenteritis, for a child with diabetes with an insulin pump, or for a baby receiving bottle feeds. These were all cases where recording nutrition or hydration levels could assist staff identify early changes to the patients' health.
- There was a choice of meals and a special children's menu. However, children were able to go to the food trolley to choose the food they wanted if they were unable to order from the menu.
- As a result of feedback from older children relating to small portion size on the children's menu, they were now able to order from the adult menu if they wished.
- There was a dining room on the children's ward and children were encouraged to eat in the dining room but were able to choose where they ate.
- Support was available for mothers to express breast milk in a private room on the neonatal unit. Formula milk was also available.
- Where fluid balance charts were in place, they were completed accurately and the volumes totalled every 24 hours.

Patient outcomes

- The service participated in national audits for which it was eligible including Epilepsy 12, the National

Paediatric Diabetes Audit and the National Audit of Children with Asthma. The results for the national audit of children with asthma carried out in November 2013 indicated the trust was broadly in line with the national results for most parameters. However, the percentage of children re-admitted within three months of discharge with wheezing was slightly higher at 14.3% than the national average of 12.6%. Documentation of some aspects of discharge planning whilst scoring better than the national average, results identified the need for further improvement. For example, follow up arrangements were not made in 38% of cases in Walsall in contrast to 64% nationally.

- The trust had completed significant work to improve the care and management of children with asthma. A specialist asthma nurse had been appointed and work had been completed across hospital and community services, including an asthma care pathway, training for doctors in the accident and emergency department and an agreement relating to referral criteria with local GPs. There was a children's asthma support group and work had been carried out with local schools who could sign up as 'Asthma Friendly' schools. We were told there had been a reduction in multiple admissions for children with asthma and we saw the percentage of multiple admissions within 12 months was lower than the England average (February 2014 to January 2015).
- The National Paediatric Diabetes Audit assesses the quality of care and outcomes for children and young people with diabetes. Performance was below the England average in some aspects however, senior clinicians told us one of the reasons for this was the small number of patients whose data had been included for some parts of the audit. Since the audits had taken place there had been changes to improve data quality and also initiatives to improve the management of children with diabetes. Packages of care had been developed to reduce multiple admissions to hospital among children and young people who had a history of these. "Diabetic camps" had been introduced to improve the education around diabetes and improve self-management.
- There was no documented action plan to improve following the Epilepsy 12 audit. The lead consultant for epilepsy told us they did not see the data that was submitted for the audit.

Services for children and young people

- The number of multiple admissions for epilepsy was higher than the national average but there was a lack of awareness of this in the trust and none of the managers or clinicians we talked with were able to explain this.
- Emergency re-admission rates (within two days of discharge) for children's and young people's services was slightly lower than the England average (January 2014 to December 2014). For children between one and 17 years the re-admission rate was 2.6% for paediatrics compared with an England average of 2.7% and the re-admission rate was 2.8% for general surgery compared with an England average of 3.1%. For infants under one year the re-admission rate was 2.5% against an England average of 3.3%
- A play specialist and play specialist manager worked across the children's ward and the paediatric assessment unit and would go to the outpatient department if requested. This process was well managed and resources were not stretched. There was evidence of developments which had been initiated by the play specialists in terms of the sensory resources and play programmes for children in hospital for extended periods. Parents commented on the positive input of the play specialists and staff told us they were very good with children with complex needs.

Competent staff

- All the staff we talked with said they had annual appraisals and were well supported by their manager. Trust data indicated that 95% of staff on the paediatric unit had received an appraisal within the last year.
- We talked with three staff who had commenced work at the trust within the last year and they told us they had received a comprehensive induction and had been assigned a mentor for support and guidance.
- There was a part time practice development lead on both the children's wards and on the neonatal unit and they worked alongside staff as well as providing training. Competency frameworks were in place and assessments were carried out for staff appropriate to their grade.
- Staff were encouraged to obtain nationally recognised qualifications appropriate to their role. For example, the play specialist had specific qualifications related to hospital play.
- Staff told us of opportunities they have had to develop their skills further and in line with the development of the service. For example, an orthoptist told us: "I have

been lucky, I do a lot here. I have done training and developed low vision and dyslexia clinics." Orthoptists are part of ophthalmology team completing eye testing and working with patients who typically have amblyopia (lazy eye) and strabismus (squint). They may work with patients who have suffered brain injury.

- Parents we talked with had confidence in the knowledge and skills of staff. One parent said: "staff know what they are doing. They are very good."

Multi-disciplinary working

- The neonatal unit used multi-disciplinary notes and we saw evidence of the input of professionals such as the dietician and physiotherapist.
- All the staff we talked with told us there were good relationships with other professional groups and each profession was listened to and their input was respected.
- Dedicated physiotherapists with expertise in paediatrics held clinics in the paediatric outpatients department and provided physiotherapy to the children's wards and neonatal unit.
- There were good links with community services and we were told of a number of initiatives to develop integrated care pathways with community services.
- The trust worked within the local neonatal network utilising joint protocols and working with other local providers within the network to agree transfers of babies to enable access to specialist services and repatriate babies where this was safe and appropriate.
- There were transition clinics for young people with asthma and those with diabetes with clear criteria for the transfer of patients to the adult service.

Seven-day services

- At least one consultant was on site from 8am until 7pm in the evening on weekdays and from 9am to 3pm at weekends. There was a consultant on call at other times. Staff said they could access a consultant when they needed them and were happy with the arrangements.
- There was support from diagnostic and support services such as radiology, CT scanning and physiotherapy.
- The phlebotomy clinic in the children's outpatients department had developed a clinic that was open until 7pm in the evening following feedback from patients to enable them to attend without missing school.

Services for children and young people

Access to information

- Staff had good access to guidelines and policies through the trust intranet. These included neonatal network guidelines.
- Staff had individual email accounts and information was shared with staff through emails, newsletters, staff meetings and handovers.
- We saw information was available for patients in the waiting room of the children's outpatients department and information in folders predominantly about nutrition and breastfeeding support.
- A website had been developed to provide information for parents of babies who were admitted to the neonatal unit. It was targeted at those parents whose babies were expected to be cared for on the unit and those who were being transferred from other facilities. A poster at the entrance to the neonatal unit gave information about the neonatal network and an app for parent for parent information. A link on this enabled parents to access the neonatal unit website.

Consent

- We talked with parents who said they were asked for consent for staff to undertake procedures and staff had explained everything to them. One parent said that prior to their child's surgery: "staff explained the procedure and provided them with a written information leaflet." They said: "I was given time to digest it and wasn't rushed." They went on to say their child might need surgery again in the future and they were not sure they wanted it, but they felt the decision was theirs to make with their child and they felt in control of the decision.
- Staff had a knowledge of the need to assess the competency of the child or young person to give consent themselves to ensure that informed consent was obtained from the appropriate person. They were familiar with the 'Gillick' competencies and 'Fraser' guidelines.

Are services for children and young people caring?

Good



Services for children and young people were caring.

Parents and children praised the staff for their care and sensitivity in all areas of the service.

They felt informed and involved in decisions about their care and treatment. They said they were given full explanations and were able to ask any questions they had and staff provided emotional support when they needed it.

Compassionate care

- Children and parents we talked with praised the staff and the care provided in all areas of children's and young people's services. One person said: "everything has been perfect." Another said; "the care is really good."
- Staff recognised the individual needs of their patients and tailored their approach accordingly. For example, we talked with a parent who said: "staff are very good with (the child) as he has emotional problems." Another said: "they speak to (the child) on their level."
- We saw bravery certificates were given to children who attended the outpatients department for phlebotomy. A member of staff said: "this is the heart of the department. It is very important to get care right."
- We observed a patients' privacy being maintained whilst they were being weighed in the outpatients department. Staff were sensitive to the privacy of children on the wards, drawing curtains around the bed and ensuring they were appropriately covered. The breastfeeding room on the neonatal unit had a sign on the door instructing people to knock before entering.
- The children's ward had a high proportion of en-suite single rooms enabling children and young people to be accommodated according to their needs and preferences.

The trust scored about the same as other trusts in the national children's survey for 2014.

Understanding and involvement of patients and those close to them

- Children and parents felt fully involved in decisions about their care and treatment. On the neonatal unit one set of parents said: "staff have been brilliant. They have always explained everything." "Every time we rang up they always told us exactly what was going on." They talked about how the staff had encouraged them to be involved with the care of their baby and let the parents take over when they were there, but they trusted staff to care for their baby when they were not able to be there.

Services for children and young people

- On the children's ward one parent said: "we get an update every morning." They told us they had been taught to provide emergency care in preparation for when their child was discharged. Another parent said there was time for parents to ask questions and they were also given written information.
- Similarly, in the orthoptic department a parent said: "if I feel I have questions, I ask and they always give you an answer or guide you on to who to speak to." "Initially, I was given written information and lots of explanations."
- On the children's ward, all nursing care documentation was kept in a folder at the bedside and patients and their family could access them. Most of the care plans we looked at on the ward had been signed by a parent to indicate their involvement in the care plan.

Emotional support

- Parents on the neonatal unit told us staff provided them with emotional support and were sensitive to their anxieties and concerns. On the children's ward, one parent said: "they (staff) have been really helpful and put our minds at ease." They went on to say staff understood when they needed to get away from the ward for a time.
- The adolescent unit had a 'Who can I talk to board?' giving information about bullying and the butterfly project (a project to provide support to children and young people who self-harm).
- An asthma support group had been introduced for children and young people with asthma.
- Two nurses on the neonatal unit had been designated as bereavement coordinators and had developed support for parents whose baby died on the unit. They had introduced memorabilia boxes and a digital camera had been purchased to enable photos to be taken for parents and parent facilities had been improved. They were given an award from the neonatal network for bereavement work.
- There is a Community Neonatal Outreach service which is nurse-led with a specific community role, which offers support to local parents following discharge from the Neonatal Unit.
- The Neonatal Unit facilitated a 'Helping Hands' parent support group, which met monthly off site in the local Children's Centre, and were hoping to develop a 'Buddy system' for parents with babies on the neonatal unit supported by a charity.

- In children's diabetes, there was a recognition of the need for access to the CAMHS service for some children and young people. It had not been possible to address this fully, but one session per month of consultant psychiatrist involvement had recently been agreed.

Are services for children and young people responsive?

Good



Children's and young people's services were responsive.

The children's ward, paediatric assessment unit and the children's outpatient department provided an age appropriate environment for children. Physiotherapy and orthoptist clinics were provided in a dedicated area within or adjacent to the children's outpatients department.

The trust was working with other stakeholders to develop services to meet the needs of the local population.

Delays were identified in the transfer of some patients requiring specialist services to other facilities, but the trust was working collaboratively with other stakeholders to mitigate these.

Service planning and delivery to meet the needs of local people

- The trust had identified and responded to a high incidence of asthma in the local population and increases in the number of multiple admissions of children with asthma by further developing pathways that spanned hospital and community services.
- The trust was working with the local neonatal network to address neonatal bed capacity issues within the locality, but there was no clear plan to reduce the number of babies who needed transfer to other hospitals due to capacity issues at the trust. The trust's plans to expand the neonatal unit from 15 to 20 beds would only enable the unit to function more safely with the number of beds it frequently utilised. Over the previous year, 45 new-born babies had been transferred to other facilities due to a lack of capacity at the trust and additionally there were transfers of mothers about to give birth due to a lack of capacity in the unit.
- The children's ward, paediatric assessment unit and the children's outpatient department provided an age

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appropriate environment for children. The artwork on the walls was of a high standard and appropriate to the area. The children's orthoptic clinic next to the outpatients clinic would have benefitted from a similar approach.

- The environment and facilities within the children's ward and the paediatric assessment unit was 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
- The children's ward had 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 timber play equipment and seating for parents and older children.
- Parents could stay by the bedside in both the neonatal unit and the children's ward. On the children's ward there was a sitting room and relatives' room that was en suite where parents and families could stay when their child was at the end of their life or needing high dependency care. Parents really appreciated the facilities for parents at the trust and compared it very favourably to the facilities available at surrounding hospitals.

Access and flow

- The trust had experienced an increase in midwifery referrals following changes in maternity services in the surrounding area. This had led to an increase in demand for neonatal provision. Neonatal critical care bed occupancy was between 109% and 123% from April 2015 and June 2015.
- Staff identified issues with the timely transfer of level 3 new-born babies to other units due to neonatal capacity issues in the neonatal network.
- We saw the records of a patient who was transferred to another hospital following birth due to a lack of capacity on the neonatal unit. There was a wait of over 24 hours for the retrieval team to collect the baby. A checklist had been completed prior to the baby's transfer to ensure all relevant action had been taken and information handed over to aid the safe transfer.
- Although the trust had been working with the Clinical Commissioning Group and the local mental health trust

to improve the care and management of CAMHS patients, there were times when the trust had not been able to secure a bed in a specialist mental health facility for a period of several days when this was needed.

- We identified issues with the outpatient appointment booking system. Appointment letters were sent out through the new electronic patient administration system. Incidents had been reported where the appointment letter sent to the patient gave a different appointment time to the clinic list. The physiotherapists and orthoptists who booked their own appointments using the system told us they had experienced similar problems initially, but they had been resolved and they were no longer having problems.
- When we visited the children's outpatients department and the Orthoptic clinic, we found clinics were running on time. Staff told us they would go into the waiting room and apologise if the clinic was running late. Two patients we talked with about clinic waiting times told us they were normally seen on time. One person said: "waiting times aren't too bad. It is very rare we are late for an appointment."
- However, a patient told us it was very difficult to contact the orthoptic clinic by telephone if they needed to change an appointment. They said: "you can never get through on the phone. It sometimes takes me three weeks of constant ringing to change an appointment. During the inspection, we saw there was no receptionist for the orthoptic clinic and the orthoptists themselves were staffing the reception desk when they were able.

Meeting people's individual needs

- Specialist paediatric nurses were in place to provide support to children and young people with long-term conditions such as diabetes and asthma. Advanced neonatal nurse practitioners were in place on the neonatal unit.
- Children and young people up to the age of 16 were cared for on the children's ward. However, CAMHS patients were accepted up to and including 17 years. Staff told us that if a teenager over the age of 16 asked to go to the children's ward, the bed manager would liaise with the ward to discuss.
- Information provided in the waiting room in the outpatients department was only provided in English.

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Given the high proportion of people from non-English speaking backgrounds living in the local community, it would have been helpful to provide the information in other languages.

- Some information leaflets were provided in Bengali, the most common language of non-English speakers in the local community.
- Staff told us they were able to access interpreters when this was necessary. They said they did this through the switchboard. Interpreters were not always available immediately but they could be booked. The trust used its own staff as interpreters where these were available. Unless they have had their language skills assessed and had specific training, this is not good practice.

Learning from complaints and concerns

- The information leaflet about making a complaint in use in children's and young people's services was not adapted for children and we did not see an easy read leaflet for people with a learning disability.
- Most of the parents we talked with did not know how to make a formal complaint and did not recall seeing any information in relation to this. However, they said they would feel able to speak to the nurse in charge about any issues. One parent said: "when we first came to the ward, they came to introduce themselves and said if you have any problems, come and talk to me." They said they had raised an issue about the ceiling tiles and it had been addressed immediately.
- One parent had used the patient advice and liaison service (PALS) previously and told us they would know how to contact PALS and knew about the complaints procedure.
- Staff told us they received feedback from complaints either individually or as a team. One staff member said: "if it affects the team something will be put up on the notice board."
- Complaints and lessons learned were discussed at clinical governance meetings.
- In the outpatients department staff said they received feedback from the sister verbally and via emails. A staff member said: "we have had a lot of positive feedback about the blood room which was really good. It is good to get positive feedback as well as bad. The evening phlebotomy service was set up as a result of feedback from patients and families."

Are services for children and young people well-led?

Requires improvement 

There was no clear vision and overall strategy for children's and young people's services and the trust appeared to be reactive rather than proactive in taking the service forward.

Ward managers and matrons in children's and young people's services were motivated, enthusiastic and demonstrated good leadership skills. Senior clinicians were committed to their specialty and there were examples of developments of services for individual patient groups.

However, there was no clear vision and overall strategy for children's and young people's services and the trust appeared to be reactive rather than proactive in taking the service forward.

Clinical governance processes were being developed. A range of quality metrics were reported and discussed monthly at the clinical governance meetings but the service was not managing risk appropriately as risks remained on the register unchanged for extended periods. Documented action plans were not available for all national audits and senior managers were not conversant with the issues that had affected the performance in these audits.

Feedback mechanisms were in place in all areas of children's and young people's services and we saw examples of changes that had been put into place following the feedback received.

Vision and strategy for this service

- The plans for services for children and young people in Walsall were predominantly focused on the expansion of the neonatal unit. There was little evidence of a broader or longer-term vision for the service and we had concerns that the neonatal expansion did not take full account of the numbers of babies who were being transferred to other units due to a lack of capacity at Walsall Manor Hospital.
- We were told there was currently no formal strategy, but workshops were being held to engage with staff and obtain their views. The intention was to develop a strategy within the current financial year.

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- A clinician told us they wanted to take the service forward but were frustrated because despite representations, nothing was done and there was no strategic plan for their specialty. Staff had ideas how to improve the service but felt their ideas fell on 'deaf ears' when they were given opportunities to voice their opinions and ideas.

Governance, risk management and quality measurement

- Monthly clinical governance meetings were held at which national and local audits, quality metrics, incidents and complaints were discussed.
- The matrons had developed a range of quality metrics specific to children's and young people's services covering infection prevention and control, patient experience, patient safety and effectiveness. Performance against these was reported monthly at the clinical governance meetings.
- Quality performance was displayed in the inpatient areas on Quality and Safety Information noticeboards. These provided up to date information for the children's ward and the paediatric assessment unit but the board on the neonatal unit had not been kept up to date.
- Senior managers for the service and were not always knowledgeable about clinical quality performance issues within specific specialties for example, action plans for national audits and multiple admissions for children with epilepsy,
- There was a risk register for women's and children's services. This identified key risks such as neonatal capacity and staffing but some of the risks we identified during the inspection had not been recorded and some risks had featured on the register since 2012 with little change.
- Local leaders told us that staffing the neonatal unit was often a challenge, especially with the increase in neonatal admissions, but felt the risks that this posed was not managed appropriately by senior leaders and the executive team.

Leadership of service

- Children's and young people's services sat within the division of women's, children's, and clinical support service. This was further broken down into four care groups. Neonatal services were in the women's and neonatal care group while, children's services were managed by the children's and family care group.

- Leadership at ward level was good. Ward managers were knowledgeable about their service and balanced their management and clinical responsibilities effectively. Staff told us they felt well supported and valued. A staff member told us: "(the ward manager) is very approachable and willing to listen, and she understands what needs to be done. We have staff meetings once a month and everything is audited."
- Matrons were also visible in the clinical areas and staff said they listened and tried to address concerns raised. One staff member said; "Matron tries to do things to make things better. When there are issues she tries to resolve them."
- Junior medical staff felt well supported and a newly qualified doctor said: "I feel protected; there is lots of support and I can approach anyone, I have never had any worries."
- There was a varied response from staff when asked about the visibility of the executive team. One staff member said: "the Director of Nursing knows you and comes up to the ward." Another staff member said: "they had never seen the Chief Executive or Director of Nursing on the ward."

Culture within the service

- The trust values were known and understood by staff who were committed to achieving them.
- Staff we met were open and welcoming. They were proud of the care provided and acknowledged the challenges the service faced. One staff member said: "I love my patients and want to give the best safe care."
- Most of the staff we talked with felt there was an open and supportive culture within the service. One person said: "In my experience people are fully supported. There is no blame culture here."
- Staff emphasised the positive team working and support across different professional groups. A ward staff member said: "even though staffing can be bad sometimes, the team is great, it feels like working with friends." A member in another area said: "I genuinely love working here and we all work well together."

Public engagement

- We saw the 'pants and tops' initiative in place, to gain the feedback of children and their families. Children were encouraged to provide comments in the outline of a pair of pants to communicate what they did not like about the service, and do the same in a top (t-shirt)

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outline to communicate what they felt was good about the service. This feedback was displayed in each clinical area and was generally very positive. We saw an example of a parent comment and attached to it was a top comment indicating the issue had been addressed while the child was still in hospital and the child was happy.

- On the neonatal unit parents gave feedback on the baby's discharge from the unit and the results of the feedback was displayed on the Quality and Safety Information Board.
- Patient feedback forms were used in the outpatients department and orthoptics. These were given to every patient wherever possible. We saw the original forms returned for June and July 2015 and all the feedback was positive.

Staff engagement

- Staff showed enthusiasm and commitment to the service and were able to describe the main challenges for the service. They showed a loyalty to the trust and




when they identified stresses or challenges, they told us the trust was trying to make things better. For example, "Time has been spent in trying to make sure we have enough staff."

- A consultant we talked with said they felt they had a poor relationship with 'management' and did not feel clinicians were involved in developments. They were not listened to and did not see senior management.

Innovation, improvement and sustainability

- Improvements in children's and young people's services were focused on the expansion of the neonatal unit.
- We were told the service was being awarded the best practice tariff for epilepsy and diabetes.
- The role of the advanced neonatal nurse practitioner (ANNP) had been developed and there were six ANNPs undertaking activities and roles previously allocated to medical staff. They also provided an outreach service to the babies receiving intermediate care on the maternity unit. They provided experienced support and advice for medical trainees and took the place of the junior doctor thus providing consistency and continuity at that level.

End of life care

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

Information about the service

Walsall Healthcare NHS Trust provides end of life care throughout the trust. Patients with palliative or end of life care needs are nursed on general wards throughout the hospital.

End of life and palliative care services are provided as part of the medicine and long-term conditions division and are supported by mortuary and chaplaincy services.

The trust has a specialist palliative care team (SPCT). This is an integrated team between the hospital and the community which is managed by the professional lead for palliative and end of life care. However, day-to-day care is provided by two separate teams; one for the community and one for the hospital. The SPCT in the hospital consists of a palliative care consultant, four specialist palliative care nurses, a lead nurse for end of life care and two occupational therapists.

During our inspection, we visited 11 wards where end of life care was provided, the chapel and multi-faith room, the mortuary and the general office.

We spoke with two patients, four relatives and 33 staff, including the SPCT, ward based sisters, nurses and health care assistants, doctors, mortuary staff, porters and administration staff.

We observed interactions between patients, their relatives and staff, considered the environment, and looked at 25

‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) records, 13 medical and nursing care records and 14 medication charts. Before our inspection, we reviewed performance information from, and about, the hospital.

End of life care

Summary of findings

End of life care services overall required improvement.

DNACPR forms were not completed fully and mental capacity assessments (MCA) were not completed for patients deemed not to have capacity to make and communicate decisions about resuscitation.

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 to stay. Spiritual needs of patients were not always addressed and anticipatory medicines for the five key symptoms in the dying phase were not consistently prescribed. There 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. The trust had a policy for advanced care planning (a structured discussion with patients and their families or carers about their wishes and thoughts for the future) and had started to implement amber care bundles, but these were not used consistently.

There were, however, governance processes in place and regular audits to assess the effectiveness of end of life care. Most staff fulfilled their responsibility to report incidents and there was evidence that actions were taken as a result of reported incidents. End of life care training was mandatory for all clinical staff.

The SPCT demonstrated good multidisciplinary working and provided a seven day service. There was strong and committed leadership within the SPCT and the team was well respected in the trust. Patients who were referred to the SPCT were seen quickly and the team provided care to a high percentage of non-cancer patients.

End of life services at this trust were caring. Patients' pain, nutrition and hydration needs were met. Patients and relatives spoke positively about the care they received and patients were treated with compassion, supported and involved in their care.

Are end of life care services safe?

Good



We rated the safe domain for end of life care as good.

Anticipatory medicines for the five key symptoms in the dying phase were not consistently prescribed for patients.

Most staff fulfilled their responsibility to report incidents and there was evidence that actions were taken as a result of reported incidents.

Some of the fridges in the mortuary were not always functioning.

End of life care training was mandatory for all clinical staff. Arrangements to minimise risk, such as pressure damage and malnutrition, were in place and patients' records were stored securely.

Incidents

- Staff reported incidents through the trust's electronic reporting system. All staff we spoke to were familiar with this process. Most staff we spoke with said they were encouraged to report incidents; however, some of the non-clinical staff we spoke with had experience of being discouraged from reporting incidents.
- Between February and May 2015, the SPCT reported 43 incidents, relating to patients receiving end of life care. These included both incidents that happened in the community and in the hospital.
- Lessons were learned and shared to make sure action was taken to improve safety. The SPCT had identified an increased number of incidents related to the delivery of medication via the T34 McKinley syringe pumps, for example, the wrong type of syringe being used, which had caused the medication to leak and not be administered to the patient. These pumps are used for patients who require a continuous infusion of medication to control their symptoms.
- We saw evidence that these issues had been discussed at the trust's palliative and end of life strategic delivery group, who had set up a sub group to review and act on these incidents. The SPCT recorded this as an issue on the end of life care risk register. We saw evidence that the SPCT had shared learning from these incidents in a

End of life care

'prescribing update' newsletter and arranged further ward based teaching. Many of the ward based staff we spoke to confirmed they had received training on these pumps.

- In May 2014, an external review was conducted of how fetal remains were stored and disposed of at the trust. We saw evidence of this review and of the actions taken. Staff in the mortuary spoke openly about this and were able to tell us the review's findings and could describe the changes in practice that resulted.
- The duty of candour regulation states that providers should be open and transparent with people who use services when things go wrong with care and treatment. The SPCT showed they had a good understanding of duty of candour, although they had not had cause to use it.

Cleanliness, infection control and hygiene

- Staff followed the policy for cleanliness and infection control by observing 'bare below the elbows' policy, washing hands and wearing appropriate personal protective clothing.
- As part of the last offices procedure (the process where the body is prepared for transfer to the mortuary) nursing staff would complete both a 'checklist following death of a patient' and a 'mortuary passport'. Nursing staff would document any information regarding an infection risk on these forms to alert any member of staff of the potential risk.
- The trust had a policy for infection prevention and control procedures for deceased patients. This policy stated that body bags or polythene liners should be used for deceased patients with infections or where bodily fluids were present. However, porters told us that they were not always informed when these were needed. This could result in delays in transporting the deceased patient while the porters collected appropriate equipment.

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.
- Following an incident where a pump could not be located for a patient, senior leaders of the SPCT had daily contact with the medical engineering department to check the availability of the infusion pumps. We saw

evidence of actions taken to address shortfalls in the availability of infusion pumps, for example, by collecting infusion pumps back from community areas. We saw evidence that the lack of syringe pumps had been escalated to the trust's palliative and end of life strategic delivery group. With the exception of one person, all staff told us there were no delays in obtaining infusion pumps for patients when needed.

- There were sufficient fridges in the mortuary for the storage of the deceased however, mortuary staff told us that some of the fridges would often break down. This had been on the department's risk register since May 2014. The risk register stated that replacement fridges were needed and that in the meantime temperatures and breakdowns would be monitored. We saw evidence of temperature and frequency of breakdown being monitored and noticed that some of the fridges had been out of order for a total of six days throughout July and August 2015. We saw no evidence that fridges were to be replaced. The broken mortuary fridges were not occupied.
- Additionally, mortuary staff told us they tried not to use the top trays of the fridges because there was a lack of manual handling equipment to do this safely. However, the trust subsequently supplied photographic evidence that this equipment was available for use.

Medicines

- We reviewed medication charts for 14 patients who were nearing the end of life. Half of these patients had anticipatory medicines prescribed appropriately. Five of the patients had some anticipatory medicines prescribed. Two patients did not have any anticipatory medicine prescribed. The indication for the use of each medication was not always documented on the charts. This could lead to inappropriate administration, as some of the medications could be used for different symptoms but would need to be given in different doses.
- The SPCT audited 20 medicine charts every month. Ten of these were of patients known to the SPCT and 10 were of patients who had not been referred to the SPCT. During the three-month period between June and August 2015, for the 30 patients seen by the SPCT, all 30 had anticipatory medicines prescribed. Only nine of the 30 patients who were not seen by the SPCT had anticipatory medicines prescribed. The SPCT had taken steps to address this by including teaching on

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anticipatory medicines on junior doctors study days and introducing small reference cards which fitted into ID badges. These cards provided prescribing details of anticipatory medications and acted as a prompt to remind doctors to prescribe in a timely manner.

- The trust participated in the National Care of Dying Audit (May 2014). For prescribing of anticipatory medication, the trust scored 50%, which was the same as the England average.
- Staff on some wards told us that anticipatory medicines were often prescribed once the patient started to experience symptoms, and were not always prescribed in advanced. This meant there could be delays in patients receiving medication to control their symptoms.
- Anticipatory medicines had been added to ward stock lists (for relevant wards) so were readily available as needed. Staff confirmed there were no problems with obtaining these.
- A palliative care specialist pharmacist worked one day a week at the hospital and three days at a local hospice. The trust used the West Midlands Palliative Care Guidelines which were developed by a local network. Hospital pharmacists were members of this network and involved in developing these guidelines.

Records

- On all wards, nursing documentation including care plans, risk assessments, observation charts and medicine charts were kept in a folder at the bottom of each patient's bed. This meant that they were easily accessible for staff providing care.
- Medical records were kept securely in a locked trolley located at the nursing station.
- We reviewed the records for 13 patients receiving end of life care. Notes were accurate, complete, legible and up to date.

Safeguarding

- Staff we spoke with had an understanding of safeguarding. None of the staff we spoke with were able to recall any recent safeguarding incidents relating to end of life care.
- Staff knew who the trust safeguarding lead was and felt confident to contact them for advice or support if required.

- We saw there was an up to date safeguarding policy in place and staff were able to demonstrate how to access it.

Mandatory training

- The Leadership Alliance for the Care of Dying People published the new approach to caring for people in the last few days and hours of life. This focuses on achieving five priorities for care. These were included on the trust's mandatory clinical update day, which all clinical staff attend. The five priorities of care are that the possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly. Sensitive communication takes place between staff and the person who is dying and those important to them. The dying person, and those identified as important to them, are involved in decisions about treatment and care. The people important to the dying person are listened to and their needs are respected. Care is tailored to the individual and delivered with compassion and with an individual care plan in place.
- All mortuary staff had undertaken the general mandatory manual handling training. The trust told us that they are currently working with the mortuary team to develop specific training for mortuary staff which would better meet the needs of these specific roles.
- Overall, completion of mandatory training stood at 92% for the SPCT. Over 80% of the SPCT had completed the clinical update day, fire safety and patient handling training. All staff in the SPCT had completed conflict resolution, equality and diversity, information governance and safeguarding children level one training.

Assessing and responding to patient risk

- We reviewed the nursing records of 13 patients who received end of life care. Risks such as falls, malnutrition and pressure damage were assessed using national recognised tools. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess malnutrition risk and the Waterlow tool used to assess patients' risk of pressure ulcers.

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- We saw evidence that nurses reviewed and repeated these risk assessments. Staff took action on the result of these risk assessments for example, patients who were at risk of pressure damaged were nursed on pressure relieving mattresses.
- The trust completed an audit of 117 DNACPR forms in April 2015. Results showed that 94% of these had been signed or endorsed by a senior doctor, 94% were legible and 93% had a clear reason given for the decision. Discussions with patients were only documented on 28% of the forms and discussion with relatives documented on 77% of the forms. The trust told us that this information was still to be presented to the care group leads who would then in turn decide the actions to be taken.

Nursing staffing

- Patients requiring end of life care were nursed on general medical and surgical wards, throughout the hospital. Nursing staff we spoke to on these wards told us there were days when they were understaffed. However many told us that they would always prioritise care given to those patients in the last hours or days of life.
- Within the medical wards, for example, we reviewed information about nurse staffing levels and found that for the period between June - August 2015 between 86 and 88% of planned qualified nurse shifts were covered, and between 106 and 109% of planned care worker support staff shifts were covered. This indicated that the shortfall in qualified nurses was being filled with unqualified support staff. Between March 2015 and August 2015 14% of qualified nurse shifts and 37% of care support worker shifts on medical wards were covered by bank or agency staff.
- The SPCT consisted of five nurses, which equated to 4.4 whole time equivalents (wte). This included one nurse who was the end of life care lead. Ward staff told us that the SPCT were very visible on the wards and always available to provide advice and support.

Medical staffing

- There was one full time palliative care consultant in post, available Monday to Friday 9am to 5pm. Outside of these hours there was a consultant on call rota with the neighbouring hospice and hospitals.

- The palliative care consultant worked closely with the community based palliative care consultant and would cross cover when required, for example, to cover leave.
- A foundation year 1 (Junior) doctor was also attached to the SPCT.

Major incident awareness and training

- The trust was in the process of developing a major incident plan. We reviewed a draft version of this and the role of the chaplaincy services in a major incident had been identified.

Are end of life care services effective?

Requires improvement



We rated the effective domain as requires improvement.

Patients were at risk of not always receiving effective care and treatment.

The trust participated in national audits and performed better or the same as the England average for four out of the seven organisational key performance indicators (KPI) and better or the same as the England average in eight out of the ten clinical KPI.

Patients' pain, nutrition and hydration needs were met. Staff had access to end of life care training. The SPCT demonstrated good multidisciplinary working and provided a seven-day service.

Evidence-based care and treatment

- End of life care mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standard 13 relating to best practice in end of life care. However, for some statements there were inconsistent practices. For example, standard six states that "people approaching end of life are offered spiritual and religious support." This was not consistently offered to all patients. The trust was aware of this issue and monitored it through a monthly audit of 20 sets of records for patients who had received end of life care. The results showed spiritual needs were documented for 25 out of 60 patients in the three-month period between June and August 2015. The trust was taking steps to address this and was in the

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process of developing an individualised end of life care plan, which contained prompts to assess spiritual needs. The trust was able to show us a draft version of this care plan.

- At the time of our inspection the trust was developing guidelines to support staff in delivering end of life care. These were based on national guidance such as recommendations from the Leadership Alliance for the Care of Dying People. Following our inspection the trust have finalised these guidelines and we saw it to be detailed and helpful.
- The trust had a policy for advance care planning. Advance care planning is a process of discussion between an individual and their care provider. It might include the person's concerns, what is important to them, their understanding of their illness, their preferences for types of treatment or where they wish to be cared for. The trust's policy stated it was important to initiate end of life care discussions at the earliest opportunity so that forward planning can happen. However, from reviewing patient records we saw that these discussions only happened when a patient had been recognised as being in the last few weeks/days of life and had been referred to the SPCT.
- Since January 2013, the trust had been registered on the Transform Programme. This was developed by the National End of Life Care Programme, in partnership with the NHS Institute for Innovation and Improvement. This programme helped trusts to deliver high quality, compassionate end of life care, accessible to all who need it.
- In response to the independent review of the Liverpool Care Pathway (LCP) in July 2013. The LCP was removed nationally. Since the removal of the LCP the trust waited for national guidance regarding an appropriate replacement. However, the trust realised this was a local decision and began to develop a replacement End of Life Care Plan. The plan was in draft form at the time of the inspection. It was called the Individualised Care Plan and we were told post inspection the plan was due to be rolled out to acute, community, hospice and nursing homes, in a phased approach beginning January 2016. In the meantime, staff delivering end of life care was encouraged to use the 'five priorities for care' to deliver care to those patients during the last few days and hours of life. The 'five priorities for care' are recommended by the Leadership Alliance for the Care of Dying People and are recognised as best practice. Staff

we spoke to on the wards could talk about the five priorities, and could give specific example of how they provided this care. The trust had changed relevant documentation in light of the removal of the LCP, for example, we saw the SPCT referral form had been changed to include 'end of life care'. At the time of the inspection, the trust was developing their own individualised end of life care plan, and was able to show us a draft version of this.

- Some of the staff we spoke with on the wards told us that since the LCP had been removed they missed having a specific plan of care for patients receiving end of life care. They told us a dedicated document was needed to give prompts and guidance for care and to ensure all care was documented in one place. At the time of inspection, we saw nursing care was documented on the trust's standard pre-printed care plans and treatment plans and records of conversations with patients and relatives were documented in the medical records. We reviewed the records of 13 patients who were receiving end of life care and saw evidence that care had been based on the five priorities.
- The trust had introduced the amber care bundle on seven of the wards as part of a phased roll out 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. The SPCT had supported a group of amber care bundle champions; these were ward-based nurses who were given extra training in order to support its introduction in their own ward areas. The introduction of the amber care bundle was a relatively new initiative for the trust and the SPCT team acknowledged that it was not used consistently in these ward areas. We saw one example where it would have been appropriate to use the amber care bundle, but it had not been implemented. Staff we spoke with on the seven wards could talk to us about the principles of the amber care bundle and showed good understanding of it, but acknowledged that it was not used as much as it could be because it was still in its infancy.

Pain relief

- The patients and families we spoke with said that pain had been managed appropriately.

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- We saw documented evidence that patients' pain was reviewed every two hours, and observed nurses asking patients if they were in pain and if they were comfortable.
- We reviewed the medication charts of 14 patients who were nearing the end of life, and saw that pain-relieving medication had been prescribed.

Nutrition and hydration

- Results from the National Care of the Dying Audit (May 2104) showed that the trust scored better than the England average for 'reviewing the patients' nutritional requirements' (52% compared with an England average of 39%) and for 'reviewing hydration requirements' (65% compared with 48% for the England average).
- Staff told us that patients receiving end of life care who had complex nutritional needs were referred to the multi-professional specialist nutrition team.
- We reviewed the care records of 13 patients receiving end of life care and saw that 11 of these had had their nutrition and hydration needs documented, however all were receiving appropriate food and drink. Dietitians had seen some of these patients and some patients had received artificial fluid and nutrition.

Patient outcomes

- In the National Care of the Dying Audit (May 2014) the trust achieved four out of seven organisational key performance indicators (KPI) performing better or the same as the England average for six out of the seven of these KPI. The trust performed better or the same as the England average in eight out of the ten clinical KPI. For example, the trust failed KPI 2, which related to access to specialist support for care in the last hours or days of life. The trust scored three out of a possible five for this KPI, which was better than the England average of two. KPI 3 related to care of the dying: continuing education, training and audit. The trust achieved this KPI scoring 17 out of a possible 20 which was better than the England average of seven.
- The trust scored four out of four and achieved KPI 4, which related to trust board representation and planning for care of the dying. This was better than the England average of two.
- The trust achieved KPI 5, which related to clinical protocols for the prescription of medications for the five key symptoms at the end of life and scored five out of five, which was the same as the England average.

- The trust achieved KPI 6, which related to the clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient and scored nine out of nine which was better than the England average of seven.
- For the clinical KPIs: KPI 1 related to multi-disciplinary recognition that the patient is dying; the trust scored 96% compared to an England average of 59%.
- For the KPI 2, which related to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying, the trust scored 79% compared to an England average of 74%. For KPI 3, which related to communication regarding the patient's plan of care for the dying phase, the trust scored 78% which was better than the England average of 57%. For KPI 4, which related to assessment of the spiritual needs of the patient and their nominated relatives or friends, the trust scored 16% which was worse than the England average of 37%.
- The trust contributed data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council 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.
- Anticipatory medicines were not always prescribed consistently. These are medicines prescribed for the five key symptoms patients experience in the dying phase. These symptoms are pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness.

Competent staff

- Most staff we spoke with said they had received some training on end of life care on the mandatory clinical update day. We saw evidence that registered nurses from each ward had received training to enable them to safely administer medications through the T34s McKinley infusion pumps.
- The SPCT provided a variety of end of life training, which was available for all clinical staff. Some of the examples included a two-day palliative care foundation programme and advance care planning. We saw examples of training that had been delivered to doctors.

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- Grand rounds are used in hospitals as a teaching tool for doctors. We saw examples of how grand rounds had been used to share learning from the National Care of the Dying Audit (May 2104) and case studies had been used to promote good practice.
- Porters we spoke with said they had not received any specific end of life training; Porter managers told us that newly appointed staff would have the opportunity to learn from other, more senior porters.
- Staff sought verbal consent from patients prior to providing care.
- We reviewed the DNACPR forms for 25 patients, across nine wards. We found that many were not completed fully. On one form, the person completing the form had not signed and dated it and on another, the writing was illegible which meant the reason for the DNACPR decision was unclear.

Multi-disciplinary working

- The SPCT were a multi-disciplinary team, consisting of doctors, nurses and occupational therapists.
- The SPCT told us that multi-disciplinary team meetings occurred every week, between the hospital SPCT, the community SPCT and the local hospice. Staff 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 trust had a palliative and end of life strategic delivery group that was multi-professional and met every other month to provide leadership for end of life care services.

Seven-day services

- The SPCT nurses were available seven days a week, between the hours of 9am to 5pm. Outside of these hours staff told us they could telephone the local hospice called Compton Hospice for support and advice at any time.
- The palliative care consultant was available Monday to Friday. There was an on call rota for palliative care consultants within the Walsall, Wolverhampton and Dudley area for out of hours. This provided cover 24 hours a day, seven days a week.
- Viewing of deceased patients in the mortuary was available 9am to 4pm Monday to Friday and Saturday mornings. There was no provision to view the deceased outside of these hours.

Access to information

- All the information required to deliver effective care and treatment to patients was readily available to staff, for example, care plans, risk assessments and medication charts were located at the end of patients beds.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's Mental Capacity Act (MCA) policy stated that staff should make a formal two stage functional test of capacity for all major decisions. The DNACPR forms we reviewed stated that that 19 of the 25 patients lacked mental capacity. For these patients staff should have recorded an assessment of the patient's mental capacity and documented a best interest decision. However, only two of the 19 patients had this information recorded in their medical records, for one of these this was recorded six days after the DNACPR form was completed. This was relayed to senior management who stated they would look into this as a priority. On 12 occasions, nothing was recorded on the form to say that the decision had been discussed with patients or an explanation given when it had not been discussed. We saw evidence that in all but three cases discussions with family members had been documented on the form.
- The trust completed an audit of 117 DNACPR forms in April 2015. Results showed that 94% of these had been signed or endorsed by a senior doctor, 94% were legible and 93% had a clear reason given for the decision. Discussions with patients were only documented on 28% of the forms and discussions with relatives documented on 77% of the forms. The trust told us that this information was still to be presented to the care group leads who would then in turn decide the actions to be taken.
- In November 2014, a staff member reviewed DNACPR forms as part of a ceiling of care audit and found that 22 out of 52 (42%) had been fully completed.
- At the time of inspection the trusts DNACPR policy was out of date with a review date of July 2015, however the policy has since been updated.
- Discussions with patients and families about care and treatment were documented in all the records we reviewed however, discussions with patients regarding DNACPR decisions were not always recorded on the DNACPR form.

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Are end of life care services caring?

Good



End of life services at this trust were caring.

Patients and relatives spoke positively about the care they received. Patients were treated with compassion, supported and involved in their care.

There was no dedicated bereavement service.

Compassionate care

- We spoke with two patients and four relatives during our inspection. Feedback was consistently positive about the way staff treated patients receiving end of life care. One relative described the care as exceptional; one patient described the care they had received as excellent and all their wishes had been respected.
- Two relatives we spoke with told us the ward nurses were approachable and always asked if they needed refreshments. Two relatives said they appreciated being able to visit at any time.
- We observed staff talking with both patients and relatives in a kind and friendly manner. Staff demonstrated the importance of treating patients and relatives with compassion and sensitivity.
- Viewing of deceased patients was carried out in the mortuary by appointment only and was available all day Monday-Friday and Saturday morning.
- Mortuary services demonstrated an understanding and respect for patients' cultural and religious needs. There were facilities within the mortuary for washing the body for religious and cultural reasons.
- There was a comment box in the mortuary where visitors could leave feedback, this was overwhelmingly full of compliments.

Understanding and involvement of patients and those close to them

- The trust participated in the National Care of the Dying Audit (May 2014). Results showed that the trust performed better than the national average in relation to health professionals' discussions with both patients and relatives.

- Patients and relatives we spoke with said they had been involved in their care and that staff had explained their care and treatment in a way they could understand.

Emotional support

- Relatives we spoke with specifically praised the support they had received from the SPCT.
- Chaplaincy services were available with the hospital to provide emotional support with representatives being available from the Church of England, Hindu, Roman Catholic, Muslim and Sikh faiths. 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?

Requires improvement



Overall, we rated the responsiveness of the service as requires improvement.

End of life care was not always responsive to patient's needs. Patients requiring end of life care did not always achieve their preferred place of care. Side rooms were not always available for patients in their last days/hours of life and there were limited facilities to allow relatives to stay.

Spiritual needs of patients were not always addressed. There was not a dedicated bereavement service which meant bereaved relatives had to wait in a general area to collect belongings and certificates.

The SPCT were responsive. Patients who were referred to the SPCT were seen quickly and the team provided care to a high percentage of non-cancer patients. Diversionary beds had been secured at a local nursing home, which meant patients receiving end of life care in hospital could be discharged sooner if this was their preference. Additionally, a diversionary pathway meant that patients who required short stay admissions for treatments could be admitted to the hospice rather than receiving care in the acute hospital setting. The chaplaincy services provided support for patients individual needs.

Service planning and delivery to meet the needs of local people

End of life care

- The trust did not have any dedicated beds for end of life care and patients 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/hours of life, but that this was not always possible as side rooms were used for patients with infections.
- Staff told us that often patients died in a bay with five other patients; they spoke of their frustration with this and realised that this compromised the respect and dignity of patients and their families. During our inspection, we spoke with a family of a dying patient who were upset that there was no side room available, they had asked for one but the nurse had told them “we simply do not have any.”
- The trust did not have a dedicated bereavement service. This meant that bereaved relatives collected death certificates and belongings from the general office. Staff told us there were good procedures in place to ensure death certificates were issued in a timely fashion however, felt it was inappropriate for distressed relatives to wait in a general area. The trust told us there were plans to develop a bereavement suite and have a dedicated bereavement officer. We saw evidence of a business case to secure funding for a bereavement officer and bereavement support worker dated July 2014. We saw evidence that a job description for these posts was discussed at the bereavement sub group meeting in October 2014. However, at the time of inspection (September 2015), there was no bereavement team in place and the trust could not tell us when this would happen.
- The route that people have to walk to from the mortuary to the general office was long, uneven, outside and poorly signposted.
- Facilities for relatives wishing to stay with patients who were in the last days or hours of life were limited. Staff said whenever possible they would try to accommodate this by providing camp beds, but space was often limited
- Patients had timely access to the SPCT. For the three months between May and July 2015, 100% of the patients referred to the SPCT were seen within the time requested by the referrer. Without exception, all staff told us how accessible and responsive the SPCT were.
- The SPCT saw a high proportion of patients with non-cancer diagnosis. For 2013/14, 33% of patients seen had a non-cancer diagnosis, compared with the national average of 25%.

Meeting people’s individual needs

- The trust assessed the patient individual’s needs for example, nutrition requirements, using a standardised nursing assessment booklet. During our inspection, we saw evidence this had been completed.
- In response to the National Care of the Dying Audit (May 2014) the trust had re-designed the nursing assessment booklet to include a section on assessing patient’s spirituality. However, during our inspection, we reviewed 13 records for patients who were receiving end of life care and this section was fully completed for only five of these patients. Nursing staff told us the booklet was “unwieldy” and took too long to complete.
- The trust told us they had implemented a chaplaincy ‘contact form’. This was left at the patient’s bedside and any contact with the chaplaincy service recorded on it. We saw evidence of this in use.
- The trust acknowledged it needed to do more to ensure the needs of patients living with dementia and receiving end of life care were met. We saw minutes of the palliative and end of life strategic delivery group where this had been discussed however, no actions had been identified.
- Chaplaincy services were available in the hospital, with representatives from the Church of England, Hindu, Roman Catholic, Muslim and Sikh faiths. Posters advertising the chaplaincy services were clearly displayed on all ward entrances. Leaflets about the service were on most ward areas. Ward staff told us that the chaplains visited the wards most days.
- We saw evidence where families had submitted prayer requests through the chapel. Services for Christians were available three times a week, Muslims once a week and Sikhs once a month.
- We visited the chapel and prayer room and the multi-faith prayer room. The chapel and prayer room contained Christian religious articles; however, a separate part of the room could be screened off for non-Christian worship. Prayer mats and holy books were available and Quibla (the direction that should be faced when a Muslim prays) signposted in both areas. Leaflets were available such as Spiritual Care in

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Hospitals for Sikh patients. The multi-faith room was a large bright room with nearby ablution room. However, signage to the multi-faith room was not clear. Two smaller prayer rooms were also available in the hospital.

- We saw one example where a patient could not speak English. Staff used a translation sheet of common words to aid communication with this patient. Patient records showed conversations about their care and treatment had been translated through family members, which is not good practice. The trust told us there was access to an external translation service however, staff we spoke with said a lot of staff spoke different languages and these would act as translator. Using staff or family members as interpreters is not considered good practice.
- Staff told us they would provide the trust's bereavement booklet when a loved one dies. This explained the grieving process. This booklet was available on most of the wards. Staff also provided a booklet describing what to do following a death which gave practical advice such as collecting death certificates. These were also readily available on the wards.

Access and flow

- The trust had introduced a diversionary bed scheme. This consisted of three beds 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 as it would be unsafe. There was a standard operating procedure for this scheme which clearly identified which patients were suitable for referral and the procedure to follow. We saw evidence that the trust had evaluated this scheme and told us the use of these beds meant reduced numbers of patients being admitted to the hospital who did not need acute care and patients receiving end of life care in hospital could be discharged sooner if this was their preference.
- The trust audited patients preferred place of care for death during its monthly review of 20 sets of records of patients who have died. Ten of these records were of patients known to the SPCT team and 10 of patients who were not known. During the three month period between June and August 2015, for those patients who were known to the SPCT team 21 had a preferred place of care documented, of these, 17 patients achieved their preferred place of care. For those patients who had not been seen by the SPCT, only six of the 30 records had a

preferred place of care documented and only one of these patients achieved their preferred place of care. This meant that patients did not always receive the care in an environment of their choosing especially if they had not been referred to the SPCT.

- The trust's palliative care consultant had successfully negotiated out of hours admission during weekdays with the local hospice, which enabled patients to achieve their preferred place of death. However, transfer to the hospice was not possible at weekends because medical cover is provided by local GPs who are not contracted to admit new patients to the hospice. The SPCT recognised this shortfall, and told us it was on their "wish list" for improvements.
- The trust had developed an alternative pathway for palliative care patients. This meant that palliative care patients who required short stay admissions for treatments such as blood transfusion for example could be admitted to the hospice rather than receiving care in the acute hospital setting.
- The trust had introduced a 'rapid discharge pathway home to die' to support the discharge within four hours of those patients who wished to die at home. The trust had a standard operating procedure for this which clearly identified staff roles and responsibilities. This process was in the pilot stages and the trust was unable to tell us how many patients had achieved discharge within four hours
- Staff told us that having occupational therapist within the SPCT speeded the discharge process up. The palliative care consultant gave us specific examples of rapid discharge of patients to the local hospice in order to achieve their preferred place of death.

Learning from complaints and concerns

- The trust had a complaints policy and procedure and staff knew how to support patients who wished to make a complaint. The trust had not received any complaints about its end of life service.

Are end of life care services well-led?

Requires improvement 

Overall, we rated the leadership of the service as require improvement.

End of life care

There was no bereavement lead for the trust and no bereavement office to support relatives.

The mortuary fridges were more than 27 years old, often broke down and were located above head height and difficult for mortuary staff to use.

The trust leadership had not replaced Liverpool Care Pathway (LCP) with a trust own version in a timely manner.

The current practice regarding DNACPR and mental capacity was not consistent.

There were, however, governance processes in place and regular audits to the effectiveness of end of life care. There was strong and committed leadership within the SPCT.

Vision and strategy for this service

- The trust's end of life strategy was being developed in association with the Walsall Clinical Commissioning Group (CCG) at the time of our inspection. The SPCT had been consulted with this development.
- There was no other formal strategy in place at the time of our visit.

Governance, risk management and quality measurement

- Quality and risk was managed through the monthly specialist quality group for palliative and end of life care. Minutes from these meetings showed a wide range of issues were covered including review of incidents and risks.
- There was a risk register for palliative care and end of life. This was integrated with the community service. The risks identified on this register reflected concerns staff had for example, the increase in incident reporting relating to the T34 infusion pumps.
- Breakdowns of the mortuary fridges were on the mortuary risk register, since May 2014. This had been reviewed in September 2015, but the only action taken had been to monitor the frequency of the breakdowns.
- Following the national cessation of the use of the LCP, the trust failed to introduce an effective replacement. The trust had waited for national guidance regarding a replacement strategy. However, the trust then realised a replacement was a local decision. By this time several months had past which had delayed the development of the replacement End of Life Care Plan. A draft version had been created, however this had not been finalised and was not in use at the time of our inspection. The

trust acknowledged that the care plan had taken time to develop, but were seeking wide consultation from both staff and patients and felt it was important "to get it right". The trust told us they were reducing this risk by providing education on the five priorities of care to staff during the mandatory clinical updates days.

Additionally, patients who would have been traditionally placed on the LCP were referred to the lead nurse for end of life care.

- We talked to the end of life senior clinician who explained the aim was to obtain agreement across the local healthcare system to have the same End of Life Care plan document across all care settings including; community, acute trust, care homes and hospices, this took time. The document was in now in draft form and called the 'Individualised End of Life Care Plan'.
- At Walsall Manor hospital we saw evidence that despite the late implementation of the 'End of Life Care Plan' we saw local ward managers had ensured care plans were individualised, that relevant conversations were documented and that patients wishes were considered and acted upon as far as reasonably possible.
- End of life guidelines were being developed at the time of inspection. Amber care bundle had been introduced but staff were not using it consistently.
- The current practice regarding DNACPR and mental capacity was not consistent; mental capacity assessments were not routinely undertaken for the DNACPR decision.

Leadership of service

- We saw evidence of committed leadership of the SPCT service, but little evidence of wider trust leadership to drive the service forward.
- We saw there was no bereavement lead within the trust to provide advice and support to relatives and there was no dedicated bereavement office where relatives could go for support for practical advice for funeral arrangements.
- Staff told us 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.
- There had been some changes to end of life care delivery within the trust, for example, the increased number of non-cancer patients referred to SPCT and the introduction of weekday out of hours admissions to the local hospice.

End of life care

- The trust had a palliative and end of life strategic delivery group, chaired by the Director of Nursing which provided leadership for end of life care. The professional lead for palliative and end of life care chaired this multi-professional group. Membership included the community SPCT, representation from the CCG as well as the director of nursing. Minutes from this meeting demonstrated a wide range of issues was discussed for example results of the National Care of the Dying Audit and implementation of the amber care bundle.
- Without exception, the ward staff praised the SPCT. One member of staff said they were “fantastic you just have to ring and they are there”. Many told us how approachable and responsive they were. They were also proactive and provided clear plans for patients.

Culture within the service

- The SPCT spoke positively about the leadership and told us the professional lead for palliative and end of life care was visible and supportive.
- All staff within the SPCT 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 patients.

Public engagement

- Result from the National Care of the Dying Audit (May 2014) showed the trust did not achieve the indicator that asked for a formal process to collect views from bereaved relatives or friends.
- The trust had engaged with members of the public through a series of events designed to obtain the views of the public in developing services for the future. We saw evidence of an engagement event held in August 2015 where the public were consulted on the five priorities for care and the trust told us another one was planned for October 2015.
- At the time of inspection, the trust was undertaking an online survey to look at public attitudes to death and dying.






Staff engagement

- A working group had been set up to develop the individualised end of life care plan that would replace the LCP. This group was multi-professional and membership included ward nurses, chaplaincy and representation from the community.

Innovation, improvement and sustainability

- The SPCT monitored their service by the monthly audit of 20 sets of patient’s records and used the information from these audits to make improvements. For example, in order to improve the prescribing of anticipatory medicines, small reference cards had been developed for doctors to carry and teaching for junior doctors had been provided.

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

Information about the service

Outpatient services at Walsall Healthcare NHS Trust are mainly located on the ground floor and served by several reception desks. During 2014, there were 360,553 first and follow up outpatient appointments.

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.

During our inspection, we spoke with 28 patients along with some of their relatives. We also spoke with 63 members of staff including reception and booking staff, nurses of all grades, radiographers, health care assistants, medical students, doctors, consultants, secretaries, managers and domestic staff. We observed care, received comments from our listening events and from patients and the public directly. We also reviewed the systems and management of the departments including the performance information.

Summary of findings

Overall, we found that outpatients and diagnostic imaging required improvement.

Systems were in place to monitor risk however, there was evidence that the systems and processes were not always adhered to.

We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care.

Whilst we found the service had been responsive to local patient needs, the trust electronic records system had caused major backlogs with the appointment system and caused loss of data in the appointments system.

Clinics were being overbooked and we saw evidence of this. Staff told us this had become common practice, which led to clinics over running and frustration for patients who experienced long waits. These waiting times were not currently recorded or reported as incidents.

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 (England average is 7%) and patients cancelled 8% of appointments (England average is 6%).

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The capital replacement programme was not in line with the requirements of the imaging department. Many devices were overdue replacement and required regular attendance to maintain their functionality.

The shortage of radiologists in the imaging department affected the service they were able to provide. The reporting backlog currently at two weeks for routine x-rays was felt to be a risk by the imaging service manager.

Local leadership was good in outpatients and imaging. Managers understood their staff and provided an environment where they could develop.

Are outpatient and diagnostic imaging services safe?

Requires improvement 

There were systems and processes in place for ensuring outpatient and diagnostic imaging were safe, however, there was evidence that the systems and processes were not always adhered to.

Vacancies across the service had affected service delivery and patient experience. Some areas did not have the space or capacity to deal with the demand on the service.

Cleaning and routine checks on equipment were inconsistent.

Diagnostic imaging departments had robust policies and procedures in place. These were based on the ionising radiation medical exposure regulations to protect patient's, staff and the public.

The radiographers had good support networks in place for expert advice when needed. However, the vacancies in the department were affecting the quality of patient care and some of the equipment was unreliable.

Incidents

- Between May 2014 and April 2015 there were no never events reported by the outpatient and diagnostic services, there were 90 incidents reported across OPD and Diagnostics, 61 related to OPD and 29 to diagnostics. We saw two serious incidents (both in the reporting category slips, trips and falls).
- Staff we spoke with demonstrated a good understanding of the incident management process, which was accessed via the hospital intranet. They told us that they received feedback and lessons learnt from incidents and also received a weekly update via email on quality matters which included incidents.
- Senior staff told us that all staff who reported an incident received feedback following investigation of the incident and that all incidents were reported to the monthly quality meeting.
- We saw an incident details report dated 24 April 2015 which described the root cause analysis, learning and actions to be taken of an incident involving an histology specimen.

Outpatients and diagnostic imaging

- The access team had responded to the incidents that occurred due to the patient administration system which was still seeing problems with basic performance, for example, booking appointments and in response to this a 'super user group' had been set up. The patient administration system is a computerised patient record system. The group had redefined roles and responsibilities and were looking at issues such as staff training, bar coding and electronic patient records.
 - We spoke to staff in the radiology department. They were aware of the incident reporting system and described one incident that had been reported by a radiographer. We saw there was good feedback to imaging staff following incident investigation. Incidents were discussed at the monthly imaging quality meeting and monthly at the imaging operational committee.
 - We were provided with information concerning formal notifications made by the trust to the CQC IR(ME)R inspectors of exposures judged to be 'Much Greater than Intended' under regulation 4(5) of IR(ME)R. We were assured that there was an understanding at the trust of which errors were notifiable to us. Examples of these notifiable errors include: CT scan of the wrong patient, taking an x-ray of the left foot when the right foot was intended, not archiving images correctly, requiring a repeat exposure.
 - The numbers and the different 'types of error' were not significantly different to those from other trusts and each presented little additional risks to patients involved. Each investigation had been completed or was still under investigation at the time of our inspection. In every case, our inspectors require evidence or assurances that these errors are investigated locally, with a view that awareness of staff groups involved in the error was raised, and actions taken to mitigate the chances of a repeat.
 - We saw the hospital Duty of Candour Policy and templates for duty of candour letters. Staff could articulate a good understanding of the duty of candour and what it meant to patients and staff.
- Cleanliness, infection control and hygiene**
- On visual inspection, all areas we visited in outpatients and diagnostics appeared clean and tidy.
 - We found that curtains in changing rooms and treatment rooms were clean but were not labelled to indicate next replacement date. A schedule of cleaning for the curtains was not available on request.
 - We saw that the vinyl floor covering was in good condition and unmarked.
 - All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), this is Department of Health best practice guidance.
 - All soft furnishings were wipeable and undamaged.
 - There were well-stocked glove and apron dispensers throughout the outpatient areas.
 - We observed good hand hygiene practices and good use of hand sanitiser gel. Gel was available at numerous points including reception desks.
 - The outpatient department was given prior notice of infectious patients by the infection control team. A side room was available for use by infectious patients; once this was vacated, a rapid response cleaning team would deep clean it before making it available for further use.
 - We inspected the radiology and imaging departments. We saw the cleaning rotas which were signed and up to date.
 - We saw the hospital infection prevention and control policy dated January 2015, which outlined clear lines of accountability and a named director for infection prevention and control who reported directly to the board. We also saw a range of other infection prevention and control policies including:
 - Hand Hygiene and Personal Protective Clothing
 - Decontamination of Medical Devices
 - Isolation Policy
 - Management of blood and body fluid spillages
 - The hospital reported that 76% of staff had attended infection prevention and control training against a target of 90%.
 - Infection control policies were available on the intranet although when we asked a member of staff to show them to us they were not found easily. Infection prevention and control is paramount to patient safety and policies should be readily available for reference.
 - The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
 - We saw a patient led assessment of the care environment (PLACE) audit for the outpatient

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department dated May 2015. This showed that the environment had been inspected and that all actions listed to remedy any faults or errors had been completed.

- Blood and mercury spillage kits were readily available and staff told us they had been trained in their use.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins
- During inspection we saw a commode in one of the outpatient consulting rooms that did not have any labelling indicating whether it was clean and fit for use
- We inspected the daily cleaning schedules of several of the rooms in the outpatient department. The daily cleaning schedule in room 003 had not been completed for the day and the daily room temperature check had only been completed two days out of the past nine with no reason being given as to why it had not been checked. The daily cleaning schedule in room 006 was missing. This meant that staff could not be assured that the rooms had been thoroughly cleaned as recommended and therefore increasing the risk of contamination. Overall, there was a lack of consistency in the use of daily cleaning schedules.
- We were told that the matrons conducted monthly assurance audits which were collated by the infection control team and reported at the infection control committee meeting. We saw the minutes and enclosed papers of the infection control committee meeting dated July 2015 and although the audits were mentioned there were no actions or timescales to support concerns raised at the meeting.
- There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.
- Hand hygiene audits were carried out monthly using the World Health Organisation (WHO) 'Five Moments' audit tool based on WHO guidelines for hand hygiene.
- Hand hygiene audit results were collated and displayed on the hospital dashboard for benchmarking purposes.
- We saw the annual hand hygiene compliance report collated by the infection prevention and control team dated July 2015, which stated, 'The audit indicates that the overall trust compliance to hand hygiene within acute areas had increased since the last audit completed in August 2014.'

- We were told by the infection prevention and control team that they were sent the names of any staff who failed a hand hygiene audit and that they delivered extra training to that staff member.
- Within imaging services we saw suitable seating arrangements in brightly lit, clean environment. Information boards were available to inform patients about procedures and any waiting times.
- Imaging services had private changing facilities available with guidance to follow when changing.
- We visited a clean utility room in outpatients and observed the portable appliance testing (PAT) notice on the fridge was dated April 2013 and therefore outside its routine safety maintenance check. PAT is a process by which electrical appliances are routinely checked for safety once a year.

Environment and equipment

- Medical records staff told us that they had waited four and a half months for ergonomic chairs. They also told us that the purchase of a higher kick step stool had been turned down by the divisional spend group even though it had been identified as an action following a health and safety risk assessment. A kick step stool provides extra height to enable staff to access hard to reach places. This potentially could adversely affect staff health and safety.
- We saw on the equipment log for imaging and x-ray that the year of planned replacement for all equipment was 2020.
- The trust have since told us that they are conducting an external peer review of the gamma camera images to ensure it is fit for purpose. In the meantime the trust have arranged alternative access for complex investigations requiring a high quality image.

Medicines

- The medicines cupboards we inspected in outpatients and imaging and were locked and secure, all stock was within expiry date and there was evidence of stock rotation
- There were no medications left out in unsecured areas.
- We saw that the outpatients' drug keys were kept in a key safe in a locked room and a log book was in use to sign keys in and out.
- Sterile and intravenous fluids were stored in clean utility rooms.

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- The drug fridges we inspected were locked and only contained relevant items.
- Two of the resuscitation trolleys we checked in outpatients had out of date equipment on them. The resuscitation trolley in dermatology required three items replacing and the resuscitation trolley in the procedure corridor also required three items replacing. This showed that daily checks were not being carried out thoroughly. When we informed the staff in charge they quickly replaced the out of date equipment.
- In imaging the resuscitation trolley was found to be in checked and in order.
- We saw good systems in place throughout outpatients and diagnostics for the safe storage of FP10 medicines prescriptions including signed and dated log books.
- We observed a pacing procedure where chlorhexidine was used in a pot with application sticks rather than following the national guidelines of individual soaked sticks. Following a nationally reported never event this practice was no longer classed as safe practice. The observation of this incident was raised with the manager and it was identified that this was a one-off incident and individual soaked sticks were available.
- We saw the policy for the administration and disposal of radioisotope dated 27 July 2015 was understood and followed by the staff in the department.
- We saw that a medical record tracking system was in place using a bar code system, however we were told that not all wards or departments utilised the system so it was not utilised as effectively as it could be.
- We were told that missing records were recorded as a clinical incident. We saw a log of incidents reported by outpatient staff between February 2015 and May 2015. There were thirty six reports of missing medical records. This means that the information needed by the consultant to make an informed decision about the care and treatment of the patient was not available.
- The trust could not provide information on the percentage of patients seen in outpatients without their full medical record being available. They told us, "If health care records are not available for the OPD appointment. The Consultant / Clinician have full access to Fusion (the clinical portal). Available electronically to view by individual patient are referral letter, outcome letter(s) following OPD appointments, correspondence letters, results from x-rays/scans/bloods etc."
- The receptionist we spoke to had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended and placing medical records face down when placed ready for the nurse.

Records

- Medical records staff worked 24/7, 364 days per year in order to ensure that medical records were readily available for all patients.
- We observed that medical records in use in the outpatient department and imaging department were stored securely. Some patient information was also stored electronically such as referral letters, clinic appointments, blood and x-ray results.
- We spoke to a receptionist who told us that medical records were collected each morning from the medical records department. We were also told that missing records was a regular occurrence 'every day' and that when this happened there was a system in place to set up a temporary record using the electronic patient information. The temporary files were clearly marked so that they could be included or reconciled with the permanent record when located.

Safeguarding

- The hospital reported good compliance levels for safeguarding children and adults training which exceeded their internal target of 90% and 93% for safeguarding children level two.

Outpatient and Imaging all staff - safeguarding children 94.74%

Outpatients and Imaging all staff – safeguarding adults 97.37%

- We saw both the safeguarding children and safeguarding adults policies dated September 2014. Staff we spoke to demonstrated a good understanding of safeguarding procedures.
- We saw a member of staff in the outpatient department follow the safeguarding adult's policy when a very frail

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elderly patient who appeared neglected arrived for an appointment. This means that staff were equipped with the skills to recognise when a child or vulnerable adult is at risk and knows how to escalate the concern.

Mandatory training

- Mandatory training included fire safety, patient handling, conflict resolution, equality and diversity, information governance and safeguarding children level one.
- Within diagnostic imaging staff reported good compliance levels for mandatory training Within Outpatients staff achieved 83.1% and diagnostic imaging service achieved 97%. The internal target for mandatory training was 90%, which meant that not all staff in outpatients had achieved the target.
- In OPD and diagnostic 94.7% of staff attended MCA and DoLS training, 39.4% of staff attended Prevent training and 97.4% of staff attended safeguarding adult training.
- At the time of our visit the band one health care assistants working in the outpatient clinics had not attended care certificate training but we were told that this was planned for the future but there was not an actual planned date .
- Radiology were not achieving all mandatory training targets but staff told us that this was due to insufficient training days planned not to the availability of staff to attend.
- The hospital reported that mandatory training levels for diagnostic imaging services were at 95.9%, safeguarding children at 97.9% and safeguarding adults at 100%.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) system enabled nursing and medical staff to identify if a patient's condition deteriorated and therefore to take action before it became serious and staff told us they would use this if they observed a patient becoming ill.
- There were working panic buttons in all the outpatient consulting rooms, which meant that if there was an emergency staff could call for help immediately.
- The trust was unable to provide us with information on the percentage of patients who waited over thirty minutes to see a consultant. They told us they were exploring the use of touch screens within OPD clinic areas for nursing staff to enable real time data entry.
- We visited the outpatients department at lunchtime on both days of our inspection. We saw that patients were

arriving for afternoon appointments and that clinics were unattended. For example, in the ear nose and throat clinic patients were arriving at 1.20pm for their 1.30pm appointment and nobody was there to receive them. This meant that potentially if patient became ill or required assistance, no staff were there to help them.

- We were told that all women attending for a surgical and radiological procedure were asked if it were possible they might be pregnant and offered a pregnancy test if they answered yes.
- We saw signage supporting this in all departments. This complied with the national institute of clinical excellence guidance on preoperative tests.
- The department had a radiation protection committee which met every six months. Radiation protection advice was commissioned from a neighbouring hospital. There were five radiation protection supervisors in place, one for each modality and access to a laser safety expert. This meant that there was a good network of expert advice for any radiation queries that arose.
- Dose reference levels were evident for x ray rooms and the World Health Organisation checklist was used for interventional procedures.
- We saw the minutes of a dose referencing review meeting dated April 2015 with actions arising and allocated to individuals such as training, audit documentation and incidents.
- A radiation safety policy was in place which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste.

Nursing staffing

- Nursing staff told us and we saw that staffing levels in the outpatient department were adequate and that outpatient bank staff were available if required.
- Staffing levels were adjusted to meet the demands of the clinics, we saw evidence of this on the staff rotas.
- Outpatient clinic briefing meetings were not in place at the time of our visit but we were told that there were plans to introduce a daily 'huddle' meeting.
- Administrative staff shortages in outpatients meant that patients could be sat in a waiting area with no staff in

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attendance. When administrative staff arrived, they had to catch up with any backlog of patients, which caused them to be under pressure. We observed this during the inspection.

Medical staffing

- Across the service, we saw medical staffing was adequate to meet the needs of people, however we were told there were some vacancies.
- There were sufficient consultants to see the booked patients. Locum doctors were used when necessary in some areas.
- We saw a comprehensive locum induction pack and checklist which locums were required to complete before they could start work.
- Radiologist shortages were identified on the risk register with demand exceeding capacity in the department. Failure to fill the advertised vacancies had led to a known reporting backlog. Out of hours reporting had been outsourced in order to increase capacity during normal working hours as part of planned investment to mitigate this risk.
- Vacancies included one consultant radiologist, a band 6 CT radiographer, one sonographer vacancy and administrative staff vacancies at the time of the inspection. This meant that patients were waiting to be seen longer than they should be and some patients had not been checked in by administrative staff.

Radiology Staffing

- There was one radiographer vacancy, one sonographer vacancy and administrative staff vacancies at the time of the inspection.
- Radiology staff sickness was currently 4% and a high turnover of staff was reported. One reason for this was the change in working hours which had been instigated.
- A consultant ultra-sonographer had been employed at the trust, however agency and locum ultra-sonographers were used to backfill the vacancy.

Outpatients and support services

- The sickness rate for this group varied between 5.08% and 8.96% between December 2013 and May 2015. There was no break down by staff group.

- The vacancy rate for “Outpatient and support services” was 11.34%. Whole time equivalent establishment for this care group was 186.47. There was no break down by staff group.

Major incident awareness and training

- Staff told us that the hospital held a major incident practice annually. The hospital major incident plan was not available to view at the time of the inspection. However, each department we visited understood their role during such an incident and they had their own contingency plans in place.

Are outpatient and diagnostic imaging services effective?

Patients’ needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Staff obtained written and verbal consent to care and treatment, which was in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

We saw that staff worked collaboratively to meet patients’ needs in a timely manner.

Evidence-based care and treatment

- Oncology NICE guidelines were followed for early recognition and detection of ovarian cancer. GPs promoted this process with ultrasound being completed prior to attendance at the clinic.
- The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines were followed as an aid to good clinical practice in conditions such as miscarriage management and removal of retained products.
- Where appropriate, patients were approached to take part in in clinical research trials.
- In radiology, interventions and patient outcomes were submitted into the national database for outcome comparisons and these were measured against those trusts undertaking similar procedures.

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- It is a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) for audits to be carried out to ensure safe exposure and practice. Examination audits had been completed to comply with IR(ME)R safety policy.
- Diagnostic reference levels (DRL) were monitored and audits of the levels completed. Where levels were raised, the equipment was checked in line with the manufacturer's recommendations. The staff in the department had regular contact with the radiation protection advisor.
- The quality assurance lead radiographer had introduced a quality audit programme and begun auditing the quality of the department imaging. Bi-monthly radiation, quality and equipment checks were completed and the findings fed back to the staff.
- Inappropriate referrals had been audited on GP knee requests. The audit concluded that some referrals were inappropriate so the IR(ME)R guidelines were reissued and cascaded to the GPs.
- There were six reporting radiographers with dedicated reporting time.
- In the imaging department, we observed the World Health Organisation (WHO) checklist for interventional radiology was found to be routinely completed well.

Pain relief

- We observed that FP10 prescription pads were available in clinics.
- We saw that prescriptions for pain relief were recorded in patients' notes and altered to meet patients' needs when necessary.
- All the patients we spoke with told us that they had been asked if they were in pain prior to an x-ray or investigative procedure.
- Staff told us that patients were asked if they had any pain as on occasions alternative treatments or procedures can be arranged to aid the patients comfort.
- When a patients pain level had caused an investigation, x-ray or procedure to be cancelled the patient was asked to visit their GP to address the pain control before re-booking with the hospital.

Patient outcomes

- We saw the 'follow up to new patient ratio' was below the England average from March 2014 to December 2014; one of the lowest (best) in England at a 1 to 1 ratio.

- Currently the hospital does not capture the data to show the percentage of patients waiting over 30 minutes to see a clinician.
- As part of the outpatients transformation work they were exploring the use of touch screens within the OPD clinic areas enabling 'real time' data entry. Data collection would allow the trust to review their current waiting times and assess the outcomes for patient experience.

Competent staff

- An induction plan was in place for all new staff to gain competencies for their job role. This varied depending on the persons role, for example in the women's outpatient department health care staff were competent in recording patients' blood pressure and weight and some nursing staff were competent in giving advice, scanning and internal investigations.
- Continual professional development was promoted in the departments. Staff were encouraged to widen their understanding of different aspects of the service. Staff told us they were able to identify specific learning through the appraisal process.
- Completion of mandatory training levels was high in all areas for example in the women's health outpatients it was recorded as 100%.
- Staff received clinical supervision with the clinical psychologist monthly including visual competencies when carrying out procedures for example positioning, privacy and dignity.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.
- The imaging department were seen to have effective clinical supervision and mentoring systems in place for staff and they were proud to tell us they regularly developed their own staff.
- We saw imaging had competency frameworks for equipment use and they had nominated key trainers for each item of equipment, for example the MRI scanners, portable x-rays and ultrasound scanning.

Multidisciplinary working

- At the time of the inspection, the outpatient department did not hold pre clinic briefings; however they were planning to introduce these to increase staff awareness of the activity and any issues in adjacent clinics.

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- Verbal referrals were made between departments and the patient administration system supported the process of transfer of details.
- Written referrals were arranged when care was to be continued at another hospital. Letters were sent to GPs regarding their patients and a summary of consultations, treatments and investigations from the outpatient clinics.

Seven-day services

- The outpatients department was open Monday to Friday with occasional 'list reduction' incentive clinics being held on Saturday mornings.
- The radiography department was available seven days a week with an on call system available out of hours.
- The imaging staff managed their own 'out of hours' services and consultants carried out diagnostic reporting when required.
- Pathology laboratory was available out of hours on an on call basis. Blood sciences were available 7 days, 24 hours a day. Microbiology service was available Monday to Friday 9am to 5pm and out of hours had an on call service.

Access to information

- Staff told us and we saw that they had access to trust policies and procedures on the intranet.
- X ray and diagnostic imaging results were available electronically, which made them promptly and readily accessible to staff.
- Electronic access to pathology, microbiology and radiology results were available.
- Explanatory leaflets were available to assist staff to explain procedures and investigations to patients. Pre-operatively patients had discussions with the nursing staff to ensure they understood the procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the x-ray room and the gynaecology outpatient clinic.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).

- Staff knew the procedures to follow to gain consent and understanding from patients, including involving other professionals. Carers were encouraged to escort their relative to appointments to offer support.
- We saw examples of accurately completed consent forms.
- We heard a doctor discussing the treatments that were available during a consultation, giving the patient time to consider the options.

Are outpatient and diagnostic imaging services caring?

Good



We heard examples whereby people had been well supported, their dignity protected and shown respect whilst in the hospital.

We observed and patients told us that the staff were friendly and approachable. Staff were observed to be discreet and kind when individuals were upset.

We observed the staff supporting patients that required assistance and emotional support.

We found that due to administration staff shortages in outpatients, patients could be sat in a waiting area with no staff in attendance during lunch times and the start of clinics. Patients told us they had to wait for staff to attend to register their arrival. Then, when staff arrived, they had to catch up with any backlog of patients, which caused them to be under pressure. We observed this during the inspection.

Compassionate care

- We inspected the consulting rooms in the outpatient department. There was a curtained, spacious examination area which meant that patient's privacy was maintained. Chaperones were available for all patients.
- In the 'bed bay' within imaging, we saw patient's privacy was compromised. Mixed sex patients were being cared for next to each other in an area with no curtains in place or screens in use.
- We observed patients being greeted in a friendly manner in all areas.

Outpatients and diagnostic imaging

- We observed many examples of staff explaining to patients the procedure and process of their investigation. Staff gave patients time to ask questions and address any concerns.
- Staff told us they protected patient's privacy when clinical discussions took place and we were told by patients we spoke with that they had been treated with the utmost respect whilst in the hospital.

Understanding and involvement of patients and those close to them

- We saw that the outpatient department kept a wide choice of patient information leaflets, which meant that patients were supported to make informed choices about their care.
- Patients we spoke with told us they had been fully informed about the procedure and investigations that were planned or had taken place. We were told that the staff were very compassionate and when bad news was given, they had been kind and sincere. One patient told us they had received bad news at their appointment; the staff gave them time to ask questions before they left the department.

Emotional support

- We heard many examples from patients of the staff reassuring them and their kindness. Patients told us how staff had been supportive during their treatment explaining how procedures may feel and offering emotional support and encouragement.
- Patients told us staff were caring and professional. We observed staff to act in a professional way, offering discreet assistance where necessary.
- One patient told us their care had protected their dignity and with her consent, the staff had fully involved their partner in all communications.
- Most patients told us they were kept informed about follow-up appointments via letters. One person told us they did not attend an appointment and they were very pleased that someone rang them to rearrange another appointment.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Some people were not able to access services for assessment, diagnosis or treatment when they need to due to long waiting times. Cancer waiting times were constantly fluctuating and referral to treatment time targets were not being achieved.

The diagnostic waiting times had been higher than England average but were seen to be improving. A significant number of patients were waiting for follow up appointments.

Outpatient and imaging staff were seen to be participating in the "my name is" initiative to introduce themselves to patients. Interpreter service was available when booked in advance. Short notice support was not always available.

Service planning and delivery to meet the needs of local people

- Waiting times were not displayed in the waiting areas for patients.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in the corridors.
- The capital replacement programme had not been planned. This meant that the majority of the equipment was due for or overdue to be replaced.
- Scanners and imaging equipment were supported by service agreements; however, some equipment parts were becoming more difficult to replace for example the Gamma camera was 10 years old and parts for the camera were becoming obsolete. One senior manager told us "the camera will break down and we will not be able to obtain the parts". We saw the trust was unable to purchase a new camera due to lack of funding.
- Direct digital equipment had been purchased two years ago which gave improved imaging results and voice recognition reporting
- Local key performance indicator was 85% of x-rays would be reported on within one hour. Currently it was taking 90mins to report.
- For inpatients, 90% of CT and MRI results were returned to the patient within 24hours.

Outpatients and diagnostic imaging

- We were told that the histology and haematology department upgrade was signed off 12 months ago and this was now overdue.

Access and flow

- During 2014, the 'did not attend' rate (DNA) was in line with the England average (9%) with overall trust level at 9% and Manor Hospital at 10%. This showed evidence of an increase during 2014 from 8% to 11%. When patients did not attend the doctor reviewed the individual medical notes and organised a re-book or discharged the patient. The departments were considering ways to address non-attendance including text reminders.
- The percentage of people seen by a specialist within two weeks for all cancers was between 85% and 90% in quarter three and quarter four 2014/15.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was above the England average ranging between 97% and 99% between quarter one 2013/14 and quarter four 2014/15.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was 75% and below the England average at 90%. By quarter one 2014/15 this figure increased to 80%.
- The percentage of people waiting over six weeks between July 2013 and August 2014 was below the England average. From November 2014 onwards the percentage of people waiting over six weeks rose 1% to 7% in February 2015.
- Between February and May 2015, 13 clinics were cancelled with reasons recorded such as annual leave or service redesign.
- Waiting times for patients once they have arrived in the department were not registered.
- We were told that many of the problems with the patient administration system were due to user inexperience. In order to mitigate this the access team had system super users in place to support other staff in the use of the system. We visited the outpatient department at around 1.15pm to find that all the staff were at lunch but patients were arriving for appointments with nobody to greet them and tell them what to do. Some patients approached us to ask for assistance.
- We looked at the outpatient department computerised booking system for the clinics. We saw that one clinic had several double booked appointments. We discussed this with the Matron who told us that

consultant secretaries had access to the system and often added extra patients to already full clinics. The matron had introduced a system to monitor this problem. Clinic lists were signed off by matron

- We were told that consultants had to agree to frequent DNA patients to be taken off the list and that this was very time consuming.
- Staff told us there was a backlog of x-rays waiting to be reviewed which meant that reports/results were delayed. There was an action plan in place to improve reporting times and this was now down to two weeks

Meeting people's individual needs

- Outpatient and imaging staff were seen to be participating in the "my name is" initiative.
- We noted that water coolers were available throughout the outpatients department. We were told by day surgery staff that sandwiches and hot and cold drinks were available for day surgery patients following their procedures. Hot meals could also be ordered if requested.
- We were told that interpreting services could be booked for patients attending outpatient appointments if the original referral notice stated an interpreter would be required. The hospital employed two interpreters who could be contacted through the switchboard. We were told that when interpreters were not available staff were used to interpret (this is not recognised as good practice) but they had not received any specific training to do this. Information leaflets for patients attending the day surgery unit or endoscopy unit were not available in different languages.
- The staff in all areas were confident to support patients with complex needs such as learning disabilities and dementia. Where possible carers or relatives were invited to attend with the patient.
- The imaging policy described ensuring the patients identity could be confirmed by a relative during the checking of the patient's wristband in cases where the patient was unable to do so.
- In the X-ray department, we saw dementia friendly wall art had been designed to keep patients calm in unusual surroundings.
- Translation services were available on a booking system. Urgent translation services were not so freely accessible and staff told us that multi-lingual staff supported patients were possible.

Outpatients and diagnostic imaging

- In radiology, a standard operating procedure was in place for fault reporting of equipment. Each room had equipment checklists. Staff told us that the Gamma camera regularly broke down and when this happened patients were sent to a neighbouring hospital for their radionuclide scans. Staff also told us the quality of images produced by the older equipment was poor for some examinations.

Learning from complaints and concerns

- From 1 September 2014 to 30 August 2015, there had been 135 complaints received across OPD and Radiology. The outpatient's matron told us the main reason for complaints in the outpatients department was waiting times.
- In May 2015 outpatient and radiology received no complaints.
- There was no system in place for monitoring patient waiting times.
- We saw that PALs signs were situated throughout outpatients and imaging explaining how to raise any concerns or complaints.

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

The capital replacement programme was not in line with the requirements of the imaging department. Many devices were overdue replacement and required regular attendance to maintain its functionality.

The shortage of radiologists in the imaging department affected the service they were able to provide. The reporting backlog currently at two weeks for routine x-rays was felt to be a risk by the imaging service manager.

Staff were aware of the trust vision, but they did not always feel they were valued when their professional needs were not considered such as not maintaining their protected continued professional development time.

Vision and strategy for this service

- All the staff we spoke with were fully aware of the trusts visions and values including ensuring individuals were cared for, in safe hands and part of a team, however they did not always feel that their needs were considered in the particular departments.
- We were told they did not feel listened to and when issues were raised they did not get the response or feedback that the vision portrays.
- Inter-departmental succession training was taking place. This was a process of identifying and developing internal staff with the potential to fill key positions in the department in the future. This process encouraged staff to remain at the trust.
- The 2015-2017 transformation programme strategy set out that outpatient services would be transformed by increasing productivity of the departments. This would enable them to deliver a better experience for the patients for example reduce waiting times for appointments and waiting times in the clinics.

Governance, risk management and quality measurement

- Shortage of radiologists in the department affected the service provided. The reporting backlog currently at two weeks for routine x-rays meant there was a risk that patient's results were delayed.
- The nuclear medicine Gamma camera was overdue for replacement at a considerable expenditure which financially was not available, there was no strategic plan in place to address the need to replace the gamma camera. Staff told us management ignored their concerns and expected staff to continue working with it knowing it regularly broke down and the images it produced were not of good quality. The trust have since shown us a risk assessment that was completed for the gamma camera that indicates these issues were discussed by the trust board and a mitigation strategy agreed. The gamma camera was installed in 2005. The risk assessment dated 17 April 2014 states "Aged Gamma Camera, installed 2004 it is now 10 years old. Out of date technology has led to behind the times techniques. RCR recommends 7 year renewal programme, NICE suggest use of the newer techniques and studies provide evidence to show the newer technology far improves specificity and sensitivity. Machinery needs replacing"

Outpatients and diagnostic imaging

- The trust have since set out an independent review of the image quality from the gamma camera and a process to allow patients access to an alternative provider where image quality is critical to their clinical case management.
- Vacancies for consultant histopathologists, microbiologists and haematologists were all currently advertised. The reduced staffing impacted on the quality of the service received, for example increased waiting times.
- National government agencies (including the Health and Safety Executive and the Environment Agency) monitor the use of specific radiation sources and how they are stored.
- Equipment issues had been raised with the senior management of the trust but this was felt to be overlooked and the future service was not being considered.
- Dose reference levels were reported to be within national limit however, this would be reduced significantly with the use of new equipment. The trust was not being proactive and seeking ways of reducing the dose of radiation.
- In outpatients, some staff told us that they occasionally found themselves alone in a late afternoon clinic, staff told us they had informed senior management of the risk of lone working, however, no action was taken by senior management to mitigate this risk.
- The department had a radiation protection committee which met every six months. Radiation protection advice was commissioned from a neighbouring hospital. There were five radiation protection supervisors in place, one for each modality and access to a laser safety expert. This meant that there was a good network of expert advice for any radiation queries that arose.

Leadership of service

- The outpatient senior managers told us they had formed an outpatient transformation project group to look at issues such as staffing levels and DNA's. We saw the group action plan, version three dated October 2015, which identified 96 actions, 58 of which had been completed. We did not see timescales for the remaining 38 actions.
- There was a strong leadership team within radiology. We heard how staff felt supported and valued by the senior staff in the department.

- One senior radiographer told us that management were very supportive but that she had not had any management time or held any staff meetings due to the pressure on the service
- We visited the porter's distribution area. Porters told us they never saw senior managers visit the area.

Culture within the service

- We heard of a mixed culture of staff satisfaction within both the outpatients and imaging departments.
- The majority of staff we spoke with told us they felt settled working in the department, valued and well informed about any developments. They told us they worked well together as teams in all the outpatient and radiology departments.
- However, we were told by some staff that there were incidents where management had taken a heavy handed approach to problem solving and the problems relating to the patient administration system had caused frustrations within the OPD team. Some staff had been blamed for the system problems which had left them feeling unsettled and unhappy.
- Good working relationships and support networks had been built with the local hospitals and radiation protection advisor.

Public engagement

- The outpatient department had a patient forum group consisting of 15 members. The group had been meeting for five years. Matron told us that the group were consulted about hospital signage, patient information leaflets and patient letters.
- They met quarterly to review the documentation and discuss any current issues. Minutes of the meetings were recorded and sent to the members. We saw some of the patient friendly leaflets that had been developed.

Staff engagement

- 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. Nursing and medical staff introduced specific health care themed updates and new practices.
- All nursing and medical staff had individual trust email accounts and these were used to circulate messages and alerts.

Outpatients and diagnostic imaging

- The trust intranet published news bulletins and important information with links to more detailed information and guidance, for example: future plans of the trust and service specific updates.

Innovation, improvement and sustainability

- A Consultant Radiographer now worked in the imaging department reporting on films and supporting the team of advanced practitioners and radiologists. A consultant sonographer had also been recruited to support the Sonographer and Radiologist team.
- GP 'walk in' service for access to plain film x-rays had proved successful.
- GP evening training for appropriate 'referral' to outpatients and radiology services was well attended.
- The use of three armed gowns had been introduced for privacy purposes in x-ray. The overlap of the gown ensured the person's body was fully covered.
- £17,000 had been saved in gynaecology clinics by changing some of the service equipment during a supplier review.
- Bi-annual transvaginal scan workshops were held for two days by the consultant in the gynaecology clinics. Approximately 150 women attend at each workshop to volunteer for a scan. Although this was a training session for staff, when any problems were identified the volunteer was referred for further consultation and treatment.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure there are adequately qualified staff across all services to meet the needs of patients to protect them from abuse and avoidable harm.
- The trust must ensure medication is stored, administered and recorded appropriately across all services.
- The trust must ensure patient confidentiality is maintained at all times across all services.
- The trust must ensure all Fire Exits are kept free.
- The trust must ensure there is an adequate supply of equipment in good working order and fit for purpose across all services. Any mitigation to replace equipment must have clear reasons, regular review, up-to-date action plan clearly demonstrating alternative options and timescales to support actions.
- The trust must ensure equipment is stored appropriately without compromising patient and staff safety and staff can access equipment when required.
- The trust must ensure steps are taken to secure the contents of the treatment room on the children's ward which could pose a risk to children and young people who might self-harm.

Action the hospital SHOULD take to improve

Emergency Department SHOULD:

- The trust should consider re-designing the seating arrangement in the ED general waiting area to provide some personal space between the seats.
- The trust should improve staff annual appraisal rates within the ED.
- The trust should ensure all staff can be easily identified by patients and visitors at all time on duty.
- The trust should better inform patients and their relatives/friends about the streaming systems in operation in the ED and how they are going to be attended to.

- The trust should review the purpose and use of the ED log sheets.
- The trust should consider setting out its overarching vision for the ED.

The Medical Services SHOULD:

- The hospital should provide a protected, suitable environment for physiotherapy.
- The trust should review its stock of equipment including, but not limited to syringe pumps and weighing scales.
- The trust should ensure feedback is given on all reported incidents.
- The hospital should ensure that the patient safety dashboards on display in medical wards are maintained with up-to-date, accurate information.
- The hospital should inspect its physiotherapy equipment to ensure it complies with infection prevention and control guidelines.
- The hospital should arrange for a patient group directive to be written for the administration of saline flushes.
- The trust should ensure fluid balance front sheets are consistently completed for any patient having their fluid intake and output monitored.
- The trust should review the contents and layout of its nursing assessment documentation booklet.
- The trust should reinstate a programme of acute illness management training for nurses working on medical wards.
- The trust should review its major incident training and the method of its delivery to improve understanding among staff.
- The trust should take action to improve staff understanding of the meaning of the butterfly symbol to indicate patients living with dementia and the purpose of butterfly bays onwards.
- The trust should ensure it consistently reports on its performance against the NHS 18week referral-to-treatment target.
- The hospital should ensure proper translation services are used to communicate with patients who do not understand English and that patients' families or friends are not thought of as an option for translation.

Outstanding practice and areas for improvement

The Surgery services SHOULD

- Review the low uptake of medical devices training across the trust where 75% of staff needed to be trained in order to use the new intravenous pumps. Wards 10 and 11 had still not reached their 75% target.
- Review the environment in recovery for children post-surgery. The environment in the recovery area in theatres was not child friendly.
- Ensure operating theatres are deep cleaned on a regular basis and should review how equipment is stored in the theatre environment.
- Ensure equipment used specifically for children in the operating theatres is up to date.
- Should ensure intravenous fluids are storage in secure environments.
- The trust should ensure access to translation services was easier to access.
- The trust should review the provision of physiotherapy services to ensure initiatives such as the 'joint school' can be re-established.

Critical Care Services SHOULD

- The trust should review their morbidity and mortality review process to ensure all deaths are reviewed.
- The trust should review their checking system for fridge temperatures to ensure fridge temperatures are rechecked if temperatures are out of range, to ensure medicines are stored at the correct temperature.
- The trust should review infection control procedures to ensure staff wash their hands after removing gloves and aprons rather than just using sanitising gel.
- The trust should review junior medical cover to ensure doctors are available to attend consultant ward rounds in critical care and document contemporaneous patient plans in notes.
- The trust should review multidisciplinary team-working in critical care to enable multidisciplinary team ward rounds and effective multidisciplinary team-working.
- The trust should review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.
- The trust should ensure patients have access to patient information leaflets in languages other than English.

Maternity and Gynaecology services SHOULD

- The trust should ensure fridges used for the storage of medicines are kept locked and are not accessible to people.
- The trust should ensure that medicines that look similar are not stored next to each other.
- The trust should consider how it enables staff to attend required training and supports staff to gain additional qualifications to support the service.
- The trust should consider how it can improve the care records, to ensure that risk assessment and safeguarding issues are easy to locate.
- The trust should consider the use of specialist midwives to improve the experience of families including:-bereavement, teenage pregnancy and diabetes.
- The trust should consider ways to support and improve active birth.
- The trust should consider ways to reduce the induction of labour and caesarean section rates.
- The trust should consider ways of improving the sharing of information and improving engagement with midwifery staff, so they are aware of and involved in future developments.
- The trust should consider ways to improve breastfeeding support to new mothers.
- The trust should consider involving patients fully in the care decisions by developing a ward round on the delivery suite to incorporate every woman present.
- The trust should consider ways to improve relationships between maternity and gynaecology to allow the joint use of the gynaecology theatre.
- The trust should evaluate the management of outliers on the gynaecology ward.
- The trust should consider NICE and best practise recommendations and ensure the trust guidelines reflect up to date guidance.
- The trust should consider individual feedback to incident reporting.
- The trust should consider the ways to inform patients of the role of Supervisors of Midwives.
- The trust should consider the use of an assessment tool for the prevention of pressure ulcers for all maternity patients.
- The trust should consider the use of the maternity safety thermometer tool.
- The trust should consider a way to identify when a piece of equipment is clean and ready for use.

Outstanding practice and areas for improvement

- The trust should improve the cleanliness of the delivery suite and delivery suite theatres.
- The trust should consider the use of disposable straps for the CTG machines.
- The trust should consider the use of wireless CTG monitoring.
- The trust should consider trialling the child abduction policy.
- The trust should consider increasing audits to improve practice such as the audit of one to one care in labour.
- The trust should consider the use of a debrief for patients following a caesarean section to discuss suitable mode of birth if they choose to have more children
- The trust should consider the need for a policy for transferring women to a tertiary unit.
- The trust should consider the need for a transition care ward for babies requiring additional care.
- The trust should consider a pool evacuation policy and suitable equipment to evacuate patients in all areas where pools are used.
- Improve the consistency of checking resuscitate on delivery suite.
- The trust should consider a strategy for capping bookings for the service as the number of births increases.
- The trust should consider an alternative if the lease on the midwife- led unit is not renewed.

Children and young people services SHOULD

- The trust should take steps to further improve the safety of, and reduce risks to, CAMHS patients receiving care on the children's ward.
- The trust should ensure the neonatal unit is suitable for the service provided and is large enough to accommodate the number of babies using the service at any one time.
- The trust should review the scope and conduct of root cause analyses and the process used to review mortality and morbidity to ensure all possible contributory factors are considered.
- Action should be taken to maintain the standards of hygiene and cleanliness within the Starfish suite and equipment within the suite and ensure it is appropriate for the purpose for which it is used.

- The trust should ensure patient records and referral documentation is available in a timely way for children's outpatient attendances.
- The trust should ensure there are action plans in place to improve practice in relation to national quality audits and monitor progress against these.

The End of Life care services SHOULD

- The trust should take action to ensure they have sufficient mortuary fridges in working order.
- The trust should ensure all patients who are nearing end of life have anticipatory medicines prescribed.
- The trust should ensure all patients approaching end of life have their spiritual and religious needed assessed and are offered support.
- The trust should finalise and implement the individualised end of life care plan as a replacement to the Liverpool care pathway.
- The trust should ensure both amber care bundles and advance care planning is used consistently.
- The trust should introduce a dedicated bereavement service.
- The trust should consistently identify preferred place of care and support patients to achieve this.
- The trust should ensure there are appropriate areas for patients in the last days/hours of life which provide for the privacy and dignity for both patients and their relatives.

The Outpatient and diagnostic imaging services SHOULD:

- The trust should replace unreliable equipment in the radiology unit.
- The trust should consider improving the post-operative procedure facilities for patients attending the day surgery unit and the endoscopy unit.
- The trust should ensure all staff have access to trust policies and procedures.
- The trust should ensure receptionists are available to meet and greet patients when they are attending for appointments and procedures.
- The trust should ensure staff handling food for patients should have attended basic food hygiene training.
- Resuscitation trolleys should be checked daily as recommended by the royal college of anaesthetists.