Care Quality Commission

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Surgery	Good
End of life care	Outstanding
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Sandwell General hospital is a major hospital located in Birmingham, England operated by Sandwell and West Birmingham Hospitals NHS Trust, serving a population of around half a million people. There are two main acute locations, City Hospital and Sandwell General Hospital. The trust also provides community services in the form of inpatients, alongside other community services such as district nursing and community palliative care. All community services are offered in the Sandwell area.

Sandwell General Hospital is an acute teaching hospital and provides range of general and specialist hospital services. The trust was established on 1 April 2002 following approval given by the Secretary of State for Health to amalgamate Sandwell Healthcare NHS Trust and City Hospital NHS Trust.

We carried out an unannounced inspection at Sandwell General Hospital where we only visited the medical service on 16 February 2017. This was followed by a short notice focussed announced inspection on 28 - 30 March 2017, with further unannounced visits on 6 and 11-13 April 2017.

We have made judgements about five core services within Sandwell General Hospital and rated each one individually. However, we have not provided an overall rating for Sandwell General Hospital as this does not form part of our regulatory process for focussed inspections.

Our key findings were as follows:

- Incidents were reported, investigated and learned from to improve safety and staff were committed to being open and honest with patients when things went wrong.
- The trust had an identified clinical audit lead for the urgent and emergency care department.
- Urgent and emergency care service trust wide met the RCEM standard of patients being treated within one hour of arriving.
- The trust's monthly average total time in ED for all patients was consistently lower than other English trusts and this was a stable trend.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- Multi-disciplinary team (MDT) working was evident throughout the hospital.
- There was a holistic approach to patient, care was tailored to meet patient's individual specific needs. The service regularly reviewed the complex care needs of patients to promote coordinated, safe, and effective palliative and end of life care.
- The mortuary on both had improved its flooring and condition since inspection 2014
- The service provided access to care and treatment 24 hours a day, seven days a week.
- An IR(ME)R committee monitored, analysed and reported incidents in the diagnostic imaging department. All IR(ME)R documentation was in place a vast improvement since inspection 2014.

We saw several areas of outstanding practice including:

End Of Life Care

Summary of findings

- The palliative and end of life care service ensured that patients and their families were involved in their care and their choices and preferences were upheld, including where they would prefer to be for their care and when they died.
- The palliative and end of life care service integrated coordination hub acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week 24 hours a day.
- The service reacted speedily to referrals by providing an urgent response team in order to meet patient's needs quickly.
- Staff went the extra mile to ensure patients received the right care in the right place at the right time.
- Staff showed great compassion, empathy and an understanding of patient's needs and preferences.

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

Importantly, the trust must:

Action the hospital MUST take to improve

Emergency Department

- Storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- Improve the standard of records completed by doctors when patients are admitted to wards from the ED.
- Patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.
- Staff identify patients at risk of sepsis and follow the sepsis pathway in place.
- Doctors use the appropriate proforma in place for effective clinical pathways.
- Sufficient substantive registrar cover overnight for the safety of patients.
- Ensure there is a designated appropriately safe room available within which to care for patients with mental ill health
- Ensure the security and safety of staff working in the ED at all times.
- Unplanned re-attendance rate to the ED within seven days is reduced.
- Information about patients' assessment and condition recorded by consultants and doctors is sufficiently detailed, precise and legible.
- Patients are treated within one hour of arriving.
- Patients are admitted, transferred or discharged within four hours of arrival in the ED.
- Take effective action to mitigate the increasing risks to patients from overcrowding in the ED and respond effectively to risks identified and escalated by ED local leaders.

Medical Care service

- All staff across medical services are up-to-date with basic life supporting training.

Summary of findings

- Temporary staff being used are competent to fulfil the role.
- Resuscitation medicines and equipment are stored in a way to protect from tampering and that storage and availability is consistent across all areas within the medical service.
- Guidance from the Resuscitation Council (November 2016) is being followed.
- Sufficient storage for equipment on medical wards to avoid delay in relevant equipment being received by ward staff, and to avoid out of service and in service equipment being stored together.
- Sufficient staffing and skill mix to meet safe staffing requirements on medical wards.

Surgery

- Measures are in place to prevent further Never Events to protect patient's safety.
- Records of care and treatment provided to patients are accurate and complete.

Outpatient Department and Diagnostic Imaging

- Resuscitation trolleys are checked daily, medications and fluid bags are stored appropriately and trolleys are secure and tamperproof.
- All staff are up to date with their safeguarding mandatory training
- All staff undergo regular assessments to ensure they are competent and confident to carry out their roles.

Action the hospital SHOULD take to improve

Emergency Department

- Consider reviewing arrangements in place to support the number of newly qualified nurses allocated to the ED.
- Reviewing arrangements in place in order to successfully rotate staff between Sandwell Hospital and City Hospital ED sites.
- Consider reviewing arrangements in place for Human Resources support to the ED staff team and leaders.

Medical Care service

- Using a consistent approach for documentation across the medical service. We saw variations in fridge temperature documentation and patient records.
- Staff are knowledgeable and understand the policies in place to prevent and control infection.
- Updating the disinfectant solution log to ensure it reflects clearly how long a solution has been pre-made for.
- Staff are consistently completing relevant risk assessment documentation.
- All staff are confident with procedures and up to date with relevant training for emergency events, such as fires.
- All staff are clear about Deprivation of Liberty Safeguards (2007) and when it is appropriate to make an application to authorise a deprivation of liberty.
- Continue with improvements made to reduce waiting times and average length of stay for some specialities.
- Continue with improvements to gain JAG accreditation for the endoscopy unit

Surgery

- Review the system of pooling surgical patients to ensure that patients are not put at risk.

Summary of findings

- Identify a non-executive board member to champion theatres issues at board level and support the service.
- Repair work surfaces in theatres to comply with infection prevention and control guidance.
- All junior doctors are familiar with escalation process should patients treatment or discharge be delayed by imaging department issues.
- Safety thermometer information is displayed on the wards. Staff members should be aware of their ward scores.
- Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.
- Wider learning is promoted through complaint trends being shared across all areas of the trust.

Outpatient Department and Diagnostic Imaging

- System and environment for taking children's bloods is child friendly including a children's phlebotomist.
- Staff in the phlebotomy department confirm the time when numbing cream has been applied by the children's outpatients department prior to taking any blood samples.
- Patients are given the opportunity to be weighed in private.
- Prescriptions for controlled drugs (FP10's) are stored securely at all times in accordance with trust policy.
- Hand hygiene compliance is regularly monitored and recorded in the outpatients department.
- Staff have an understanding of their responsibilities in relation to the Mental Capacity Act, 2005.
- Patients' notes are kept securely at all times in the outpatients department.
- Staff know who the safeguarding leads are at the trust.
- Staff appraisals are up-to-date.
- Equipment and furniture in the outpatients department is moved regularly to enable a thorough clean.

End Of Life Care

- Updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.
- Mandatory training for mortuary staff includes infection control training.
- Medical staff document reviews of patients care on their specialist care plans when these are being used.

Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated this service as requires improvement because:

- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. The standard of records completed by doctors when patients were admitted to wards from the ED risked compromising patient care. Resuscitation basic life support training uptake by staff was below the trust target. Only 50% of doctors held safeguarding children training at level 3 competence. Consultant cover was rated as a high risk for the Sandwell ED and the trust identified lack of substantive registrar cover overnight as a 'new risk'. Security within the ED and timely access to security staff was an ongoing issue of concern for ED managers and staff.
- Appropriate forms and systems were in place for effective clinical pathways but doctors were not always using them. Royal College of Emergency Medicine (RCEM) audit results for Sandwell Hospital ED were mixed and staff were not always aware of audit outcomes in practice to improve care.
- During 2016, Sandwell Hospital ED had a rate of 83.3%of patients admitted, transferred, or discharged within four hours of arrival in the ED; the Department of Health's standard is 95%. During 2016, the percentage, across both ED sites, of patients waiting between four and 12 hours from the decision to admit until being admitted was better than other English trusts. However, this performance declined through 2016 from 1% of patients waited more than four hours in January to 10% by December. When the ED was very busy patients had to queue on trolleys in the corridor after triage while they waited for treatment. The numbers of patients leaving without being seen was showing a rising trend in 2017.

Summary of findings

- Some staff told us the executive leadership was not visible in the ED and staff we spoke with did not readily know the organisation's values. Actions identified by senior trust managers to deal with the increasing risk of overcrowding in the ED did not address the problem as a hospital wide systems issue and the ED leaders were left to manage it. Security risks identified and escalated by matron were not addressed effectively by divisional managers.
- Local or divisional ED leaders had not identified the poor quality of many doctors' notes and clerking.

However:

- Incidents were reported, investigated and learned from to improve safety and staff were committed to being open and honest with patients when things went wrong. ED managers encouraged performance transparency within the department. Systems were in place to manage risks such as time to initial assessment of patients, infection control and staffing levels and to contribute to safeguarding children.
- The trust had an identified clinical audit lead for the urgent and emergency care department. Sandwell Hospital ED participated in RCEM audits and research network data collection and undertook a plan of local clinical audits. There was a consultant led 'rapid assessment and treatment' (RAT) in place for some periods of the week. There was a GP service on site as part of the triage arrangements to take some pressure off the ED services and to avoid admissions where possible. The trust developed nursing staff to acquire skills to carry out some clinical procedures doctors usually perform and emergency nurse practitioners led the minor's injuries and illnesses stream.
- Patients and relatives we spoke with made very positive comments about the care they received and the staff who treated them. ED staff were attentive to patients and relatives including those

Summary of findings

they were not directly treating at the time. Staff gave patients information about their condition and involved them and their relatives/carers/ parents in treatment plans and options

- Sandwell Hospital recently opened a 32-bed emergency assessment unit for medical and surgical emergencies, as well as GP referrals. During 2016, the urgent and emergency care service trust wide met the RCEM standard of patients being treated within one hour of arriving, for most months. There was a patient 'flow' management system through the department when it was busy. The trust's monthly average total time in ED for all patients was consistently lower than other English trusts and this was a stable trend. Sandwell ED managers followed the trust's procedure and investigated and responded to complainants in a timely way and made changes because of complaints and concerns.
- Local leadership of the Sandwell Hospital ED was strong. The matron and lead ED consultant led progressive change and improvement as far as their roles allowed and under very challenging circumstances. The ED leadership reported on its activity and performance through the governance arrangements of the trust to the executive through a series of monthly meetings. These reports included how risks were being managed. The emergency medicine division was working towards cross-site working for consultants and rotation for other staff to achieve consistency of quality and development.

Medical care (including older people's care)

Good

We rated this service as good because:

- There was a good incident reporting culture. Staff understood their role and responsibility in reporting incidents and responded appropriately to signs or allegations of abuse. There was evidence of wide spread learning and initiations to improve safety and processes in place to keep people safe.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes. Most outcomes for people who used services were positive and met expectations. They participated in relevant local

Summary of findings

and national audits, including clinical audits and other monitoring activities such as reviews of services. Results were used to improve care and treatment and patient outcomes.

- There was a strong and visible person-centred culture and staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. Staff responded compassionately when patients needed help and supported them to meet their basic personal needs when required. They encouraged patients and their relatives to be involved in their care and in making decisions.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. There was a proactive approach to understanding the needs of different groups of people. Reasonable adjustments were made and actions taken to remove barriers when people found it hard to access services.
- Local leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. They actively empowered staff to drive improvement and a culture where the benefit of raising concerns was valued.

However;

- Staffing was an issue in areas with understaffing and inappropriate skill mix resulting in a reliance on bank and agency to reach establishment. There were no systems in place to ensure temporary staff were competent to deliver effective care and treatment.
- It was difficult to release staff from clinical duties, which resulted in the cancellation of staff training. Mandatory training completion was low, including basic life support training and fire warden training.
- Not all staff were compliant with infection control and prevention. There was inconsistent knowledge and understanding of the trust's key infection control policies and a lack of challenge when staff were non-compliant.

Summary of findings

- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- There was confusion around the requirements of the Mental Capacity Act (2005) and for Deprivation of Liberty Safeguards (2007). Applications to authorise a deprivation of liberty were not always made appropriately. There were restrictive options used but it was not always documented if these restrictions were consented.
- There was no specific risk register for the medical service; it was incorporated with the emergency care division, which made the risks related to the medical service unclear. Arrangements for risk escalation were not always effective and although the ward risk registers were fed into the divisional risk register, there did not appear to be any local risks other than staffing on the register. However, staffing was not specific to ward but generic across specialities.

Surgery

Good

- We found that despite of some specific issues within theatres, infection prevention and control practices were good.
- Medicines were secured and staff access was auditable.
- Overall incident reporting and awareness was good.
- Nursing and medical staff levels were good and staff had the skills and knowledge relative to their role.
- Engagement with national clinical audit was good with evidence of learning from audit outcomes.
- Patients received appropriate care following nationally recognised pathways including control of pain.
- Multi-disciplinary team (MDT) working was evident throughout the service

Summary of findings

- Patients told us that they received compassionate care, were involved in decisions about their care and supported when they were anxious or worried about their condition.
- Patients with special needs received appropriate support; staff understood how to support patients with dementia or other memory problems.
- Supervisors had a good understanding of their staff, were supportive, and provided an environment, which enabled staff to provide good care. We saw examples of innovative practice from individual members of staff, which had been adopted into practice across the trust.

However

- The trusts policy of pooling surgical patients had the potential to cause harm. Pooling of patients was a system where surgery patients were grouped by speciality and would be operated on by whichever surgeon was on duty for that speciality on the day of surgery, rather than by the consultant who had reviewed their case and recommended the procedure.
- Patient records contained errors and omissions.
- We saw some surfaces in theatres were cracked or had the wipe clean surfaces chipped or damaged which had not been repaired since the previous inspection in 2014.
- One member of the supervisory staff in theatres had a poor understanding of what constituted a serious incident, which meant we could not be assured incidents were always classified appropriately.

End of life care

Outstanding ☆

- End of life care at Sandwell Hospital was organised and delivered by a specialist palliative and end of life care service based at the hospital within the palliative care suite.
- There was a holistic approach to patient care and care was tailored to meet patient's individual specific needs. The service regularly reviewed the complex care needs of patients to promote coordinated, safe, and effective palliative and end of life care. Patients and their families were extremely happy with the services

provided to them and thought the care they received was 'wonderful'. Patients and relatives told us that staff went that extra mile to not only meet their needs but to exceed them.

- The service provided access to care and treatment 24 hours a day, seven days a week. There is one single point of access for patients and health professionals (the Hub) to facilitate services that provide excellent coordinated care for patients and their families.

Outpatients and diagnostic imaging

Good

- The trust followed the National Institute for Health and Care Excellence (NICE) clinical guidelines.
- Staff knew how to report incidents and told us that they received feedback. An IR(ME)R committee monitored, analysed and reported incidents in the diagnostic imaging department.
- All IR(ME)R documentation was in place.
- The diagnostic imaging department provided a seven-day service for patients requiring x-ray, computed tomography scans and interventional radiology.
- Staff in the outpatients department held additional clinics to reduce waiting times.
- The trusts follow up to new rate was one of the best in England.
- There were pathways and procedures in place for urgent referrals to the diagnostic imaging department.
- We saw that staff adhered to infection control policies and that there were robust processes in place for the cleaning of probes in the diagnostic imaging department.
- Staff in diagnostic imaging used the pause and check protocol. This ensured the patient, the examination and the referral were correct.
- We saw that staff were polite, caring, professional and compassionate towards patients.
- Staff fully explained procedures to patients; they gave patients time to ask questions and talked to patients in a way they could understand.

However:

Summary of findings

- Resuscitation trolleys were unlocked and did not have tamperproof tags. Staff did not always record daily resuscitation trolley checks. Syringes of adrenaline and intravenous fluid bags were not stored appropriately.
- Staff in the outpatients department weighed patients in the corridor; this could lead to some patients feeling embarrassed as other patients and staff may have overseen.
- Staff did not keep patient notes secure in the outpatients department; this meant they were vulnerable to unauthorised access.
- Children had blood tests in the hospitals main phlebotomy department; we visited the department and found it was not child friendly.
- There had been a workforce review of staffing and this had led to significant changes at the trust, we saw pockets of low staff morale in the outpatients department caused by such changes.
- Staff in the outpatients department did not have their competencies assessed to ensure they were confident and competent to carry out their role.
- We were not assured that prescriptions for controlled drugs (FP10s) were being stored securely in outpatient areas in accordance with trust policy.
- Some staff had a limited understanding of the Mental Capacity Act, 2005.

Sandwell General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Sandwell General Hospital

Sandwell General Hospital was originally an infirmary added to the West Bromwich union workhouse in 1884. After improvements during the 1920s and 40s, the infirmary then became a separate institution named Hallam Hospital, after rebuilding in the 1970s, the hospital was renamed Sandwell District General Hospital. In April 2005, an £18m Emergency Services Centre opened on the Sandwell General Hospital campus. This facility replaced the old Emergency Department that was destroyed by the largest fire in National Health Service history. It incorporates a comprehensive Emergency Department facility, Emergency Assessment Unit and Cardiac Care Unit.

In 2015, the Emergency coronary care service was transferred from Sandwell General Hospital to City Hospital, Birmingham.

Sandwell General Hospital provides a comprehensive range of medical and nursing services including general medicine, surgery, plastic surgery, orthopaedics, gastroenterology and rheumatology.

During December 2015 to November 2016, the trust had 102,151 patients admitted to the trust as inpatients. 1014,513 people attended outpatient clinics and 234,359 patients attended urgent and emergency care services trust wide across two sites.

Our inspection team

Our inspection team was led by:

Team Leader:

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

The team included 21 CQC inspectors, 34 specialist advisors to include Consultants, Doctors, Matrons, Nurses, Midwives, Therapist, and one 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

CQC analysts, planners, and recorders also supported the inspection team.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew.

We carried out an unannounced visit on 16 February concentrating solely on the medicine core service. This was followed by a focussed short notice announced visit covering five core services on 28 to 30 March 2017 and further unannounced visits on 6, 11, 12, and 13 of April 2017.

We concentrated on the following five core services:

- Urgent & emergency services
- Medical care (including older people's care)
- Surgery
- Outpatient and Diagnostic Imaging
- End of life care.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

We met with the trust executive team both collectively and on an individual basis, we also met with service managers, leaders, and clinical staff of all grades.

During the visit we held focus groups and interviews with a range of staff who worked within the service, such as, palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Facts and data about Sandwell General Hospital

The annual turnover (total income) for the trust was £436 million in 2015/16.

Sandwell General Hospital has 460 beds and 15 wards, serving a population size of 530,000 across West Birmingham and six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

In January 2014, the trust invested £3 million in creating a new blood sciences laboratory at Sandwell Hospital, which processes more than 7,000 samples and produces around 30,000 test results a day. It is designed to fit with the needs of the proposed new Midland Metropolitan Hospital in Smethwick in October 2018.

The health of people in Birmingham is generally worse than the England average. Birmingham is one of the most deprived districts/unitary authorities in England, and about 29% (72,000) of children live in low-income families. Life expectancy for both men and women is lower than the England average at 8.3 years lower for men and 5.9 years lower for women in the most deprived areas of Birmingham.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

Sandwell Hospital emergency service provides 24-hour emergency and urgent care to its local population. It provides care to children in a specialist emergency paediatric room for 12.5 hours a day. It sees in excess of 80,000 adult and child new attendees each year, which equates to about 250 patients a day and is a major trauma unit. Sandwell is a metropolitan borough with local issues relating to social deprivation, unemployment, and varied and changing ethnicity. The trust's emergency department covers services at Sandwell Hospital and at City Hospital.

In 2015/16, the trust had 227,808 attendances at its urgent and emergency care services trust wide across two sites. This is within the high end of the range compared to those of all other trusts in England.

The Sandwell Hospital ED saw a high acuity level of patients with many elderly patients admitted. During our inspection, we spoke to approximately 15 people, followed the care pathway of 14 patients, including children by reviewing their notes and spoke with 26 staff across a range of roles.

Summary of findings

We rated this service as requires improvement because:

- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. The standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and increased risk to patients. Uptake of resuscitation life support training was lower than the trust target and the doctor's uptake of child safeguarding training at level 3 was unlikely to reach its target for the year. Consultant cover was rated as a high risk for the Sandwell ED lack of substantive registrar cover overnight was a 'new risk'. Security within the ED and timely access to security staff was an ongoing issue of concern for ED managers and staff. The designated mental health bay, used for mental health assessment was isolated from the major's area. However, it was a standard cubicle and we noted ligature points and accessible cabling that could accommodate suicide.
- Appropriate forms and systems were in place for effective clinical pathways but doctors were not always using them. Royal College of Emergency Medicine (RCEM) audit results for Sandwell Hospital ED were mixed and staff were not always aware of audit outcomes in practice to improve care. Shortage of nursing staff meant a number of newly qualified nurses had been allocated to the ED and

experienced staff had to support them in this challenging environment. Staff understanding of deprivation of liberty safeguarding processes was poor.

- During 2016, Sandwell Hospital ED had a rate of 83.3% of patients admitted, transferred, or discharged within four hours of arrival in the ED; the Department of Health's standard is 95%. During 2016, the percentage across both ED sites of patients waiting between four and 12 hours from the decision to admit until being admitted was better than other English trusts. However, this performance declined through 2016 from 1% of patients waited more than four hours in January to 10% by December. When the ED was very busy patients had to queue on trolleys in the corridor after triage while they waited for treatment. The number of patients leaving before being seen was rising at the beginning of 2017.
- Some staff told us the executive leadership was not visible in the ED and staff we spoke with did not readily know the organisation's values. Actions identified by senior trust managers to deal with the increasing risk of overcrowding in the ED did not address the problem as a hospital wide systems issue and the ED leaders were left to manage it. Security issues raised by the matron through the trusts' governance systems had not been adequately addressed by divisional managers.

However:

- Incidents were reported, investigated and learned from to improve safety and staff were committed to being open and honest with patients when things went wrong. ED managers encouraged performance transparency within the department. Systems were in place to manage risks such as time to initial assessment of patients, infection control and staffing levels and to contribute to safeguarding children. Matron used handover and safety briefings, spot checks and feedback to individual staff to focus on specific monthly topics in order to improve safety and quality.
- The trust had an identified clinical audit lead for the urgent and emergency care department. Sandwell Hospital ED participated in RCEM audits and research network data collection and undertook a plan of local clinical audits. There was a consultant led 'rapid assessment and treatment' (RAT) in place for some periods of the week. There was a GP service on site as part of the triage arrangements to take some pressure off the ED services and to avoid admissions where possible. The trust developed nursing staff to acquire skills to carry out some clinical procedures doctors usually perform and emergency nurse practitioners led the minor's injuries and illnesses stream.
- Patients and relatives we spoke with made very positive comments about the care they received and the staff who treated them. ED staff were attentive to patients and relatives including those they were not directly treating at the time. Staff gave patients information about their condition and involved them and their relatives/carers/parents in treatment plans and options
- Sandwell Hospital recently opened a 32-bed emergency assessment unit for medical and surgical emergencies, as well as GP referrals. During 2016, the urgent and emergency care service trust wide met the RCEM standard of patients being treated within one hour of arriving, for most months. There was a patient 'flow' management system through the department when it was busy. The trust's monthly average total time in ED for all patients was consistently lower than other English trusts and this was a stable trend. Sandwell ED managers followed the trust's procedure and investigated and responded to complainants in a timely way and made changes because of complaints and concerns.
- Local leadership of the Sandwell Hospital ED was strong. The matron and lead ED consultant led progressive change and improvement as far as their roles allowed and under very challenging circumstances. The ED leadership engaged staff in quality improvement and reported on its activity and performance through the governance arrangements of the trust to the executive through a series of monthly meetings. These reports included how risks were being managed. The emergency medicine division was working towards cross-site working for consultants and rotation for other staff to achieve consistency of quality and development.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- The standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and this could increase risk to patients.
- For February 2017, the ED showed only 66% compliance with the Royal College of Emergency Medicine (RCEM) recommended maximum time from arrival to receiving treatment.
- Staff at the nurses/doctors workstation in the major injuries/illnesses area had no view of some cubicles to supervise the condition of patients as the cubicles were situated behind the wall at the back of the workstation.
- Consultant cover was rated as a high risk for the Sandwell ED and in January 2017 the trust had identified lack of substantive registrar cover overnight was as a 'new risk'.
- There was no designated appropriately safe room within which to care for patients with mental ill health.
- The trust found through audit of one system put place in to identify children at risk of abuse that ED staff were completing the questionnaire less than half of the time and this showed a deteriorating trend.
- Just over half of the medical staff held safeguarding children competence training at level three.
- Resuscitation: basis life support training up take was not compliant with the trust target and rated as 'red' for risk.
- The designated mental health bay, used for mental health assessment was isolated from the major's area. However, it was a standard cubicle and we noted ligature points and accessible cabling that could accommodate suicide.
- Security within the ED and timely access to security staff was an ongoing issue of concern for ED managers and staff.

However:

- Incidents were reported, investigated and learned from to improve safety and staff were committed to being open and honest with patients when things went wrong.
- Staff followed hygiene and control of infection good practice.
- Plans were in place to reconfigure space in the ED to improve staff view of cubicles within the major's area and security alarms had been fitted within the minor's area to protect staff.
- The introduction and investment of automated medication dispensing systems within the ED had helped with medicine stock control, accurate dispensing of medicines and also included specific safety features.
- Improved systems to identify children at risk of abuse or exploitation had been put in place and audited by the trust since our last inspection. The ED worked with partner organisations in ongoing work to identify child sexual exploitation.
- The RCEM recommended maximum time to initial assessment of patients arriving by ambulance should be within 20 minutes of arrival or handover by ambulance crew. Sandwell Hospital ED time to initial assessment was on average 17 minutes in January 2017 and 16 minutes in February 2017.
- The ED operated a triage and a streaming system. There was an external GP service on site and all walk in patients went there first for streaming. Patients arriving by emergency ambulance were taken straight to the major's area where there was a resuscitation bay and ambulance triage area. Staff could monitor patient's progress through the ED streams from a real time electronic tracking and flagging system, paediatric patients went onto a separate screen waiting list.
- There was a system in place during busy times to manage safely corridor queued patients.
- The minor's triage system was nurse led by emergency nurse practitioners (ENP) and was also referred to as the 'fast track'.
- Matron used handover and safety briefings, spot checks and feedback to individual staff to focus on specific monthly topics in order to improve safety and quality.
- The ED used an acuity tool to establish the staffing levels of nurses within the major's stream of the ED.
- The trust was actively recruiting consultants for the ED.

- A paediatrics emergency medicine consultant (PEM) took up post with the trust in January 2017 and they worked across the trust's two ED sites at four days a week.

Incidents

- Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between February 2016 and January 2017, the trust reported no incidents, which were classified as never events for urgent and emergency care (source: Strategic Executive Information System (STEIS).
- In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England, between February 2016 and January 2017. For Sandwell General Hospital ED these were two falls, two diagnostic incidents and one instance of sub-optimal care of a deteriorating patient (STEIS).
- As a result of the investigations into the incidents of patients, falling while in the ED the trust was reviewing and improving the falls assessment tool at the time of our inspection.
- We noted incidents reports information on notice boards in the ED together with the top level account of outcomes and learning including, for example the incident report on falls assessment and learning outcomes about related documentation. Nursing and health care assistant staff we spoke with were able to talk to us about this. There was a named ED nurse for overseeing the reported incidents and feeding back outcomes to the staff team.
- The emergency medicine speciality report to the Board for January 2017 identified, 'at Sandwell there were 184 incidents reported in January, down by seven on the previous month, the most common cause group for Sandwell being 'admission' related with 62 incidents reported (32.98%) which was mainly made up of patients waiting over eight hours. In December, there were 63 admission related incidents reported. 29 incidents (15.76%) were related to 'verbal abuse/ aggression', down from 34 on the previous month and 27 (14.67%) related to 'pressure sores'. Pressure sores have not previously been reported in the top five groups. There has been a significant improvement in the number of incidents in web holding with the number unprocessed at 50 from 229'.
- The trust had a policy and procedures in place to exercise the duty of candour requirement. Sandwell Hospital ED staff we spoke with did not recognise this term or know about the trust's duty to inform and communicate if significant harm had occurred to a patient in its care. However, they spoke about their duty to be open and honest when things go wrong for patients. One Sister gave us an example of an inadvertent over-dose of medication that was investigated after the patient was informed of the error and given a written apology.

Cleanliness, infection control and hygiene

- All areas of the ED were visibly clean and well organised with no accumulated clutter. We found the same when we returned for an unannounced visit. We spoke with a member of the housekeeping staff who showed us the cleaning schedules including periodic duties for the department. There were cleaners allocated to all shifts seven days a week.
- However, the VDU screens on the nurses/doctors station, used by dozens of different staff each day, were dirty from finger contact. Housekeeping staff told us it was nursing and medical staff responsibility to clean this equipment. This issue was raised at our last inspection in 2015.
- All ED cubicles including four paediatric cubicles could be isolated to control infection.
- The ED safety and quality audit dashboard data for February 2017 showed hand hygiene rated as 'amber' at 94% compliance. However, we observed staff cleansing their hands and wearing personal protective clothing, which was changed between patient contacts. Nurses and doctors had their arms bare below the elbow in line with trust policy. Alcohol gel was available in dispensers around the department and reception/waiting area.

Environment and equipment

- There was audio and visual separation of the children's waiting area from the adult section of the ED.
- We noted resuscitation equipment was appropriate for patient's needs including within the paediatric resuscitation bay for children with all sizes of equipment. There was a system in place for daily

checking of this equipment. We saw a sample of check records for January to March 2017 and noted they were complete and signed off by a registered nurse. Notes were made where any equipment was missing or needed to be replaced and these notes were signed off as actioned.
- Staff raised no concerns with us about the availability and quality of equipment.

Medicines

- We found the introduction and investment of automated medication dispensing systems within emergency departments had helped with medicine stock control, accurate dispensing of medicines and also included specific safety features. For example, the system provided electronic calculations for high-risk medicines to help support correct prescribing.
- The ED dashboard data for February 2017 showed audit rated safe storage of drugs was 'red' at 75% compliance. The controlled drugs audit found 98% compliance. Data sent to us by the trust showed medicines management training for the ED at 94% which was 'amber' rated.
- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.

Records

- We looked at the notes of two patients who were in the resuscitation bay at the time of our inspection visit. We found initial and subsequent assessments were completed and observations were completed and recorded.
- We looked at the notes of 11 patients admitted to the emergency assessment unit (EAU) from the ED on the days of our inspection visits in March and April 2017. We found seven were poorly and inadequately completed/ scant and or illegible/with extensive use of three letter acronyms that we could not interpret and/or missing signatures or names of the clerking doctor. Although we found care and treatment subsequently provided to each of these patients during their stay in the EAU was appropriate, this standard of recording risked compromising patient care.
- For two patients out of the 11 sets of notes we looked at in the EAU the clerking doctor had not used the 'Situation, Background, Assessment, Recommendation' handover tool (SBAR) in place when the patient was transferred to the EAU.

Safeguarding

- The trust target for safeguarding training was 95% and this was to be achieved in the reporting year by 1 October 2017. Figures as of 30 August 2017 provided by the trust show the majority of nursing and medical staff trained to level 2 child and adult safeguarding competence. However for safeguarding children at level 3 eighty-four percent of nursing staff expected to undertake this training had done so (five had a future booking) and for medical staff it was fifty percent.
- The ED had systems in place to identify children that may be at risk of abuse or exploitation. For example children and young people at risk of child sexual exploitation (CSE) were indicated with a flag on the electronic patient records system. This was to support risk assessment and referral to the CSE team when the child presented in Sandwell ED.
- The trust's safeguarding specialist nurse conducted a quarterly survey of ED attendance across both hospital sites of children assessed as at risk of child sexual exploitation (CSE) as part of an on-going and developing child sexual exploitation (CSE) health group set up with partners within the local care economy.
- For Sandwell ED for all three months October to December 2016 a trust paediatric liaison nursing service review all children's attendance cards found of the safeguarding children questions were not completed consistently. There was an average of 50% non-compliance with this new system, which showed an increase from previous quarter of 46%. The questions on the paediatric attendance card were: 'Parental responsibility? Y/N; Have you or your child ever been involved with social services? Y/N; Do you have an assigned social worker? Y/N; Contact details'.
- During our inspection visit we heard reception staff checking- in child patients. They asked the accompanying adult for details of the school the child was attending if they were over three years old. Reception staff confirmed to us the paediatric liaison workers checked all paediatric patients' records to identify any regular ED attenders.

- The Sandwell ED had no designated safe room where patients with mental ill health could be cared for and treated while they waited for mental health assessment or admission to a limited availability of specialist beds. Staff told us for very vulnerable and confused patients they used the ambulance triage bay, which had a direct line of sight from the nurses/doctors station.

Mandatory training

- The trust target for mandatory training was 95%. This target was set in October 2016, therefore the trust had until October 2017 to achieve it. The Sandwell Hospital ED dashboard as of August 2017 reported the mandatory training compliance rate at 88.9% against the trust target of 95%.
- We noted staff mandatory training status was kept on display near the staff room. The trust had reviewed its policy and procedure for sepsis and matron confirmed the staff training on the sepsis pathway had improved the 'door to needle' time.
- Compliance rates across the topics were variable. Data sent to us by the trust showed for example, the emergency services department rated as 'amber' for compliance with workplace fire safety training at 86%; patient moving and handling was 'red' at 47% compliance; information governance: access to health records was 97% compliant.
- The bank office managed mandatory training but additional training was accessible on request. Mandatory training included infection prevention & control, fire safety, conflict resolution, health & safety, information governance, basic life support, safeguarding and moving & handling patients and heavy equipment.

Assessing and responding to patient risk

- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust emergency medicine division across both hospital sites met the standard for eight months over the 12-month period between December 2015 and November 2016. Performance against this standard fluctuated around the standard over the period. In November 2016, the median time to treatment was 63 minutes compared to the England average of 59 minutes, slightly above the standard of 60 minutes. We noted the Sandwell Hospital ED dashboard for February 2017 showed 66% compliance with the RCEM recommended maximum time.
- The RCEM recommends time to initial assessment of patients arriving by ambulance should be within 20 minutes of arrival or handover by ambulance crew (which may be up to 15 minutes after they have arrived at the ED) whichever is earlier. For the trust overall the median time from arrival to initial assessment (for emergency ambulance arrivals) was better than the overall England median over the 12 month period between December 2015 and November 2016. In November 2016 the median time to initial assessment trust wide was four minutes compared to the England average of seven minutes. The trust target was less than 15 minutes and the ED metrics showed performance at Sandwell Hospital ED was on average 17 minutes in January 2017 and 16 minutes in February 2017.
- During our inspection visits we looked at three sets of paediatric patient records and noted time to triage from arrival ranged between two and seven minutes.
- We noted Sandwell Hospital ED operated a triage and a streaming system. The streaming system directed patients arriving on foot into minor injuries or illnesses and major injuries or illnesses. There was an external GP service on site and all walk in patients went there first for streaming. Patients arriving by emergency ambulance were taken straight to the major's area where there was a resuscitation bay. There was an ambulance triage area in the major's part of the ED and these patients could be redirected to the minor's area or to the GP service if more appropriate after assessment and triage.
- We observed patients' status within the triage system was tracked on electronic screens that flagged for time targets and processes. All ED staff including reception staff could check patients' position at any time. This meant reception staff could track patients waiting over 15 minutes to be assessed/triaged and those who were directed back to the main waiting area from the major's stream after assessment. Paediatric patients went onto a separate screen waiting list.
- We also noted reception staff were aware of every person who by-passed their desks to sit in the waiting area without checking in. There was a 'chest pain bleep' within reception held by a nurse in the major's area between 10am and 10pm.

Urgent and emergency services

- Matron told us adult major's triage was undertaken by a senior band 5 nurse or band 6 nurse and rarely, a band 7 nurse. We heard conflicting evidence about a rapid assessment and treat (RAT) processes in the ED. We saw it happening during our inspection visit but local leaders told us the trust had put no funding into a RAT and this caused difficulty.
- The minor's triage system was nurse led by emergency nurse practitioners (ENP) with two rooms; one for adult patients and one for children which also doubled up as an adult's bay. This was also referred to as the 'fast track'.
- There was a separate paediatrics unit within the ED; we noted reception staff directed children to it. Two of its four cubicles were monitored. Paediatric nurses who triaged patients between 9.30am and 10pm staffed this. We saw this system at work over the two days of our visit. Staff confirmed after 10pm paediatric trained adult nurses took over this role.
- The trust told us there was one paediatrics trained ED consultant and all consultants were APLS providers as were 'most' middle grade doctors. The paediatrics ED had 5.6 whole time equivalent nurses trained to advance paediatric life support (APLS) competence. These were all band six and higher nurses. All staff held paediatric immediate life support competence (PILS).
- However, staff told us a new recruitment drive of band 6 and band 7 nurses had resulted in a backlog of training need for the APLS. The trust mitigated this situation by offering paediatric triage nurses the abridged paediatric basic life support training (CPLS) course while they awaited places on the APLS course.
- Data sent to us by the trust after our inspection visit showed resuscitation: basic life support training rated as 'red' at 71.43% compliance for the Sandwell Hospital ED staff.
- The adult/general major's area had cubicles with doors (in line with current building standards) including the five monitored cubicles that served as a 'step down' from resuscitation. Visibility of monitored cubicles was on the trust's risk register because of the doors and also as we noted, staff at the nurses/doctors workstation could not see some cubicles at all from that position as the cubicles were situated behind the wall at the back of the station.
- Matron told us a reorganisation of the ED space was planned by the end of April 2017. The trust was installing a new emergency buzzers system in cubicles during our inspection visit and we heard them being tested.
- The designated mental health bay, used for mental health assessment was isolated from the major's area. However, it was a standard cubicle and we noted ligature points and accessible cabling that could accommodate suicide.
- Staff told us the ED was usually very busy and often patients were queued on trolleys along the corridors. We did not see this during the two days of our announced visit or the evening of our unannounced visit so we were not able to observe how this was managed in practice.
- However, we noted from the staffing board there were no identified corridor nurses but there was an identified 'supernumerary' nurse and 'floating' (HCA). We asked a local leader about this; they told us when the ED was fully staffed as it was that afternoon, they allocated a Band 5 nurse to corridor nursing duties or a band 3 HCA. When the department was not fully staffed the band 3 HCA moved between supporting the majors cubicle or ambulance assessment nurse and the corridor patients.
- During the evening of our unannounced visit, when staff told us the day time had been very busy, we observed two patients in the corridor at 7pm who had been assessed and were moved into an ambulance triage cubicle for tests and treatment and out again when ambulances arrived, until they were absorbed by the through flow of the major's stream.
- The service had specific processes in place to quickly identify and manage some deterioration in patients. For example, we saw a sepsis pathway and chest pain pathway in place.
- Documenting national early warning scores (NEWS) was identified as one of the ED matron's 'Focus' topics for February 2017. This meant Matron was using handovers and safety briefings to highlight NEWS and escalation, carried out spot checks and addressed the individual staff members and the issues at the time.
- The sepsis pathway audit had scored only 39% in January 2017 and 48% in February 2017.

Nursing staffing

- The nursing establishment use of acuity tool for the major's area was one qualified nurse to every four

patients and we noted this level of staffing during our visits. Matron told us ED achieved almost 100% compliance with this ratio and agency staff use was 'occasional'.

- However, newly qualified nurses being unable to work as unsupervised bands 5's at the Sandwell ED was on the trust's risk register. This was because they lacked experience for such a challenging environment.
- The ED was staffed by physician associate, band 5 to band 7 nurses- emergency nurse practitioners, paediatrics nurses and adult nurses trained in paediatrics and health care assistants. Local leaders told us they rely on bank staff, as sickness was an issue.
- Two paediatrics trained nurses (RGN) staffed the paediatrics ED between 9.30am and 10pm. A band 6 paediatrics nurse worked in the unit for four to five days each week. The matron had converted a dual qualified band 6 nurse from adults to second paediatrics nurse in the paediatrics unit and this arrangement was due to move into place a few weeks after our visit. The team had four band 5 and two band six nurses with a band seven supervising from the main ED. We noted there were no health care assistants (HCA) on duty; this meant nurses had to undertake all the tasks including dressings and observations. Matron told us they used agency paediatrics nurses 'on occasion' and were planning an arrangement to rotate some nurses within paediatrics services, the ED, the paediatrics assessment unit and the paediatrics ward to increase flexibility across rosters.
- The four cubicle minor's area was staffed by three emergency nurse practitioners (ENP) who covered shifts 10am to 2.30pm and 2.30pm to 10pm. They saw children for minor injuries.

Medical staffing

- In October 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was also lower than the England average.
- Group directors told us consultants in the urgent and emergency care department of the trust worked predominantly at one site except for one team that worked across both sites at Sandwell General Hospital and City Hospital Birmingham. There were named clinical supervisors for trainees and named consultants for a site on call and for presence.
- Consultant cover was from 8am to 10pm with an overlap of shift in the middle of the day and on call. There were two registrars at night which, the matron described as 'very responsive'. However, there was no middle shift to overlap for continuity of care at the weekends. Managers told us at the weekends 12 hour consultant cover was provided in the ED via rosters for six hours by permanent trust consultants and then a six hour shift was covered by locum consultants, "if no one takes the second shift it stays empty". Two new ED consultants were due to take up posts shortly after our inspection.
- A paediatrics emergency medicine consultant (PEM) took up post with the trust in January 2017 and they worked across the two ED sites at four days a week. The consultancy lead told us a further post was going to be funded to provide two more shifts each week across the two sites to have five days a week PEM presence in the trust.
- The consultancy lead for the emergency medicine division told us across both hospital sites there were 24 middle grade doctors working in the trust's ED's.
- Staff told us medical cover was allocated to the paediatric ED at Sandwell Hospital 'as appropriate'; they 'try' to allocate a doctor after 2pm. Advanced paediatric nurse practitioners at band 7 sister level would lead clinically as necessary.
- Matron told us occasionally doctors were moved into the minor's area to support the gaps in the roster currently for ENP's but two posts were in the pipeline.
- We noted 'medical staffing- consultants' was on the department's red/amber risk register and lack of substantive registrar cover overnight was identified as a 'new risk' in the emergency medicine speciality report to Governance for January 2017.
- When we visited the ED unannounced during an evening, we observed the shift handover. We noted it was well attended by all staff and the sister in charge gave the incoming team a comprehensive account of the situation. This was followed by a patient-by-patient board handover at the nurses/doctors workstation between the nurses in charge of the shifts.

Major incident awareness and training

- The ED had a major incident room and we saw there was a rolling rota of training events. The most recent had been for a chemical incident. Storage facilities for major incident equipment had been improved since our last inspection.

Urgent and emergency services

- We noted 'lock-down of Sandwell ED, security of staff' and 'security on escalation' were on the trust's amber/ red risk register identified on the emergency medicine speciality report to Governance for January 2017. Matron told us the ambulance entry door into the ED was a concern, as it could not be secured. A staff member had been attacked by a patient returning to the department this way after being escorted out of the main entrance by security staff. This was identified on the ED risk register as 'red' rated for some months without significant progress on mitigation.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Appropriate proforma were in place for effective clinical assessment and pathways but doctors were not always using them, for example assessment of pain in some adults and children, the situation background assessment recommendation (SBAR) handover tool.
- The trust's overall unplanned re-attendance rate to the ED's across both sites, within seven days was worse than the national standard of 5% and generally worse than the England average.
- The trust's arrangements to trial the rotation of staff between Sandwell Hospital and City Hospital ED site had been unsuccessful and ceased. Relationship between nurses and doctors had made some progress, however more work was needed.
- Staff understanding of deprivation of liberty safeguarding processes was poor.

However:

- The trust had an identified clinical audit lead for the urgent and emergency care department. Sandwell Hospital ED participated in Royal College of Emergency Medicine (RCEM) audits and research network data collection and undertook a plan of local clinical audits.
- Action plans for improvement where necessary following the national and the local audits and these were followed by planned re audits.
- There was a consultant led 'rapid assessment and treatment' (RAT) in place for some periods of the week.
- The trust developed nursing staff to acquire skills to carry out some clinical procedures and emergency nurse practitioners led the minor's injuries and illnesses stream.
- A practice development nurse supported a number of newly qualified nurses that had been allocated to the ED.
- Staff had access to up to the minute information about patient's progress through the ED and their treatment plans.
- Staff had a clear understanding about mental capacity and consent to treatment at every stage of medical intervention.

Evidence-based care and treatment

- Policies were based on NICE and Royal College guidelines and tools were in place to follow these pathways. For example, there was a sepsis six pathway embedded, the neutropenic pathway displayed on the wall for staff to refer to and a stroke pathway was in place and a protocol document readily accessible for staff to use.
- The Sandwell Hospital ED dashboard showed the number of neutropenic sepsis patients for February 2017 was 16 and this represented an increase of 34% from January 2017. Neutropenic sepsis is a systemic infection that occurs in the setting of decreased blood neutrophils.
- However, we looked at the records of six patients admitted to the emergency assessment unit (EAU) from the ED during 29 and 30 March 2017. We noted the ED clerking doctor had not completed the situation background assessment recommendation (SBAR) handover tool in place for two patients; there was no formal assessment (quantitative) of pain despite the numerical algorithm printed on the ED clerking proforma for one patient or use of/documentation of important negative symptoms and no discharge plan for another patient who was subsequently re admitted after collapse 12 hours later and referred to the stroke registrar
- Local leaders told us Sandwell Hospital ED saw a high number of stroke patients presenting. The resuscitation service had a designated stroke team called to the ED through alerts. This received priority use of the hospital CT scan. They said this pathway worked well.

- The emergency medicine department had a dashboard of quality and safety indicator data from local audit. We saw Matron displayed the results for the Sandwell Hospital ED on a board outside her office to inform and involve staff and patients. The matron also identified on a display, a number of 'focus' themes for the month where improvement was needed. For example for February 2017 they were: documenting, (national early warning) NEWS scores; repeating observations; SBAR documentation; pain score and clean and tidy.

Pain relief

- We looked at three sets of notes for paediatric patients and noted two had pain scores recorded and the third did not.
- The Faculty of Pain Medicine's Core Standards for Pain Management (2015) requires all in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs.
- We noted the service had a numerical algorithm printed on the ED clerking proforma. However, we found from a sample of records of six patients admitted to the EAU that no formal (quantitative) assessment of pain was recorded for a patient who presented with chest pain, although pain relief was first administered within 15 minutes.
- We noted the trust's 'new pain management protocol' on display for staff to consult in the major's area. Pain score was one of 'Focus' topics posted on the matrons board for February 2017.

Nutrition and hydration

- We observed food, drink by way of confectionery; crisps, juices, and water were available for patients and relatives who were waiting within the ED. The two patients and their relatives we saw waiting in the corridor on trolleys when we visited unannounced confirmed staff had offered them food and drink.

Patient outcomes

- The trust had an identified clinical audit lead for the urgent and emergency care department. Sandwell General Hospital ED participated in Royal College of Emergency Medicine (RCEM) audits and undertook a plan of local clinical audits. The clinical audit lead undertook baseline audits of the service from the national audit results, developed action plans for improvement where necessary following the national and the local audits and we noted these were followed by planned re audits.
- Sandwell Hospital ED submitted data to the trauma audit and research network (TARN) for 2015 and 2016. Reports were produced every three months with process and outcome measures for Sandwell Hospital compared against the database.
- For example, for paediatrics emergency medicine, in the 2015/16 RCEM audit for vital signs in children, Sandwell Hospital was in the upper quartile compared to other trusts for three of the six measures and was in the lower quartile for one of the six measures. The measures that performed in the lower quartile were:
- Measure (1) (b): All children attending the emergency department with a medical illness should have a set of vital signs consisting of capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. Data sent to us by the trust showed the emergency medicine audit lead had put in place an action plan for improving performance against this measure and planned a re-audit in April 2017.
- In the 2014/15 RCEM audit for initial management of the fitting child, Sandwell General Hospital was in the upper quartile compared to other hospitals for one of the five measures (eye witness history recorded, 100%) and was in the lower quartile for one of the six measures although the hospital scored 98% for the measure (presumed aetiology recorded). Sandwell Hospital met the fundamental standard of checking and documenting blood glucose of all patients actively fitting on arrival in the ED.
- However, during our inspection visit we found from talking to staff in the paediatrics area there was poor dissemination of RCEM clinical audit findings. For example, staff were unaware of the RCEM fitting child audit result and unaware of the observations audit and for example, body mass index (BMI) recording had not improved.
- In the 2015/16 Procedural Sedation in Adults audit, Sandwell Hospital was in the lower quartile compared to other hospitals for four of the seven measures. The remaining two measures were between the upper and lower quartiles.
- Data sent to us by the trust showed the audit lead undertook a national audit baseline assessment in June 2016 where poor recording and lack of use/awareness of

an available proforma was identified as an explanation of the level of compliance. A national audit (response) action plan was put in place and the trust undertook an update audit in February 2017 where it found, 'the action was completed and a revised procedural proforma was put in place with ongoing education to relevant staff. Consent has been added as part of the proforma, with verbal advice given at present, although this will soon to be in the form of a post-sedation leaflet/card. Full compliance has continued' and are audit scheduled for April 2017.

- We noted a chest pain triage tool proforma in clipboards near the nurse's station where staff could easily access them.
- The trust submitted RCEM consultant sign-off audit data for 2016 in January 2017 for standards for consultant sign-off, standards for asthma and standards for severe sepsis and septic shock, the reports were due in May 2017.
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the Sandwell Hospital rated as mixed but predominately favourable for measures compared to other hospitals. We noted from the trust had ongoing actions to meet the NHS England target of 100% of patients who are recognised as having sepsis will receive the sepsis 6 within 1 hour. These included a well-embedded bleep system, which had improved outcomes for the prescription of anti-biotics within an hour. We noted the 'sepsis trolley' set up and readily available to staff in the ED.
- Dashboard data on display in the ED however showed for February 2017 Sandwell Hospital had scored only 48% in the trust's sepsis audit although this represented an improvement from January 2017 when it scored 39%. We found when we looked at records of a sample of six patients admitted to the emergency assessment unit (EAU) from the ED during the 48 hours of our announced visit; the ED had overlooked one possible septic patient. They were discharged after they had first presented, returned the next day after a collapse and became a medical admission.
- Trust local clinical audits included a pain audit undertaken across the emergency medicine department. This showed Sandwell Hospital ED at 91% (amber against the trust target) for February 2017.
- A health care records local audit begun in May 2015 and due to report to the Board in March 2017 showed Sandwell Hospital ED at 93% amber rated for February 2017. The ED safety matrix showed 64% for children and 85% for adult patients' compliance with documentation, which was 'red', rated.
- Data sent to us by the trust reported for 2016/17, 72% of patients presenting with fractured neck of femur were operated on within 36 hours which is the national standard set of which 93% were operated on at Sandwell Hospital.
- We noted on the days of our visits there was a 'rapid assessment and treatment' (RAT) process in place which was consultant led. Consultants told us this was used effectively allowing patients to leave the ED quickly.
- However, data showed between December 2015 and November 2016, the trust's overall unplanned re-attendance rate to the ED's across both sites within seven days was worse than the national standard of 5% and generally worse than the England average. In the latest period, trust performance was 8.2% compared to an England average of 7.8%. Rates were stable throughout the year and showed no overall trend of worsening or improvement.
- The ED dashboard data for February 2017 showed against a target of less than 5% the unplanned re-attendance rate was 7.55%.

Competent staff

- The ED held monthly team meetings and early morning meetings that covered both shifts. We saw working material from training sessions in the staff room. A new starter told us they had received training and induction.
- We saw evidence of good teamwork within the minors, majors, and paediatrics areas of the ED and between the streams. The trust had introduced the role of physician associate to provide some of the technical skill that falls in-between the role of nurse and doctor and emergency nurse practitioners to lead the minor injuries and illnesses stream.
- The sickness absence rate for the Sandwell Hospital ED reported in the dashboard for February 2017 was 4.52%. This was higher than the national good practice target of 3%. Annual appraisal compliance for the year as of February 2017 was 85.33% against a trust target of 95%.
- We noted information on revalidation was displayed on the wall in the ED staff room.

Multidisciplinary working

- Staff in paediatrics ED told us there was room for improvement in the relationship between the ED and the paediatrics ward as neither fully understood each other's systems.
- Departmental leaders told us they had "done a lot of work" on relationship between nurses and doctors since our last inspection for example holding open meetings. However, the arrangements to rotate staff between the two ED sites had been unsuccessful and had ceased. Local leaders said the relationship had improved but some specific personality dominance remained. Health care assistants told us other staff were supportive and helpful.
- ED consultants told us the stroke pathway worked effectively with a timely response from speciality consultants.
- There was a GP service on site within the ED as part of the triage arrangements to take some pressure off the ED services and to avoid admissions where possible. Staff told us however that in some circumstances this could lead to patients length of stay in the ED being increased with patients 'being pushed from pillar to post' around the ED areas, for example if GP's sent patients to the minors area for 'observations' to be done.
- Patients were admitted to an emergency assessment unit (EAU) from the ED and by the GPs where they could be assessed before being discharged or transferred to an inpatient ward.

Seven-day services

- The ED at Sandwell Hospital was open 24 hours each day for seven days a week throughout the year. The paediatrics ED area was staffed by paediatrics nurses between 9.30am and 10pm each day. Outside of those times paediatric trained nurses in the major's ED team on duty attended to children with support from staff on the paediatrics ward if necessary.

Access to information

- There were electronic and paper systems in place to gather and record information about patients' condition and status in relation to tests, results, risk assessments and plan of care and treatment throughout the ED processes. These included clinical handover checklists for nurses receiving a patient from the ED and a doctors clerking proforma.
- Staff had access to patient's test results, protocols and recommended treatment pathways and the trusts policies and procedures through the electronic system.
- However, we found from a sample of six adult patient paper records we looked at clerked from the ED into a different part of the hospital; four did not have full assessment and treatment/test details completed.
- ED consultants expressed concern about delays accessing radiology reports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found some contradictory evidence about deprivation of liberty safeguarding (DoLs). Senior nursing staff in the ED we spoke with had a good understanding of the concept of deprivation of liberty but did not recognise the term deprivation of liberty safeguarding as a process under the Mental Capacity Act (MCA). They said they did not do it but had heard other staff saying 'we need to make a DoLS application'.
- However, local leaders told us the ED did not make DoLS applications as patients were in the department for only a short time and the ward staff would deal with applications when they were admitted, 'we work with the MCA and capacity and staff are aware of that more than DoLS'. ED staff should be aware of deprivation of liberty safeguards and how to make an urgent application for one. We noted the trust's DoLs 'sweep' audit document for January to March 2017 did not include either of the emergency departments.
- All staff we spoke with were clear about the policy of consent and non-restraint of patients, understood 'mental capacity' and said they worked with security staff and a process of one to one support for confused or mentally agitated patients that challenged the service.
- Specifically including consent on the revised proforma was one aspect of the trust's response to improve procedural sedation in adults required because of the RCEM audit 2014/15 outcome. The trust had put in place an action plan and a local re audit was scheduled for April 2017.

Urgent and emergency services

Are urgent and emergency services caring?

Good

We rated caring as good because:

- All of the patients and relatives we spoke with made very positive comments about the care they received and the staff who treated them.
- We noted ED staff were attentive to patients and relatives including those they were not directly treating at the time.
- Staff gave patients information about their condition and involved them and their relatives/carers/parents in treatment plans and options.
- The ED benefitted from emotional support services available within the hospital including bereavement and Chaplaincy services.

However:

- The trust's ED Friends and Family Test (FFT) across both sites performance (percentage recommended) was generally worse than the England average between January 2016 and December 2016. In the latest period, December 2016 overall ED trust performance was 79% compared to an England average of 86%.

Compassionate care

- Between January 2016 and December 2016 the trust's urgent and emergency care department Friends and Family Test (FFT), across both sites, performance (percentage recommended) was generally worse than the England average. In the latest period, December 2016 trust performance was 79% compared to an England average of 86%. Two dips in performance at the trust were seen in February/March 2016 and October 2016, where performance fell to 73%.
- During our inspection visit, for Sandwell Hospital ED dashboard data on display outside Matron's office, there was no score for the FFT for February 2017 as data was awaited.
- All of the patients and relatives we spoke with made very positive comments about the care they received and the staff who treated them.
- We noted ED staff were attentive to patients and relatives. This included those they were not directly treating at the time. For example, we saw a doctor approach a relative they passed in a corridor that seemed unsure of where to go and a receptionist went to fetch a beaker for a patient who asked for a drink of water.

Understanding and involvement of patients and those close to them

- Parents of paediatric patients we spoke with told us staff were helpful and pleasant and they had been involved in discussion about the care and treatment plan for their child.
- Adult patients and their relatives we spoke with said they had clear information about the plan for treatment and staff had been involved them in discussions about it.

Emotional support

- The ED benefitted from emotional support services provided by the wider hospital including bereavement and Chaplaincy services.

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

Requires improvement

We rated responsive as requires improvement because:

- During 2016 to 2017, Sandwell Hospital ED performance was 83.3% for patients admitted, transferred, or discharged within four hours of arrival in the ED. The Department of Health's standard is 95%.
- During 2016 the monthly percentage, across both ED sites, of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. However the trend was a decline; in January 2016, 1% of patients waited more than four hours for admission whereas by December 2016 10% waited more than 4 hours.
- When the ED was very busy patients in the major injuries and illnesses stream had to queue on trolleys in the corridor in between triage, assessment, tests and treatment.

Urgent and emergency services

- During 2016, there was overall upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Sandwell Hospital. In December 2016, 51% of ambulance journeys had turnaround times over 30 minutes.
- Sandwell Hospital's monthly median percentage of patients leaving the ED before being seen for treatment showed a rise for January and February 2017 from its performance through 2016.

However

- Sandwell Hospital recently opened a 32-bed emergency assessment unit for medical and surgical emergencies, as well as GP referrals.
- There was separate area for paediatric patients with a small waiting area and a play area.
- There was a patient 'flow' management system through the department when it was busy and patients were moved into cubicles for assessment, tests and treatment.
- During 2016, the urgent and emergency care service trust wide met the RCEM standard of patients being treated within one hour of arriving, for eight months over the 12-month period.
- During 2016, across both ED sites, the trust's monthly average total time in ED for all patients was consistently lower than the England average and this was a stable trend. In November 2016, an average total time in the ED was 145 minutes per patient at the trust compared to an England average of 151.
- There was an independent domestic violence advisor office within the ED. Language line was available for staff to use with patients whose first language was not English. Staff support and guidance was available from the learning disability liaison nurse.
- Sandwell ED managers followed the trust's procedure when they received complaints and investigated, responded to complainants in a timely way and made changes because of complaints and concerns.

Service planning and delivery to meet the needs of local people

- Sandwell Hospital ED had 80,268 attendances between 31 January 2016 and 22 January 2017. Of the total attendances between March 2015 and April 2016, 21.4% of patients were under 16 years of age. The percentage of ED attendances at this trust across both sites that resulted in an admission was lower than the England average in both 2014/15 and 2015/16.
- Sandwell Hospital ED had a minor injury and illness area with four cubicles including a paediatric bay. There was a paediatrics suite with four cubicles; a major injuries/ trauma and illnesses area with 15 cubicles and a resuscitation bay with four cubicles including a paediatric cubicle; a relative's room and a viewing room. There was an ophthalmology room for assessing and treating eye injury. A GP service worked within the ED.
- Sandwell Hospital recently opened a 32-bed emergency assessment unit for medical and surgical emergencies, as well as GP referrals. There are also coronary (heart) care and catheter lab facilities (using blood vessels to get to obstructions like blood clots). All emergency services are fully supported by other areas, including scans (MRI, X-ray and ultrasound) and pathology (the study and diagnosis of diseases).
- Sandwell Hospital ED is a trauma unit but not a trauma centre. The trust's main paediatrics services were at Sandwell Hospital. Other specialities such as urology and ENT and gynaecology were provided at the other site at City Hospital.
- The trust told us Sandwell Hospital ED saw a higher proportion of patients over the age of 75 than the trust's other ED at City Hospital, many of whom were admitted to wards.

Meeting people's individual needs

- We noted limited access to mental health beds was on the trust's risk register. The 'quiet room' in the ED was not set up to treat patients with mental ill health but served as a private place to undertake mental health assessment.
- There was an independent domestic violence advisor office within the ED. A telephone translator service was available for staff to use with patients who first language was not English.
- The trust had a chaperone policy. This policy set out guidance for the use of chaperones and procedures for clinical consultations, clinical examinations, investigations and clinical interventions, particularly in relation to intimate procedures.

- The ED general reception and waiting area had a range of up to date notices about support services within Sandwell and Birmingham including for domestic violence, counselling, bereavement and substance abuse.
- We did not observe any patients with learning disabilities or with dementia being treated or cared for during the times we visited the Sandwell Hospital ED. We did note reception staff supporting a patient with learning disabilities and their care worker to use the ED triage system in a way that best suited their needs. We also noted a poster in the main reception area reminding staff support and guidance from the learning disability liaison nurse was available.
- Staff told us there was a process in place they called 'specialing' (one to one support/supervision from a health care assistant) patients who had confusion or found the environment distressing. We saw no evidence of particular pathways of support for patients with dementia through the ED.
- We noted there was separate area for paediatric patients with a small waiting area and a play area. However, it could accommodate only a maximum of ten patients at a time.
- Within the ED leaflets about a range of conditions and illnesses were conspicuously on display and available for patients and relatives to take home.
- There was no information on display for patients about waiting times. We saw from governance meeting minutes ED leaders had raised this for exploration and future action.

Access and flow

- We found there was a 'flow' management system through the department when it was busy. However, Matron told us the system was working well at that time because they had sufficient nursing staff to monitor patients in corridor queues.
- When we visited on 29 and 30 March 2017, we found no patients queuing on corridors in trolleys, although there was a line of trolleys ready and waiting along a wall. When we visited unannounced on the evening of 13 April 2017 (the beginning of the long Easter public holidays weekend) we found two patients on trolleys in the corridor, both had been assessed in a cubicle and then moved to the corridor. One patient told us they had been in the department for an hour; they confirmed staff had checked on them periodically. There were three empty cubicles waiting to be cleaned. One patient was moved on into a cubicle within a few minutes of the time we arrived and the other was moved into an ambulance assessment cubicle when it became free after 20 minutes of the time we arrived. We did not observe the ED respond to its heaviest of pressure therefore.
- However staff confirmed the afternoon had been "rammed" with patients and on escalation level red alert. Some patients had waited for over an hour in the corridor as there had been no beds available in the hospital to admit them to. Staff said the longest wait that day had been five hours but they had been told nine beds were freeing soon and two had become free since that update. We heard at shift handover there were 31 patients in the department at that time and free beds had just been confirmed.
- We found during the two days of our visit the minor injuries and illnesses stream was busy but efficiently running as a self-contained unit and the paediatrics suite was steadily busy.
- The RCEM recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The urgent and emergency care service trust wide met the standard for eight months over the 12-month period between December 2015 and November 2016. Performance against this standard fluctuated around the standard over the period. In November 2016, the median time to treatment was 63 minutes compared to the England average of 59 minutes, slightly above the standard of 60 minutes. Sandwell Hospital ED dashboard data for February 2017 showed only 12% of patients were treated within one hour.
- During our inspection visit, we found from the notes of a sample of six adult patients admitted to the medical assessment unit (MAU) from the ED during that week each was seen in the ED by a doctor within a range of 30 minutes to two hours.
- From a sample of three sets of paediatric patient records we noted time from arrival to being seen by a doctor ranged between nine and fifty minutes. The patient seen after nine minutes was seen by an emergency nurse practitioner (ENP) and discharged.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust breached the standard each

month between January 2016 and December 2016. Performance against this metric showed a trend of decline, falling from 91% in January to 82% in December 2016, performance was also worse than the England average from July 2016 onwards. Sandwell Hospital ED had a rate of 83.3% from 31 January 2016 to 22 January 2017.

- Between January 2016 and December 2016 the trust level monthly percentage across both sites of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. Performance against this metric showed a trend of decline; in January 2016, 1% of patients waited more than four hours for admission whereas 10% waited more than 4 hours in December 2016.
- Over the 12 months between January 2016 and December 2016 trust wide, one patient (in October 2016) waited more than 12 hours from the decision to admit until being admitted.
- Between December 2015 and November 2016 across both sites, the trusts' monthly median total time in ED for all patients was consistently lower than the England average. Performance against this metric showed a stable trend. In November 2016, median total time in the ED was 145 minutes per patient at the trust compared to an England average of 151.
- The minor injury and illness area had four cubicles including a paediatric bay, it saw paediatrics minor injuries only and paediatrics illness was seen in the paediatrics ED suite which had four cubicles each of which accommodated isolation. There was a small waiting area and a play area in the paediatrics suite.
- Between December 2015 and November 2016, the trusts' monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was similar to the England average. During the period performance fluctuated in line with the England average (around 3.5%). Sandwell Hospitals ED dashboard showed for February 2017 their rate was 5.1% representing an increase from January 2017 which was 4.4%.
- Between January 2016 and December 2016 there was an overall upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Sandwell Hospital. In December 2016, 51% of ambulance journeys had turnaround times over 30 minutes (National Ambulance Information Group). The ED dashboard showed the average time for January 2017 was 31 minutes and for February 2017, it was 30.2 minutes.

Learning from complaints and concerns

- The trust had a complaints procedure and local leaders confirmed the target response time for a complaint was 28 days. There was a quick link on the trust's electronic system for managers to access their complaints and progress through the investigations procedures. We looked at the Sandwell ED complaint records for January 2017 and noted the ED recorded three complaints.
- The Sandwell Hospital ED dashboard for February 2017 showed four PALS queries and seven complaints had been received about the services. We saw the complaint procedure had been followed for each and the trust made changes to improve practice where appropriate. For example, one complaint was from parents of a child about the ED not dispensing medication on prescription when no local chemists were open. We noted the outcome letter was written by Matron and signed off by the executive board including the Chief Executive Officer and sent As result of the complaint the ED displayed information on local pharmacists and their opening rotation out of usual shop hours.
- Data sent to us by the trust showed from January to December 2016 there were 71 complaints made about emergency services at Sandwell Hospital. One complaint was graded as 'significant, level 4' and this was about 'all aspects of clinical treatment. The investigation report was being produced at draft stage at the time of our inspection. The trust rated seventeen complaints as 'high, level 3' and eleven of these were categorised 'failure/delay in diagnosis'.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Some staff told us the executive leadership was not visible in the ED despite during 2016-17 four challenge weeks took place, led by the Medical Director, Chief

Nurse and COO and the organisations values were not readily known by staff we spoke with. Local leaders told us the high reliance on bank nursing staff in the ED was partly due to very slow disciplinary procedures and ineffective support from Human Resources within the trust.

- Further actions identified by senior trust managers to mitigate the increasing risk of overcrowding in the ED, did not address the problem as a hospital wide systems issue and the ED leaders were left to manage it.
- Divisional managers not effectively addressing the professional cultural issues among the staff team and had not resolved the personal safety issues escalated by the matron.
- The poor quality of many doctors' notes and clerking had not been identified by local or divisional ED leaders and was not placed on the risk register.

However:

- Local leadership of the Sandwell Hospital ED was strong. The matron and lead ED consultant led progressive change and improvement as far as their roles allowed and under very challenging circumstances.
- Staff were engaged in improving the performance of the department by focussed attention on key messages and individual support to achieve the standard, sharing key data about safety and quality on a monthly basis and local leaders demonstrated a strong element of transparency in the service.
- The trust set out the vision for the new Midland and Metropolitan Hospital emergency department in its operational policy.
- The ED leadership reported on its activity and performance through the governance arrangements of the trust to the executive through a series of monthly meetings. These report included risks, complaints, incidents, patient experience, TTR's, dashboard and audits and quality initiatives.
- The trust had recently allocated some protected management hours each week for quality assurance tasks such as audit. After April 2017, a full time rotation for a band 7 nurse was being put into effect to do this.
- The emergency medicine division was working towards cross-site working for consultants and rotation for other staff to achieve consistency of quality and development.

Leadership of service

- The emergency medicine department was overseen trust wide by a general manager and a consultancy lead. The Sandwell Hospital ED was led by a matron and a lead ED consultant.
- Local leadership of the Sandwell Hospital ED was strong. The matron and lead ED consultant led progressive change and improvement as far as their roles allowed and under very challenging circumstances.
- Local leaders proactively engaged staff in improving the performance of the department. For example key data was displayed monthly about safety and quality performance and mandatory training. A 'focus' key message was identified for areas that needed to improve and matron provided briefings at handover, spot checks and individual support to achieve the competence.
- Some staff told us the executive leadership was not visible in the ED and the organisations values were not readily known by staff we spoke with. Local leaders told us the high reliance on bank nursing staff in the ED was partly due to very slow disciplinary procedures and ineffective support from Human Resources within the trust.

Vision and strategy for this service

- Staff we spoke with had mixed feelings about the new hospital. They were optimistic but anxious.
- The trust set out the vision for the new Midland and Metropolitan Hospital emergency department in its operational policy; 'The model of care will provide major emergency assessment and treatment services and local urgent care services for adults and children in Sandwell and West Birmingham who are self-referred and may arrive by ambulance or other means. The local urgent care service will accept self-referrals, urgent GP referrals including out of hours, some non-blue-light ambulance referrals, and other primary care referrals. Emergency GP referrals will also present to the Adult and Paediatric Assessment Units. It will meet the majority of the local population's emergency and urgent care needs, including Ophthalmology emergency assessment and treatment.'

Governance, risk management and quality measurement

- The ED leadership reported on its activity and performance through the governance arrangements of the trust to the executive. For example, quarterly reports were submitted to the patient safety committee through the deteriorating patient and resuscitation committee.
- There was a regular schedule of two monthly ED meetings attended by the matron and lead ED consultant, a governance meeting that looked at incidents, the dashboard and complaints and an emergency medicine operational meeting. For example, we saw the emergency medicine speciality report to Governance January 2017 included red/amber risks, complaints, incidents, patient experience, TTR's, dashboard and audits and quality initiatives.
- We noted the Sandwell Hospital ED had a risk register and local leaders confirmed identified risks were discussed and reviewed each month.
- We noted Matron had reported the incident of two consecutive attacks on one member of staff by the same patient regaining access via the major's area open doors after security had intervened. This was escalated it through the governance pathways including the risk register. However, there was no progress on the security issue identified on the risk register, 'violence and Aggression workshops- a/w (awaiting) actions from security'.
- Local leaders told us ED overcrowding was not identified on the risk register until the matron escalated the 60 patient overcrowding episodes during December 2016/January 2017 to the chief operating officer (COO). We noted from the risk register copy of 30 March 2017 that 'clinical care delays' was identified as a red rated risk, but we saw no date for this entry. The escalation policy and action cards method of step by number process and response was an existing control in place to manage it.
- However, further actions identified to mitigate the risk, to be completed by March 2017, were only the trust's estates department repairing and providing more trolleys. We saw no action identified to address the 10% rise in December 2016 of patients waiting more than four hours for admission to wards or safe discharge home. Data for this performance was not displayed within the ED safety and quality matrix. This suggested the problem of overcrowding in the ED was not owned as a hospital wide systems issue.
- The ED had no ward manager post as all managers were practitioners but the trust had recently allocated some protected hours each week for quality assurances such as audit. Post April 2017 a full time rotation for a band 7 nurse was being put into effect to do this.
- The ED safety and quality matrix reported audit data from nursing record keeping, however we found consistently poor clerking records by ED doctors and the ED leadership nor senior leaders at the trust had identified this.
- The Sandwell Hospital ED dashboard reported the Sandwell Hospital ED not operating to budget for January or February 2017. No monthly finance meeting had taken place in February 2017.

Culture within the service

- The detailed audit and dashboard monthly displays outside the matron's office for staff and public information indicated a strong element of transparency in the service. The 'focus' display of areas that needed to improve communicated an inclusive expectation to staff.
- Staff in all areas of the ED told us their team and sub teams worked well together and were supportive of each other.
- Staff said they felt able to speak up when mistakes were made. Nurses we talked with spoke very highly of the matron. They said they also received good support from the team leader. They commented on professional relationships between medical and nursing staff as ' improving'.

Public engagement

- We saw no examples of public engagement specific to the ED during our inspection of Sandwell Hospital. The trust was undertaking public engagement in general in relation to the provision of the new hospital in 2018.

Staff engagement

- Staff appeared to work well together and support each other. Matron confirmed she had been involved with the design of the ED in the new hospital under construction.
- However, some staff in the minor injuries area of the ED told us they were unhappy about the plans to reconfigure the major's area and put ambulance assessment inside the minor's area. They felt their views were not heard by local leaders.

Urgent and emergency services

Innovation, improvement and sustainability

- The emergency medicine division was working towards cross-site working for consultants and rotation for other staff to achieve consistency of quality and development. One nurse on duty during our inspection visits to the Sandwell Hospital ED told us it was their first shift at Sandwell as they usually worked at City Hospital, they said found Sandwell ED was run differently to City ED. A doctor rotation between the medical assessment units of the two hospitals was due to commence in April 2017. ED local leaders told us they were hopeful this would improve the consistency of doctor leadership style and communication issues at Sandwell Hospital and embed better practice.

Medical care (including older people's care)

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

Information about the service

Sandwell General Hospital has 460 beds of which 217 are medical beds and 18 are haematology beds. The hospital provides medical services from nine wards, which includes two acute medical assessment wards, two general medicine wards, one of which is also elderly care and the other an extra capacity ward. There is a respiratory and gastroenterology ward, a hyper-acute stroke unit, a stroke and neurology rehabilitation ward and a haematology ward, which also housed the day case unit for chemotherapy. The hospital also has an ambulatory care unit, an endoscopy unit and an older persons' assessment unit.

The trust had 53,305 medical spells between November 2015 and October 2016. Sandwell General Hospital saw 40% of the trust's overall medical spells (21,069) of which 65% of admissions were emergency spells.

We visited the hospital in February 2017 for an unannounced inspection and in March 2017 on a short notice announced inspection. During both inspections, we visited all nine wards, the oncology day unit, the endoscopy unit and the ambulatory care unit.

We spoke with 11 patients and relatives, 44 members of staff including members of the senior executive team, three consultants, four junior doctors, 12 senior nurses, 11 junior nurses, eight health care assistants, a physiotherapist, a housekeeper and a ward clerk.

We reviewed 17 patient records and observed board rounds, ward rounds and clinical handovers of patients between shifts. Before and following the inspection, we reviewed information and data about medical services that the trust provided to us.

We carried out an inspection as part of our comprehensive programme in October 2014, where we identified areas that required improvements. The medical care service had an overall rating of requires improvement with safe, responsive and well-led rated as requires improvement, and effective and caring rated as good. There were five actions that the trust 'should do' identified in the October 2014 inspection that related to medical services. These actions were regarding staffing, mandatory training, care plans and documentation, patient awareness and agreement with treatment plans, and medicines management.

Medical care (including older people's care)

Summary of findings

We rated this service as good because:

- There was a good incident reporting culture. Staff understood their role and responsibility in reporting incidents and responded appropriately to signs or allegations of abuse. There was evidence of wide spread learning and initiations to improve safety and processes in place to keep people safe.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes. Most outcomes for people who used services were positive and met expectations. They participated in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Results were used to improve care and treatment and patient outcomes.
- There was a strong and visible person-centred culture and staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. Staff responded compassionately when patients needed help and supported them to meet their basic personal needs when required. They encouraged patients and their relatives to be involved in their care and in making decisions.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. There was a proactive approach to understanding the needs of different groups of people. Reasonable adjustments were made and actions taken to remove barriers when people found it hard to access services.
- Local leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. They actively empowered staff to drive improvement and a culture where the benefit of raising concerns was valued.

However;

- Staffing was an issue in areas with understaffing and inappropriate skill mix resulting in a reliance on bank and agency to reach establishment. There were no systems in place to ensure temporary staff were competent to deliver effective care and treatment.
- It was difficult to release staff from clinical duties, which resulted in the cancellation of staff training. Mandatory training completion was low, including basic life support training and fire warden training.
- Not all staff were compliant with infection control and prevention. There was inconsistent knowledge and understanding of the trust's key infection control policies and a lack of challenge when staff were non-compliant.
- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- There was confusion around the requirements of the Mental Capacity Act (2005) and for Deprivation of Liberty Safeguards (2007). Applications to authorise a deprivation of liberty were not always made appropriately. There were restrictive options used but it was not always documented if these restrictions were consented.
- There was no specific risk register for the medical service; it was incorporated with the emergency care division, which made the risks related to the medical service unclear. Arrangements for risk escalation were not always effective and although the ward risk registers were fed into the group, there did not appear to be any local risks other than staffing on the register. However, staffing was not specific to ward but generic across specialities.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- There were periods of understaffing or inappropriate skill mix. Some wards were reliant on the use of temporary staff to fulfil safe staffing requirements. There were no formal systems for ensuring sufficient competency of temporary staff, and the way in which the hospital used temporary staff did not always ensure that people's safety was protected.
- Staff completion of mandatory training was low for some subjects. There were difficulties releasing staff for training due to staffing levels, which resulted in cancellation of training sessions. Not all staff required to attend fire warden training had attended. There were no practice runs to ensure staff were confident with procedures they needed to take in the event of a fire.
- Staff had inconsistent knowledge and understanding of some of the trust's infection control policies, which resulted in non-compliance. There was a lack of challenge from ward staff when staff were not compliant with infection control procedures.
- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- The trust did not monitor the escalation pathway to assess whether patients were reviewed within the agreed timeframe when their national early warning score increased.
- There were variations in documentation used throughout the medical service, which caused some confusion and inconsistent implementation of the hospital's safety processes.

However:

- Openness and transparency about safety was encouraged and there was a good focus on incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and reported incidents and near misses; and were supported and treated fairly when they raised concerns.
- Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly involved. The hospital investigated incidents, identified actions to improve and relevant staff were involved in the learning process.
- Staff identified and responded appropriately to signs or allegations of abuse and worked effectively with others to implement protection plans.
- Staff recognised and responded appropriately to changes in risks to people who used services. The hospital used the national early warning score (NEWS) to identify patient deterioration and we saw examples of appropriate responses.

Incidents

- There was a good incident reporting culture within the medical division at the hospital. There was evidence of a good track record on safety and of widespread learning from incidents in areas.
- Between February 2016 and January 2017, the trust reported no incidents that were classified as never events for medical care. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the hospital reported 18 serious incidents in medical care, which met the reporting criteria set by NHS England between February 2016 and January 2017. Of these, eight of the incidents were infection control incidents, seven were falls and three were pressure ulcers.
- There was a good focus on incident reporting. The trust encouraged staff to report incidents and staff told us they felt able to do so. Staff at the hospital reported 2,247 incidents in medical care between January 2016 and December 2016. Staff categorised the majority of

the incidents as no harm (46%), 39% as low harm, 4% moderate harm and 0.1% as severe harm or death. There were 317 near misses reported, which equated to 14% of the total reported incidents.

- We reviewed a serious incident report related to the medical group that was in line with the National Patient Safety Agency NHS guidelines. The report included evidence of discussion with the patient's family, identified learning points and an action plan to mitigate the risk of re-occurrence. Actions included wide spread training and awareness, updated policies, and competency checks for the staff member at the centre of the investigation. The report contained reference to a formal apology that the hospital staff gave to the patient's relatives.
- The hospital provided annual root cause analysis training to staff who led on more serious incidents with support from the governance teams.
- Staff we spoke with were aware of the term duty of candour and being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The trust had good processes in place to support staff with duty of candour, which included a lead person, policies and training. Staff we spoke with knew where to access the relevant policy and were able to give examples of where an incident occurred that had triggered the duty of candour.
- There were areas where the medical group missed opportunities to learn from patient deaths. There were no meetings held specifically to focus on mortality and morbidity and there was lack of evidence to suggest all specialities were discussing mortality and morbidity on a regular basis. It was the responsibility of clinicians within specialities to review all deaths within 42 days of the patient's death.
- Staff told us they discussed mortality and morbidity in monthly specialist group meetings and monthly quality and improvement half days. We saw case presentations for some specialities that were informative and detailed however; there was no evidence of discussion in other specialist group meeting minutes we reviewed. We saw some specialties had detailed audits of the number of deaths but saw no evidence of action plans resulting from mortality and morbidity.

Safety thermometer

- The NHS safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurements at the frontline are intended to focus attention on patient harms and their elimination. Data collection takes place one day each month and is submitted within 10 days of a suggested data collection date.
- The medical group used the NHS Safety Thermometer to record the frequency of patient harms at ward level. Senior staff on wards conducted monthly audits on the frequency of avoidable harms to monitor the wards' performance.
- Data from the patient safety thermometer showed that the medical directorate reported 22 new pressure ulcers, 16 falls with harm and 15 new catheter urinary tract infections between January 2016 and January 2017. The rate for all three measures fluctuated during the year.
- Ward managers we spoke with were aware of their ward's performance and displayed either results or ward performance summaries in staff only areas.
- Staff we spoke with were aware of initiatives that the hospital had taken because of the safety thermometer, such as focused care to reduce the number of falls. We asked the trust to provide us with data post-implementation of initiatives, to assess the impact on patient safety. The trust did not have any specific data for monitoring the improvements therefore, we were unable to assess whether the improvements were effective.
- We saw an initiative that staff were using to reduce pressure sores on heels that was not in line with best practice guidelines. Staff told us the initiative was trust wide; however, we did not see staff implementing this initiative in some areas within the medical directorate.
- The medical wards did not display safety information on the wards for people who used services.

Cleanliness, infection control and hygiene

- Wards and departments we visited were visibly clean and tidy and there were appropriate hand washing facilities in corridors, by entrances and by patient beds. Cleaning storerooms were secured with key lock entry and staff stored chemicals subject to Control of Substances Hazardous to Health (COSHH) appropriately.

Medical care (including older people's care)

- The hospital scored better than the England Average for cleanliness in the Patient-Led Assessments of the Care Environment (PLACE) 2016 programme. PLACE are a self-assessment of non-clinical services, which contribute to health delivered in both the NHS and the independent, private healthcare sector in England. Sandwell General Hospital scored 99% for cleanliness with a comparative England average of 98% for large acute trusts.
- On the endoscopy unit, the trust followed Department of Health guidance on decontamination of flexible endoscopes. There were arrangements in place for decontamination of endoscopes, including the separation of dirty and clean endoscopes. The trust had systems to track and record the use of endoscopes and their removal from storage.
- The trust carried out a comprehensive audit programme, which included compliance with the trust's key infection control policies, such as hand hygiene. The audits used a simple rating method so poor performance was easily identified. Some wards displayed audit results in staff only areas so staff could see their performance. However, in February on the unannounced visit, staff told us the extra capacity ward Lyndon 5, did not participate in the audit programme. On our return at the end of March, we noted that Lyndon 5 had new management and had reinstated the audit programme.
- We observed most staff complying with key trust infection control policies and saw staff challenging when visitors did not wash their hands. Most patients we spoke with told us they saw staff cleaning their hands regularly.
- Most wards scored above the trust's target of 95% for hand hygiene in December 2016 and January 2017. Two wards scored 0% in both months, but it was not clear whether the wards did not submit data or whether they failed on the audit.
- There were clear signs on the doors of patients with infections warning people of the infection risk. These signs had clear instructions, including the use of personal protective equipment and hand washing, for both staff and visitors on what they should do when entering and leaving the room. However, the use of these isolation signs varied from ward to ward.
- During our unannounced visit in February, one ward was partially closed due to an infection outbreak. The ward had appropriate systems in place to protect other patients and visitors, and to contain the infection to the two isolation bays. The trust had provided the ward with automatic mobile hand washing basins, which talked people through a systematic method on how to wash their hands effectively.
- There were areas within the medical service where infection control practices needed improvement. We observed some staff members not adhering to key infection control policies, such as hand hygiene, arms bare below the elbow and hair tied back. We observed three staff members on separate wards not complying with arms bare below the elbow. We saw two members of medical staff not washing or gelling their hands upon entering and leaving patient bed areas, one of which also had their long hair untied. We did not see these staff members challenged for their non-compliance.
- There were missed opportunities for improving infection prevention and control at ward level. The trust carried out audits and produced monthly reports on hospital-associated infections and we saw reports from February 2016 to January 2017, which included data on MRSA and Clostridium difficile (C.diff). The hospital reported 21 C.diff infections in this reporting period and we were able to see each ward's performance. However, it was not possible to report on the number of MRSA infections specifically for the medical services at Sandwell General Hospital because the trust only reported these figures at site level.
- As at March 2017, the hospital had not reached their target of completion (95%) for infection control training. The completion rate was 68% across the medical service. The ward with the lowest completion rate was Priory 5 (37%) and ward with the highest completion rate was AMU A (78%).
- Staff were not clear on all of the trust's infection and control policies, they gave differing accounts of trust practice and we saw evidence that refuted what staff had told us. This included the process for cleaning fabric curtains in patient bed areas, processes for mixing disinfectant solutions and the use of green "I am Clean" stickers, which the trust had discontinued two years before our inspection.
- We observed disinfectant solutions appearing to be in use for longer than the trust policy, which was to make fresh in the morning and discard at the end of the shift. Staff recorded when a new solution was made on a log sheet but there was no section on the log for staff to record when it was discarded. We reviewed February

and March 2017 logs and found nine occasions where the solution appeared to be in use for more than 24-hours. We were unable to determine whether the mixture had been in use for too long, or whether staff had not recorded when they had made a fresh solution. The longest timeframe we saw was between 3 and 7 March with a total time of 110 hours and 10 minutes.

- The medical wards had variable results in the MRSA screening audit. Only three wards had screened 100% of eligible patients for December 2016 and January 2017. The endoscopy unit did not screen for MRSA but did screen for tuberculosis. It is recommended that hospitals should perform MRSA screening for specific groups of patients at high risk of acquiring MRSA. This helps to detect patients who may be carrying the organism in order to minimise the risk of the patient acquiring MRSA, and to minimise the risk of transmission to other vulnerable patients.
- Sharps bins were available throughout the medical wards and departments and we observed that most were maintained appropriately. However, on one ward we observed some sharps bins that were more than two thirds full, which meant staff were at risk of a needle stick injury. We also observed one sharps bin with the lid open when it was not in use. This sharps bin was in an area where the public would have access posing a potential risk of injury. We raised this with a member of staff who took immediate action.

Environment and equipment

- Most wards were secure with electronic key fob access and staff were able to monitor people accessing the wards. There was an exception on Newton 5, as the oncology day unit was located at the end of the ward. This meant between the operating hours of the oncology day unit (8am – 5pm), the doors were unlocked. Controlled access was in place outside of these hours for visitors.
- All wards had an appropriate layout to allow single sex accommodation requirements and to allow safe monitoring of patients. Specialist wards had adapted environments to allow for more focused monitoring of acutely ill patients.
- The PLACE 2016 audit scored the hospital at 96% for condition, appearance and maintenance. The national average for large acute trusts in England was 93%, meaning the hospital scored better than the England average in this measure.
- The layout of the endoscopy unit was beneficial for the patient pathway through the unit, separating patients' pre and post-procedure. However, the unit was small and crowded; there were only four admission spaces, which did not allow for single-sex areas and five recovery beds to support three endoscopy rooms.
- All equipment we reviewed had up-to-date safety testing with the exception of one intra-venous machine in the oncology day unit. We notified the nurse in charge who took immediate action. There were stickers fixed to all medical equipment, which showed the hospital had serviced and maintained within the last year.
- There were good processes in place for the checking and replenishing of stock. On most wards we visited, equipment in storerooms was all in date. On one ward, we noted a number of equipment that had expired. Some of the equipment had expired recently (February 2017) and some had been expired for quite some time. We raised this with the nurse in charge who took immediate action.
- Most wards we visited had limited storage and were cluttered. This resulted in some wards not having enough equipment to carry out their roles and having to request equipment from central store, which caused delay and ineffective use of staff and porter time. We saw in places equipment no longer in use was stored alongside serviced equipment and equipment being stored in patient relaxation areas. We also saw some stock rooms with tall drawer cabinets that were hard to reach.
- Wards had adequate resuscitation trolleys, which contained emergency equipment and medication for use in the event of a patient suffering a cardiac arrest. The trolleys were not secure or tamper proof and staff kept them in public accessible areas, which meant there was potential for people to take and tamper with equipment. Some were covered with fabric in an effort to disguise them, however this did not make them secure or tamper proof.
- Checking of resuscitation trolleys was inconsistent across the medical service. Staff had checked and signed the majority of trolleys but there was evidence of occasions when staff had not checked the trolleys for a couple of days. All trolleys we reviewed were fully stocked with in-date equipment; however, we did find some electrocardiogram (ECG) electrodes that were out of date. We escalated this to the nurse in charge who took action immediately.

Medical care (including older people's care)

Medicines

- The trust provided guidance and information to staff in a medicines optimisation policy dated January 2016, which included detailed arrangements for prescribing, requisition, storage, administration and control of medicines. Staff told us they could access the policy on the trust's intranet.
- There was a good focus on reporting medicine errors. Staff reported incidents regarding medication via the trust's electronic reporting system, to the medicine safety officer and chief pharmacist. During January 2017 and March 2017, the trust reported 93 medicine incidents across the medical specialties. Staff reported 64 of those as no harm, 26 as low harm, and three as moderate harm. There was evidence that the service analysed trends and discussed these in relevant meetings. Staff we spoke with gave examples of medicine incidents and explained how senior staff took appropriate action to support staff members who were identified as needing extra help with medicine competencies.
- We saw that staff stored medicines securely. The introduction of a new electronic key system with an integrated audit trail had greatly improved the overall storage and security of medicines across the trust. The system only allowed authorised staff access to the medicine cupboards.
- Staff kept medicine trolleys on all wards secured to the walls and locked when not in use. We observed staff administering medicines for most medical wards and saw staff wore a red apron to highlight that they were busy and should not be disturbed during their round. We did not see the medicine trolleys unattended at any time when in use.
- The pharmacy team supported the medical wards well. The hospital had a regular ward-based clinical pharmacist and technician service, which ensured that a pharmacist reviewed and checked patients' prescribed medicines and checked all medicines were in date. There were arrangements in place for pharmacy to check patients' medicine requirements from the point of admission. For example, taking a detailed medicine history and undertaking medicine reconciliation on admission to hospital.
- Nursing staff we spoke with said pharmacy staff were accessible and told us that the pharmacy service included access to medicines out-of-hours, as well as pharmacist advice if needed when the pharmacy was closed. Staff recorded any known allergies or sensitivities to medicines on patients' prescription charts and communicated any concerns and advice about medicines to the prescribing clinician.
- There were good systems for dispensing and prescribing medicines. The hospital had introduced an automated medicine dispensing system on the acute medical assessment units, which had helped with medicine stock control, accurate dispensing of medicines and included specific safety features. For example, the system provided electronic calculations for high-risk medicines to help support correct prescribing. This machine required fingerprint recognition to access and order medicine stock. The electronic prescribing system meant that medicines could be ordered online direct from pharmacy without the need for the medicine chart to leave the ward. This helped to reduce the amount of missed doses of medicines.
- There were areas where we saw practice was not always safe when storing medicines. Although the hospital had good processes for the checking and storage of controlled drugs (CDs), we saw staff were not consistently applying the process across the medical wards. Controlled drugs (CD) are a group of medicines, which are subject to strict legislative controls due to their potential for abuse and harm.
- Staff were not consistently checking fridge temperatures on a daily basis and we saw variations in documentation staff used for recording daily fridge temperatures. The number of days where the fridge temperature checks were missing varied from ward to ward. We saw documented evidence that staff were following correct procedures when fridge temperatures were out of range but no documented evidence that the escalation had been followed up. We did not see any records to show that staff monitored the temperature of the medical storage rooms on any of the wards we visited.
- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resuscitation Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering. On most wards we visited, resuscitation trolleys were not lockable or tamper proof and staff kept these in public areas. On some wards, staff tried to

mitigate the risk of the trolleys being noticed by the public by covering with a dark cloth, but this did not ensure the contents of the trolleys were protected from tampering.

Records

- Staff mostly stored nursing and medical records securely when not in use. Most of the record trolleys we saw were lockable, but some were not lockable. Staff told us they mitigated the risk of an unauthorised person accessing records, by keeping the record trolley in front of the nurses' station.
- The hospital kept nursing records and medical records in paper format, and some aspects of patient care they kept electronically. They had an Electronic Bed Management System (eBMS), which held information about patients additional to the paper records. The eBMS system included a flagging function where staff could easily see if patients had referrals to different specialities, and whether they had an infection for example. The capacity team, consultants and nurses referred to this system for handovers. The hospital also used an electronic observation system where staff would record patient observations.
- There were areas where record keeping in the medical service required improvements. Staff recorded most risk-assessment documentation within the nursing records for each patient, with the exception of venous thromboembolism (VTE) assessments, which staff recorded on the eBMS system. Staff told us all patients had a VTE assessment on admission to the ward, however; we saw evidence that night staff were not consistently doing this for patients admitted at night.
- We saw patient confidentiality was not always respected. The wards displayed whiteboards containing patients' initial and surnames next to each bay in public accessible areas. The staff used symbols to indicate specific medical conditions for example, a red heart if the patient was waiting for a cardiology assessment or bed. We saw documents that contained confidential information about patients left unattended in public areas and times when record trolleys were left unlocked.
- We reviewed 17 patient records across the medical wards and found staff had generally completed records appropriately. However, we found staff did not consistently sign and date entries. There was a mixture of illegible signatures with no printed name and printed name but no signatures. Staff were not consistently writing their job roles down and medical staff were not consistently recording their general medical council registration number. Where signature sheets were present at the front of patient records, staff were not consistently using them. There were a number of documents present in records that had not been completed, and some that were but had no location of where the documents were completed or the staff member's name and signature.
- We saw fluid charts were not consistently recorded appropriately and was already an issue that the hospital had identified in the December 2016 audit. Results showed three of the eight wards that had completed the fluid balance audit had not reached the trust target of 95%. The lowest performance was on Lyndon 4 with staff completing 75% of fluid charts. There was some improvement in the January audit; however, what we observed reflected the December 2016 audit results.

Safeguarding

- The trust provided safeguarding adults levels 1 and 2, and safeguarding children levels 1 and 2 training. The trust expected staff to complete this training annually. As at 7 March 2017, the staff across the medical department at had surpassed the trust's target of 95% for safeguarding level 1 for both adults and children. Both modules had a completion rate of 97%. The completion rate for safeguarding adults level 2 was 82%, which was below the trust's target. Safeguarding children level 2 was also below the trust's target with a completion rate of 68%.
- All staff we spoke with had a good awareness of safeguarding and knew who to contact if they had safeguarding concerns. The trust had a safeguarding team that worked across both sites. The team consisted of an adult's safeguarding lead, a children's safeguarding lead and a dementia lead. The staff we spoke with were positive about their working relationship with the safeguarding team. They said the team were quick to respond to staff safeguarding enquiries and that the team provided the ward staff with very good support.
- There was evidence of staff reporting verbal and physical abuse through the trust's electronic reporting system. One member of staff told us that they had no

issues with raising a concern when they saw a member of staff move a patient inappropriately. The hospital took appropriate action when the incident was reported.

Mandatory training

- The trust's mandatory training programme contained 28 modules delivered through training days and e-learning. Staff we spoke with thought the training was effective and enabled them to carry out their role.
- Different staff groups had different modules they were expected to complete and the trust's target for completion was 95%. As at 7 March 2017, the hospital had reached its target for compliance for five of the 28 modules. They had a completion rate of above 90% for 11 of the 28 modules.
- There was no specific deadline or cut-off date that the trust expected all staff to complete their mandatory training by. This was because the deadlines were specific to individual staff and dependent on the date they initially took their training.
- Ward sisters were able to see their ward's compliance rate on the clinical dashboard, which displayed results with a simple red and green rating system. There was variation across the service in how staff were able to access their training rates. Some wards printed off a screen shot of the monthly mandatory training list and displayed it in staff only areas to encourage staff to take ownership of their training. On other wards a list of staff names were put on the whiteboard near the nurse's station, which also used a red and green rating for staff to see who was up to date. Staff told us they received a text and email from the trust when they were due to take a training module.
- Mandatory training completion rates for individual training modules had a wide variation. Basic life support (BLS) compliance across the medical core service was low at 56%. None of the medical wards had a completion rate of 95% or above for BLS. The average completion rate across the medical wards was 55%. The ward that scored the lowest rate of completion for BLS was Lyndon 4, a general medicine and elderly care ward, with a rate of 29%.
- Staff told us that their managers cancelled training sessions when wards were busy to prioritise staffing on the ward. Staff said when this had happened; their managers rebooked their training for a different time. A senior nurse on one ward gave us an example where they had to cancel three training sessions in one week due to an outbreak of infection on the ward. The module with the lowest completion rate was fire safety warden training at 25%.

Assessing and responding to patient risk

- The hospital had good processes in place for assessing and responding to patient risk. They used the national early warning score system (NEWS) as a tool to identify deteriorating patients. NEWS scores were calculated automatically when staff input patient vital signs into the electronic observation system, which alerted staff when the next observations were due.
- Nursing staff we spoke with were aware of what they needed to do when a patient had an increased NEWS score. They told us they were able to contact the medical staff, the emergency medical response team, or the critical care outreach team when a patient deteriorated. Staff were complimentary about the time it took for these teams to respond. Patient records we reviewed where a patient had an increased NEWS score, showed evidence of medical staff review. However, the trust did not monitor the escalation pathway and whether patients were reviewed within the agreed timeframe when their NEWS increased.
- The trust were involved in the 'Think Sepsis' campaign. Staff understood the signs of sepsis and the importance of patients with sepsis receiving antibiotics within an hour. We reviewed a set of notes for a patient with sepsis. The notes showed staff had taken the necessary steps and administered antibiotics within an hour of arrival. We did note however, that staff had not filled in the trust's sepsis tool within the patient's record.
- The hospital had previously seen high numbers of falls within the medical services. Staff at the hospital implemented a programme called focused care, to help mitigate the risk of falls for elderly patients. Focused care involved a higher staff to patient ratio for patients identified as requiring focused care. We saw this programme was implemented slightly differently across the wards. For example, some wards had all their patients on focus care in one bay in front of the nurses' station and others had their patients on focus care located in different bays across the ward. Staff also used low beds with crash mats to minimise patient injury. Nurses used this equipment as part of the risk assessment.

- We saw areas within the medical service where there was room for improvement. There was confusion amongst nursing staff and lack of awareness around the functions available on the electronic observation system for patient vital signs, which suggested that some staff did not have sufficient training on the system. Some nurses we spoke with were not aware that the system allowed senior staff to change the parameters for escalation, to consider the health conditions and needs of individual patients.
- Before our inspection, the trust had identified that staff were not completing vital signs observations in a timely manner. In order to monitor this, the trust introduced an observation chart audit into the monthly audit programme. In December 2016, all of the medical wards failed to reach the trust target. The lowest performing wards in December were the OPAU (73%) and AMU A (74%). In January 2017, the observation chart audit showed little improvement with all wards still failing to reach the trust target.
- The trust was using an initiative to reduce the pressure sores on patients' heels; however, the initiative was not based on best practice, which would include the use of heel protectors. Instead, the staff were using blue pillows to raise patients' feet. We did not see this initiative on all wards we visited, which suggested the initiative was not embedded across the trust.

Nursing staffing

- Across the medical service, we saw staff were stretched and although the wards were staffed to establishment, they were having to rely on agency and bank staff to fill in gaps.
- The trust undertook regular acuity reviews using the Safe Staffing Acuity Tool (Shelford Group). The tool enabled nurses to assess patient acuity and dependency and work out a suitable nursing establishment. At this hospital, the senior sisters collated the staffing numbers on a daily basis and reported these figures on a monthly basis to the Chief Nurse so the trust could use the data for their staffing fill rate indicator return.
- On Newton 4 and Lyndon 5, the ward managers conducted a number of meetings throughout the day called Critical Hour Evaluating Staff Support (CHESS). In these meetings, senior sisters would gain feedback from doctors, nurses and health care assistants to find out what was happening in each bay. Dependent on the circumstances, the senior sister would move staff around like a chess game to allocate support where it was most needed.
- At the time of our inspection, Lyndon 4 was trialling a different registered nurse and health care assistant (HCA) ratio, which was to last for four months at which point the ward manager would reassess. The establishment for daytime on this ward was one registered nurse to six patients and at night time one registered nurse to 11 patients. Staff we spoke with on this ward said that the establishment was not enough. The establishment did not include the need for extra staff due to patients on focused care. When there were no focused care patients, staff said the establishment was manageable but when there were, it was not manageable and left staff overstretched.
- The hospital relied on bank and agency staff to meet establishment and safe staffing figures. The hospital provided planned versus actual staffing figures, which showed that wards consistently struggled to fill their establishment. Staff who generally felt there were not enough staff to keep the wards safe echoed this. There were areas within the medical service where wards were block-booking registered nurses and HCAs to work as part of their establishment or as extra staff.
- The hospital had a vacancy rate of 9% as at 1 February for the medical directorate, this equated to 23.5 whole time equivalent staff (WTE). Nursing staff turnover rates from the period of February 2016 to January 2017 was 6% (13.5 WTE), which was within the expected range and met the trust's target of less than 11.7%. Most areas within the medical service saw low turnover rates and met the trust's target, with the exception of Lyndon 5. For the same reporting period, the hospital failed to meet the trust's target (2.5%) for nursing staff sickness with 4.7%. The trust filled vacancy and sickness by block-booking bank and agency staff.
- The hospital provided us with their total bank and agency staff usage from the period of January 2016 to December 2016. Across all of the medical wards, there was a high use of bank and agency. Average bank and agency use rates for the reporting period for the medical wards ranged from the lowest rate of 13.4% (Priory 4) to the highest rate of 73.6% (Lyndon 5). There were wards that were consistently using a very high percentage of agency and bank staff.

- A matron we spoke with told us that since the trust had implemented new directorate leadership, staffing had been the biggest improvement. Prior to December 2016, ward managers requested agency on a weekly basis but this was not always approved. Since December, if bank staff had not filled shifts within two weeks, they automatically went out to agency.
- All wards we visited had a board displaying the ratio of nurses to patients they had on shift, which was located at the entrance of the wards. Some wards had an additional white board with the number of staff they had at that moment in time, however the way in which this was displayed was inconsistent. Some wards had a list of names under nurses and a separate list of HCAs, some wards just had the number of nurses and HCAs that were present. None of the wards displayed the safe staffing posters for the public to see the planned versus actual staffing rates per shift.
- During our unannounced inspection in February 2017, Lyndon 4 appeared very busy. The ward was partially closed due to an infection outbreak, which meant there were two nurses and two HCAs who were working solely on the affected bays. This left one HCA and three nurses for the remaining three bays. When we returned on our announced inspection, the ward was much calmer and patients appeared comfortable. Staff were still busy but not as overstretched as they were on our previous inspection.
- On our unannounced inspection in February 2017, we had concerns about the skill mix on Lyndon 5. Staff told us that often staff were taken from other wards, or positions were filled using agency and bank nurses to provide staffing for this ward. Staff on this ward told us they did not have the time to carry out audits and we saw other areas of concern that suggested the staff were too busy to carry out other required tasks. For example, inconsistent checks on fridge temperatures, resuscitation trolley checks and CD checks. On our return in March, we saw vast improvements on this ward. There had been a newly appointed interim matron for this ward and since the appointment, the establishment of nursing and HCAs had risen with an extra two HCAs specifically for focused care. Staff on this ward told us that they had seen and felt vast improvements to the ward within the previous four weeks.
- The trust risk register stated that there was a risk to safe staffing related to medicine inpatients as staffing levels and the skill mix of staff had fallen below the agreed levels. This identified risk was an on-going issue for the trust and was reviewed on a quarterly basis. Actions taken to mitigate this risk included the review and agreement of bank pay rates for specialist areas, block bookings of agency staff and regular engagement with the nurse bank.
- Nurse handovers were structured and comprehensive. We observed a number of nursing hand-overs from different wards whilst on inspection. Handovers started with an 'all staff' safety brief where the nurse coordinator on duty talked through the patients with the nursing staff and HCAs present. On some wards, this safety brief was done in the ward manager's office and on other wards; it was done huddled around the nursing station.
- Most patients we spoke with thought there were enough staff on duty to care for them. Some patients told us the daytime was not an issue for them but found there were not enough staff working at night time. This meant it took longer for the staff to assist them when needed.

Medical staffing

- The trust covered most medical specialities across two hospital sites and as such reported medical vacancies cross-site. Only some medical specialties the trust provided were site specific. The trust's vacancy rate for medical staff within medical services was 11.4% with 28.3 WTE vacancies as at 1 February 2017. For the period of February 2016 to January 2017, the trust had a turnover rate of 11% for medical staff, which equated to 15.1 WTE staff members leaving. This was just below the trust target of 11.7%.
- For the same period, the trust used an average of 6.6% locum medical staff across the medical service. The month that saw the highest average use of locum medical staff was December 2016 and the ward that used the most locum medical staff was Lyndon 5, where 100% of the medical staff covering this ward from February to December were locum staff.
- The trust had an establishment of 12.5 whole time equivalent consultant posts across the trust's four AMUs. As at 1 February 2017, the trust had four substantive consultants in post, four locum consultants and four vacancies.
- Consultants covered the AMUs from 8am until 7pm. Outside of these times an on-call consultant provided cover. Staff told us that it had been difficult to determine

who the clinical lead was on the AMUs at Sandwell General Hospital, but the hospital had recently appointed a permanent clinical lead on AMU B. Staff said the difficulty remained for AMU A.

- There was good medical cover for the hyper-acute stroke ward (Priory 4) and the transient ischaemic attach clinics seven days a week. The trust employed 3.0 WTE stroke consultants, 8.0 WTE neurology consultants and a stroke specialist registrar. The medical staff covered the stroke wards from 9am until 6pm Monday to Friday, 9am until 6pm on the weekends and on-call out of hours.
- There were no permanently based doctors on the ambulatory care unit. Junior doctors that covered AMU also covered this unit. Staff told us that there had been times when the junior doctors had missed off the unit from their lists in favour of the next patient on AMU. Staff on the unit said that it was down to a misunderstanding of the process and was easily corrected. The unit had support from the on-call general internal medicine specialist registrar Monday to Friday for 24-hours a day.
- The OPAU had consultant cover Monday to Friday but when the consultant was on leave and during weekends, the accident and emergency consultants covered the unit.
- Junior medical staff were based on wards from 8.45am to 4.45pm weekdays with the support of a specialist register and a registered medical officer between 9am and 9.30pm. Junior doctors and advanced nurse practitioners (ANPs) provided cover for all medical wards at night.
- Junior doctors rotas complied with the trainees' contract for 2016 and staff told us the trust had slightly modified their rota from August 2016 to comply with the new contract. Junior doctors told us they were busy and could be stretched, but the workload was manageable and they were very happy working for the trust.
- Medical handovers were structured and comprehensive. We observed a number of ward and board rounds whilst on inspection. Ward rounds generally started at 8am, where the lead consultant and junior doctors reviewed all patients on the ward. A board round commenced directly after where the medical staff, nursing staff and therapy staff attended to discuss each patients' treatment plan. There were discussions of discharge and decision-making incorporated patients' best interest.

Major incident awareness and training

- The trust reviewed and implemented a major incident plan in April 2016 and recently updated the cold weather policy. All staff we spoke with were aware of the plans and knew how to access them. The major incident plan included tasks for staff to undertake in the event of a power cut and a fire.
- Senior ward sisters were responsible for evacuation in the event of a fire. All senior sisters we spoke with were aware of the fire evacuation plan and knew where it was located. The trust provided fire safety warden training and fire response team leader training for the senior sisters.
- Although there were good processes in place, the uptake of training was poor. The hospital required three sisters to complete the fire response team leader training of which only two had completed. Seven senior sisters had to complete the fire safety warden training, but only one had completed. Staff told us that the hospital did not carry out regular procedural run-throughs and that it was covered in the training modules.

Are medical care services effective?

Good

We rated effective as good because:

- The hospital planned and delivered patient care in line with current evidence based guidance. The service monitored the care delivered to ensure consistency of practice and compliance with relevant guidelines. Action plans were in place to address non-compliance and progression had been made.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes. Most outcomes for people who used services were positive and met expectations. They participated in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Results were used to improve care and treatment and patient outcomes.
- Most staff were qualified and had the skills they needed to carry out their roles effectively and in line with best

practice. The learning needs of staff were identified and training was put in place to meet those learning needs. Staff were supported to maintain and further develop their professional skills and experience.
- When patients received care from a range of different staff, teams, or services, this was coordinated. Staff generally worked well together to understand and meet the range and complexity if patients' needs.

However;

- There were no systems in place to ensure temporary staff were competent to deliver effective care and treatment. The hospital relied on the agency to ensure temporary staff were competent to fulfil their role.
- There was confusion around the requirements of the Mental Capacity Act (2005) and for Deprivation of Liberty Safeguards (2007). Applications to authorise a deprivation of liberty were not always made appropriately. There were restrictive options used but it was not always documented if these restrictions were consented.

Evidence-based care and treatment

- The hospital provided staff with information and guidance in the form of policies and procedures. They reviewed these policies and procedures regularly and they were in line with the National Institute of Health and Care Excellence (NICE) guidance. Staff we spoke with were aware of the NICE guidance relevant to their speciality and knew where to access the guidance from the trust.
- The hospital had a local audit programme, which covered a number of medical specialties and there was evidence that the local audits were in-line with national guidance, such as NICE. We saw action plans to address areas of non-compliance with the guidance and saw that there was evidence of progress against these.
- The hospital contributed to national audits including the National Diabetes Inpatient Audit, the National Cancer Patient Experience Survey, the Lung Cancer Audit and the Sentinel Stroke National Audit Programme.
- The hospital had a number of care pathways across the medical service. Staff we spoke with were aware of most of the pathways, in particular the stroke pathway that was specifically relevant for the Sandwell site, as this was where the stroke unit was situated. There were a number of care pathways in place on the ambulatory care unit and the hospital had recently introduced a dementia and delirium pathway.

Pain relief

- The hospital carried out pain audits monthly and all wards with the exception of Lyndon 5, participated. We reviewed pain audit results for December 2016 and January 2017, which showed that most wards at the hospital reached 100%. There was one ward in January that had a score of 0%, but it was unclear if the ward had not participated or they had failed the audit.
- Staff told us that they assessed patient pain regularly when they carried out vital observations. The electronic tool used for observations had a pain score assessment. We observed staff asking patients how their pain was during our visit and observed pain medicine administration when patients required.
- Patients we spoke with told us that staff managed their pain well and that they had adequate pain relief. They told us that staff offered pain relief but at times they had to ask for some.
- The physiotherapists on the stroke wards were trained to administer Botox for pain relief in line with NICE guidelines.

Nutrition and hydration

- The hospital used the nationally recognised screening tool, Malnutrition Universal Screening Tool (MUST), which allowed staff to identify risks and actions to lessen malnutrition in patients. Staff told us that they carried out MUST assessments on patients within the first 12-hours of admission and then on a weekly basis.
- The hospital audited the completion of MUST charts on a monthly basis using 10 randomly selected records pre ward. We reviewed audit results for December 2016 and January 2017, which showed that most wards had completed MUST charts appropriately.
- Most patient records we reviewed showed that staff had carried out nutritional risk assessments and took relevant action. However, there was one set of notes for a patient who had been admitted to hospital with a condition that caused difficulty in swallowing, where staff had not managed nutrition well. The staff filled out MUST that showed a risk of malnutrition but there was no evidence of a referral to a dietitian. There was also a

miscommunication between the SALTs, physiotherapy team and the nursing staff. The patient went for three days before staff made a referral to the SALTs, and went for five days without any nutritional aids.

- Staff completed fluid balance charts are part of a standard daily care record for all patients. From the records we reviewed, it was difficult to determine if staff were consistently completing the charts or if some patients were not taking in enough fluid.
- The hospital audited the completion of fluid balance charts on a monthly basis and wards had identified completion of fluid balance charts were an issue for them. We reviewed audit results from December 2016, which showed that three wards did not reach the trust's target of 95% completion. The January audit showed improvement with seven wards scoring 100%.
- We observed that staff provided jugs of water for each patient on all wards we visited. Patients we spoke with told us that they had adequate drinks and most were pleased with the food choice but the food portions were a little on the small side.
- We saw there was a variety of choice of food options, including vegetarian, halal and gluten free for patients. We observed separate toasters in ward kitchens for gluten free patients.
- Nursing staff on the stroke wards were trained to carry out a basic swallowing assessment and the hospital had a designated speech and language team (SLT) for patients who required a full swallowing assessment.
- The hospital was trialling the removal of protected meal times on wards to allow patients' relatives to come and sit with the patients at meal times. All wards except for the stroke rehabilitation ward (Newton 4) had removed protected meal times. Staff on this ward explained that although they valued relatives being involved with the patients care, they felt meal times were a very important part of the patients' rehabilitation. They were finding that when the protected meal times were taken away, patients were not eating and drinking adequately because they were embarrassed to make a mess in front of their relatives. A number of relatives complained about the state of the patients clothing during meal times and staff felt that patient dignity was at risk. Staff also found that patients' relatives often took over and provided assistance for the patient, which hindered the patients' rehabilitation.
- Protected meal times on this ward maintained patient dignity and helped to progress their rehabilitation, by allowing patients to eat their food by themselves without feeling embarrassed and allowed staff to clean the patients after their meal, before visitors came to see them.
- The Patient Led Assessments of the Care Environment (PLACE) 2016 audit scored Sandwell General Hospital 93% for food, which was better than the England average (89%) for large acute trusts.

Patient outcomes

- Sandwell General Hospital took part in the quarterly Sentinel Stroke National Audit programme (SSNAP) and performed well in most of the measures. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit covering the period between April and July 2016. This grade had not changed since the previous audit (January to March 2016), but it had declined from a B grade achieved in the three previous audits. The worst performing domains on the audit over the period April 2015 to July 2016 was for the speech and language therapy measure and the standards by discharge measure.
- The hospital results in the Heart Failure Audit 2015 were better than the England and Wales average for all standards relating to in-hospital care and discharge. The hospital performed best for the percentage of patients who had input from a specialist and for percentage of patients who were prescribed medicines on discharge.
- The hospital performed better than the England average in 10 metrics of the 2015 National Diabetes Inpatient Audit (NADIA) and worse than the England average in seven metrics. The best performing metric in terms of difference to the England average was the metric "Foot risk assessment during stay". The hospital assessed 71% of patients compared to 34% nationally. The worst performing metric at the site in terms of difference to the England average was meals timing, with 39% of patients reporting good meal timing compared to 62% nationally.
- We reviewed the average length of stay of patients in the medical service from November 2015 to October 2016. The hospital generally had a higher than average length of stay for elective specialties and lower than average for most non-elective specialties. The non-elective speciality that had an average length of stay higher than the England average was stroke medicine at 13.2 days

compared to 11.2 days. Clinical haematology and gastroenterology elective specialties had higher than average lengths of stay at 8.9 days compared to 5.7 days, and 3.8 days compared to 3.3 days respectively.

- The trust did not perform so well in the 2016 Lung Cancer Audit. They performed worse than the minimum standard (80%) for patients seen by a cancer nurse specialist (67.3%). They performed significantly worse than the national level (63.6%) for fit patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy (48.6%) and slightly worse than the England average (38%) for the survival rates at the hospital (36%). The trust did perform better than the level suggested for 2016 for patients with small cell lung cancer (SCLC) receiving chemotherapy.
- Between October 2015 and September 2016, patients at Sandwell General Hospital had a higher than expected risk of readmission for non-elective admissions and a slightly higher than expected risk for elective admissions.
- Risk of readmission for elective gastroenterology was more than double the expected rate, although risk of readmission for the other most common elective specialties (medical oncology and clinical haematology) was slightly lower than the expected level. Risks of readmission were higher than the expected level for all three of the most common non-elective specialties, general medicine, stroke medicine and geriatric medicine.

Competent staff

- Staff told us there were plenty of opportunity for them to develop their skills and competency at the trust. Staff on specialist wards undertook specialist training for example, staff on Lyndon 4 had external and internal specialist training for dementia. The nurses on Newton 5 had all undertaken a chemotherapy double degree module at a local university.
- The hospital had a good programme for newly qualified nurses. Once appointed, the first four weeks were for incorporating induction, training and a supervision period. New staff had a 12-month development programme where a senior nurse would meet monthly with the new starter for four to six months.
- The hospital had competency checks on some wards for staff. Staff on Newton 4 had developed their own supervision model for junior staff called the Junior Experiencing Leadership (JEL) model, which ran for three months. It included a mentoring programme with designated senior mentors and competency checklists to cover clinical skills, nurse in charge essential communication and management. The aim of the JEL model was for junior staff to develop their knowledge, skills and competencies while practising what they had learnt in order to gain confidence. On Priory 4, registered nurses and health care assistants worked through a stroke competency framework, which covered a six-week period.
- All senior nurses we spoke with told us about a ward managers' development programme that they had attended in 2016. They felt the training was very helpful. There were also advanced training courses and action centred leadership courses available if required.
- All junior medical staff we spoke with spoke positively about working for the trust. They said they had a good induction and were allocated an educational supervisor. They generally felt well supported and spoke about attending weekly training sessions, however; there were no formal clinical skills training. We observed a good teaching relationship between junior and medical staff whilst on ward rounds.
- Specialist registrars said they had access to monthly general medicine training days and the trust required them to attend at least six of these each year. In addition, there was acute medicine training on a monthly basis for which the trust required 80% attendance.
- There was evidence of regular appraisals taking place at the trust. All staff we spoke with said they had an appraisal within the previous 12 months.
- The trust checked medical staff and nursing staff had undertaken re-validation to maintain their registration. Staff told us they were supported during revalidation. This is the process by which licensed doctors and registered nurses are required to demonstrate on a regular basis that they are up-to-date and fit to practice. Revalidation aims to give extra confidence to patients that the trust and the General Medical Council regularly check doctors, and the trust and Nursing Medical Council regularly check their nurses.
- Although there were many opportunities for staff to develop, the medical service was struggling to release staff from clinical duties to undertake training due to staffing levels. Staff told us that planned training sessions were often cancelled.

- There was a lack of assurance around agency staff competencies. The hospital bank staff were substantive staff carrying out extra shifts, so the ward managers had the assurance that bank staff were competent and had mandatory training. Staff told us that agency staff underwent a local induction but did not have a competency checklist on their initial shift. Senior nurses relied on the agencies to ensure agency staff were up-to-date with mandatory training and competencies.
- Staff told us there had been times where agency nurses were unable to carry out certain competencies required for the role that was not discovered until half way through a shift. This had been an issue on the extra capacity ward, which at times was staffed solely with agency nurses. Staff also told us about an incident where a patient had missed two doses of insulin because the agency nurse caring for the patient was not aware that there was a separate chart for insulin prescriptions.

Multidisciplinary working

- There was evidence of multi-disciplinary working within and between wards and departments in the hospital. We observed good multi-disciplinary team (MDT) working whilst on inspection. Most staff told us that MDT working at the hospital was good, some staff told us of a previous disconnect between the nursing and medical staff on some wards, which was beginning to improve.
- We observed safety briefings at the beginning of a shift on AMU B and Newton 4. Both wards had good staff attendance. On both wards, all nursing staff and health care assistants were present and the meetings were comprehensive and well structured.
- We observed ward and board rounds on AMU B and Lyndon 4, which had a good MDT presence. MDT meetings were structured and comprehensive, they discussed referrals to other specialties, safeguarding, packages of care and discharge.
- Newton 4 and Priory 4, the two stroke wards, had their own physiotherapy gym located on each ward and shared the speech and language therapists (SALT), physiotherapists and occupational therapists between them. All staff we spoke with spoke very highly of the therapy teams.
- All staff we spoke with spoke highly of the specialist nurses and specialist support teams, such as the safeguarding lead, learning disabilities and dementia lead, and the emergency resuscitation team. They said whenever they made referrals, the specialist nurses and support teams responded promptly and were always very helpful. Staff on AMU B worked closely with the specialist heart failure nurse as they cared for a high number of cardiac patients on the ward. They said, "The heart failure nurse is absolutely fantastic and extremely knowledgeable."
- Staff on Newton 5 told us that the cancer specialist nurses were always involved with patient care and that the palliative care team was not always needed but was involved for many patients on the ward. Staff spoke highly of both specialist teams.

Seven-day services

- Consultants covered the AMUs from 8am until 7pm. Outside of these times an on-call consultant would offer cover.
- The hospital had a stroke consultant onsite Monday to Friday from 9am to 6pm to cover the stroke wards. At weekends, there was a consultant presence onsite from 9am until 5pm to cover the hyper-acute stroke ward (Priory 4) and high-risk transient ischaemic attack (TIA) clinics, as well as consultant on-call cover from home. Outside of these hours' a consultant would cover on-call from home unless there was a thrombolysis call where a consultant would need to attend onsite. A stroke specialist registrar on-site supported the team Monday to Friday 9am to 5pm and at weekends and out-of-hours on-call.
- The OPAU had consultant cover Monday to Friday but when the consultant was on leave and during weekends, the accident and emergency consultants had to cover the unit.
- The endoscopy unit had recently introduced a Saturday clinic to reduce waiting lists, consultants covered these.
- A team of therapists covered the medical wards during the week, excluding the two stroke units for which there was a specialist ward-based team. Physiotherapy was available on-call over the weekend. Wards held meeting on a Friday afternoon to identify patients who required physiotherapy over the weekend or discharge planning for a weekend discharge.
- The SALTs worked 8am to 4.30pm, Monday to Friday and on-call during weekends and the physiotherapists worked 8am to 4.30pm seven days a week. The occupational therapists shared their time between the wards and home visits and worked 8am to 4.30pm Monday to Friday.

- Pharmacy was open between 9am and 5pm Monday to Friday, from 10am to 1.30pm Saturday and from 10am to 1pm on Sundays and bank holidays.
- Imaging services at the hospital were available for patients classified as urgent at the weekend.

Access to information

- Staff told us that one of their main issues was with the trust IT system, which was slow and difficult to use. The intranet strength in some areas of the hospital made it very difficult for staff to access patient information in a timely manner.
- The trust was in the final stages of implementing a new IT infrastructure including a new electronic patient record, which was expected to be complete by the end of 2017.
- Medical records travelled with patients when transferring from ward to ward. Staff told us generally the patient records arrived with patients, however; there had been times when the notes had not come through straight away.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided medical staff with basic consent training. Nursing staff on the elderly care ward had undertaken specialist dementia training, which included advanced training in consent. The compliance rate across the medical service for consent training was 93% for medical staff against a trust target of 95%. Patients told us that staff generally asked their permission before giving care and treatment, and we observed staff asking patients if they were happy for them to take observations.
- Nursing staff we spoke with understood that mental capacity assessments were a test of whether patients could comprehend the dangers of whatever is proposed. They told us that the doctors carried out formal mental capacity assessments.
- We saw good practice in the endoscopy unit surrounding consent. They had three separate consent forms, one for patients that were just having a colonoscopy, one for patients who were just having a flexible sigmoidoscopy and one for combined gastroscopy and colonoscopy. The consent form included a comprehensive explanation of the treatment and clearly set out the risks involved.
- We reviewed five patients' notes that contained assessment sheets for the use of bed rails. Nurses had signed and dated these forms but we did not see any consent clearly documented from the patient. Neither did we see any mental capacity assessment or best interest decision if the patient lacked capacity.
- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was variable and somewhat confused. A number of members of staff told us that they referred every patient on focussed care for a DoLS application. We saw one patient's record who had been referred for DoLS on AMU B. We saw no evidence that a mental capacity assessment had taken place and the reason for the referral was documented as, "Patient is on focussed care."

Are medical care services caring?

Good

We rated caring as good because:

- Staff responded compassionately when patients needed help and supported them to meet their basic personal needs when required. They encouraged patients and their relatives to be involved in their care and in making decisions.
- There was a strong and visible person-centred culture and staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. Patients' privacy and confidentially was respected and staff treated them with dignity, respect and kindness during interactions.
- Patients' emotional and social needs were valued by staff and were embedded in their care and treatment. Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients' were supported to maintain and develop their relationships with those close to them, their social networks and their community.

However:

- Some wards performed poorly at times in the NHS Friends and Family Test.

Compassionate care

Medical care (including older people's care)

- During the inspection, we saw staff treating patients with kindness, compassion and respect. We saw many examples of staff showing empathy and encouragement to patients they cared for with a sensitive and supportive attitude.
- We saw staff introducing themselves to patients, speaking with them in an appropriate manner and asking patients their preferred name. We witnessed staff calling patients by those names.
- On ward rounds and when staff were taking observations, the curtains were pulled around the patients' bed areas so staff could maintain dignity and confidentiality. We saw on one occasion that a patient became upset by news received from the doctor. The staff present showed compassion for the patient and asked if they would prefer the curtain closed until they felt less emotional.
- All patients we spoke with were complimentary about the care staff provided. They all said staff were courteous and respectful and that staff treated them with kindness and compassion. One patient said, "Staff are so pleasant and helpful," another patient said, "Staff are out of this world, couldn't do any better."
- For the CQC in-patient survey 2015, the trust scored about the same as other trusts when patients were asked, "Did doctors talk in front of you as if you weren't there?" and, "Did nurses talk in front of you as if you weren't there?" Both of these questions had improved from the 2014 in-patient survey. On inspection, we did see times when doctors talked to each other, referring to the patient as if they were not there, however the consultant informed the patient before they did this.
- The hospital participated in the national NHS Friends and Family Test. They had a response rate of 30% for medical care between January 2016 and December 2016, which was better than the England average response rate of 25%. The FFT is a survey that gives people who use NHS services the opportunity to provide feedback on their experience at ward level. It asks people if they would recommend the services they have used to their friends and family.
- During May 2016 and October 2016, a number of medical wards saw a decrease in FFT scores with one ward (Lyndon 4) consistently scoring below 72 from August 2016 to November 2016. The lowest score for the medical services at this hospital was for Newton 4 in August 2016 and was a score of 40. For the rest of the 12 month period, Newton 4 scored consistently above 93 with the exception of May (80), June (70) and July (83).
- The hospital displayed FFT results on the public notice boards outside each ward. However, we visited the hospital in February, March and April 2017 and noticed that the display boards were not always updated. For example, on the display board outside of AMU B, the display still showed September 2016 results.
- The hospital performed better than the England average for the privacy and dignity aspect of the Patient-Led Assessments of the Care Environment (PLACE) 2016 audit. Sandwell General Hospital scored 89% for privacy and dignity against a comparative England average for large acute trusts of 83%.

Understanding and involvement of patients and those close to them

- During our inspection, we observed staff provided information to patients and their family members regarding their care and treatment. One patient's family member told us that the doctors and nurses had provided their elderly relative with such clear information, that their elderly relative was able to explain what was happening to the family and the family were able to understand.
- We observed staff explaining to patients what they were about to do before continuing with the task. For example, we saw a staff member explain to a patient that they were going to take a blood pressure reading. The patient acknowledged then the staff member closed the curtains to the bay and took the reading.
- The National Cancer Patient Experience Survey 2015 showed that the hospital was about average for patients receiving understandable answers to important questions most of the time, and for patients being involved in decisions about care and treatment. The same survey showed the trust was performing in the top 20% of trusts for patient's family having the opportunity to talk to doctors.
- The CQC In-patient Survey 2015 showed the trust was performing about the same as other trusts for patient involvement as much as they wanted to be in decisions about care and treatment.
- Five patients we spoke with understood what was happening with their care and treatment and felt they had been involved in decision-making. One patient we

spoke with said that their carers and family had been involved but they felt they had not been involved in decision-making. English was not this patient's first language. Family members of another patient we spoke with told us that they have had to initiate and prompt staff to give information about their elderly relative's care. They said, "[Staff] have explained well to all of the family but [we are] not involved enough in decision making. Nan gets confused; we have explained this [to staff]."

Emotional support

- Patients we spoke with felt that staff gave adequate importance to their psychological wellbeing and provided emotional support. One patient said, "The staff are out of this world, they could not do any better." Another patient we spoke with said, "I could never complain [about staff], all very good, I could not find fault."
- Staff gave additional time and support to patients when needed. We observed a medical consultant sitting at eye level with a patient who expressed concern whilst on ward rounds. They spent longer with the patient to answer questions and to offer emotional support. We observed the consultant comforting the patient when they got upset, offering a tissue and gently holding their hand whilst they explained what they knew so far about the patient's condition. This greatly eased the patient's anxieties.
- The CQC In-patient Survey 2015 showed that the trust performed about the same as other trusts for patients felt they had enough emotional support from hospital staff during their stay.
- Staff carried out assessments of patient anxiety and depression. There were standard patient forms and specific withdrawal from alcohol forms that included questions on anxiety. On Newton 4, the staff had developed their own "Hospital Anxiety and Depression Scale", which asked patients to fill out a short questionnaire on how they were feeling.
- The hospital employed a team of chaplains to provide spiritual care to people of all faiths and those with no faith. The Chaplaincy consisted of a team of trained hospital chaplains from four major faiths, which included Christianity (including Roman Catholic) Muslim, Hindu and Sikh. If a patient required a chaplain of a different faith, the hospital employed a bank chaplain or contacted the relevant faith leader. The Chaplaincy team provided a 24-hour emergency call out service and they held a register of other faith leaders who were willing to attend in an emergency if a patient required. The hospital's chaplains and chaplaincy volunteers covered all wards and departments and had a regular programme of pastoral visiting.
- Staff told us they had access to Better Understanding of Dementia (BUDS) and the trust's psychiatric liaison team for patients with mental health concerns. We saw there were variations of mental health assessment forms in different areas of the medical service.
- Newton 5 ward staff told us that specialist cancer nurses were heavily involved with patient care and treatment and offered emotional support.

Are medical care services responsive?

Good

We rated responsive as good because:

- The hospital planned and delivered services in a way that met the needs of the local population. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances.
- The hospital had taken action to address waiting times and delays for some specialities. They had an ongoing programme to improve patient flow, timeliness of discharge and reduce length of stay.
- Reasonable adjustments were made and actions taken to remove barriers when people found it hard to access services. There were a multitude of languages that the trust was able to interpret and there were adjustments made to the environment to enable a more dementia friendly experience in most of the medical areas.
- It was easy for people to complain or raise a concern and staff treated them compassionately when they did so.

However:

- Some patients we spoke with told us they were moved late at night, which caused them confusion and upset.
- At times, we saw some patients did not have their call bells close, which meant they were not able to alert nurses if they required assistance.

Service planning and delivery to meet the needs of local people

- The trust was in the process of building a new hospital where most of the specialities would combine. As part of this process, the senior management team were reviewing the number of medical beds and capacity for each of the specialities by looking at demand.
- The hospital had seen a higher than predicted demand for medical beds in the previous months. As such, they an extra capacity medical ward to help deal with winter pressures and demands. The trust engaged regularly with their local clinical commissioning groups around commissioning for extra beds within the medical service.
- The trust had recently undergone changes to a partnership they had for oncology and cancer services. As part of the changes, the trust had multiple patient meetings to give patients an opportunity to help the trust plan and develop improvements to the service. Some improvement ideas that came from those meetings included the potential of a minibus transportation service between hospital sites.
- A member of the clinical team helped develop a homeless patient pathway due to increasing numbers of homelessness in the local area. The team recognised the need to help treat mental health and social illness alongside acute illness for this group of patients. This involved the trust teaming up with other health providers and partners in the local area to offer help and support for the homeless. Early statistics showed that the pathway had reduced readmission rates for patients who had been frequently admitted to hospital.
- Sandwell General Hospital provided a stroke specialist hospital and housed the trust's hyper-acute stroke unit and stroke rehabilitation unit. The trust has had engagement with the local ambulance service that takes patients directly to Sandwell General Hospital if they suspect stroke. Any patients that were at City Hospital were transferred via ambulance to the Sandwell site.
- The hospital had been previously assessed for a JAG accreditation before our inspection but was not successful in achieving it. JAG accreditation demonstrates a hospital has the competence to deliver against national endoscopy standards and measures. Reasons were for crowded space and long waiting lists.
- The endoscopy unit will be moved to the new hospital and will be combined with the endoscopy unit from the City site the trust runs. Unfortunately, there was no space for improvement due to the hospital premise. The unit also reviewed their service and made improvements to enable patients more access to the clinic at the same time as reducing their waiting lists. This included the introduction of an extra clinic on a Saturday and the appointment of two locum consultants.

Access and flow

- The trust had an ongoing programme to improve patient flow, timeliness of discharge and reduce length of stay. This included eight work-streams that teams within the trust had taken forward, which included improving the timeliness of supply of 'to take home medicines' (TTOs), patient transport, complex discharges and ward clinical team working. Staff we spoke with had seen improvements.
- As part of this programme, the hospital had implemented a new process called "Going Red to Green" to ensure progression of patient care and avoiding delays. The system included a series of going red to green meetings that took place throughout the day after the morning ward and board rounds. Patients were classified as red when they were no longer receiving acute care and were ready for discharge. These patients could be ready to go home and others could be waiting for TTOs, diagnostic scans or for other specialities. Red patients' hospital numbers were given to senior medical staff in red and green meetings who would chase up the treatment and see why it had been delayed. Patients were classified as green if they were still receiving acute care.
- The hospital's ambulatory medical assessment was consistently beating its projections for admission avoidance, which aided patient flow throughout the hospital. The purpose of the unit was to provide assessments, diagnosis, treatment, onward referrals, or discharge for patients that did not require an overnight admission to the hospital wards. The unit accepted

referrals from general practitioners (GPs), accident and emergency and other specialities. Staff on this unit told us they had 24 referral pathways for treatment within the area including for example, hypoglycaemia, headache and chronic obstructive pulmonary disorder.

- There was a consultant led virtual clinic for patients following discharge from AMU, where consultants communicated directly to patients and their GPs by letter or telephone without the need for a formal outpatient appointment.
- The hospital had previously failed to gain JAG accreditation for the endoscopy unit partly due to a lack of an electronic scheduling system and long waiting lists. We reviewed an action plan that the hospital had prepared for JAG accreditation, which outlined the steps the hospital were taking to achieve accreditation. The action plan included improved booking processes, improved list utilisation through reduced 'did not attend' (DNAs) and cancellations, and the introduction of a weekend list.
- Patients told us that staff had managed the journey from admission to the correct ward well with very few changes of ward having taken place. Data the trust provided showed that in the previous 12 months, the hospital saw no bed moves or one bed move for the majority (93%) of patient spells.
- From data the trust provided, it was clear that patient flow was still a challenge for them. There were areas within the medical division where responsiveness needed further improvement.
- Referral to treatment times (RTT) for the hospital varied between specialties. Between March 2016 and December 2016, the trust overall consistently performed worse than the England overall performance for RTT within 18 weeks for admitted pathways, with the exception of January and February. The latest figures for December 2016 showed an overall performance of 88% versus the England overall average of 90%. Individual specialties that performed better than the England average were geriatric medicine, rheumatology and cardiology. Individual specialities that performed worse than the England average were gastroenterology, neurology, dermatology and thoracic medicine.
- The average length of stay varied across specialities but was mainly longer than the England average. Between October 2015 and September 2016, the average length of stay for medical elective patients was higher than the England average of 4.1 days. For medical non-elective patients, the average length of stay was lower than the England average of 6.7 days. Of the specialities with the highest activity, non-elective stroke medicine (13.1 days) and elective clinical haematology (9.1 days) had the highest average length of stay, which were both above the England average (11.2 days and 5.7 days respectively).
- The trust was facing difficulties with their oncology services after the withdrawal from the previous service level agreement (SLA). They were struggling to replace roles that were previously filled by the SLA and this had resulted in excess waits for oncology clinics. We saw this was an item on the trust's medical group risk register. The trust had been mitigating this risk by using locums and closely monitoring the waiting times through the cancer wait team.
- The trust had different processes in place for referral of patients to different specialities, most were electronic referrals but some were still in paper format, which caused some delay. For example, community referrals had a separate referral letter.
- A number of patients we spoke with told us they were moved late at night, which had caused them some upset and confusion. One of those patients was moved at 11.30pm and most of the patients were moved from AMU to other wards. We reviewed hospital data on the number of bed moves after 10pm. From August 2016 to January 2017, the hospital had 1,149 bed moves after 10pm of which the majority were from AMU A (837). The hospital did not include the move from accident and emergency to AMU A in their data.
- The trust had an electronic discharge system that produced discharge letters and listed patients' to take home medicines. However, the system was not effective and increased the time taken for pharmacy to receive TTO requests. This was due to the system not linking with pharmacy, which meant staff had to print TTO lists and manually take them to pharmacy.
- Staff told us patients who were waiting for cardiology beds at City Hospital often occupied AMU beds disrupting patient flow. The week before our announced inspection in March, staff said there were five patients occupying beds on AMU B after the cardiology team had accepted them, some of whom were discharged from AMU B by the cardiology team before they had received a cardiology bed. There had been times where these

patients were waiting for a couple of days before a cardiology bed became available. Staff told us that AMU A had precedence when a cardiology bed became available.

- The trust reported five mixed sex breaches from the period of February 2016 to January 2017. Four of the breaches were in December of which two were on AMU A and two were on AMU B. The fifth breach happened in January 2017 and was on Priory 4. The breaches on the AMUs were due to capacity pressures and were all pre-approved. The breach on Priory 4 was due to confusion amongst staff related to gender breaching in a particular bay during the night, due to no senior presence on the night shift. Staff reported all breaches on the incident reporting system and in the clinical commissioning group report.

Meeting people's individual needs

- Medical services at the hospital across all medical wards were good at meeting people's individual needs. We observed some outstanding practice on Newton 4 when responding to people's individual needs. Staff on this ward showed a passion for helping give patients their lives back after they had suffered stroke or brain trauma.
- Staff on Newton 4 recognised the importance of social activities to help patients recovering from brain injury and stroke in their rehabilitation. The service included a breakfast club, where patients cooked breakfast for each other and cleaned up afterwards. There was a designated kitchen for patients on this ward where they cooked breakfasts and washed up themselves with staff members help and support. On special occasions, the patients' consultants and family were invited to sit and have breakfast with the patients. Staff felt this was a great way of building relationships with their patients and making them feel able, helping with their rehabilitation and emotional wellbeing.
- The ward had an internal stroke research team and the team ensured patients had the opportunity to be involved with research. The staff on this ward developed a delirium pathway called the 'Raised Approach', which assessed patient confusion and reduced delirium and acute illness. They also developed a patient booklet that included a communication sheet so patients were able to hold on to their goals themselves and so they were easily accessible. These booklets were care bundle plans that the patients owned and were kept with them on their visits to the hospital. They were available in a number of languages.
- Most wards at the hospital had diabetes link nurses who attended all diabetes governance meetings to share feedback between the specialist team and the wards. The hospital used the 'Think Glucose' pathway for patients with diabetes.
- The hospital served a diverse ethnic community and staff told us they discussed and established patients' cultural and religious needs at the beginning of admission. Staff accommodated religious needs where possible and provided halal meals for patient, ordered through mealtime coordinators.
- The translation services at the hospital were easily accessible and staff said they used the service regularly. Staff told us there were often bilingual staff working on wards, which they utilised to help with day-to-day essentials for patients, like providing hot drinks for example. We saw multiple languages printed on the walls and lifts of the hospital.
- The trust employed a learning disabilities specialist nurse and a lead for dementia care who provided advice and support to ward staff and patients. Staff we spoke with were aware of who they were.
- Staff were aware of the trust's involvement with the John's Campaign, which meant relatives were able to stay overnight with patients that had learning disabilities, dementia, did not speak English well or were very unwell. Staff also told us that the trust provided relatives with free parking, food and beds when staying with patients.
- There was no specific dementia ward at the hospital however; most patients living with dementia were treated on Lyndon 4, which was an elderly care ward. All staff on this ward had received dementia specialist training.
- There was a pop-up bus stop on this ward, which was a place for staff to take patients to for a short while when they became confused and asked to go home. Research had shown that this was a good way to calm patients living with dementia.
- The PLACE 2016 audit scored the hospital at 83% for the wards being dementia friendly, which was better than

the comparative England average of 73%. Some of the failures on the audit were due to bays not having larger clocks or clocks with multiple faces to allow visibility from all angles.

- The hospital provided patients with discharge letters, which included space for nursing comments. The electronic system generated letters for patients' general practitioners (GPs) and staff gave a printed copy of the letter to the patients. Staff told us they would hand over to care home or domiciliary care nursing staff when discharging elderly patients and patients with complex medical histories.
- Most patients we spoke with told us that nurses saw them in a timely manner, however at busy times it took longer for nurses to respond and they often heard call bells ringing for some time. During inspection, we heard nurses responding to call bells in a timely manner.
- During the February unannounced visit, we observed a number of patients on one ward who were not able to call their nurse as their call bells were out of reach and they had limited mobility. This was not an issue when we returned in March; all call bells were within patients' reach.

Learning from complaints and concerns

- Staff we spoke with at ward level knew what they needed to do if a patient wanted to complain. Patients we spoke with were aware of how to complain if they needed to.
- We saw hospital display boards with information for the public on complaints, concerns and compliments, where the hospital referred the public to the hospital PALS. We saw there were many patient information leaflets on all wards, which included a complaints leaflet.
- Staff told us they discussed complaints during ward governance meetings, group speciality meetings and quality improvement half days, where they often received feedback. Some wards shared learning from complaints in complaint folders and on staff room display boards. We saw that the hospital posted feedback to public concerns on the public display boards titled, "You Said…We Did."
- Ward staff took initiatives to learn from and decrease the number of complaints. Staff on Newton 4 developed meetings for family members called "Quality Listening Time (QLT)", which enabled relatives to meet with the patients' care team and set goals, discuss discharge planning and to ask any questions they had about their relatives care. It also gave the staff an opportunity to explain about stroke and expectations. The ward had seen a decrease in the number of complaints they had received since the implementation of QLT.
- The hospital had received complaints about the time it took to have blood samples taken and undergo chemotherapy. As a result, they changed to a two-step model, where patients came in for blood tests one day and returned the next for the chemotherapy. This had reduced the time patients waited and reduced the number of complaints.
- The hospital received 86 complaints across the medical service from January 2016 to December 2016. Almost 50% (40) of these complaints related to all aspects of clinical treatment, 17% (15) related to communication with patients and 15% (13) related to attitude of staff. We did not identify any trends when we reviewed the complaints data.

Are medical care services well-led?

Good

We rated well-led as good because:

- Local leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. They actively empowered staff to drive improvement and a culture where the benefit of raising concerns was valued.
- Managers were aware of issues within the medical services relating to variations in consistency of the quality of service provision. A number of projects were implemented to address these but at the time of inspection, it was too early to demonstrate a significant impact.
- Staff were aware of and understood the vision and strategic goals of the service. Safe innovation was supported and staff had objectives focused on improvement and learning.
- Clinical and internal audit processes generally functioned well and had a positive impact in relation to quality governance, with evidence of action to resolve

concerns. Staff actively raised concerns and those who did were supported. Concerns were investigated in a sensitive and confidential manner, and lessons were shared and acted upon.
- A number of staff within the medical services had won awards from external organisations for good practice in their specialities.

However:

- There was variability in the effectiveness of leaders at ward level. There were teams that were working in silos and although the matrons met regularly, wards did not always work cohesively to incorporate innovative practice and ideas. Innovative ideas did not appear to be shared or implemented effectively across the medical service.
- Clinical leadership and engagement was variable across the medical service. The level of challenge and oversight of senior medical staff and locums was limited. Staff raised concerns around the stability of the middle management in some specialities where turnover had been high.
- There was no specific risk register for the medical service; it was incorporated with the emergency care group, which made the risks related to the medical service unclear. Arrangements for risk escalation were not always effective and although the ward risk registers were fed into the group risk register, there did not appear to be any local risks other than staffing on the register. However, staffing was not specific to ward but generic across specialities.

Leadership of service

- The trust managed medical services at Sandwell General Hospital within the medicine and emergency care group. The care group consisted of three directorates, the emergency care, admitted care and scheduled care. Acute medicine sat within emergency care and the other services were divided between the admitted care and the scheduled care directorates. A clinical director, general manager, matron and a therapist or deputy general manager led each directorate.
- Senior managers were aware of the issues relating to variations in the consistency in delivery of a quality medical service. The trust had a number of projects in progress to drive quality improvement.
- All staff we spoke with said that since the implementation of the new nursing leadership team, they had seen positive improvements. They felt the leadership team were open and listened to their concerns and their views on how to improve. They said they had seen the nursing leadership team more in the four weeks they had been in post than they had seen the previous leadership team over a number of years.
- Ward managers went on a management development programme in 2016, where they strengthened their management skills. All ward managers we spoke with felt that this training was effective and helped them to manage their staff more effectively.
- All ward sisters we spoke with during the announced inspection said they felt well supported by their matron and that matron was open, listened to their concerns and responded positively. During the February visit, staff on Lyndon 5 had expressed concern about the level of support on the ward. On the March visit, we noted the trust had appointed a new interim matron to Lyndon 5. Staff spoke highly of the change and said there was a vast positive improvement on the ward since the new appointment, particularly in the level of support they received and structure to the service.
- Most staff we spoke with said they felt supported by their senior ward sisters. They said they had plenty of opportunity to openly discuss issues and found the senior sisters to be helpful and available.
- Junior doctors we spoke with were very positive about the medical leadership, felt supported and were happy to work at the trust. They said the trust was a good learning environment.
- We found variability in the visibility of senior ward sisters on the floor and their clinical input. On the stroke wards, the senior sisters were hands on, visible and helped with the morning washing of patients.
- Staff we spoke with were aware of the trust's whistleblowing policy and ability to raise concerns. However, the trust had recently appointed a number of 'Freedom to Speak up Guardians', and although the senior nurses knew who they were, the junior ward staff did not.
- We saw the trust had made some progress since the last inspection, however; we noted significant challenges remained.
- Three months prior to the inspection, the trust had reviewed the matron workforce within medical services

and had reduced the number of matrons. Staff felt that since the reduction in matron workforce and given the challenges within the medical wards, it was difficult for matrons to sustain work commitments.
- Consultants we spoke with on the endoscopy unit raised concerns about a frequent change in middle managers and felt that the main management focused more on the trust's other hospital site.

Vision and strategy for this service

- Senior managers told us their vision was to provide a world-class service to the local population. They said the opportunity provided by the move to the new hospital, was enabling them to review the provision of medical services across the trust to consider best practice and how it could be achieved in the new service. They recognised the need to harmonise practice across the two hospital sites.
- All staff we spoke with were clear on the trust's four main priorities for the move, which included the move to the new hospital and continuity of care. Matron who covered the AMUs spoke of an eight-week cross-site rotation in preparation for the move to the new hospital.
- The trust displayed their values in a variety of areas within the trust and staff were aware of what they were but had some difficulty in articulating them.

Governance, risk management and quality measurement

- were directorate level meetings, which included group speciality meetings. Ward level governance meetings also took place on a regular basis with some wards holding regular hot topics meetings.
- The trust held quality improvement half days, which included review of mortality and morbidity, complaints, incidents and shared learning. Staff we spoke with found these half days useful and said managers were receptive to suggestions put forward by staff.
- Each ward had a performance dashboard, which fed into the medical services integrated performance report that was discussed at the trust board meetings. This included measurement of performance against national and local targets and ward level information related to key performance indicators.
- Each ward held their own risk register, which the senior sisters updated on a regular basis. Any new risks that ward staff identified were either owned locally or could be escalated to the next level within their group. This included to directorate or group level. Some wards printed a hard copy of the risk register and displayed them in the staff room and ward managers office. The ward risk register then fed in to the directorate risk register and updated by the risk owner. The risk items review frequency depended on the level of risk, frequency was defined by the owner of the risk and was based on when actions might be implemented.
- The trust had an initiative in progress to improve the consistency of clinical care. This was part of the safety plan and known as 'always events' which identified 10 key investigations/interventions which staff reviewed for each patient. Staff recorded performance against this on a daily basis and we saw evidence of this in patient records.
- We reviewed the group risk register and saw that there were generic and specific corporate level risks relating to each site.

Culture within the service

- Staff we spoke with from all areas generally had positive things to say about the culture of the hospital and openness of the staff. Nursing staff generally felt valued.
- Junior doctors were happy to work at the trust and spoke of a high level of mutual support and solidarity at the hospital.
- A senior sister explained how the staff were very open and honest. They gave examples of nursing staff escalating mistakes that would not have been noticed to their supervisors.
- Staff spoke about a low morale at the end of 2016, but since the trust had made changes, staff morale had improved.

Public engagement

- The trust had recently undergone changes to a partnership they had for oncology and cancer services. As part of the changes, the trust had multiple patient meetings to give patients an opportunity to help the trust plan and develop improvements to the service. Some improvement ideas that came from those meetings included the potential of a minibus transportation service between hospital sites.
- The trust invited feedback from patients through an inpatient survey about the service they received. We saw the trust advertised this on public display boards at the entrance of each ward. On these boards were sections titled, "You said…We did", which gave the public

information on the actions they had taken in response to the publics' comments. For example on one board it said, "Promise to involve you in the individualised care planning for you or your relative." This indicated that involving patients and relatives in care planning was previously an issue raised by the public.

Staff engagement

- Staff were positive about the 'listening into action' events held within the trust and said they had the opportunity to discuss issues affecting the service. However, some staff felt there was little two-way communication between staff on the floor and the senior managers.
- The system in which staff received feedback varied across the wards. Some wards produced weekly newsletters; some held hot topics meetings and others had a combination of a weekly newsletter and meetings. All staff we spoke with felt that they received feedback when concerns were raised. This was either done by one-to-one meetings if the topic was particularly sensitive, or anonymised in one of the ward meetings. Staff felt confident that actions were taken with information raised in most cases.
- We saw that some areas within the medical service recognised good practice amongst staff and rewarded their staff for their efforts. On Newton 4, the staff had developed a staff award of the month, which incorporated views of peers, managers and patients. The staff member who was deemed the staff member of the month was awarded with a trophy and their name would be displayed on the wall of the ward.
- The trust held an annual star awards ceremony for staff where individuals and wards were nominated and rewarded for good practice and innovation. Newton 5 won the trust's Compassion in Care Award 2016, with one nomination saying, "It is a very happy caring place, makes you forget how ill you are."
- Many staff and wards within the medical services won awards for their work. For example, the hyper-acute stroke unit (Priory 4) won the Beacon Services 2015 Stroke Team Award for Excellent Patient Care, Service Delivery and Integration. The Occupational Therapy Breakfast Group on Newton 4 won the Stroke Awards West Midlands Stroke Association award.

Innovation, improvement and sustainability

- The trust's medical services were progressing with re-configuration of services in preparation for the move to their new hospital.
- The trust developed the ambulatory medical assessment area to improve patients' access and reduce the need for admission to hospital. Staff within the unit had developed 24 new medical care pathways ranging from chest pain and headache to syncope and upper GI bleeds.
- The respiratory service was selected to take part in the Future Hospitals Project, which aims to deliver an integrated care and 'whole system' approach to respiratory care in Sandwell and West Birmingham.
- The trust was the first in the UK to carry out the Endobarrier procedure for patients suffering from diabetes and obesity, which leads to weight loss.
- A clinician at the trust led the way to develop a homeless patient pathway and team to ensure good integrated care after treatment in the acute hospital.
- We saw lots of innovation in particular on Newton 4, with the development of the breakfast therapy group, the development and introduction of the JEL model and the development of pathways and safety initiatives.

Surgery

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

Information about the service

Surgical services at Sandwell General Hospital are provided as part of the trusts surgical division. Governance and management of the service is provided by the same senior leadership team across the trust.

There are eight theatres, consisting of two dedicated day surgery theatres, two elective orthopaedic, one colorectal, one National Confidential Enquiry into Patient Outcome (NCPOD), one trauma and one plastics/trauma. The theatres were supported by four wards, the surgical assessment unit and day case surgery unit.

The trust had 33,123 surgical admissions between October 2015 and September 2016. Emergency admissions accounted for 10,690 (32%).

The service was last inspected in 2014. At that time a number of issues were identified which led to surgical services at Sandwell General Hospital being rated as requires improvement with the safe domain rated as inadequate. During this inspection we found that improvements had been made in many of the areas previously identified as concerns.

During this inspection we visited four wards, the surgical assessment unit and the day surgery unit. We observed practice in theatres. We spoke with 39 staff including doctors, nurses and support staff of all grades and experience.

We spoke with 18 patients or their family members and we reviewed records regarding the general running of the department and maintenance of equipment and services. We reviewed eight sets of patient medical/care records.

The inspection team consisted of a CQC inspector and two specialist advisors. The team worked closely with a surgical inspection team working at City Hospital during the same inspection.

Surgery

Summary of findings

We rated this service as good because:

- Nursing and medical staff levels were good and staff had the skills and knowledge relative to their role.
- Infection prevention and control practices on the wards areas followed good practice guidelines.
- Medicines were stored securely and were accessible to nursing staff through an electronic locking system which provided an audit trail of use.
- Overall incident reporting and awareness was good, staff understood what needed to be reported and how this assisted learning.
- Engagement with national clinical audit was good with evidence of learning from audit outcomes.
- Patients received appropriate care following nationally recognised pathways including control of pain.
- Multi-disciplinary team (MDT) working was evident throughout the service
- Patients told us that they received compassionate care, were involved in decisions about their care and supported when they were anxious or worried about their condition.
- Patients with special needs received appropriate support; staff understood how to support patients with dementia or other memory problems.
- Supervisors had a good understanding of their staff, were supportive and provided an environment which enabled staff to provide good care. We saw examples of innovative practice from individual members of staff which had been adopted into practice across the trust.

However

- Whilst infection prevention and control practice by staff in theatres followed good practice guidelines. We saw that some work surfaces in the theatres area were cracked, chipped or damaged. This issue had been highlighted during the inspection in 2014.
- Lack of compliance with best practice guidance relating to the pooling of surgical patients had the potential to cause harm. Pooling of patients was a system where surgery patients were grouped by speciality and would be operated on by whichever surgeon was on duty for that speciality on the day of surgery, rather than by the consultant who had reviewed their case and recommended the procedure.
- Patient records we checked contained errors and omissions.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- We found that long standing infection control issues within theatres had not been addressed.
- Not all staff in theatres had a clear understanding of the serious incidents which had occurred in the department or the wider trust.
- Patient records we looked at contained errors and omissions.
- We found that national guidance in relation to the pooling of surgical patients was not always followed which had the potential to cause harm. We saw how a patient had been listed inappropriately for surgery.
- Safety thermometer information was recorded but not displayed on the wards in a way which patients and visitors could understand. Staff members were not aware of their ward scores. Safety crosses showed days on which harm had occurred during that month, but did not identify the type of harm, be it pressure ulcers, falls or other recordable issue.
- Resuscitation trolleys were not locked and contained fluids and ampules which could potentially be tampered with, although this was mitigated by the restricted access to some areas and regular checking by staff.

However:

- Infection prevention and control systems were good which helped to mitigate the issues in theatres.
- There was a good culture of incident reporting particularly by ward based staff.
- Analysis of historic Never Events had led to improvements in practice and policy.
- Medicines were stored securely and were accessible to nursing staff through an electronic locking system which provided an audit trail of use.

Incidents

- In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between February 2016 and January 2017.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between February 2016 and January 2017, Sandwell General Hospital reported two surgical incidents which were classified as Never Events. Both incidents related to operations upper limb (arm) procedures; one where an operation in was started on the radial side of the arm when it was supposed to be on the ulna side; the other incident involved failure to remove a metal drill guide from an operation site. These incidents had resulted in Guidance being issued to ensure compliance with the World Health Organisation (WHO) safety checks which staff completed for each procedure. Analysis and learning from these events was on-going.
- We saw how serious incidents and never events were reviewed with root cause analysis (RCA) completed. Monthly audits were completed by senior nursing staff of all incidents to identify themes. Learning was shared amongst teams and outline information was shared across other disciplines. We saw how policy and practice had been updated following one historic never event. The issue had involved retention of a 'pack' used to control bleeding. Practice had been to place a wrist band on patients when a pack was inserted to remind staff of its presence. On this occasion bleeding had been difficult to control and two packs had been used. When staff later came to remove the packs they only removed one. Following the RCA the procedure was changed such that if two or more packs were used then the corresponding numbers of wrist bands were used. This meant staff who may not have been present when the packs were inserted would know how many packs had been used and could ensure the correct numbers were recovered.
- Between February 2016 and January 2017, the surgical division (excluding ophthalmology) reported 1007 incidents to the National Reporting and Learning System (NRLS). These were categorised as 2 Deaths, 2 severe harm, 36 moderate harm, 225 low harm and 738 no harm.
- When we spoke with staff in theatres they were aware of incidents in their area or those affecting their team,

however; they were not all aware of serious incidents or learning from other teams or other areas of the trust. Information on incidents was available through the theatres dashboard but there was no way to tell is staff had reviewed it. Staff we spoke with on the ward areas had a positive attitude towards incident reporting and saw this as a method of learning. They were able to tell us how learning had been shared from other areas during meetings and handovers.

- Mortality and morbidity meetings took place monthly. We saw minutes of the meetings which showed how issues were discussed to ensure that best practice was followed and any learning was identified and shared. The minutes also showed how multi-disciplinary meetings and liaison with specialists at other trusts had taken place during treatment.

Duty of Candour

- Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff we spoke with understood the need to be open and honest with patients. When things did go wrong there were systems in place to respond to patients and their families. Nursing and theatre staff were aware of their obligations under duty of candour; they described awareness training they had received. Senior nursing staff and consultants understood their responsibilities and were able to describe instances where duty of candour had been triggered.

Safety thermometer

- The Safety Thermometer is used in ward areas to record the prevalence of patient harms and to provide information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data collection took place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the trust reported eight new pressure ulcers, four falls with harm and one new catheter urinary tract infection between January 2016 and January 2017.
- The surgical wards did not display safety thermometer information; however they did display safety information in form of a safety cross. The cross was formed out of the days of the month and each day was colour coded as it passed to indicate if there had been any harm on that day or not. The safety cross did not show patients staff or visitors information about individual harms such as; pressure ulcers acquired in hospital, falls, catheter related urinary infections or Venus thrombolysis (VTE's). Specific ward data was available and ward managers were aware of their performance. Data such as patient safety, patient experience, infection prevention and control, staffing and finance were logged and reviewed for each ward but the information was not shared publically in a way which patients and visitors could understand.
- Daily venous thromboembolism (VTE) audits were completed which showed that staff were complying with measures to help prevent VTE's and that accurate recording took place.
- Theatres introduced the theatre dashboard in October 2016. The dashboard contains performance information for staff in addition to providing access to other information such as policies and guidance. Safety information and medical alerts were also shown on the system.

Cleanliness, infection control and hygiene

- We found that ward areas appeared clean and tidy. Theatres departments on each level had hand washing facilities and sanitising gel dispensers inside the main doors. We saw that floor signs reminded staff to use the wash basins and gel. On one level a recorded message played whenever a person passed into or out of the entrance reminding them to wash their hands.
- We observed staff in theatres and on wards washing their hands or using hand gel appropriately. Personal protective equipment in the form of disposable gloves and aprons were readily available throughout the wards and we saw staff making use of these. Patients told us they saw staff changing aprons and gloves, washing and using gel "all the time", and they had not seen any change in the staff behaviour due to our presence.

- We saw that disposable jackets were available and used by theatre staff when they left the theatres area and entered the main body of the hospital. On returning to theatre the jackets were removed, this reduced the risk of contamination being spread into or out of the theatre area.
- We saw that all the staff in the ward and theatre areas observed the 'bare below the elbow' guidance.
- During the last inspection in July 2014, some theatre staff were criticised for wearing nose masks loosely around their neck between operations or whilst using their rest room. During this inspection we did not observe any staff wearing masks inappropriately. We asked the lead theatre nurse about staff wearing mask inappropriately; they advised us that it did still occur but that improvements had been made since the last inspection. They told us that staff were encouraged to discard face masks after each procedure in line with current best practice.
- The trust used an external commercial company for the sterilisation of theatre equipment. Staff told us that this system occasionally resulted in instrument pack wrappings being damaged in transit. However, they told us that there were always sufficient sets available, which meant that services were not affected.
- We saw that some work surfaces within the theatre area had cracks or chips in the protective surface. This was an issue highlighted in the 2014 inspection. Staff were aware and we were told they take greater care when cleaning these areas to reduce the potential for infection. It was suggested that repairs had not been carried out because of the disruption this would cause and the area may be re-developed when the new hospital premises opens.
- We saw that systems were in place to enable isolation of patients with infections or those who were vulnerable to infection. Side rooms and barrier nursing formed part of the trust policy.
- There had not been any outbreaks of methicillin-resistant Staphylococcus aureus (MSRA), methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C.Diff) during the period January 2016 to January 2017.
- We saw that cleaning schedules were in place on the wards and in theatre areas. Cleaning staff explained the procedure they followed and explained the schedules for daily weekly and monthly cleaning.

Environment and equipment

- During 2015 the theatre management board chaired by the hospital chief operating officer completed a review of all theatre equipment identifying its expected expiry date, this had been taken to the trust board and a roll out of replacement equipment was commenced with a fulfilment date of 2020. The review had ensured that equipment which would require replacement was identified in good time and was not left until it became unserviceable. We saw that equipment was well maintained and had identified service dates.
- Resuscitation trolleys in ward areas were well stocked and we saw logs which showed that daily checks were completed. However; we also noted that the trolleys contained fluids and intravenous preparations which were not secure and therefore vulnerable to contamination. Resuscitation trolleys in theatre areas were also well stocked and checked daily. These trolleys were not locked, but the lead nurse explained that as they were in a secure area it was not necessary to lock them which they told us was in line with local policy.
- Prior to outsourcing the sterilisation of equipment the sterile services occupied a large area on the second floor of the hospital adjacent to the level 2 theatres. We saw how this area had been utilised for the storage of equipment and consumables. Each item had a dedicated shelf area with clear stock levels. Support staff used digital scanners to identify and order replacements as they were used. The theatre lead nurse described the process and explained how the storage space, stock rotation and ordering had greatly improved efficiency in theatres. Staff had easy access to all items they might need to perform the various procedures.
- Equipment such as specialist beds and hoists were available for bariatric patients. All the equipment we saw was marked to show that it had been inspected in line with the manufacturer or suppliers recommendations.

Medicines

- We saw that medicines were stored appropriately and records were accurate. The wards had recently introduced an electronic locking system which staff told us had improved access to medication as they no longer

had to find the staff member carrying the keys in order to access the secure cabinets. The electronic system also provided a robust audit trail of when and by whom the cabinets had been accessed.
- Agency staff who were qualified to administer medication were allocated their own electronic key for the duration of their shift. The keys had to be signed for and the allocation of the keys was overseen by a substantive ward nurse. This meant that use of the key by agency staff could be monitored in the same way as regular staff.
- Patients we spoke with told us that staff provided their medication in a timely manner. Patients who were prescribed medication on an 'as required' basis told us that staff were responsive when they requested their medication.
- Medication administration charts for each patient were completed as the medications were given and witnessed as taken; before staff moved onto the next patient, this reduced the potential for errors.
- Staff involved with medication administration wore red bibs which identified their role and were marked Do Not Interrupt. This helped prevent distractions for staff and minimise the risk of errors.
- Allergies to medication were clearly documented in the prescribing documentation. Presence or absence of allergies was recorded in 93% of cases on prescription sheets.
- Nursing staff we spoke with were aware of policies on administration of controlled drugs and followed Nursing and Midwifery Council – Standards for Medicine Management guidance.

Records

- Patient records were paper based and secure records trolleys were on each ward where records were stored when not being reviewed or updated by staff. This was an improvement since the previous inspection in July 2014 when we observed that records had been left insecure on the wards.
- The trust were working towards being paper-light (as opposed to paper free) and patient notes, x-ray reports and other documents were in the process of being electronically scanned and saved. Staff told us that this would make access to patient information easier.
- The trusts clinical effectiveness committee reported in the 2015/2016 records audit that a daily entry was made in 96% of cases where deemed relevant. Patients who were at high risk of Venous thromboembolism (VTE) and who were eligible to receive thromboprophylaxis were prescribed it (94%). Safer surgery checklist audit showed 99% compliance with the completion of the three sections for those areas currently reporting on their performance. For elective lists, there was 99% compliance, with the brief and debrief requirements. This suggested that records were complete and to a high standard. However; we reviewed eight sets of patient records and found issues with five.
- We check patient records as we wanted to ensure that information which staff and patients had told us was reflected in the records. In reviewing five sets of records on one ward we found errors or incomplete details in all five records. All the notes contained a pre-assessment and consent forms. Post-operative progress notes were completed to a high standard. However; only one of the five records contained a venous thromboembolism (VTE) assessment. MRSA screening was missing from one record. Dedicated care pathways were documented in three of the five cases a fourth had an incomplete record and the fifth had a blank record sheet. One set of notes for a patient who was still on the ward contained a discharge letter dated ten days earlier. There was no WHO checklist in one set of records.
- Pre-operative assessments took place in the pre-assessment clinic and we saw that the individual information was re-checked on the day of surgery which ensured that information was current and correct for those patients.

Safeguarding

- Staff we spoke with were aware of the different types of abuse and how to identify them. Healthcare workers told us they would escalate concerns to nursing staff. A safeguarding lead was available in the hospital for advice and guidance. Nursing staff were aware of who the safeguarding lead was and how to obtain support if they required it.
- Staff were able to describe instances where safeguarding concerns had been reported, these included instances where elderly patients were being cared for by their partners who themselves were in need of support through to concerns for the welfare of patients' children.
- The trust annual target for safeguarding training was 95%. The trust provided data which showed that Sandwell General Hospital Surgical Services compliance

at 7 March 2017 was; Level 1 safeguarding 96%, Level 2 at 81.5% and level 3 at 100%. Safeguarding was one of the trusts mandatory subjects and was an ongoing process throughout the year. Staff who had not completed the training were on target to complete it before the end of the period, with the exception of those reported as long term sick.

Mandatory training

- Mandatory training was delivered through a combination of face to face lessons and lectures on training days and e-learning. Mandatory training reviews formed part of the trusts appraisal system which encouraged staff to attend training.
- The trust target for training compliance was 100%. There were 31 mandatory subjects including refresher courses. These included, manual handling, fire safety, basic life support, information governance, safeguarding and infection prevention and control. All subjects had to be revisited annually and staff were responsible for identifying opportunities to train. Because staff attended different training sessions and completed different mandatory subjects at different times cumulative training figures for each department did not reflect actual performance. We saw records in theatres and on the wards which showed how managers monitored attendance and compliance.
- Training records showed a wide variance between wards and departments in completion rate, for example at the time of the inspection, the wards completion rate ranged between 60% and 100%. However, we were told that this was due to departments and wards attending training at various times throughout the year. Planned projections for attendance were on target to achieve 100% compliance by the end of the training year (July).
- Medical staff mandatory training rates also showed a wide variance in the completion rate. Compliance ranged between 43% and 96%, with planned projections for attendance being on target to achieve 100% compliant by the end of the training year (July).
- Theatre staff compliance with mandatory training was 88%. All theatre staff had received training in basic life support. Theatre nurses, anaesthetists and Operating Department Practitioners (ODP's) were all trained in advanced life support techniques.
- We observed staff using appropriate manual handling techniques when assisting patients on wards and when transferring them from the trolley to theatre table.

Assessing and responding to patient risk

- The trust operated a system of pooling patients for elective surgery. This meant that whilst a patient might attend a specialist clinic and be reviewed by a particular consultant surgeon. Where surgery was the preferred course of treatment the patient would go forward to the pool of patients requiring that speciality. Theatre lists were completed according to speciality and acuity and the surgery would be carried out by whichever of the surgeons was operating on that day covering that speciality.
- We saw evidence of how this system provided an efficient patient flow, however we were concerned that the system reduced the level of patient/doctor understanding and had the potential to lead to harm. An example of the potential for harm occurred during our inspection.

National guidance in respect of pooling patients advises that to reduce risk there should be robust measures to ensure that patients who are not suitable to be pooled are identified and taken out of the system. A consultant explained to us how they had reviewed the pooled patients which they were to have operated on that day. A patient had to be removed from the list as they because they had undergone a previous procedure which meant the planed endoscopic treatment was unsuitable. National guidance precluded the use of endoscopic procedures where previous scar tissue could potentially be compromised. This had not been identified during the pooling process which could have led to the procedure being carried out and the patient being put at risk. The consultant stated that an incident would be reported through the trust incident management system to highlight the issue as a near miss.

- We found robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist in the four theatre sessions we observed. All stages were carried out correctly and recorded, as the procedure stipulates. Whilst observing, we saw that the checklist was completed on all occasions including the 'time out' session.
- WHO checklist records audits were completed and unannounced observation of practice was completed by managers. Checklists were recorded electronically by theatre staff during the procedure. Swab counts were verbally checked and noted on theatre white boards.

Where packs were used to reduce or prevent bleeding, a wrist band was placed on the patient for each pack used, enabling staff who removed the packs later to recognise the how many had been used. This practice had been introduced following learning from a previous never event.

- Discharge arrangements followed national guidance, day-case patients were provided with written information regarding the procedure they had undergone and symptoms they might experience.
- Confidential Enquiry into Patient Outcome and Death (CEPOD) classification, describes the need for immediate, urgent, expedited or elective surgery. One CEPOD specific theatre was staffed 24 hours a day, seven days a week for immediate life, limb or organ-saving intervention including the intervention for acute onset or clinical deterioration of potentially life-threatening conditions.
- National Early Warning Scores (NEWS) were recorded for each patient which assisted staff to recognise deteriorating patients and escalate to senior nursing staff or doctors.
- Staff on the wards followed recognised pathways of care; observations were completed in line with the patient's acuity and co morbidities. Escalation routes were available if patient's vital signs fell outside expected parameters.
- Each day a theatres team brief lead was identified and they discussed the safety messages and infection control issues with the team from the theatres dashboard. The team brief was then completed on the dashboard. The brief followed national guidance with prompts to establish that everyone was present, covered any staff or staffing issues, equipment required, and any additional support which may be required in order to perform the planned procedures. Comment boxes were completed where appropriate and the team brief was submitted and saved on the system. The brief could only be saved once all sections had been completed. The team de-brief was conducted in the same way and again all sections needed to be completed before the information could be submitted and saved.
- Junior doctors completed routine examinations and responded to concerns from nursing staff. Consultants conducted ward rounds and were available for advice or guidance.

Nursing staffing

- Prior to 2015 the trust used an in-house acuity tool to collect acuity data on a daily basis and nurse to patient ratios were allocated based on that system. In 2015 and the Group Directors of Nursing undertook a biannual acuity review using the Safe Staffing Acuity Tool (Shelford Group). This was last undertaken in Surgery in January 2017 and the results and recommendations were still being collated at the time of our inspection.
- Daily staffing numbers were displayed on the wards and collated daily on a spreadsheet which could be viewed by all ward managers and matrons in Surgery. This data was reviewed weekly by the Group Director of Nursing and is also used for the monthly Chief Nurse submission and to facilitate the UNIFY safe staffing return. Staffing ratios on the Surgical wards were:

1:6 on days and 1:8 nights on Lyndon 2 and Priory 2,

1:6 on days and 1:11 on nights on Lyndon 3 and Newton 3 (Trauma Wards)

and D21. These 3 wards have a middle shift 10am to 10pm to span the busiest period.

- All wards had a supervisory ward manager who was not included in the ward numbers but does work clinically when there were staffing gaps on the wards. Within Surgery there was a daily bed capacity meeting attended by the ward manager or junior sister from each ward and any staffing issues across surgery at Sandwell General Hospital were discussed to ensure efficient and safe use of skill mix particularly in areas with high numbers of vacancies. We observed one such meeting.
- We looked at staffing levels during two weeks in February 2017. During the weeks of 13 and 20 February 2017 the total number of planned nursing and healthcare worker shifts during the period was 1568, of which 924 were nurses and 644 were healthcare workers. We saw that 32% of all shifts had to be covered by bank or agency staff. Whilst all shifts had been covered, regular nursing staff told us they were concerned that the trust were reliant on such high levels of agency use.
- Sickness rates for Sandwell General Hospital nursing staff ranged between 9.5% and 10%.
- Theatres carried vacancies which were filled by the trusts own theatre bank staff. The lead theatre nurse explained that there was a drive across the trust to

reduce 20 theatre sessions (One theatre sessions equates to a morning or afternoon session). The reduction had been identified following a review of capacity and demand. The impact of reducing the number of sessions meant that the vacancies would not need to be filled.

Medical Staffing

- We found that the hospital had sufficient numbers of doctors with the required skills and experience to meet patients' needs
- Nursing staff told us that doctors were available and approachable.
- Consultants and junior doctors worked across site in the trust. Surgical medical staff consisted of 37% consultants, 14% middle grade doctors and 14% junior doctors. England averages were 44%, 10% and 10% respectively.
- Consultants completed ward rounds each day and middle grade and junior doctors were present 24/7 on the wards. We observed staff during ward rounds and saw how junior doctors were supported by consultants when discussing diagnosis or options for treatment.
- Out of hours consultant was available for cross-site cover between 6pm and 8am. On call rotas had been an issue for consultants during the 2014 inspection. Having fewer consultants than similar sized hospitals meant that each consultant had more duty days than colleagues in the other hospitals. However, no concerns were raised during this inspection. Consultants told us that rotas were manageable and fair.
- Comprehensive medical staff handovers took place at the beginning of each shift and following 'on call' shifts. Cases were discussed and issues and options identified.

Major incident awareness and training

- Major incident policy and plans were in place, which described staffs responsibility regarding their actions should an incident occur. Sandwell General Hospital was the trust preferred site for major incident casualties. Staff we spoke with understood where to find information in the event of a major incident. Table top exercises were completed to embed procedures with staff.

Are surgery services effective?

Good

We rated effective as good because:

- Surgery services provided a wide variety of procedures, which followed national recognised care pathways. Outcomes for those patients who received surgery were for the most part higher than national averages.
- Staff reviewed care plans and assessments daily.
- Staff engagement with national and local audits was good.
- Appraisals and effective supervision provided staff with the support they required to enable them to provide effective care.
- Multidisciplinary team (MDT) meetings took place including consultation with specialist staff at neighbouring teaching hospitals.

Evidence-based care and treatment

- Patient care was based on recognised pathways following national best practice. Trust guidance was available on the intranet and was based on recognised pathways of care. These included fractured neck of femur and sepsis care.
- Care plans were based on patient's individual needs and included appropriate risk assessments including falls risks, and nutritional requirements including malnutrition universal screening tool (MUST) scores. We saw that assessments were completed on admission and were updated if patient needs changed.
- Venous thromboembolism (VTE) assessments were recorded preoperatively, in line with national guidance, which was one indication of how procedures followed national guidance.
- We saw guidance or changes to policies were communicated to staff through minutes of meetings and via email messages and intranet news items.

Pain relief

- Matrons conducted pain relief audits as part of their monthly quality reviews. Audits identified that patients were satisfied with the pain relief they had received. Patients we spoke with told us that staff were responsive when they asked for analgesia or were in discomfort.

- Patient records showed how pain relief options had been discussed with patients in the surgical assessment unit.

Nutrition and hydration

- Patient-Led Assessments of the Care Environment (PLACE) 2016 reported food score as 94% for the trust and 93% for Sandwell General Hospital. This was above the England average score of 89%.
- Healthcare assistants conducted comfort rounds and provided patients with food and drinks. A drinks trolley was available for patients to provide themselves with drinks throughout the day.
- Wards operated a system of protected meal times, this meant that other than in extreme cases, patients would not be disturbed for tests, imaging or consultations during their meal times. Visiting was restricted during these times other than for relatives or carers who were assisting patients to eat. Relatives and carers were actively encouraged to remain on the wards and assist if their loved ones required help with eating or to keep them company and provide emotional support.
- Where patients required additional assistance to eat or their condition required additional monitoring, food and fluid balance charts were added to their records.
- Malnutrition Universal Screening Tool (MUST) assessments were completed and intravenous fluids were prescribed and administered, when diet and fluids were restricted. Referral to a trust dietician was arranged when concerns relating to a medical condition, malnutrition or dietary intake were identified.

Patient outcomes

- Between October 2015 and September 2016, patients at Sandwell General Hospital had a higher than expected risk of readmission compared to the England average for non-elective admissions. This included the top three specialties based on count of activity (General Surgery, Trauma and Orthopaedics and Ophthalmology) and a higher expected risk for elective admissions including the top three specialties based on count of activity (General Surgery, Trauma and Orthopaedics and ENT).
- In the 2016 national Hip Fracture Audit, the 30-day mortality rate at Sandwell General Hospital; that is the number of patients who died within 30 days of surgery was 10.7%. This was worse than in 2015 when the rate was 7%. The national standard for the proportion of hip fracture patients having surgery on the day of or day after admission was 85%. The trust only achieved 71.6%. This was however an improvement over 2015 when the trust only achieved compliance in 68% of cases.
- Reduced performance when compared to previous years was also seen in respect of:

Perioperative surgical assessment; The assessment of care before, during and after surgery. The national standard is 100%. The 2016 rate for the trust was 94.9%, whilst it had been 95.4% in 2015.

The proportion of patients not developing pressure ulcers was 95.5%, which was in line with the majority of trusts in England. However, the 2015 figure had been 98.8%.

The overall length of stay in hospital for surgical patients averaged 16.3 days which was better than England averages and placed the trust in top 25% in the country. However this was still slightly worse than the trust achieved in 2015 when the average length of stay was 16.2%.

- In the 2015 Bowel Cancer Audit, the trust achieved better performance than the England average in respect of length of stay following a major resection (removal of part or all of an organ). The 90 day post-operative mortality rate was 5.4% which was within the expected range. However it was worse than the 2014 performance of 4%. The two year mortality rate was 15.7% which again fell within the expected range. However this was clear improvement over the 2014 rate of 32.3%. Unplanned re-admission within 90 days was within the nationally expected range. The trust performed better than expected in relation to the 18 month temporary stoma rate in rectal cancer patients undergoing major resection. The 2015 rate was 36.7%.
- In the 2015 Oesophago-Gastric Cancer National Audit (OGCNCA), criticised the data quality submitted by the trust. The audit found that 15% of records for emergency admissions. The trust is part of the regional strategic clinical network in this speciality. The proportion of patients treated in the network with the expectation of survival was 34.7% which was in line with national figures. The network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level with better co-operation between hospitals within a network producing better results.
- In the 2016 National Emergency Laparotomy Audit (NELA) hospitals were awarded colour coded outcome

results based on their performance. Sandwell General Hospital achieved a green (over 83.3%) rating for pre-operative documentation relating to risk of death. They received amber (between 50% and 79%) Sandwell General Hospital achieved an amber (50-79%) rating for:

Access to theatres within clinically appropriate time frames.

Number of high-risk cases with a consultant surgeon and anaesthetist present in the theatre.

Number of highest-risk cases admitted to critical care post-operatively.

The 30-day mortality rate following emergency laparotomy at Sandwell General Hospital was within expectations.

- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, Performance on Groin Hernias and Varicose Veins was worse than the England average, with fewer patients reporting an improvement, and more reporting a worsening compared to the England as a whole.
- Performance on Hip Replacement and Knee Replacement operations was similar to the England average.

Competent staff

- The trust held 10 quality improvement half days each year. This enabled staff to undertake directorate specific training which did not form part of their mandatory training. This increased skills and knowledge and enhanced staff competencies.
- Staff received annual appraisals by the ward manager where their individual performance and professional development was discussed. April 2016 to February 2017 records showed that 100% of nursing staff on surgical assessment unit, 95% of theatre nursing staff and over 78% of nursing staff on the surgical wards had received an appraisal. Non-appraisal was due to long-term sickness or absence. Current appraisal rates were on target to be achieved in line with the trusts target of 100%. We saw records for the previous three years which showed that the same areas had achieved 100% during those periods.
- Agency staff completed an induction with senior nurses when they first worked on the wards or in theatres. We were told that most agency staff were regular attenders and had a similar knowledge of local practise and procedures as employed staff.
- Each set of theatres identified a theatre lead, who was responsible for ensuring that processes and guidance were followed. Staff from all grades rotated as theatre lead. Staff told us that this had increased individual skills but also improved overall engagement in the process and understanding of the roles involved.
- Nursing staff on the surgical wards at Sandwell General Hospital rotated between wards on a three monthly basis; this enabled them to maintain and increase their skills.
- Additional training and competency reviews were available to enable nursing staff to increase their skills. These included; medicines management and venous cannulation.
- Consultants received appraisals as a requirement of their professional revalidation.
- The trust are registered with the Skills Funding Agency as a training organisation. The Skills Funding Agency provides funding to suitable organisations to enable training of staff.

Multidisciplinary working

- We saw multidisciplinary working in the wards we visited. Occupational therapist and physiotherapists attended ward rounds on a daily basis Monday to Friday and were involved with patients assisting in pain control and encouraging movement and independence.
- Orthopaedic wards had dedicated occupational therapists available to their patients.
- An orthogeriatrician reviewed all elderly patients who had suffered fractured hips prior to discharge.
- Dieticians, speech and language therapists and social workers were available for referral if required.
- We saw evidence from mortality and morbidity meeting notes which showed how consultation with specialists in neighbouring hospitals had taken place in complex cases or where outcomes had not progressed in line with care pathway expectations.

Seven-day services

- Surgical wards operated on a 24/7 basis to support patients prior to and following surgery.
- Junior doctors were on site 24/7 and consultant cover was available on a trust wide call out basis for out of hours.
- Theatres maintained emergency cover 24/7 with one theatre staffed overnight. Systems were in place to re-call staff on an on-call basis if there were additional

emergencies. One such incident had occurred the evening before our inspection when theatre staff who were about to go off duty remained to facilitate and emergency case.

- Physiotherapy ran a six-day service with reduced hours on a Saturday and no ward presence on a Sunday. We were told that patients admitted over the weekend would be seen by the on-call team of physiotherapists when required. Occupational therapy service ran a weekday service only.
- Pharmacy support was available out of hours and at weekends through a call out system. Nursing staff did not describe any issues with obtaining medication for patients either whilst on the wards or at the time of discharge.

Access to information

- Computer terminals were available at nurse stations on wards which enabled nursing staff and doctors to access trust policies and procedures via the intranet, news bulletins and email systems. Staff could also access national and international resources via the internet.
- Staff had individual log-in details which meant that personal information was protected.
- Theatre staff had access to computers in the theatre offices on each level. In addition to the trust intranet site they also had a dedicated theatres dashboard for staff. Senior staff had identified that there was need to improve communication between the different staff groups within theatres and the different theatre sites within the trust. The dashboard which is an electronic information system was produced. The system has safety messages as well as access to the trust policies for theatres. Infection control issues were listed with detailed guidance on cleaning required. It also provided access to patient information tools, hand hygiene guidance and incident reporting a shared calendar and anaesthesia register. The system was also used to complete the theatre team brief and debrief in line with the World Health Organisation best practice guidance.
- Some medical staff complained that there were multiple systems which they had to access and the systems did not 'talk to each other' which meant they spent considerable periods of their time accessing different systems to ensure they fully understood the needs of their patients. They told us this reduced the time they could spend with patients, and slowed the process down.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the previous inspection in 2014 we found that staff understanding and implementation of processes under the Mental Capacity Act was poor. During this inspection we found staff had a good working knowledge of the Act and its principles. Staff we spoke with were able to describe the process for assessing a person's mental capacity and what needed to be done if a patient lacked capacity to consent to treatment which was in their best interest.
- Doctors and nursing staff received mental capacity act training as part of their annual mandatory training. In common with other mandatory training subjects; compliance varied across wards and individual teams. We saw that compliance in the period 2014/2015 and the period 2015/2016 had been 100%. Guidance to staff was available on the trust intranet.
- Consent forms were signed by all patients or best interest meetings involving relative's carers and medical staff took place prior to surgical procedures being carried out. We were told that some patients arrived in the surgical assessment unit on the day of surgery who had not previously signed consent. Where this occurred patients were reminded of the procedure it's benefits and possible side effects or negative consequences and were asked to sign their consent. All the patient notes we reviewed contained signed consent forms.
- Between January 2016 and December 2016, the trusts consent audit report showed that of 7384 patients, 17% of patients were consented on the day, however it was identified that some patients did sign consent on the day, following specific admission guidelines. This report also identified that 80% of patients received an information leaflet to consider the operation proposed, a report conclusion recommended that the trust should consider amending consent forms to be clearer about signatures for the provision of information, receipt of information and consent for procedures.

Are surgery services caring?

Good

We rated caring as good because:

- Staff were attentive, caring and demonstrated compassion for their patients
- Patient told us that staff were kind and friendly.
- NHS Friends and Family Test response rate was better than the England average. Results had been variable between 73% and 97% but more recently ranged between 93% and 98%
- Patients and their family members told us that they had been given clear information and explanations about procedures and care which had enabled them to make informed decisions.

Compassionate care

- We observed staff as they interacted with patients and visitors. We saw that staff were friendly and approachable, smiling towards people as they approached them.

We noted that even during busy periods staff portrayed a calm presence. Call bells were answered promptly.

- The Friends and Family Test response rate between January and December 2016 for Surgery at Sandwell General Hospital was 18% which was worse than the England average of 29%.
- The number of patients who would recommend the service to family and friends if they required the same procedure differed across wards and throughout the year data was not available for every month in some locations. The average for each surgical ward between January and December 2016 was: Lynden 2 scored 83% (based on eight months data available), Lynden 3 scored 87% (12 months data), Newton 2 scored 92% (11 months data), Priory 2 scored 87% (10 months data) and SAU achieved84% (12 months data).
- Theatres completed patient satisfaction surveys with a random sample of ten per month. The surveys had all been positive and patient comments had been used to identify improvements. One example had been the provision of soft weave blankets following feedback from patients.
- Patient-Led Assessments of the Care Environment (PLACE) 2016 reported privacy and dignity score as 88% for the trust above the England average score of 83%.

Understanding and involvement of patients and those close to them

- Patients and family members told us that doctors and nursing staff had provided information about their procedure. They told us that they had found all staff to be approachable, patient and understanding, when they had questions or concerns.
- Staff told us how they endeavoured to explain procedures and treatments in a way which was appropriate to the patient or their family. They said that they always gave people time to consider what they had been told and they were asked if they understand or need clarification.
- We observed numerous exchanges between staff and patients and we saw how staff explained what they were doing and ensured that the patient understood and consented before providing care.

Emotional support

- Patients told us that nursing staff had reassured them when they had felt anxious or worried. Nurses told us that if they were unable to reassure a patient they would ask the doctors or consultant to spend time with them.
- When bad news had to be given to patients or relatives this was given by consultants or specialist nurses.
- Patients or relatives were able to use the hospitals multi faith prayer room when they wanted to spend time alone with their thoughts. Chaplains were available to assist in meeting the spiritual or religious needs of all patients and their relatives. The trust employed specialist faith chaplains from the Christian, Hindu, Muslim and Sikh communities
- Patients with relevant conditions were referred to outside agencies or charities for ongoing support.

Are surgery services responsive?

Good

We rated responsive as good because:

- Between January and December 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been better than the England overall performance for the whole period with a stable trend.

- Between October 2015 and September 2016, the average length of stay for surgical elective patients at Sandwell General Hospital was 3.2 days, compared to 3.3 days for the England average.
- For the period March 2015 to December 2016, the trust cancelled 905 surgeries. Of the 905 cancellations, only five were not treated within 28 days.
- Translation services were easily accessible.
- Patient-Led Assessments of the Care Environment (PLACE) 2016 reported dementia friendly score as 91% for the trust above the England average score of 75%.
- Care and treatment were based on patient's individual needs.
- Complaints were treated seriously. Staff saw the system as an opportunity to learn and improve.

However:

- Referral to treatment times for plastic surgery and trauma & orthopaedics were worse than England averages.
- Theatre utilisation rates were low.
- Planning the delivery of imaging services without porters meant that nursing and medical staff were taken away from their principle role to escort patients.

Service planning and delivery to meet the needs of local people

- The trust was due to open a new hospital the Midland Metropolitan Hospital in October 2018. We were told that many of the surgical services provided at Sandwell General Hospital would be provided by the new hospital. Some surgical services would still be provided at the site; exact details were still being considered.
- Between October 2015 and September 2016, the average length of stay for surgical elective patients at Sandwell General Hospital was 3.2 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 4.1 days, compared to 5.1 for the England average.
- Patients with a learning disability were able to visit the hospital in advance of their admission to reduce their anxiety when they were admitted. We were able to observe a patient with a learning disability in theatre during our inspection. We saw how they were supported through the process.
- When we asked staff about blocks to performance; nurses of all levels and from all wards, junior and mid-career doctors and consultants all told us that whilst imaging services had improved dramatically since the last CQC inspection in 2014. The ability to transfer patients to and from imaging was a major factor and block to performance at Sandwell General Hospital. We were told that City Hospital had a porter service to transfer patients to and from imaging, whilst Sandwell General Hospital relied on nursing staff or junior doctors to convey patients. This system required the staff to remain with the patient while waiting for the imaging to be completed. All concerned told us that this was a costly waste of clinical time and affected their ability to get on with their own job. We were told that the issue had been escalated through various team and quality meetings but no improvement had been made. One group of three junior and mid-career doctors told us they had two patients who had been waiting over seven days for x-rays to be taken. Senior staff told us that any issues with patients waiting imaging would be raised daily at the capacity meetings and would be graded red. They felt that the reported waits were a misunderstanding and that other factors had influenced the patients stay.
- The surgical assessment unit at Sandwell General Hospital received referrals from the Emergency Department (ED) at the hospital and from City Hospital ED. Referrals also came from clinics and GP's. The only exception to hospital ED referrals was fractured neck of femur patients where the pathway admitted them directly to a ward. The unit had 18 beds, but could flex to 20 if required. Beds were in four bays and staff merged bays to prevent mixed sex accommodation, for example if the number of female and male patients were similar then two bays would be allocated to each sex. If there were more female than male then staff would make three bays female and one male.

Access and flow

- The hospital held three site meetings each day when bed capacity, patient discharges, blocks to performance and staffing issues were all discussed. The senior nurse on duty for each ward attended the meetings. Some nursing staff told us that whilst they understood the importance of the meetings, they felt that losing a member of the nursing team added pressure to an already busy environment.

- Venous thromboembolism (VTE) audits were completed daily and covered the previous period 2pm to 2pm. This assessed compliance with VTE testing and ensured that tests were completed in all appropriate cases.
- Between January and December 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been better than the England overall performance for the whole period with a stable trend. Data for December 2016 showed 78% of this group of patients were treated within 18 weeks versus the England average of 73%. General surgery data showed that 91% of patients were seen within 18-week referral time.
- Five surgical specialties were above (better than) the England average for admitted RTT (percentage within 18 weeks):-

Urology 87.3% against an England average of 79.5%

Oral Surgery 87% against an England average of 70.1%

Ophthalmology 80.7% against 77.8%

General surgery 76.4% against 75.4% and

ENT 76.4% against 68.9%.

- Two surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).

Plastic surgery 70.4% against an England average of 82.5% and

Trauma & Orthopaedics 56.3% against 65.9%.

- Cancelled operations. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period March 2015 to December 2016 the trust cancelled 905 surgeries. Of the 905 cancellations only five were not treated within 28 days.
- Cancelled operations as a percentage of elective admissions included all cancellation rather than just short notice cancellations. For the period March 2015 to December 2016 trust level cancelations were largely similar to the England average.
- The theatre lead nurse, who carried out the functions of theatre manager, told us that cancelled lists were extremely rare occurrences, and there had only been two instances in the last eight years where whole lists had been cancelled. Individual cancelations might be caused as a result of sickness or last minute leave. The bulk of procedures were able to proceed due to the trusts pooling of patients, which meant that any surgeon with the appropriate skills might perform the patients operation as opposed the practice of the reviewing surgeon completing the surgery.
- Discharge arrangements followed the trusts policy and procedure. Patients left the hospital with a discharge letter, take home tablets and advice sheets. Where possible relatives escorted patients home or transport was arranged.
- Theatre utilisation at Sandwell General Hospital for the three months October, November and December 2016 averaged 71% of total capacity. Theatre utilisation affects the number of operations which are performed and therefore impacts of waiting lists, and the income generated by trusts.
- Senior nursing staff on the surgical wards told us that surgical outliers; surgical patients cared for on non-surgical wards did not occur at Sandwell General Hospital; they did however say that occasionally medical outliers may be cared for on surgical wards. These tended to be patients who were reasonably well with low acuity waiting for home care packages or test prior to discharge.
- Systems were in place which ensured that surgical patients were cared for in the most appropriate location, for example ward Newton 3 took post-operative patients with high acuity. Lyndon 3 had 16 elective beds and 17 step down beds. The step down beds were used by patients from Newton 3 as their acuity fell and the elective beds were used by elective day patients. This closed ward system meant that patients were cared for by appropriately skilled staff and prevented outliers; patients whose needs would be better met in a ward dedicated to their condition. The ward sister told us that since October 2016 there had only been one admission to the ward which was not appropriate, this had been caused by capacity issues in the hospital during the night and the patient was transferred the next morning.
- Some consultants expressed concerns regarding managerial issues and pressures. For example, we were

told that the trust had agreed through pressure from the Clinical Commissioning Group (CCG) to fixed number theatre lists. This meant that each theatre list had to have a set number of patients per list. Previously surgeons could build the lists based on the total time each procedure took. They felt that fixed numbers could lead to operations being rushed and posing a risk to patients.

Meeting people's individual needs

- Carers and family members were actively encouraged to attend the hospital and be involved in the care and support of their relative. This included helping at meal times, and supporting them emotionally. The trust provided pull-out beds to enable them to stay overnight. Meals were also provided to assisting relatives and carers which meant they could remain with their loved ones for longer periods. This was in addition to general visiting.
- Patients with complex needs or learning difficulties had complex care folders. The folders contained information collected from the patient or their carers about their likes, dislikes and interventions to help support the patient if they become anxious or distressed. Patients with a learning disability were able to visit the hospital prior to admission. Carers were encouraged to stay with patients to support them.
- Translation services were available in the form of telephone interpreter service. Face to face interpreters could be arranged if required and given sufficient notice.
- Bariatric equipment was readily available and the staff experienced no delay in receiving beds, chairs and moving equipment when ordered for a specific patient.
- Patient-Led Assessments of the Care Environment (PLACE) 2016 reported dementia friendly score as 91% for the trust above the England average score of 75%.
- Patients living with dementia were highlighted with butterfly markers on their bed, similar systems were used to identify patients at risk of falls or other special needs. Patient records were also tagged so that staff were aware that the patient might need additional support or more time to consider their response.
- Discharge letters were sent to patients GP's explaining any treatments or procedures which had been completed, with recommendations for continued care where appropriate. On discharge patients and carers were given information leaflets with details for ongoing care and how to obtain information or support if they had any concerns. Staff also explained to patients and carers what care and support would be required on leaving the hospital. Where appropriate people were signposted to charities and support groups.

Learning from complaints and concerns

- The trust had an up to date complaints policy. Patients who wished to complain or raise concerns were supported by the trusts' Patient Advice and Liaison service (PALS). We saw leaflets referring people to PALS available throughout the public areas of the hospital. The trust web site also contained information to help people understand the complaints system and the PALS service.
- We spoke with staff about complaints from patients and their relatives. They had a clear knowledge of the type of issues most often complained of. They assured us that all complaints were taken seriously and people were listened to
- Staff told us that they accepted complaints as a tool for learning. One nurse told us, "If I've been complained about, I want to know what I've done so that it doesn't happen again". We were told that complaints about individuals were raised with them which gave them an opportunity to put their side or reflect on the circumstances. General learning from these complaints was shared within the team although we were told that it was often obvious who the issue related to. Wider learning from complaints did not appear to happen unless an incident report had been generated which required communication with a wider audience.
- Between April 2016 and March 2017 there were 84 complaints received for surgery at the hospital. The main issues related to attitude of nursing staff, communication and dietary requirements. The Clinical Commissioning Group (CCG) told us that they felt the trust responded well to any concerns raised with them.

Are surgery services well-led?

Good

We rated well-led as good because:

- Managers and supervisors understood their staff and how to support them in their work.
- Relationships between different staff groups fostered collaborative working.

- Innovative practice on wards and in theatres had allowed staff to influence how they worked, increasing efficiency and improving the environment for patients and staff.
- Staff described a positive leadership culture and felt supported by their managers who were visible in the departments and provided an open door policy.

However:

- The use of agency staff to cover long standing vacancies caused anxiety for permanent staff.
- Some staff were unsure how future changes to the trust would affect them in their role.

Leadership of service

- The trust's operated a triumvirate leadership system across the different directorates. This involved a doctor or consultant, a nurse or lead professional and an operations manager leading each area. This ensured that clinical operational and practical concerns were all represented when issues were discussed or decisions made.
- Staff told us that managers and supervisors were approachable and understood their role and provided the support they needed to carry out their role.
- Senior nurses, managers and clinicians respected each other's role. We observed interactions between different staff groups and different levels of seniority. We saw that exchanges were polite, professional and respectful.
- Middle level managers and clinical leads were known to staff. We were told that they were supportive and approachable.
- Senior nursing staff told us that there was very little executive level presence on the surgical wards. However they told us that executives and senior managers were approachable and supported them in their role.

Vision and strategy for this service

- The trust vision, "2020 vision" was 'to be renowned as the best integrated care organisation in the NHS'.
- Nine 'I will' values had been identified in consultation with staff and formed the ethos of work in theatres and on surgical wards. The 'I will' values encouraged staff to take responsibility for the service they provided by asking them to 'Make people welcome', 'Find time to listen', 'Be polite, courteous and respectful', 'Keep people informed', 'Admit to mistakes', Value the patients point of view', 'Be caring and kind', 'Keep people involved' and 'To go the extra mile'.
- Staff understood their role and how they contributed to trust values and vision.
- In addition to the 2020 vision and the nine values. The trust had also identified four strategic objectives which were to provide services from buildings fit for 21st century health care. To provide the highest possible clinical care. In partnership with primary and social care to deliver an increasing range of seamless and integrated services across hospital and community settings.
- Surgical services had completed a review of services in preparation for the completion of the move to the new hospital this had included reviewing the location, age and serviceability of equipment.
- There was a sense of anticipation amongst clinical teams and nursing staff that services would improve when the new hospital opened. However many expressed anxiety regarding uncertainty for their own future. Concerns were mainly in relation to which of the trust's hospital sites they would be required to work at.
- Strategic plans were in place to move the majority of the surgical services to the new hospital, although we were told that some services would remain and be enhanced at the Sandwell General Hospital site. These services had still to be identified.

Governance, risk management and quality measurement

- Theatre governance meetings took place on a monthly basis. The meetings were cross site which ensured that issues at one location were highlighted and understood across the trust. We reviewed minutes of the meetings held on 3 January, 9 February and 7 March 2017. We saw that incidents and their severity, review of risk register, completed audits, training and PDR compliance and sickness rates, were all standing agenda items.
- The trust had a quality and safety plan for 2016-2019 which had an outcome to aim to be among the best in the NHS. They aimed to reduce deaths in hospital that could be avoided, such as sepsis, so that they were among the top 20% of comparable NHS Trusts in the UK.
- The risk register for surgery included staff shortages and equipment issues. An example being that theatres did not have an uninterrupted power supply (UPS). We saw

how this and other issues had been reviewed and options identified to resolve or mitigate the risks. Staff were aware of issues on the risk register which affected their area of work. Senior staff on wards and in theatres had access to and understood the issues on the risk register. They were involved in the review, mitigation and resolution of the risks.

- The matron compiled monthly exception reports to identify early issues with specific indicators, including nursing staff indicators, management and leadership indicators and quality and safety indicators. Depending on the findings, local action was taken when appropriate or escalated to the senior management teams or group director. We saw January 2017 report which identified the indicator findings. For example, we saw that there had been no formal complaints, audit results were documented, Friends and Family Test results were monitored and the top three key risks were identified.
- Junior doctors had raised the issue of delays in the discharge of patients who were waiting for imaging services. Senior managers told us that delayed discharge and delays to imaging should be reported at the daily bed management meetings and would be addressed at that time. They stated that no such issues had been raised through the system. Delayed discharge due to imaging was not on the risk register.
- We saw minutes of team meetings on wards and in theatres. The trust also provided copies of minutes of clinical governance board meetings for the surgery. These minutes covered the period November 2016 to January 2017. We saw that agenda items included audits, never events, the clinical effectiveness, risk register and serious incidents and complaints across the directorate. We saw how information and learning was shared through feedback and circulation of minutes of these meetings.
- We found that the lack of a porter service to escort patients who required imaging services removed more experienced staff from their primary role; this increased the workload for nursing and junior doctors who remained on the wards while colleagues were committed on escort. We were advised that the issue had been escalated by local managers but had not been supported by the executives.

Culture within the service

- We found consultants and doctors to be enthusiastic and confident. They described their colleagues as helpful communicative and supportive. One consultant explained how they had chosen Sandwell General Hospital after working in a number of local hospitals.
- Whilst planned nursing numbers were maintained on the wards through the use of bank and agency staff the staffing shortages resulted in tiredness and low morale amongst some staff. Nursing staff vacancies and high use of bank and agency staff to cover these were a concern to permanent nursing staff on surgical wards. Local managers had raised staffing issues and followed trust procedures to try to fill vacancies with permanent staff.
- Staff felt supported by their managers and believed they had been responsive to change and what they believed were high workloads. However they told us they felt they had no more to give. There was no more flexibility within the numbers of staff available. Nursing staff told us they loved working at Sandwell General Hospital despite their concerns.
- Theatres staff had their own mantra – 'We can'. We were told of instances where staff had returned to work or remained at work when emergency cases had arisen.
- The trust supported staff in relation to meeting the requirements of Duty of Candour. Staff received awareness training in line with their role.

Public engagement

- The trust was due to open a new hospital the Midland Metropolitan Hospital in October 2018. Public opinion had been sought prior to commencement of the build. The trust website had news articles for the public and for staff to show progress on the build.
- The trust website also contained information to the public regarding annual performance, governors meetings, charitable services and PALS.
- Patients and visitors were encouraged to provide feedback on services both through local survey and through the NHS friends and family test. They were also encouraged to raise issues at the time with staff who were dealing with them so that issues could be resolved quickly.
- We saw how public opinion had influenced the environment in theatres where soft weave blankets had been purchased following feedback from patients.

Staff engagement

- All nursing, healthcare, clinical and managerial staff had personal email accounts which were used to send group or individual messages.
- Staff meetings took place in all areas of surgical services which enabled a communication route between staff and senior and executive managers.
- The trust intranet had information on latest developments or medical alerts and other news as well as access to trust policies and procedures. The chief executive sent a weekly email message to staff.
- Staff told us that their immediate managers kept them informed about developments or issues where they could; however some staff told us that there was little information regarding future roles when the new hospital opened which left them feeling vulnerable.

Innovation, improvement and sustainability

- The theatre lead nurse at Sandwell General Hospital had developed a theatre communication tool. The tool was accessible to all theatres staff across the trust. Links to surgical policies and procedures were included which enabled staff to access information from one log-in point. Because access to these trust documents was through links it had the benefit of always showing the latest information. If the primary document was amended or updated it was that same document which staff accessed. The communication tool also carried minutes of meetings which enable staff who could not attend to update themselves. Most importantly the tool included the World Health Organisation (WHO) five steps to safe surgery briefing system. This provided theatre staff with an electronic rather than hand written briefing form which we told had improved compliance. Medical alerts and other theatre based news also appeared on the system.
- Health promotion care plans were being gradually introduced on to the surgery wards to promote individuals general health, alongside their surgical procedures.
- The trust were working towards being paper-light with an electronic patient record system due to be introduced later in 2017.
- Whilst we were told that some theatres and surgical wards would be retained at Sandwell General Hospital following the opening of the new Midland Metropolitan Hospital, final decisions were still being made. We were assured that the trust were retaining all the current surgical services.

End of life care

Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Outstanding
Well-led	Outstanding
Overall	Outstanding

Information about the service

Sandwell and West Birmingham Hospitals NHS Trust provide one integrated end of life care service for people living in Sandwell and West Birmingham. The trust serves a population of 530,000 people in the West Birmingham and Sandwell area who have a Sandwell and West Birmingham GP.

The service had a five-year strategy that included the development of the integrated team and is currently being developed to identify further developments.

The integrated end of life and palliative service included:

- A connected palliative care coordination hub, which is a single point of access available seven days a week 8am to 8pm.
- An urgent response team available seven days a week, twenty-four hours a day.
- Acute and community specialist palliative care nurses available seven days a week with on call arrangements for evening and overnight.
- Palliative medicine consultants available five days a week with on call arrangements evening, overnight and at weekends.
- End of Life Care Facilitators were available seven days a week from 8am until 8pm.
- A Macmillan Occupational Therapist Team available seven days a week between 8am and 4pm.
- The Heart of Sandwell Day Hospice, open Monday to Friday which can accommodate up to 12 patients each day.

The service had a register of all patients who the service had identified to be in their last 12 months of life. Between 1 April 2016 and 31 March 2017, 1003 patients had been added onto the end of life register. There were 511 deaths on the end of life register who had a supportive care plan (SCP).

There was also a certificate and bereavement team (CARES) on the hospital site who arrange for the medical cause of death certificate to be released and also provide more practical support such as registering the death and contacting the funeral director.

As part of this inspection, we visited four wards at Sandwell Hospital including critical care. We also visited the emergency department (ED). We visited the mortuary and met with mortuary staff. We visited the chapel and met with a chaplain and we met with the staff in the CARES office. We spoke with four patients, two sets of families and 22 staff including palliative care consultants, doctors, palliative care managers, palliative care nurses, and ward staff. We looked at six sets of patient records.

End of life care

Summary of findings

We have rated the end of life services at Sandwell Hospital as Outstanding overall. This is because;

- Experienced staff provided a compassionate and responsive evidence based service for end of life care patients.
- The service provided comprehensive joined-up care with access to care and treatment in both acute hospitals and in the community, seven days a week, 24 hours a day.
- The service followed evidenced based guidance incorporating NICE Guidance including NICE QS13 End of Life Care for Adults (Nov 2001/updated Mar 2017) and The Five Priorities for Care of the Dying Person (Leadership Alliance 2015).
- Staff were knowledgeable about the trust's incident reporting process and we saw concerns were investigated and learning shared.
- The service had one single point of access for patients and health professionals to coordinate end of life care services for patients known as the Hub. This meant patients received the right care at the right time in the right place.
- The palliative and end of life care service was very well developed across the trust and held in high regard by all of the wards we visited.
- End of life and palliative care was a priority for the trust. The service was well developed, staffed, and managed as part of the iCares directorate within the Community & Therapies clinical group
- There was a clear governance structure from ward and department level up to board level. Good governance was a high priority for the service and was monitored at regular governance meetings.
- Staff were proud of their service, and spoke highly about their roles and responsibilities, to provide high levels of care to end of life patients. This included arranging care for pets so that patients could come into hospital and arranging for a patient be discharged to a more appropriate location to be nearer to their friends and to enable them to receive the nursing care specific to their needs.
- Patients were involved in their care and were enabled to make choices. This included choosing the place where they wished to receive palliative care and where they would prefer to die. The palliative and end of life care team ensured that patients were discharged quickly to their preferred place.
- Advanced Care Plans and Supportive Care Plans (SCP) were used across the trust for end of life patients. They were used as a person centred individual care record to include all the needs and wishes of a patient and their family.

However:

- Medical staff had not always recorded daily reviews of patients on the patient's SCPs when these were in use and had not always recorded information about discussions they had had with the person and/or their family member on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.
- The trust's 'Anticipatory Medication Guidelines' was due for review in September 2016 but no updated guidance was available. We could not be assured staff were following the most up-to-date guidelines.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and senior staff fully supported them to do so. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate, and current picture of safety.
- Performance within end of life care and palliative care services showed a good safety record. When something did go wrong, there was appropriate thorough investigation. Lessons were learned and communicated to support improvement in other areas as well as services that were directly affected.
- Staff working within end of life and palliative care services had received up-to-date mandatory training.
- Safeguarding vulnerable adults and children was given priority within the palliative care and end of life services. Staff had taken appropriate steps to prevent abuse from occurring, responded appropriately to any safeguarding concerns and worked with others to implement protection plans.
- Staff numbers and skill mix were planned, implemented, and reviewed to ensure that people received timely and appropriate care and treatment. Any staff shortages were responded to quickly and adequately. There were effective staff handovers to ensure staff were aware of and managed risks to people who used the service.
- Staff assessed, monitored and managed risks to people who used the service on a day-to-day basis. This included signs of deteriorating health and any increase in distressing symptoms. A consultant and palliative care clinical nurse specialist were either on duty or on call to discuss patients and their treatment needs seven days a week and 24 hours a day.

However:

- Medical staff had not always kept clear records. Doctors had not always written in Supportive Care Plans (SPC) following reviews of patients where there was a designated area for medical reviews and some information which should be recorded on DNACPR forms was missing.
- The trust's 'Anticipatory Medication Guidelines' was due for review in September 2016 but no updated guidance was available. We could not be assured staff were following the most up-to-date guidelines.

Incidents

- Between February 2016 and January 2017, staff working within end of life and palliative care services reported 19 incidents. There were 16 'no harm' and low harm incidents and three moderate harm incidents reported. Incidents included identified power, phone and information technology failures, which could lead to delays in patients contacting the service for advice. One incident related to a medication error, one to a patient sustaining a fall, one to a lack of documentation about the level of care provided and another to lack of availability of anticipatory pain relief for a patient.
- No serious incidents had been reported in the palliative and end of life services between 1 February 2016February 2016 and January 2017January 2017.
- There were no never events reported by the palliative and end of life service between 1 February 2016February 2016 and January 2017January 2017. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff had access to the hospital's electronic system and knew how to report incidents. Staff told us they received feedback about the outcomes of incidents they had reported in the form of emails from their managers.
- Learning from incidents took place. For example when concerns were raised about the care a patient had received this resulted in a change to the way staff recorded care given to patients.
- The specialist palliative care team reviewed incidents relating to end of life care as a standing agenda item at their quarterly business meeting. Staff said this ensured feedback and learning was shared and understood by the whole team. A manager told us and we saw that incidents and outcomes were also discussed informally at staff handovers and at the weekly multidisciplinary

team (MDT) meeting. Minutes from the end of life, Steering Group Meeting for November 2016 and January 2017 showed senior staff also discussed incidents and learning from incidents.

- Duty of Candour (DoC) is regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- Staff described incidents that DoC may relate to. There had been no incidents that required DoC investigation for the end of life and palliative care service at Sandwell Hospital.
- We spoke with ten staff about DoC including medical and nursing staff and they were all aware of their responsibilities with regards to be being open and honest with patients in their care.

Safety thermometer

- The NHS safety thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.
- Data from the Patient Safety Thermometer showed that the trust reported 2222 new pressure ulcers, 1616 falls with harm and 1515 new catheter urinary tract infections between January 2016 and January 2017. Rates from all three fluctuated throughout the year.
- There had been no new harms reported from patients with palliative care and end of life services in these figures.
- Senior ward sisters were generally aware of their ward's performance in relation to the safety thermometer and safety crosses were displayed on the ward and used to track pressure ulcers and falls each month.

Cleanliness, infection control and hygiene (only include if there is a palliative care ward)

- Policies and standard operating procedures were in place to ensure the mortuary staff complied with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. The trust had carried out a Pathology Environmental Health and Safety Inspection Checklist audit on 25 January 2016 and 20 October 2016, which included assessing waste management, hand hygiene, and use of personal protective equipment. The mortuary was fully compliant with infection control on both audits.
- We reviewed training records and found that 100% of staff from the palliative care team had completed their mandatory training on infection prevention control.
- The ward areas we inspected were clean. There were sufficient hand wash sinks and hand gels in bays, at the entrance to wards and near side rooms.
- We saw the mortuary was clean and hand-washing facilities were available for staff to use. Personal protective equipment was provided on wards and in the mortuary. We saw nursing and medical staff washing their hands on entry to wards and before and after providing hands on care to patients. We saw that all staff including mortuary staff followed the arms bare below the elbow policy in clinical areas.
- Mortuary staff and staff on wards were aware of the process and precautions to follow in respect of transporting patients from wards to the mortuary in cases where the patient was infected or there was the possibility of contamination. A staff member showed us the policy for staff to follow.
- The trust's infection prevention and control policy was up-to-date. We noted it was due for review in April 2017. Staff could easily show us policies relevant to their area of working. These were easily accessible on the trust's intranet.
- The hospital scored better than the England Average for cleanliness in the Patient-Led Assessments of the Care Environment (PLACE) 2016 programme. PLACE are a self-assessment of non-clinical services, which contribute to health delivered in both the NHS and the independent, private healthcare sector in England. Sandwell General Hospital scored 99% for cleanliness with a comparative England average of 98% for large acute trusts.

Environment and equipment

- McKinley T34 syringe drivers were being used by the trust. The trust had 106 McKinley T34 syringe drivers in use, shared across both acute sites. Managers and palliative care and nursing staff on wards told us that there were no issues with ordering or obtaining equipment promptly for patients who were receiving end of life care.

End of life care

- Nursing staff told us they could access syringe drivers out-of-hours from the medical device storage area as porters had keypad access and would deliver them to the ward.
- We saw equipment used on wards to nurse patients with palliative care needs such as profiling beds, specialist mattresses, and cushions to prevent pressure ulcers.
- The mortuary at Sandwell hospital had 120 fridge provisions which were never full to capacity and we saw the fridges were in good working order.
- The Estates Building Management System (EBMS) monitored mortuary body storage systems. Any faults (such as problems with the fridge temperatures) were picked up and a 'common alarm' fault signal re-transmitted to estates on-call managers mobile phones 24/7. A call would then be made to the switchboard who would contact the on-call Mortuary technician for response.
- The PLACE 2016 audit scored the hospital at 96% for condition, appearance and maintenance. The national average for large acute trusts in England was 93%, meaning the hospital scored better than the England average in this measure.

Medicines

- Anticipatory medication was provided to ensure prompt and effective symptom control and to reduce distress and anxiety for patients. Guidelines for the use of these were contained in Supportive Care Plans (SCP), located in each patient's record.
- We saw that anticipatory medicines had been appropriately prescribed and detailed information such as why the medicine could be given and timings and frequency that the medicine could be administered.
- Staff on the wards told us and we saw they routinely kept stocks of palliative medicines for when patients required these.
- Records showed those patients referred to the specialist palliative care and end of life team had their medicines reviewed by the team. This was done in consultation with other medical staff involved with the patients' care.
- Patient's medication needs were discussed during the weekly multi-disciplinary Team (MDT) meetings.
- Cytotoxic drugs are potent drugs used to treat patients with cancer otherwise known as chemotherapy. There are strict precautions for staff to follow when handling these drugs to prevent harmful contamination. We saw cytotoxic drug spillage kits were available to minimise risks to patients or staff in the event any toxic medicines leaked or were spilled.
- The end of life care and palliative care team had advanced nurse prescribers within the team. We observed that nurses who were qualified to prescribe medicines for symptom management reduced the delay in patients receiving medicines to ease suffering. We saw an example of an advanced nurse prescriber (specialist palliative care nurse) prescribing medication for the commencement of a syringe driver for a patient on a ward.
- Patients and their families were kept informed about medication changes. We observed a specialist palliative care nurse discussing medication with a patient's family. The nurse explained how the patients' symptoms would be managed better with a change in medication and the reasons for this. The family told us they were happy with how the patient's medication was explained to them.
- The trust was not carrying out audits of patients' medication needs, including pain relief needs

Records

- We reviewed six sets of patient records. We saw use of the Supportive Care Plan (SCP) for patients on wards. This plan was designed for patients with a progressive life limiting illness where the focus of care is on comfort and quality of life. For some this was the last phase of their illness, other patients may be expected to survive this episode of care and be discharged from hospital.
- The SCP detailed actions for staff to follow once active interventions were considered inappropriate and emphasised comfort and quality of life. These included, stopping unnecessary tests, observations, anticipatory medication guidelines and documenting the patient's preferred place of care.
- The SCP included risk assessments of patients' nutrition, mobility, and skin integrity. The care records we looked at showed these risk assessments had been regularly reviewed.
- We saw the critical care 'treatment options plan'. This is a document that helps staff plan end of life care for patients. The plan is centred on a pathway designed for patients with potential life limiting illnesses where the

focus of care may become comfort and dignity in dying. For some this will be the last phase of their critical illness, other patients may be expected to survive this episode of care and be discharged.
- SCPs were reviewed daily by nursing staff including regular reviews by the specialist palliative care nurse.
- Medical staff had reviewed patients daily and had written in the patient's medical notes but had not always recorded this on the SCP in the designated area for medical reviews.
- Patient records were stored securely on wards in locked cabinets accessible only to ward staff with a code.

Safeguarding

- The staff we spoke with were extremely knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse and they understood what processes to follow. This reflected safeguarding legislation and local policy.
- The trust target for safeguarding training both vulnerable adults and children (level 1 and level 2) was 85%, the palliative care and end of life service team had exceeded the trust safeguarding training requirements. At the time of the inspection 100% of staff had completed safeguarding adults level 1 and 85% of staff had completed safeguarding adults level 2 training. In addition, 100% of staff had completed safeguarding children level 1 training and 92% of staff had completed safeguarding children level 2 training. These training figures exceeded the trust training target of 85% for safeguarding both vulnerable adults and children (level 1 and level 2).
- Staff we spoke with knew how to raise concerns and report safeguarding incidents. We saw flow charts and information displayed (including relevant telephone numbers) in staff offices for staff to refer to when required.
- Staff we spoke with knew who to contact if they had any safeguarding concerns. They told us the safeguarding lead was easily accessible if they required further advice. They understood their responsibilities to safeguard vulnerable adults and children from abuse in line with safeguarding standards and the trust's policy.
- The trust had safeguarding children and safeguarding adult's policies in place. Staff showed us they could easily access these via the intranet. Both policies included information about types of abuse, a flow chart for staff to follow when reporting abuse in addition to useful contact details such as Sandwell Children's Social Services Team (MASH) and the trust's safeguarding team.
- We observed in the multidisciplinary team meeting (MDT) staff discussed safeguarding concerns regarding end of life patients and appropriate arrangements had been made.

Mandatory training

- The trust's palliative care and end of life service provided treatment and support to end of life patients in both acute hospitals and in the community. The trust provided records of mandatory training showing an average training compliance across the trust of 82% against an 85% trust target. Staff mandatory training included: conflict resolution 100%, equality and diversity 100%, fire safety 96%, food safety 100%, harassment and bullying 100%, health and safety 100%, infection control 85%, information governance 100%, medical devices 76%, medicines management 84%, moving and handling (non patient load) 50%, moving and handling (patient handling) 96%, basic life support 67% and safeguarding vulnerable adults and children level 1 100% (adults and children), and level 2 (85% adults and 92% children), against a trust target of 95%.
- Mandatory training for mortuary staff consisted of moving and handling – patient handling, Safeguarding Adults Level 1 and Safeguarding Children Level 1. As of March 2017, 100% of mortuary staff for both acute sites had completed all of their mandatory training against the trust target of 95%.

Assessing and responding to patient risk

- Staff handovers we observed were effective at identifying and managing patient risk.
- The introduction of the Supportive and Palliative Care Indicators Tool (SPICT) helped staff to identify patients requiring palliative care and end of life service. The SPICT is a guide to identifying patients at risk of deteriorating and dying. The tool looked at general indicators of deteriorating health and clinical indicators of one or more advanced conditions. This tool was available on the wards via a hard copy and easily accessible on the intranet. One of the palliative care

consultants sat on the deteriorating patient committee ensuring that experiences were discussed and learning and knowledge was shared and dissipated between medical and nursing staff.

- Patient's records incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw patients had been regularly reviewed including for pain and symptom control.
- The palliative and end of life care service provided a face-to-face service across both acute sites between the hours of 8am to 8pm over seven days a week. The team provided telephone on-call cover outside of these hours from 8pm until 8am across City Hospital and Sandwell General Hospital and provided advice and support to patients, relatives and staff where required. A senior nurse prioritised all calls received at the hub dependent on patient need and individual risk of the patient. Palliative and end of life care service staff told us and information received from the trust showed urgent cases were seen within 30 minutes of referral to the team.
- End of life care facilitators provided a single point of access telephone service to provide clinical advice. A palliative care urgent response team, consisting of general palliative care nurses was available 24 hours a day, seven days a week to visit and support people who had been discharged from hospital and had asked to be cared for in their homes.
- Patients at the end of life could be referred to the palliative and end of life care service directly via the connected palliative care coordination hub by carers, and health professionals on the wards. End of life care facilitators would then visit patients at end of life on the wards. Once they had assessed and reviewed the patient there was clear documentation in the patients' record of the visit and any recommendations made were written in those notes. End of life care facilitators would also discuss the patient's care with the medical and nursing teams caring for that patient.
- Staff told us end of life patients under the care of the palliative and end of life care service were triaged daily according to their needs. Patients who were dying and in need of daily symptomatic review and or family support were seen by palliative and end of life care staff each day. Those patients who were more stable and were comfortable and settled were seen less frequently. The ward staff could contact the palliative and end of life care service to request additional support if the need arose.
- Regular review of end of life patients by the palliative and end of life care service identified if patients had increased needs. The weekly MDT meeting helped to ensure that specific needs of individual patients were monitored and met.

Nursing staffing

- We saw there were sufficient and appropriate palliative and end of life care staff to meet the needs of end of life patients at Sandwell Hospital.
- Within the connected palliative care hub there were five acute clinical nurse specialists (CNS) (4.6 WTE), one lead band 7 end of life facilitator, five band 6 WTE end of life care facilitators with one WTE vacant post, two band four care coordinators (1.28 WTE) and five band two administrators. Staff took calls at the hub between 8am and 8pm, seven days a week. There was always one facilitator on daily who would triage patients and two palliative care nurses would visit and assess patients on the wards across both hospitals. During the weekend, this number was reduced by one nurse on the wards where one nurse covered both hospitals.
- The urgent response team had one senior sister WTE (band 7) team lead, nine WTE junior sisters (band 6) palliative care nurses and one occupational therapist. Staff told us there was usually at least two staff on duty. The service operated 24 hours a day.
- The Macmillan therapy team had three band 6 staff (2.8 WTE) with one rotational band 5 staff member (1 WTE) and one band 4 therapy assistant (0.85 WTE). Occupational therapists and occupational support workers in the team supported end of life patients.
- In order to fill any gaps in the service and respond to capacity requirements the palliative and end of life care service had started a rotation between acute and community specialist palliative care nurses. We saw that this had allowed staff to work in either acute or community settings when required in response to patient need.

Medical staffing

- The Sandwell and West Birmingham Trust (SWBH) palliative and end of life care service consisted of 1.6 whole time equivalent (WTE) palliative medicine

consultants. The consultants provided care, treatment and advice for all end of life patients within Sandwell and West Birmingham Hospital Trust. This included both hospitals and the community.

- The Association for Palliative Medicine of Great Britain and Ireland and the National Council for Palliative Care guidance states there should be a minimum of one WTE consultant per 250 beds. The trust had 764 beds (460 beds at City Hospital and 304 beds at Sandwell hospital). This equates to in excess of three WTE consultants. Despite the trust falling well below this recommendation, we saw this did not have a negative impact on patient care. As the palliative and end of life service was large and well supported by administrative staff, we saw this offset this deficit in consultant hours.
- The two palliative care consultants worked flexible hours around their fixed commitments, which included attending ward rounds, MDT meetings, and clinics. The two consultants were available face to face Monday to Friday 8am to 4pm for all the sites (as needed). Out-of-hours, consultants were available for advice over the phone 24/7. If input was needed face-to-face, this was available via the Hub.

Other staffing

- The trust employed four full-time mortuary technicians covering both City and Sandwell Hospital sites. Mortuary staff worked at both acute sites and staff told us the rota system ensured there were sufficient staff on each site to meet the demands of the mortuary service.
- Porters transported patients from the hospital wards to the mortuary. They had out-of-hours access to the mortuary and porters were trained to book deceased patients into refrigerators to accommodate..

Major incident awareness and training

- We saw the trust had a major incident plan in place. Palliative and end of life care service staff and mortuary staff we spoke with were aware of the plan and could access it on the trust's intranet.
- Mortuary staff at Sandwell Hospital had additional facilities available in the event that the mortuary became full but could accommodate 120 patients. Mortuary staff who had worked at the hospital for many years confirmed that they had never known the mortuary to be full to capacity.
- Mortuary staff told us in the event of a power cut there was an emergency generator in place.
- Data received from the trust showed the palliative and end of life care service staff had not received major incident planning or training. This had been raised during the previous CQC inspection. However, staff we spoke with knew where to access information and policies on major incidents if they needed to.

Are end of life care services effective?

Outstanding ☆

We rated effective as outstanding because:

- There was an excellent holistic approach to assessing, planning, and delivering end of life and palliative care and treatment.
- There was effective multidisciplinary working to ensure that patients received innovative, efficient and joined up care that reflected their needs and choices.
- Evidence-based care and treatment were used to support the delivery of high quality end of life and palliative care.
- There were systems in place to monitor and improve quality and patient outcomes. The palliative and end of life service performed better than the England average for all of the five clinical indicators.
- The continued development of staff competence and skills was recognised as being integral to ensuring high quality end of life and palliative care.
- Staff could access the information they needed to assess, plan and deliver care to patients in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005. Staff supported patients to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However;

- There was a need for the anticipatory medicines policy to be reviewed as the last available policy required review by September 2016.

Evidence-based care and treatment

- The palliative care and end of life team provided excellent end of life care in line with current evidence based guidance, standards, best practice, and legislation. For example, the Department of Health's end of life care strategy (2008) and NICE quality standards for

end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life.

- The palliative care and end of life team attended Gold Standards Framework meetings with GPs to help ensure patients were receiving the best possible palliative and end of life care and support.
- We saw that the supportive care plan had been implemented across the trust with an advanced care plan available for those patients within the last 12 months of life. Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and in the manner of their choosing.
- The trust's 'Anticipatory Medication Guidelines' was due for review in September 2016 but no updated guidance was available. We could not be assured staff were following the most up-to-date guidelines.
- We saw the trust had taken part in the End of Life Care Audit – Dying in Hospital, 2016. This report outlined that the aim of the audit was to "improve the quality of care and services for patients who have reached the end of their lives, and who are dying in hospitals in England." Results for the trust's palliative and end of life care service found that in relation to key symptoms that could be present around the time of death, there was documented evidence that pain was controlled in 79%; agitation/delirium in 72%; breathing difficulties in 68%; noisy breathing in 62% and nausea/vomiting in 55%. If results are restricted to those with length of stay over 24 hours, there was documented evidence that anticipatory medication (prn) was prescribed for the key symptoms: for pain in 75% of cases; agitation/delirium 69%; breathing difficulties 66%; nausea/vomiting 66%; noisy breathing/death rattle 62%.

Pain relief

- Patients identified as needing end of life care were prescribed anticipatory medicines which included pain relief. These 'as required medicines' were prescribed in advance to properly manage any changes in patients' pain or symptoms. We saw that these medicines had been administered appropriately and there was guidance in place for staff who were prescribing the medication.
- We saw wards stocked pain-relieving medication as part of the "as required medicines", which meant that patients did not have to wait for pain relief.
- The trust told us and we saw they had a separate pain management service that followed policies based on NICE and Royal College guidelines. The service chose not to use the 'Faculty of pain medicines' core standards for pain management (2015) guidelines specifically for palliative and end of life care.
- We observed that staff discussed pain relief and pain management plans with patients and their relatives. We saw that staff asked patients if they had any pain and how often they were taking their medication as required pain relief.
- We observed a specialist palliative care nurse assessing a patient's pain control. The nurse identified a need to change the way the patient received pain relief. The nurse discussed the reason to commence a syringe driver with the patient's family as the patient was unable to respond and immediate action was taken to implement the change.
- We reviewed five prescription charts of end of life care patients. They all had the required information regarding the patient's medication needs.

Nutrition and hydration

- Patients' records showed that individuals identified as being in the last hours or days of life had had their nutrition and hydration needs fully evaluated and appropriate actions followed. These records clearly documented discussions with relatives.
- The trust's specialist care plan included ongoing medical review of patients' nutrition and hydration needs. We looked at six patient care records and saw individual nutrition and hydration needs had been assessed. Care plans were in place, nutritional needs reviewed and actions clearly recorded.
- Patients could choose the meals, snacks and drinks they wanted from the menu but if they fancied anything else the staff could telephone down to the kitchen and request this for them. Special diets were catered for such as diabetic diet, fork mash diet and gluten free diet.
- We observed patients had plenty of drinks and snacks and meals were placed within their reach. Staff helped patients who needed help to eat their meals. We saw a

nurse helping a patient to eat their lunch. Patients, relatives, and staff confirmed food and drinks were replenished throughout the day and that patients could have drinks and snacks whenever they wanted these.

- When patients were nearing the last days of their life and did not have an appetite staff encouraged families to offer them little sips of water to keep their mouth moist and to keep the patient comfortable. Where families were not present, we saw that staff did this.
- The quality of nutrition and hydration patients at the end of life received was assessed as part of the End of Life care Audit, 2016. Where recommendations for improvements had been made, action had been taken to address this. For example, we saw frequent assessments of the dying patient's ability and desire to eat contained in specialist care plans and a senior doctor, nurse, or the speech and language therapist only made nil by mouth orders.
- The Patient Led Assessments of the Care Environment (PLACE) 2016 audit scored Sandwell General Hospital 93% for food, which was better than the England average (89%) for large acute trusts.

Patient outcomes

- The hospital fully contributed to the End of Life Care Audit, 2016. The trust carried out the national audit programme to support critical evaluation and reflection on the current clinical practice regarding the care of dying. The Ambitions Framework sets out the following ambitions to bring about an overarching vision:
  - Each person is seen as an individual
  - Each person gets fair access to care comfort and wellbeing is maximised
  - Care is coordinated
  - All staff are prepared to care
  - Each community is prepared to help.
- The Ambitions Framework identifies eight foundations that underpin all the ambitions and we saw these reflected in the care and support patients received.
- The service monitored the palliative and end of life care service to improve patient outcomes and used the information from audits to make improvements to the service. We saw that the trust had audited the use of the ACP between 1 January 2017 and 31 March 2017. Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and manner of their choosing.
- The audit demonstrated that 78% of patients had an ACP in place and the number of patients with an ACP had increased each month with just 7% of patients not having an ACP in place in April 2016. The audit also showed that 76% of patients achieved their preferred place of care and 72% of patients achieved preferred place of death.
- The trust used an advanced care plan that identified patient's choices and preferences for palliative and end of life care. The trust respectively audited records of patients who had died to review the care and treatment they had received. The audit between 1 January 2017 and 31 March 2017(information was collected and shared monthly with information for March 2017 provided by the trust following the inspection) identified: 78% of patients had an advanced care plan,
- We saw the palliative and end of life care service audit programme included audits such as: 'Percentage of appropriate patients for whom the Supportive & Palliative Care Indicators Tool (SPICT) tool is applied and an advanced care plan is made' (April 2016 – March 2017) and 'Audit of Macmillan therapy team supervision' was due to commence in April 2017.
- Palliative and end of life care service staff told us an audit of patients on the SCP had been completed in December 2016. This provided a baseline to re-audit planned for July 2017. The service hoped to see the number of patients on an SCP increase with improving end of life care provision. We had asked the trust for the results of these audits but this had not been provided.

Competent staff

- The trust aimed to ensure that, wherever possible, all new staff for which they had responsibility, completed their corporate and local induction as soon as possible after commencement with the trust, ideally within their first six weeks (non-medical staff) or two months (medical staff). All staff were given the opportunity and protected time to complete induction requirements.
- Local induction checklists and medical devices competency records were completed and copies sent to the appropriate department and a copy kept in the staff member's personal file.

End of life care

- All new medical staff received a local induction to the department in which they were working. This local induction took place within the first week of employment or as soon as possible thereafter.
- The palliative care and end of life service aimed to educate and support colleagues (hospital and community) to provide effective generalist palliative care. On the wards, this was through educating the doctors and nurses, through joint patient reviews. We saw evidence that the specialist palliative care team provided regular and ongoing training to different professional groups. These included medical and nursing staff, allied health professionals, medical, nursing and occupational therapy students, and nursing assistants. Training subjects included end of life care, anticipatory and end of life medicines, organ donation, and the role of the coroner's office.
- The specialist end of life team provided a training programme to help other ward staff become competent to care for patients who were at the end of their lives. Evaluation records showed staff who had already attended, valued the programme, reporting information was relevant, clear and well delivered. The palliative care and end of life staff team said they felt well supported by each other and used the daily team meetings and weekly multidisciplinary meetings for formal and informal supervision, learning, and support.
- Because the palliative medical team did not have any 'official' beds in the hospital, they did not have trainee doctors because their role would be supernumerary. However, they supported ward doctors who are interested in palliative medicine through quality improvement work. A ward doctor on one of the wards acknowledged this. One consultant is a foundation training educational supervisor.
- We saw from data provided by the trust the palliative and end of life service held a range of qualifications related to end of life care, which would assist staff in providing a high level of care to end of life patients. The lead nurse of the service had an MSc in advanced practice – palliative care, 27 staff were trained in advanced communication skills and 20 staff held the European certificate in essential palliative care. We found eight staff were non-medical prescribers and were therefore qualified to help manage end of life patients' symptoms, such as prescribing strong pain relief to ease symptoms.
- We saw a list of all courses the palliative and end of life service staff had attended. For example, five staff had attended the three-day palliative care conference, four staff had conducted the sage and thyme communications course, and one nurse had completed a reflexology course. The 'SAGE & THYME' model and foundation level workshop was developed by members of staff at a UK university teaching hospital and a patient in 2006, to teach the core skills of dealing with people in distress. By attending conferences and relevant training courses, the service were keen to keep updated with any advances related to end of life care in order to provide individualised care to end of life patients.
- Staff were encouraged to complete other training applicable to their role. For example Princess Alice palliative care course (through hospices/GPs), medicines prescribers course and the advanced palliative care course.
- A palliative care nurse explained that they had been supported to complete a haematology and oncology degree by the trust. This helped to extend the nurse's practice and provide them with a more in depth understanding of the oncology needs of patients.

Multidisciplinary working

- The palliative care and end of life team work in partnership with other health professionals involved in the care of the patient, such as GPs and community nurses to support and coordinate the care the patient received. The service is known as connected palliative care and is only available for adults registered with a GP within Sandwell and West Birmingham Clinical Commissioning Group.
- We observed multi-disciplinary team working when we sat in on a weekly multidisciplinary (MDT) meeting at the Hub. We observed discussions around the care and support needs of patients currently receiving palliative and end of life care within the service, based on the current register of patients. Representation included palliative care consultants, specialist palliative care nurses, district nurses, physiotherapists and occupational therapists.
- We saw, following discussions from relevant professionals involved in the person's care and treatment that plans were reviewed and decisions made about future care and treatment for each person.

End of life care

- The palliative care and end of life consultants attended four different condition-specific multidisciplinary meetings every week to advise on end of life care during patient reviews. One consultant said they regularly attended the majority of meetings.
- The palliative care and end of life consultants said they attended other multidisciplinary meetings on an ad hoc basis when requested by other teams. For example, one of the consultants attended the chest clinic the week of our inspection.
- We visited the critical care unit where there was a dedicated end of life (EOL) care team of six nurses who worked collaboratively with the palliative care and end of life team at Sandwell Hospital. The manager of the EOL on critical care explained how well the teams worked together.
- The hospital chaplain visited all wards where patients received palliative care at the end of their lives. The chaplain explained that they spent a lot of time on the critical care unit supporting patients, relatives and staff through difficult times.

Seven-day services

- The palliative and end of life care service provided a seven-day face-to-face access to specialist palliative care. The team was available from 8am – 8pm. Calls received out-of-hours were forwarded to the end of life facilitators and the trust's urgent response team. There was a clinical nurse specialist available seven days a week within the hospital and then on call during evening and weekends alongside a consultant in palliative care. This ensured experienced palliative care staff were available to provide advice to other professionals when required.
- If a patient on the ward needed a syringe driver to be set up for example, the ward nurse would set it up if competent to do so. They have a train the trainer system for syringe driver training. In the event no ward nurse was available then during normal hours the palliative and end of life care service staff would set it up and show the ward staff. If required out-of-hours site management would facilitate this if necessary.
- The mortuary operated a 24-hour service to provide mortuary cover for all hospital wards and departments. Out-of-hours the on-call mortuary staff could be contacted if relatives wanted to view relatives for example. Mortuary staff requested that relatives made appointments for viewing relatives but told us sometimes families would arrive unannounced.
- The certificate and bereavement office (CARES) was open from Monday to Friday from 9am - 4pm.
- Ward staff we spoke with were aware of how to contact the palliative and end of life care service out-of-hours to get in touch with a clinical nurse practitioner.
- The palliative care hub was open seven days a week to provide advice to professionals supporting rapid discharge by arranging admissions to home from home and hospice beds. The hub could also arrange respite and night sits to support people on discharge.

Access to information

- The NHS used computers to share patient information electronically, securely and privately. The Electronic Palliative Care Co-Ordination System (EPaCCs) used by the palliative and end of life services is an electronic record of a patient's care and treatment, including requests of how the patient wishes to be cared for. This system ensured that information about a patient could be shared (with the patient's consent), amongst health care professionals involved in the patient's care, including ward staff, palliative care nurses, medical staff, community nurses and GPs (GPs who have the EPaCCs system).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that staff obtained consent for all patients before they provided treatment and sought permission from patients to put them on the supportive care plan and end of life register and their consent was recorded. We saw written consent on patient's specialist care plans (SCP) and contained in the critical care treatment options plan.
- Nursing staff knew about the processes to follow if a patient's ability to give informed consent to care and treatment was in doubt.
- Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). A staff member gave an example of a patient with dementia care needs being

prevented from leaving the ward which would require a safeguarding referral under DoLS. Staff told us and we saw that training on the Mental Capacity Act 2005 was included as part of safeguarding training.
- Consultants told us that they undertook mental capacity assessments when required and we saw these documented in patient's notes and on the supportive care plans.
- We observed a specialist palliative care nurse gaining consent from a family of a patient regarding a change in medication. The patient had been assessed as lacking capacity.
- The specialist nurse also spoke with another patient who did have capacity. The patient was given information, opportunity, and guidance to make their own decisions about their care needs.
- We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) patient records and found that, in four of the six records where people did not have capacity to consent, doctors had recorded that they had held relevant discussions with family members. In two of these forms this information was not recorded but had been written in the patient's medical notes. We raised this with the palliative care lead and this was addressed promptly.
- The End of Life Care Audit, 2016 found at the time of death, 94% of end of life patients had a DNACPR decision in place. Documented evidence that a discussion regarding CPR was undertaken by a senior doctor with the patient was recorded for 35% of people.). The reasons documented for the lack of discussion are appropriate, but for 16% there was no reason recorded.

Are end of life care services caring?

Outstanding ☆

We rated caring as outstanding because:

- Staff showed real compassionate care to patients and their families.
- There was strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity.
- Relationships between patients, people they were close to and staff were strong, caring and supportive.
- Patients were active partners in their care and said staff kept them fully informed about their care.
- Patients were treated with dignity and respect and staff were mindful to uphold patient's privacy at all times.
- Relatives said they felt involved in decisions about their loved one's care.
- Patients and relatives praised the staff and said they were very caring. A relative said, "They are marvellous here and always go that extra mile".
- We saw that patient's emotional and social needs were highly valued by staff and were embedded within their care and treatment.
- During the MDT meeting we observed how caring, thoughtful, and compassionate all the staff team were. Consideration for the physical, emotional, and social wellbeing of each patient was paramount.
- Patient's spiritual needs were met and there was an excellent Chaplaincy service to support patients, relatives and staff.

Compassionate care

- We observed staff to be extremely kind, compassionate, and very caring. We saw that staff went out of their way and, as a patient told us, went the extra mile to help. For example we saw where a patient was very reluctant to be admitted to a care home because there was no one to take care of her dog. Staff from the Hub arranged, with the patient's consent, for the dog to be re-homed so that the patient could be admitted to the care home.
- We saw where a patient who required palliative care was experiencing financial difficulties and was about to lose their home, staff from the Hub worked with social services to ensure the patient received benefits and access to a food bank.
- We saw and families confirmed staff cared for patients in a kind, compassionate, dignified and respectful manner. Staff were highly motivated and inspired to offer kind and compassionate care.
- One family we spoke with had requested that their relative was not moved from the hospital ward because they said the staff were so caring there. A family member said, "I've never seen such caring staff".
- Staff spoke to patients politely and respected their privacy and dignity. Staff drew curtains and used side rooms when available to provide as much privacy and dignity as possible for both the patient and family and

friends visiting. We saw that staff knocked before entering patient's rooms. We observed the palliative care nurse asked family members for their permission before we could enter the side room on the ward.

- 'Dignity Curtains' were provided in bathrooms on wards to ensure that dignity and privacy were upheld for patients who needed staff in attendance when they used the bathroom.
- The trust surveyed end of life patients and their loved ones to identify their experiences of the care they received. Between 1 October 2016 and 28 February 2017 there were 37 patient surveys returned. Thirty-five identified that they were extremely likely to recommend the service and two patients identified they were likely to recommend the service. All people said they had been treated with respect.
- Staff told us there was no pressure from bed managers to move patients after they had passed away from the wards. This ensured there was sufficient time for relatives to see their relative and perform last offices if they wished without being rushed. We saw families were given the opportunity to carry out their own last offices for their relative.
- We saw from the End of Life Care Audit - Dying in Hospital, 2016 the trust performed better than the England average (84%) as 96% of the trusts patients had been given an opportunity to have concerns listened to.
- We saw results from a patient experience questionnaire the palliative and end of life care service had conducted between September 2016 and February 2017. Patients, relatives or friends with experience of end of life care at the trust completed this. There were numerous positive comments included in the results: "All staff have been helpful, professional and caring", "Everyone has been excellent felt well supported and being able to keep mom at home was great", "felt input of service has been very good from CNS, benefits advisor and hub service. Telephone support service has been very reassuring".
- The hospital performed better than the England average for the privacy and dignity aspect of the Patient-Led Assessments of the Care Environment (PLACE) 2016 audit. Sandwell General Hospital scored 89% for privacy and dignity against a comparative England average for large acute trusts of 83%.

Understanding and involvement of patients and those close to them

- When patients were in the last few days of their life families were given open visiting rights. We observed a specialist palliative care nurse explaining to a family how they could come and stay with their loved one (patient in side room) and a family member would be able to sleep over as a put-up bed would be provided for them. The nurse also told the family to make the room homely and "bring in what they needed".
- The palliative care and end of team involved and empowered relatives to help with the care of their loved ones. For example, a relative told us how the nursing staff on the ward had shown them how to administer mouth care so they could help keep their loved one comfortable. The relative said, "I feel I am doing my bit to help". The palliative care nurse gave further advice to the relative on using lip salve to help keep the patient's lips moist.
- Medical and nursing staff demonstrated excellent communication skills with patients and their families. We saw where a junior doctor effectively explained the reasoning for commencing a Specialist Care Plan (SCP) and explained to the patient and their family how the on-going review of the SCP worked. The doctor ensured the patient and their family were fully informed about the options available to them. The family told us they had understood everything clearly and left knowing where to find more information if they needed it.
- We observed how well a specialist palliative care nurse communicated with a family of a patient who was being nursed on a ward at the end of their life, explaining the options available for care and preferred place of death. The family thought that all the nurses on the ward communicated well with them. A family member said, "They (the staff) are very good at keeping us informed about what is going on".
- Staff, patients and relatives we spoke with told us staff communicated with patients in a caring and supportive manner so they understood their care, treatment and condition.
- We saw staff consistently empowered patients to have a voice and staff demonstrated they understood the importance of involving people and those who matter to them in decisions about their care.
- We saw excellent communication and discussions took place between a palliative care nurse and the family of an end of life patient who was being assessed and placed on a specialist care plan.

End of life care

Emotional support

- Patients felt staff had time for them and showed them genuine emotional support. For example, a patient told us when they were frightened about having chemotherapy the nurse sat for 20 minutes reassuring them and chatting about it. Afterwards the patient felt much better about the treatment.
- The hospital chaplaincy service offered emotional support to patients receiving palliative and end of life care. The chaplain explained how they not only followed up on referrals but also visited wards to see who else may need support.
- The chaplain gave support to staff when they needed this. This included times when a staff member visited the hospital chapel upset and needed emotional support and when a staff member had become upset on a ward when they had nursed a patient who had just died. The chaplain said, "I support staff who support patients".
- The hospital chaplain explained how they spent time on the critical care unit supporting patients, relatives and staff. Staff in the chaplaincy team could offer spiritual support to patients 24 hours a day, seven days a week. The team had chaplains from Christian, Hindu, Muslim and Sikh faiths. Other faith leaders were also welcome to visit the hospital if patients or relatives requested.
- Patient's families were very complimentary about how staff helped and supported them to face the end of life with their loved one. A family member said, "The nurse has been my rock while I am struggling to come to terms with things myself". Another family member said "They (the nurses) supported me so that I could support {patient's name}. A palliative care nurse told us "I support the family members as much as I support the patient". Following the death of their loved one staff directed family members to bereavement agencies to help them with their grief. Chaplains also visited family members on the ward and at home when requested.
- Chaplaincy staff told us they provided support to patients when requested. The chaplains conducted walk arounds to raise staff awareness about the chaplaincy service and also picked up work along the way. Chaplains told us they always go to the critical care unit: "I support staff who have been supporting patients especially on critical care wards."
- Relatives of patients who have died were given information about bereavement support and counselling services.

Are end of life care services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The service was tailored to meet the individual needs of patients who required palliative care and end of life services. Care and treatment was delivered in a way to ensure flexibility, choice and continuity of care.
- The palliative and end of life care service worked together with commissioners and other providers to plan new ways of meeting people's needs. The service had a strong focus on innovative approaches of providing integrated care pathways, particularly for patients with complex or multiple needs
- Access to care, support, and advice was managed and timely to take into account patient's needs, including those with urgent needs.
- Patient admission, discharge and moving patients between hospital care and care in the community followed models of best practice in integrated, person-centred care.
- Concerns about the service were taken seriously and appropriately responded to.
- End of life care facilitators were extremely flexible. They would visit end of life patients on wards and assess patients to determine if they should be on a SCP when required.
- Between October 2016 and December 2016, 100% of patients at the trust on an end of life care pathway were seen within 24 hours of referral to the palliative and end of life care team.
- Between 1 April 2016 and 31 March 2017, the palliative and end of life care service had not received any complaints.

Service planning and delivery to meet the needs of local people

- In 2015, the trust, with clinical leadership from the palliative care and end of life services, was awarded the

contract to be the prime provider for all specialist palliative and end of life care services for patients registered with Sandwell and West Birmingham CCG, with a population of around 500,000.

- The service had innovative approaches to providing integrated person-centred pathways of care that involved other service providers. For example, the Connected Palliative Care partnership was created to deliver the new contract with private and voluntary organisations. It specialised in end of life and palliative care to provide holistic services for patients in the last 12 months of life. The partnership included the following services: a specialist palliative team, Macmillan therapy team, connected palliative care coordination hub, urgent response team, 'Home from Home' beds, specialist hospice beds and a day hospice.
- The programme to deliver the contract included the recruitment of new staff including: a team of end of life care facilitators to provide education and advice to non-specialist teams in order to improve end of life care, additional specialist palliative nurses to enable the service to provide advice and when required support 24 hours a day seven days a week.
- In addition, the service ensured continuity of care as we saw the service the connected palliative care single point of access coordination hub was set up to take all calls and enquiries and managed a Sandwell and West Birmingham CCG end of life care register. The service ensured there was increased availability of end of life care beds with 24 hours a day seven days a week access.
- Staff arranged for occupational therapy and physiotherapy assessments to be carried out.

Meeting people's individual needs

- Sandwell Hospital provided an equitable end of life service irrespective of the patient's diagnosis, socio-economic group, ethnicity or sex. The service monitored access to its services by all groups to show that the service remained accessible to all.
- Staff told us that given the nature of end of life care this often meant that both the patient and any dependents were vulnerable. Staff gave us examples of how they organised discharge for the on-going care and support for a patient in financial difficulties and another patient with complex care needs whose home environment was unsuitable.

From our observation of the Multi-Disciplinary Team (MDT) meeting, we saw there was a holistic discussion of patients. We saw the knowledge of patient cases was excellent. The focus of the discussions was not just, on what was important clinically but also what was important to the patient personally. Examples included organising (through the Hub) respite care for a patient's pets whilst they were in hospital. The worry of the care of the pets was the main issue concerning the patient, more so than their physical symptoms.

- We also observed an MDT discussion about a patient who wanted to return to Jamaica to die. However, due to the severity and advanced stage of his illness he was unable to do so. Instead, the palliative care and end of life team had arranged with the patient and his family to transfer the patient home and to decorate his environment to help bring Jamaica to him.
- We observed how, when a patient's living arrangements were not appropriate to meet their complex palliative care needs, staff from the Hub had arranged, with the patient's consent, for a home assessment to be undertaken. Following this assessment, the patient was able to move to a more suitable home environment where community staff could meet their care needs and the home was close to the patient's friends which was important to the patient.
- Where patients required end of life care designated side rooms were available on wards. We met with a patient who was being nursed in a side room. The family said they had been made very welcome by all the staff and were really pleased that their loved one could stay in the side room for end of life care. We saw the family had been provided with hot drinks and extra chairs and there was the availability of a put up bed provided if any family member wanted this overnight. We saw the palliative nurse tell the family they could bring in items from home and make the room as homely as possible.
- Staff on wards and mortuary staff were aware of the process to follow to ensure that religious needs such as a burial within 24-hours could be achieved. CARES staff showed us the process they followed to ensure when a death certificate was required within 24-hours.
- Staff told us and we saw that translation services were available for patients at the end of life and their relatives. Information leaflets in relation to end of life

care were available in a wide range of languages. Patients were also given various leaflets containing information about how they could be involved in their care.

- There were many guidance leaflets for patients providing information on: anticipatory medicines, 'off-label' medicines, syringe drivers, 'My life' Opioid therapy (based on NICE Guidance), and the spinal cord compression card (The palliative care team had access to a 24-hour MRI so this card was to inform patients of possible symptoms and signs so they could present earlier).
- The critical care unit held a memorial service twice per year for families of patients who had died. We saw thank you notes from bereaved family members indicating how moved they had been to participate in the service and to see how staff had remembered their loved ones.
- There were plans in place for the service to work with 'Hard to Reach groups'. The service was already working with asylum seekers and immigrants who were unable to speak English to ensure that the model was responsive and accessible to individuals.
- The trust employed five full time chaplains and three part time faith leaders who provided chaplaincy support across both acute sites. The chaplaincy service provided an on-call service and staff; patients and relatives could access chaplains from a number of different faiths 24 hours a day, seven days a week. The chaplaincy service included Roman Catholic, Hindu, Sikh and Muslim faith leaders. There was also 15 volunteers working part time for the chaplaincy service.
- The PLACE 2016 audit scored the hospital at 83% for the wards being dementia friendly, which was better than the comparative England average of 73%. Some of the failures on the audit were due to bays not having larger clocks or clocks with multiple faces to allow visibility from all angles.
- The PLACE 2016 audit scored Sandwell General Hospital at 82% for the environment being accessible for disabilities, which was better than the comparative England average of 77%.

Access and flow

- Palliative care managers told us that the development of the Hub and the Urgent Response Team (URT) ensured that patients got the right care at the right time in the right place. An example was when a patient was admitted to the emergency department (ED) late on a Friday evening requiring palliative care, the URT were contacted and a specialist palliative care nurse visited the ED to assess the patient. The patient was transferred to their preferred place of care within two hours of ED admission.
- The service provided access to advice in relation to end of life and palliative care from a member of the specialist palliative care team, 24 hours a day.
- Sandwell Hospital did not have a dedicated palliative care ward and end of life patients were cared for on a number of wards across the hospital. This did not affect the quality of care end of life care patients received as the palliative and end of life care service identified end of life patients on the wards via the hub.
- There was a clear process for the transfer of care of patients from hospital to community services including care plans and medication. Whilst patients were in hospital they had an acute specialist care plan in place, when they moved to the community this moved with them but the information was then transferred to a community specialist care plan. The advanced care plan was the same for all patients.
- The connected palliative care Hub signposted patients and their families to services that provided care, advice, and equipment.
- The Hub also considered referral for specialist assessments if a patient's symptoms are difficult to manage. We saw referrals made to the speech and language therapy (SALT) for a patient with swallowing difficulties. Some patients had been referred to occupational therapy (OT). Occupational therapists formed part of the palliative care and end of life services.
- Information received from the trust for patients for the service between 1 January 2017 and 31 March 2017 identified: the Hub contacted 100% of patient within 10 minutes of the request; 100% of patients received a response within 30 minutes of request from the urgent response team. First contact within one working day of receipt urgent (specialist team) referral was achieved for 86% of patients (trust target 85%).
- The target from decision to admit a patient to a hospice or 'home from home' bed for non-urgent patients was within five days. Between 1 January 2017 and 31 March 2017, 90% of non-urgent patients were admitted into a hospice or a home from home bed within five days (trust target 60%).

End of life care

- The target from the decision for urgent admission to a hospice or a 'home form home' bed was within 24 hours. Between October 2016 and December 2016, 100% of patients at the trust on an end of life care pathway were seen within 24 hours of referral to the palliative care team.
- Between 1 January 2017 to 28 February 2017, 80% of required urgent admissions were made within 24 hours (trust target 75%).
- End of Life patients could be referred to the fatigue and breathlessness (FAB) clinic for advice and treatment management to reduce discomfort. The FAB clinic was to move to the day hospice to assist patients.

Learning from complaints and concerns

- The trust had a policy in place on the handling of complaints. Staff told us this was easily accessible on the trust's intranet.
- Staff told us they would raise complaints with their manager or direct people to the trust's patient advice and liaison team (PALS).
- Staff felt they would be listened to and taken seriously by their managers if they needed to raise a concern and felt there was an open culture where suggestions for improvement were welcomed.
- We saw learning from concerns was discussed during team meetings and at the quality improvement training.
- Between 1 April 2016 and 31 March 2017, the palliative and end of life care service had not received any complaints.

Are end of life care services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The service was driven to provide high quality palliative and end of life care with the focus on meeting patient's individual needs.
- Leaders were consistently approachable, supportive and inspired and motivated staff to deliver a high quality end of life/ palliative care service.
- The strategy to deliver an innovative, integrated end of life strategy 24 hours a day with partner agencies in both hospitals and the community was a challenge but had been achieved through the passion and determination of the leaders and staff.
- Governance and performance management arrangements were actively reviewed to identify, understand and monitor risk and meet best practice. Performance issues were escalated to relevant committees through clear structures and processes. There was clear evidence of actions to resolve any concerns
- There were high levels of staff satisfaction. Staff were proud to work for the service and spoke positively about the culture. Staff at all levels were actively encouraged to raise concerns.
- The leadership drove continuous improvement. There was a clear proactive approach to seeking out and embedding new and sustainable models of care.
- The trust had a clear vision and set of values for providing end of life care. The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.

Leadership of service

- We found that the leadership team were highly motivated, enthusiastic and inspired staff to provide high quality, safe and effective end of life and palliative care.
- The palliative and end of life service was part of the iCares directorate which is part of the Community and Therapies clinical group. A clinical group director, group nursing director, supported by the end of life service lead led the senior management team for palliative care and end of life service.
- Staff could easily tell us about the management structure and said there were very clear lines of accountability. The service lead for palliative and end of life care had a direct management responsibility for the lead nurse palliative care, the end of life facilitator lead, the therapy lead, the urgent response team lead and the project facilitator.
- Each area within the palliative care and end of life team had a manager in post. The lead nurse palliative care had a direct management role for the clinical nurse specialists for palliative care and the day hospice staff.

The end of life facilitators were managed by the end of life facilitator lead. The therapy lead managed the Macmillan therapy team. The urgent response lead managed the urgent response team.

- The leadership were highly respected by staff and staff we spoke with felt extremely well supported. Staff told us that managers were very approachable and always willing to listen to suggestions. Ward staff, mortuary staff, porters and certificate and bereavement service staff told us they felt supported by their management teams and felt listened to if they raised any concerns.
- When the End of Life Care audit - Dying in Hospital, March 2016 was conducted, the trust did not have a lay member on the trust board with a responsibility for end of life care. This was one of two organisational key performance indicators (KPIs) the trust could not meet. However, at the time of our inspection the trust had since rectified this as the board now had an end of life lay member representative and an executive director and non-executive on the trust board.
- The trust Chief Executive was chair of the quarterly palliative care board meeting which included the trust end of life service and representatives from our partner organisations, local hospices and third sector providers. End of life care was also a key element of executive committees including the Quality and Safety Committee where the Chief Nurse represented end of life care.
- The trust had both an executive director and non-executive on the board who had a responsibility for end of life/ palliative care and who regularly carried out visits to the service.
- The palliative care and end of life service lead received a SWBH 'star award', 2016 for being an 'outstanding new leader.'

Vision and strategy for this service

- The trust had a clear vision and set of values for providing end of life care. We saw the trust's five Year Strategic Plan, 2013 – 2018. The strategy included development of the palliative and end of life care service and implementation of the supportive care pathway (SCP). The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.
- Staff had been included, consulted and were fully aware of the vision and strategy for the integrated end of life/ palliative care service.
- All staff we spoke with were aware of, and understood, the vision and values of the trust and the behaviours that would achieve these values. Staff told us that their vision was to provide high quality end of life care and palliative care to meet the needs and choices of their patients.

Governance, risk management and quality measurement

- Governance and performance management arrangements were reviewed to identify risks and the needs of the service. There were monthly directorate meetings where governance and quality issues were raised and concerns could be escalated either up to the board or down to end of life care staff. There was also an in-depth quality and safety review of the performance of the division, which was undertaken annually. This identified areas which were doing well and those which needed to improve and included action plans to bring about improvements. This was fed back to staff at team meetings.
- Staff told us and we saw that there were quarterly service operational meetings. The trust called these meetings Quality Improvement half days (QIHD). The meetings discussed strategic and developmental quality initiatives within the service, which affected the delivery of end of life and palliative care services.
- The consultants within the team told us they regularly attended trust clinical governance meetings to discuss key developments, audit and governance, we saw minutes to support this. The consultants also sat on various committees to help ensure patients were receiving best quality care and treatment. One of these was the deteriorating patient committee.
- The specialist palliative care teams communicated extremely well with each other for the benefit of the patients. They had meetings to discuss day-to-day operational issues and there was a weekly multi-disciplinary team (MDT) meeting where relevant professionals came together to discuss patients' needs in depth.
- We saw that all patient deaths were reviewed as part of the weekly multidisciplinary team meeting (MDT). A consultant told us, and we saw in the MDT meeting, that they reviewed patients who had died to enable them to

share what went well, act upon, and share what may be improved upon. Staff told us and we saw that a record of these meeting was made to enable staff that were unable to attend an opportunity to read the meeting notes.

- The end of life risk register dated 3 March 2017 identified one current risk: Patients and other clinicians may not be aware to contact the hub and patients may be missed. From discussions with staff it was identified that some patients may still be 'slipping through the net' and turning up in the emergency department (ED). We saw the risk register was up to date and accurately reflected this one risk of the service.

Culture within the service

- Staff were passionate and committed to provide excellent palliative care and end of life service, demonstrating a strong patient focused culture.
- Staff spoke very positively about working in the palliative care and end of life service at Sandwell Hospital. Staff told us they would definitely recommend it as a place to work.
- Staff told us that they felt respected, valued, supported and that their achievements were recognised. There was a culture of openness and transparency and staff felt able to challenge poor practice if required whilst being supported by other staff and managers. Staff told us that the team were supportive and that managers listened to them.
- Staff were extremely proud of the team and its development and the care they delivered to patients seven days a week. One of the nurse managers told us, "What I particularly like is the staff enthusiasm to give patients the best possible care". Managers were also proud of the staff who worked for the service. A manager told us, "I am very proud of the staff who work here and am proud to be part of this service".
- Staff we spoke with said they were able to raise concerns and that managers always listened to them.
- We found that staff sickness rates across palliative and end of life services in February 2017 3.8% compared to the national sickness rate of 4.1%.

Public engagement and Staff engagement

- We saw information that showed there had been widespread public engagement to identify and shape palliative care and end of life services.
- We saw that there were ongoing press releases to show the public about developments of the end of life and palliative care service at Sandwell and West Birmingham Hospitals NHS, trust such as use of the supportive care plan and information about the connected palliative care hub.
- We saw the end of life service continued to seek patient survey information about the service they provided. The nurse manager told us it that it could be challenging to get feedback at such a difficult time but they reviewed and shared all information received including comments made by the patient and their loved ones.
- The service was working with a local university to provide full evaluation including qualitative analysis with patients, carers and staff of the service provided.
- Staff received regular key messages from the organisation, which updated them on what us going on within the trust. In addition, also a pod cast has been set up on a laptop for all staff to see.
- Staff received a copy of the Sandwell Heart Beat magazine along with their payslip, which contained information about the trust.
- There were monthly staff meetings in all palliative care and end of life services to ensure they were kept up to date on new initiatives, incidents and any complaints.
- The palliative and end of life care service regularly conducted surveys to obtain feedback from families. Senior staff fed back results of these surveys at team meetings.
- The trust was promoting the forthcoming 'Dying Matters Awareness Week 2017' to raise awareness of dying, death and bereavement.
- The palliative care and end of life service lead received a SWBH 'star award', 2016 for being an 'outstanding new leader.'
- The palliative care and end of life service held regular formal team meetings where information such as learning from deaths, incidents and audits could be shared.
- The palliative care and end of life service ran a 'Connected Palliative Care Awareness week' and highlighted the role of the supportive care plan to patients in their last year of life.
- The trust gave out a 'compassion in care award' each month to staff nominated by colleagues. An urgent response nurse from the palliative and end of life care

service won this award for March 2017. The colleague who nominated this nurse described them as: "the most caring and compassionate nurse I have ever had the pleasure of working with."

Innovation, improvement and sustainability

- The palliative care and end of life service had been nominated for the National Council for Palliative Care Awards, 2017. These health and social sector care awards recognise "exceptional people and services that have made a real difference through outstanding care, support and commitment to end of life care in England, Wales and Northern Ireland during 2016."
- Information provided by the service identified it had recently presented at a Department of Health Roadshow and received positive comments with requests to mirror the service elsewhere.
- The service delivered a partnership model with third sector organisations. The partnership provided a patient focused individualised, holistic service able to provide respite, domestic support and specialist hospice beds in addition to the specialist palliative care.
- The urgent response team was available 24 hours a day seven days a week, which enabled the service to respond to patients rapidly and when, they most needed support. This enabled patients the choice to die at home with their symptoms controlled.
- The home from home beds provided patients with an extra level of support if patients were unable to remain in their own home.
- The end of life register with increased awareness in its use from end of life facilitators had enabled end of life patients to be identified and receive timely and appropriate care and treatment in their preferred place of care.
- Care plans for end of life care had been reviewed and relaunched and were available trust wide (the supportive care plan).
- There were appropriate systems in place to review and develop service delivery and, when needed, ensure that lessons were learned and appropriate actions taken to provide excellence in palliative care and end of life services.
- The service recommended a number of improvements from the results of their audit of why end of life patients preferred place of death (PPD) was not achieved between 1 April 2016 and 31 October 2016. This demonstrated the service were keen to constantly improve the service they provided to end of life patients.

Outpatients and diagnostic imaging

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

Information about the service

Sandwell and West Birmingham Hospitals NHS Trust provides a range of outpatient services from Sandwell General Hospital, City Hospital and in the community. The outpatient clinics at Sandwell General hospital are situated on the ground and first floor.

The trust also operates a diagnostic imaging service across hospital sites; Imaging services include x-rays, computerised tomography (CT), interventional imaging, fluoroscopy and ultrasound. An on-site private provider undertakes MRI scanning on the Sandwell site. We did not inspect their facilities during our visit.

Sandwell General Hospital was inspected by the care quality commission in October 2014 and was rated as inadequate, one of the reasons for this was due to a breach of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R, 2000) within the diagnostic imaging department. During this inspection, we found that improvements had been implemented and were well embedded across the service.

During the inspection, we observed a range of outpatient clinics and visited the diagnostic imaging department. We also visited the children's outpatients department.

During the two day announced inspection we spoke with 33 staff including managers, consultants, radiologists, clinical nurse specialists, nurses, allied health professionals, bank staff, reception staff and volunteers. We spoke with 14 patients and reviewed 14 patient records.

Summary of findings

We rated this service as good because:

- The trust followed the National Institute for Health and Care Excellence (NICE) clinical guidelines.
- Staff knew how to report incidents and told us that they received feedback. An IR(ME)R committee monitored, analysed and reported incidents in the diagnostic imaging department.
- All IR(ME)R documentation was in place.
- The diagnostic imaging department provided a seven-day service for patients requiring x-ray, computed tomography scans and interventional radiology.
- Staff in the outpatients department held additional clinics to reduce waiting times.
- The trusts follow up to new rate was one of the best in England.
- There were pathways and procedures in place for urgent referrals to the diagnostic imaging department.
- We saw that staff adhered to infection control policies and that there were robust processes in place for the cleaning of probes in the diagnostic imaging department.
- Staff in diagnostic imaging used the pause and check protocol. This ensured the patient, the examination and the referral were correct.

Outpatients and diagnostic imaging

- We saw that staff were polite, caring, professional and compassionate towards patients.
- Staff fully explained procedures to patients; they gave patients time to ask questions and talked to patients in a way they could understand.
- We saw there were separate enclosed waiting areas in the diagnostic imaging department for patients who had changed into their gowns.
- The trust participated in the Friends and Family Test (FFT).Results between March 2016 and February 2016 showed that 88% of patient who completed the survey said they would recommend the service to their family and friends

However:

- Resuscitation trolleys were unlocked and did not have tamperproof tags. Staff did not always record daily resuscitation trolley checks. Syringes of adrenaline and intravenous fluid bags were not stored appropriately.
- Staff in the outpatients department weighed patients in the corridor; this could lead to some patients feeling embarrassed as other patients and staff may have overseen.
- Staff did not keep patients' notes secure in the outpatients department; this meant that the patients' notes were vulnerable to unauthorised access.
- Children had blood tests in the hospitals main phlebotomy department; we visited the department and found it was not child friendly.
- There had been a workforce review of staffing and this had led to significant changes at the trust, we saw pockets of low staff morale in the outpatients department caused by such changes.
- Staff in the outpatients department did not have their competencies assessed to ensure they were confident and competent to carry out their role.
- We were not assured that prescriptions for controlled drugs were being stored securely in outpatient areas in accordance with trust policy.
- Some staff had a limited understanding of the "Mental Capacity Act", 2005.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff knew how to report incidents and told us that they received feedback. The diagnostic imaging department had established an IR(ME)R committee that monitored, analysed and reported on radiation incidents.
- Policies and procedures were in place to ensure radiation incidents were fed into risk management.
- Staff followed infection control procedures. We saw there were robust procedures in place in the diagnostic imaging department for the cleaning of probes. The diagnostic imaging department carried out risk assessments for new and modified use of radiation.
- Staff in the diagnostic imaging department used the pause and check protocol to ensure the referral, the patient and the examination was correct.
- Pathways and processes were in place for urgent referrals to the diagnostic imaging department.

However:

- Resuscitation trolleys were unlocked and did not have tamperproof tags. Daily checks were not always recorded. Syringes of adrenaline and intravenous fluid bags were not stored appropriately.
- Staff did not keep patients' notes secure in the outpatients department; this meant that the patients' notes were vulnerable to unauthorised access.
- Senior staff in the outpatients department rarely monitored or submitted hand hygiene compliance rates for audit.
- We were not assured that prescriptions used for controlled drugs were always being stored securely in accordance with trust policy.

Incidents

- There were no never events at the hospital between February 2016 and January 2017. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the serious incident framework 2015, the trust reported no serious incidents (SI's) in outpatients and diagnostic imaging which met the reporting criteria set by NHS England between February 2016 and January 2017.
- The hospital reported that there were 485 incidents in outpatients and diagnostic imaging across the trust between February 2016 and January 2017.Of these the hospital graded 20 as severe harm, 153 as low harm, 256 as no harm and 56 as a near miss.
- The most frequent type incident reported was incorrect examination in radiology with 35 incidents reported. There were 31 'organisational issues' and 27 incidents of communication failure between trust staff.
- Staff knew how to report incidents and told us how they did this. Most staff who had reported an incident recently told us they had received feedback in relation to the incident from their manager or in an email.
- We reviewed several incidents from the trusts electronic incident reporting system and saw that senior staff investigated incidents and recorded outcomes. For example in the diagnostic imaging department, we saw that a patient had received a high dose and overexposed x-ray, which meant that staff needed to repeat an x-ray. Senior staff investigated the incident and as a result, a reflection session had taken place between the manager and the radiographer.
- The trust had established an IR(ME)R committee to ensure the trust complied with the ionising radiation (Medical Exposures) Regulations 2000.The committee met four times a year and monitored, analysed and reported on radiation incidents. We reviewed the committees' latest annual report (2015) and saw incident trends were included. The report highlighted one trend as being 'referrer wrong patient'. Staff in the imaging department had taken actions to address this such as implementing the six point ID procedure and installing a computer screensaver that highlighted incidents to trust staff.
- We saw that policies and procedures were in place to ensure that staff fed radiation incidents into risk management and those exposures much greater than intended were notified under IR (ME) R requirements.
- Most staff we spoke with did not have an awareness of the definition of duty of candour; however, staff did recognise the importance of being open and honest to patients. The duty of candour is a regulatory duty that relates to openness and transparency and requires

providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We reviewed three letters when an incident had met duty of candour regulations and we saw that when required, the letters contained an apology and the trust had met with the patient.

- We saw that there was a policy in place called 'being open following a patient safety incident'. The policy contained guidance on saying sorry, a being open flowchart and information on existing requirements regarding openness. Staff we spoke with knew how to access trust policies and procedures on the hospital intranet.

Cleanliness, infection control and hygiene

- We saw that staff in the outpatient and diagnostic imaging departments washed their hands and used hand gel before and after patient contact. This was in line with guidance from the National Institute for Health and Care Excellence (NICE) quality statement 3: Hand decontamination.
- However, the hand gels had been removed from the main outpatient areas. This was due to concerns that the dispensers were not lockable and staff were unable to monitor use. We saw posters advising patients to use hand gels in the consultation rooms or to ask staff for hand gel which staff carried on their person.
- We witnessed staff using personal protective equipment (PPE) such as aprons and gloves when in direct contact with patients. All staff were arms bare below the elbow in accordance with trust policy.
- The x-ray department carried out monthly hand hygiene audits. We reviewed the data and found the department met the trust hand hygiene compliance rate of 95% in all months (February 2016 to February 2017) with the exception of June 2016 when the department recorded a score of 93%. Trust policy was that for a score of less than 95% compliance weekly audits take place.
- We reviewed the latest infection prevention and control audit and surveillance report for February 2017 and saw that the outpatients department rarely submitted hand hygiene compliance results. We saw that senior staff had submitted hand hygiene compliance results twice in the last year (February 2016 to February 2017); this was in December 2016 when the department achieved a 99% compliance rate and in February 2017 when the department achieved 100% compliance.
- Staff told us there were no specific cleaning rotas in the outpatient department. Nurses helped with cleaning tasks when they had time.
- We saw that staff in the diagnostic imaging department completed daily equipment cleaning checklists and that there were cleaning protocols in each room.
- Cleaning teams cleaned the outpatient and diagnostic imaging departments in the evening; all areas we visited appeared visibly clean. However, senior staff told us that equipment/furniture in the outpatients department was not moved to enable a thorough clean to non-visible areas; they also told us that this had not been highlighted to senior managers as it had always been this way.
- We saw there were robust processes in place in the diagnostic imaging department for the cleaning of transabdominal and transrectal probes and for their transportation to the auto clave; staff cleaned probes before and after every patient.
- We reviewed the notes from an infection prevention and control advisory committee meeting (April 2016) and saw that the committee had discussed the vacuum packing system for flexible probes. The chief nurse/director of infection, prevention control chaired the meetings.
- We visited the interventional room in the diagnostic imaging department and found sterile techniques were used at all times and staff wore scrubs as if in a theatre environment.
- We saw that most sharps bins were in date and readily available in clinical areas. However, we saw one sharps bin dated 2015 in the diagnostic imaging department, when highlighted senior staff removed this immediately. We saw clinical waste bins were readily available to dispose of clinical waste.
- Most patients told us they were happy with the level of cleanliness at the hospital.
- Staff in the diagnostic imaging department told us patients with infections were isolated from other patients and when medically appropriate they would scan infectious patients at the end of the day.
- The hospital scored better than the England average for cleanliness in the Patient-Led Assessments of the Care Environment (PLACE) 2016 programme. PLACE are a self-assessment of non-clinical services, which contribute to health delivered in both the NHS and the

independent, private healthcare sector in England. Sandwell General Hospital scored 99% for cleanliness with a comparative England average of 98% for large acute trusts.

Environment and equipment

- We reviewed resuscitation equipment and found several gaps in the recording of daily checks in the outpatient department. We spoke to senior staff in relation to this who were unable to explain the omissions. Resuscitation trolleys were not locked and did not have tamperproof tags.
- At the time of our inspection, the outpatient nurse with responsibility for auditing was developing processes for allied health professionals to become competent in checking emergency equipment and completing any audit paperwork. The plan was that nursing staff would assess the competency of allied health professionals in the checking of emergency equipment and that they would be signed off when they were competent to do this.
- Staff in the outpatients department had recently completed a walk around to identify any environmental risks and hazards that needed fixing. Hazards identified as needing attention included loose shelving and trip risks. An action plan formulated from the results of the walk around had not been completed at the time of our inspection.
- We saw that the trust serviced equipment in line with manufacturer guidelines. There was a managed equipment service agreement in place in the diagnostic imaging department where equipment was automatically serviced.
- The PLACE 2016 audit scored the hospital of 96% for condition, appearance and maintenance. The national average for large acute trusts in England was 93%, meaning the hospital scored better than the England average in this measure.
- We saw that the imaging service carried out risk assessments for new or modified use of radiation. We reviewed a risk assessment in relation to new x-ray equipment being installed that carried a risk of ionising radiation. The risk assessment considered the risks to employees, operators and members of the public and described the control measures staff had been put in place to reduce any risk.
- We noted that there was signage in place to alert staff and the public of ionising radiation in the diagnostic imaging department.
- Staff showed us they had sufficient lead aprons for each room within the diagnostic imaging department. Aprons were stored correctly on hangers outside or inside rooms; we saw that staff screened the aprons for damage on a yearly basis.

Medicines

- Nursing staff kept all medications in locked cupboards; no controlled drugs were stored in the departments. We checked the medication cupboards in the outpatient department and found that medications were all in date. There was no temperature monitoring in place in the room; keeping room temperature records demonstrates that medicines are stored safely and is good practice.
- We noted that there was surplus stock in the medication cupboard in the outpatient department. Nurses told us they checked stock to ensure it was in date.
- Nurses had their own keys to the medication cupboards. The trust had invested in a new electronic key system that had improved the overall security of medicines. Only authorised staff had access to medicine cupboards and the electronic system had the ability to track who had accessed the medicine cupboards.
- A medicine optimisation policy dated January 2016 detailed arrangements for prescribing, requisition, storage, administration and control of medicines. The trust had shared the policy across the intranet to enable staff to have direct access.
- We saw that there were processes in place for the safe storage of FP10'S in accordance with the trust medicines optimisation policy. However, one member of nursing staff told us that they kept prescriptions on their person; another staff member told us that staff sometimes left FP10's in rooms. We did not see any prescriptions left unattended at the time of our inspection.
- We saw that patient group directives (PGD's) were in place and dated in the diagnostic imaging department. PGD' s provide a legal framework which allows some registered health professionals to supply and /or administer specified medicines to a predefined group of patients without them having to see a doctor. There were no PGD's in use in the outpatients or the children's

outpatients department. Senior staff told us that if a child required an asthma inhaler staff would discuss this with the consultant who would be responsible for writing the prescription.

- The nuclear medicine department at the trust had two full time consultants and a consultant radiologist who had an administration of radioactive substances advisory committee licence (ARSAC).
- Senior staff told us that the nuclear medicine consultant and the consultant physicist in nuclear medicine have both served as members of the ARSAC committee and that all nuclear medicine protocols had been authorised by the ARSAC nuclear medicine consultant. This ensured that the department took the medicines (Administration of Radioactive substances) Regulations 1978 (MARS) into account.
- We saw that Intravenous fluid bags and pre-filled syringes of adrenaline were stored on an open resuscitation trolley.
- At the time of our inspection the outpatients department did not carry out any outpatient surveys about medications.

Records

- We reviewed 14 sets of patient notes across the imaging and outpatient departments.

Staff signed, dated and wrote legibly in patient notes. They contained relevant, up-to-date information such as allergies, medical histories, family histories and results.

- Staff in the children's outpatient department told us that they did not always receive referral letters for children who were coming into the department; they told us that this was happening daily and that staff were currently monitoring this. We received information from a member of the executive team stating that children attending OPD without a referral was an occasional occurrence and these instances were related to children from a neighbouring children's trust. Should a child attend without a referral letter then the OPD nursing staff would make every effort to obtain the referral by contacting either the medical records department or the patient access team. If this was not possible they would make contact with the GP and ask them to fax a copy of the referral letter. Since the trust has introduced scanning of referral letters lack of original referral letters has all but ceased.
- The trust were moving towards a paper-light system with case note scanning intended to replace paper medical records from April 2017.
- Medical notes were stored off site at a secure storage facility, staff requested sets of notes in advance of appointments.
- Staff in the outpatients department told us that patient notes were not always available for clinics; however, this was a rare occasion as audits on availability of notes showed that between September 2016 and February 2017 availability of notes was above 99% in all months (58,933 patients). Staff made up temporary sets of notes when this happened using letters and information from the hospital database.
- Staff did not always keep patient notes safe. We checked the lockable cupboards in corridors in the outpatients department and found that staff had left three cupboards unlocked. This meant that staff did not keep patients records secure and that they could be vulnerable to unauthorised access.
- We saw that staff in the imaging department kept notes secure in lockable cupboards.
- Staff from the diagnostic imaging department were able to view previous diagnostic images electronically on the picture archiving and communication system (PACS).
- The trust had a managing risk and issues document in place in relation to patient records. We reviewed this and saw risks were rag rated with due dates and mitigations.
- There was a separate room in the outpatients department for the storage of notes coming into or going out of the hospital, this was secure with a keypad entry system.

Safeguarding

- Safeguarding training was mandatory for all staff. Data provided by the trust for all sites showed that 84% of staff had completed Safeguarding Adults level 2 training and 80% had completed Safeguarding Children Level 2. Ninety two percent of staff had completed Safeguarding Children level 3.The trust target compliance rate was 95%
- We reviewed individual department data from the trust and saw that cross sectional imaging radiology, radiography and ophthalmology had only a 50%

compliance rate in safeguarding adult's level 2.We asked the trust what was being done about the low compliance rate within these specialities, however we did not receive a response.

- Safeguarding leads at the trust told us that they had a stand at the hospital in March 2017 to raise awareness of Child Sexual Exploitation (CSE).They also told us that Female Genital Mutilation (FGM) had been covered in the trusts quality improvement half-day (QIHD) sessions.
- We saw that a presentation on domestic abuse awareness had been delivered to imaging staff during a QIHD in October 2016.
- In the children's outpatients department we saw that there was a letter template available for staff to use to alert GP's/relevant professionals that a child had failed to attend their outpatient appointment. The template also advised that if the child was on a child in need or child protection plan staff needed to ensure the named social worker, relevant health visitor or school nurses were made aware.
- The trust employed three staff that were qualified in delivering workshops to raise awareness of Prevent. Prevent aims to reduce the number of people becoming or supporting violent extremists and is part of the UK's counter-terrorism strategy.
- We saw there were policies in place for the safeguarding of adults and children. Policies contained information on types of abuse, staff roles and responsibilities and flow charts on actions staff should take.
- Most staff knew what to do if they came across a safeguarding situation. Staff told us they would speak to their manager or a senior staff member about their concerns. Most staff knew where to access the safeguarding policy either in paper format or on the trust intranet.
- Staff were able to provide an example of when they worked together with external safeguarding agencies to safeguard a homeless patient when they left the hospital.
- We saw that the imaging department completed an interventional radiology checklist adapted from the five steps to safer surgery checklist and that staff completed these appropriately. The checklist is a nationally recognised system of checks before, during and after surgery designed to prevent avoidable harm and mistakes during procedures. We saw that the department had started a spreadsheet to audit checklist completion and that they completed daily audit forms. Staff scanned completed checklists onto a database used by the trust and used them to complete audits.
- Processes were in place to ensure that the right person was receiving the correct scan. We witnessed diagnostic imaging staff used the pause and check protocol. The protocol is a checklist for all radiographers to complete prior to taking an x-ray. This ensured the referral; patient and examination was correct prior to exposing the patient to radiation.
- The trust had a safeguarding lead; however, most of the staff we spoke with did not know who this was.

Mandatory training

- We reviewed the training records for outpatients and diagnostic imaging across the trust and found that 89% of staff had completed their mandatory training. This was slightly lower than the trusts target compliance rate of 95%.
- Mandatory training included subjects such as moving and handling, medicines management, equality and diversity, health and safety, conflict resolution and infection control.

Assessing and responding to patient risk

- We noted that the diagnostic imaging department had robust procedures in place to ensure staff made any referrals involving ionising radiation such as x-rays and CT scans accordance with IR(ME)R regulations.
- Local rules were in place in diagnostic imaging; these were up to date and formed part of staff induction. Local rules are the way diagnostics imaging work to national guidance and vary depending on the setting.
- The diagnostic imaging department had two radiation protection advisers who were available across sites to provide radiography advice. The trust had allocated radiation protection supervisors to specific areas in diagnostic imaging.
- We saw that there was clear signage in the diagnostic imaging department informing people about the areas/rooms where radiation exposure took place.
- The diagnostic imaging department had procedures in place to ensure that staff did not unnecessarily expose foetuses to ionising radiation. The procedure references questions staff needed to ask and advised staff on the different routes to take in different scenarios.

Outpatients and diagnostic imaging

- We saw that diagnostic imaging had local rules in place to advise staff what to do if they were pregnant; the rules also advised on safe levels of exposure. IR(ME)R procedures outlined the process staff needed to follow to determine the possibility of pregnancy in patients.
- Staff could tell us the contact number they would ring if a patient became unwell whilst in their department.
- The imaging department had guidelines in place for the prevention on contrast-induced nephropathy. Additionally the department had a standard operating procedure (SOP) for determining patient suitability prior to intravenous administration of iodinated contrast.
- There were clear pathways and processes in place for urgent referrals to the diagnostic imaging department. For example, we saw there was a pathway for patients when GP's had referred a patient for an x-ray following a recent trauma.

Nursing staffing

- The senior sister was responsible for establishing staffing levels and skill mix in the outpatients department. There was no acuity tool used to determine staffing levels, this is not unusual in outpatient departments. The sister considered the number of patients and the level of patient interaction required when deciding what staffing levels were required. A workforce review in 2013 had led to staff working across both Sandwell and City hospital sites. The trust set the registered nurse to health care assistant ratio at 20:80.
- There were 82.3 WTE nursing staff in post as of February 2017. The vacancy rate for nursing staff was 8.1%.
- Eight of the staff we spoke with including allied health professionals and nurses felt that staffing levels were too low. Staff comments included "we are all suffering in view of staffing", "we meet ourselves coming back" and that "staffing levels are not enough".
- Sickness rates from January 2016 to December 2016 was 6% this was higher than the trust target of 2.5%.
- The turnover rate for nursing staff between February 2016 and January 2017 was 12.1% this was slightly higher than the trusts target of 11.7%.
- Bank usage in the outpatient and diagnostic imaging departments varied between 0% and 17%. The average was 8.5%.The highest bank staff usage occurred in August, November and December 2016 (17%).The departments with the highest use of bank staff over the period were radiography, ultrasound and the trauma and orthopaedics fracture clinic.
- There were nine whole time equivalent (WTE) Band 7 radiographers in post across the trust. There were 27 WTE band 6 radiographers, 15.8 WTE band 5 radiographers and two WTE Band 4 assistant practitioners in post.
- The vacancy rate was 14.8 WTE for band 5 radiographers, 0.5 WTE for band 6 radiographers and 0.6 WTE for band 4 practitioners. The group director told us that they hoped to fill the vacancies with newly qualified staff on completion of their studies.

Medical staffing

- Data showed as of February 2017, the Sandwell and Birmingham NHS trust reported a vacancy rate of 7.9% in outpatients and diagnostic imaging.
- Between February 2016 to January 2017, the trust reported a turnover rate of 18%.
- Between February 2016 and January 2017 the trusts locum usage varied between 0.5% at its lowest and 3.5 % in July 2016.
- The trust told us that they appointed medical staff under their speciality and therefore were not attributed to the outpatient department

Major incident awareness and training

- We saw the trust had a major incident plan in place, fire training was included in the trusts mandatory training programme.
- Awareness of the major incident plan varied amongst staff. In the diagnostic imaging department we saw that the major incident policy was included as part of the staff induction process.

Are outpatient and diagnostic imaging services effective?

The department was inspected but not rated for effective.

- The trust followed the National Institute for Health and Care Excellence (NICE) clinical guidelines.
- All IR(ME)R documentation was in place and signed.
- Staff in the diagnostic imaging department had their competencies assessed and signed off by senior staff.

- Radiographers were available 24 hours a day and worked short, long and night shift patterns.
- The diagnostic imaging department provided a seven day service for patients requiring x-rays, computed tomography (CT) scans and interventional radiology.
- Staff held additional clinics in the outpatient departments to reduce waiting times.
- The trusts follow up to new rate of 1.4 was better than the England average as it had one of the lowest rates in England.

However:

- Staff in the outpatients department did not have their competencies assessed to ensure they were confident and competent to carry out their role.
- Some staff had a limited understanding of the 'Mental Capacity Act, 2005'.

Evidence-based care and treatment

- We saw that staff followed The National Institute for Health and Care Excellence (NICE) clinical guidelines in outpatients and diagnostic imaging. For example the trust completed cardiac angiography as a first line examination in accordance with NICE guidance: - Chest pain of recent onset: assessment and diagnosis (March 2010) last updated: November 2016.We saw that results from this scan were instantaneous and that following the scan a patient was given their results, told what to do next and given a follow up appointment. The trust had a cardiologist that lectured about the procedure to other cardiologists around the country.
- We saw evidence that the trust audited compliance with NICE guidelines such as the assessment and management of psoriasis and peripheral arterial disease. We reviewed the audit in relation to peripheral arterial disease (2016) and saw that the trust was meeting NICE standards.
- We saw that all IR(ME)R documentation was in place for referrals, practitioners and operators; we noted the documentation was in date and had review dates. There were systems in place in diagnostic imaging to ensure reports were acted on in line with guidance from the Royal College of Radiologists, "Standards for the Reporting and Interpretation of imaging investigations", January 2016. For example, staff told us that they flagged unexpected findings such as an aortic aneurysms or deep vein thrombosis to the referrer, the multidisciplinary team coordinator and the specialist clinician. Staff also told us that they sent reports to GP's and uploaded them onto an electronic system, this enabled GP's who did not have a direct electronic link to access patients' reports. In exceptional circumstances, the radiologist would telephone the referrer or the GP; the department had specific reporting codes which triggered such alerts.
- There was a local audit programme in place in the imaging directorate. Projects included the adequacy of pelvic radiography for suspected hip fractures and the review of current u-scoring practice in thyroid nodules. We requested the action plans for these however; the trust did not provide these.
- We saw that local diagnostic reference levels (DRL's) were in place in the imaging department, staff discussed these in the IR(ME)R committee meetings.

Pain relief

- Doctors in clinics wrote prescriptions for pain relief if required. There was a pharmacy located close to the main outpatient department. The pharmacy was open from 9am to 5pm, Monday to Friday, 10am until 1.30pm on Saturdays, and from 10am until 1pm on Sundays and bank holidays.
- We saw that staff offered children a pain numbing cream in the children's outpatients department before they went for blood tests. We observed a phlebotomist taking a child's blood sample. We noted that the phlebotomist did not confirm the time that the numbing cream was applied, this was important as the cream may not have had long enough to take effect.
- We sat in on a patient consultation, having gained patient consent and observed the consultant discuss the patient's pain; this resulted in a change to the patients' medication and the offer of a referral to the Macmillan nurses. Macmillan nurses can provide advice and support with pain management and symptom management for people with palliative care needs.

Patient outcomes

- Between November 2015 and October 2016, the follow up to new rate for the trust was better than the England average as the overall trust rate of 1.4 was one of the lowest rates in England.
- The trust had not signed up to the Imaging Service Accreditation Scheme (ISAS).The scheme is a patient focussed assessment and accreditation programme that

is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff. The radiology group director told us that this was part of the future vision but there were no current plans for this. In the weeks following the inspection senior staff told us that they were waiting for staff vacancies to be filled before they could actively participate.

- Departments within the trust that participated in the Improving Quality in Physiological Services (IQIPS) included audiology, cardiac physiology, gastrointestinal physiology, neurophysiology, urodynamics and vascular science.
- Staff in the children's outpatients department told us that play specialists were available for specialist clinics.

Competent staff

- Staff told us they had regular appraisals and they found the process useful.
- Data provided by the trust showed that between February 2016 and January 2017 82.2% of staff had received an appraisal; the trust target for appraisals was 100%.
- Senior staff told us that staff in the outpatients department had completed training in different areas such as taking bloods and that staff completed the care certificate. The care certificate is a set of standards that social care and health workers abide by during their work.
- We saw that staff were competent to use equipment in the diagnostic imaging department. Senior staff and radiographers assessed and recorded competencies.
- Senior staff and nurses told us that staff in the outpatient department did not have their competencies assessed; this is important to ensure they were confident and competent to carry out their role. Nursing staff carried out general nursing tasks including the changing of dressings, allied health professionals ran clinics under the direction of a clinical nurse specialist and completed tasks such as collecting urine specimens and checking patients' observations. One nurse told us they had not had their competencies assessed since their training and were concerned they may lose their Nursing and Midwifery Council (NMC) pin. We observed that one staff member did not feel confident in carrying out a task for which they had attended a course.
- Managers told us that the trust was developing a three-year plan for nurses, this included nurses attending university to update their skills. Managers and nurses told us they completed nursing MOT'S which involved refresher training and checks to review and update their skills. However, this did not apply to all staff and was not checked by managers of the service.
- Two staff we spoke with (one nurse, one allied health professional) in the outpatients department raised concerns that allied health care professionals did not have the correct skills to be running clinics in specialist areas such as chest and oncology which they told us that they were. Staff told us that staff had raised the concerns with the trusts chief executive. The trust told us that from the 27th March 2017 to the 7th April 2017, allied health professionals ran 110 clinics and registered nurses ran 45. Senior staff advised us that a registered nurse oversaw all of the clinics.
- The diagnostic imaging department had a local induction programme in place for agency staff. Areas of induction included infection control confidentiality, emergency contacts and IT user access. All agency staff had to complete the induction before they could work in the department.
- We reviewed a nursing induction pack in diagnostic imaging and found it to contain information on handwashing, trust policies, safe management of sharps and a hand-washing diagram.
- National courses for nuclear medicine ran from the City hospital site and staff had access to this.

Multidisciplinary working

- Consultants, allied health professionals and nursing staff worked together to run clinics. Nursing staff spoke of good multidisciplinary working with consultants.
- We observed allied health professionals effectively working with nurses and consultants to run outpatient clinics.
- There were electronic systems in place in diagnostic imaging to share relevant information amongst professionals in different departments.
- Nurses in the diagnostic imaging department worked alongside radiologists, radiographers and sonographers and told us they felt part of the team.
- There were systems in place to share relevant information such as x-rays amongst the multidisciplinary team and with other trusts and departments.

Seven-day services

Outpatients and diagnostic imaging

- Staff told us that additional clinics were held some Saturday's and evenings in the outpatients departments, this helped to reduce patient waiting lists.
- The diagnostic imaging department provided a seven-day service for patients requiring x-rays, computed tomography (CT) scans and interventional radiology, however these were sometimes undertaken at another trust as part of the Black Country Alliance. The Black Country alliance is a partnership between several trusts whose aim is to improve health outcomes, improve people's experience of healthcare and maximise resources available.
- Radiographers were available 24 hours a day and worked short, long and night shift patterns.
- We saw that there was a standard operating procedure in place for the transfer of radiological exams out of hours.

Access to information

- Staff had access to patients' paper and electronic records such as referral letters. However, at times staff told us that patient notes were not available and that staff made temporary notes up with available information when this happened. We saw from availability of notes audits that this was a rare occurrence.
- Staff had access to computers where they could access trust policies.
- Relevant staff could access diagnostic results electronically through Picture Archiving and Communication System (PACS).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that patients gave consent verbally or in writing. For example, we saw a patient had completed a consent form for receiving an interventional contrast injection. This was in line with the trust consent for examination treatment policy, 2016.
- At the time of our inspection, we did not see any patients that required a mental capacity assessment. Staff told us they had seen doctors completing mental capacity assessments when needed.
- Mental Capacity Act training did not form part of the trust's mandatory training; Some staff had a limited understanding on the "Mental Capacity Act", 2005. For example whilst most staff knew what a mental capacity assessment was some staff lacked the confidence to carry out mental capacity assessments themselves. Three staff including two nursing staff told us they would contact someone else to complete a mental capacity assessment, another staff member told us that they did not know much about the Mental Capacity Act, 2005 but they knew it was there,
- We noted that the trust displayed the principles of the "Mental Capacity Act, 2005" on a poster within an outpatient's clinic.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We saw that staff were polite, caring, professional and compassionate towards the patients.
- Staff fully explained procedures to patients; they gave patients time to ask questions and talked to patients in a way they could understand.
- We saw there were separate enclosed waiting areas in the diagnostic imaging department for patients who had changed into their gowns.
- The trust participated in the Friends and Family Test (FFT).Results between March 2016 and February 2016 showed that 88% of patient who completed the survey said they would recommend the service to their family and friends

However:

- Staff weighed patients in the corridor; this could lead to some patients feeling embarrassed as other patients and staff could oversee.

Compassionate care

- We saw that there were separate enclosed waiting areas in the diagnostic imaging department for patients who had changed into their gowns. We saw signs telling patients where to stand in the que; this ensured other patients did not stand to close to the person at the reception desk.
- We observed a receptionist politely asking a patient to stand back to ensure the privacy of the current patient.

Outpatients and diagnostic imaging

- We sat in on patient consultations and observed waiting areas in the outpatients department and saw that staff were polite, caring, professional and compassionate towards patients. We witnessed staff introducing themselves and making patients comfortable.
- We saw that the trust had a chaperone policy in place and staff were aware of this. Managers told us that consultants never carried out intimate examinations without a chaperone.
- There was one private room in which staff could weigh patients and take their observations within the busy outpatients department; staff told us they tried to use this room if possible. However, we noted that staff in the outpatients department still weighed patients in the corridors; the CQC highlighted this during our last inspection in 2014. We spoke to a patient who we saw that staff had weighed in the corridor; the patient told us that staff had not offered them the opportunity to be weighed in private.
- We saw a consultant in the outpatient department using a dictaphone in the corridor where other patients could overhear.
- The hospital performed better than the England average for the privacy and dignity aspect of the Patient-Led Assessments of the Care Environment (PLACE) 2016 audit. Sandwell General Hospital scored 89% for privacy and dignity against a comparative England average for large acute trusts of 83%.

Understanding and involvement of patients and those close to them

- The trust participated in the Friends and Family Test (FFT).Results between March 2016 and February 2016 showed that 88% of patient who completed the survey said they would recommend the service to their family and friends. The FFT is a feedback tool for patients to provide feedback on their experience.
- We witnessed that staff provided clear explanations to patients receiving care and treatment. We saw that consultants told patients what would happen next.
- We saw that staff spoke to patients in a way they could understand and that staff ensured patients had time to ask any questions.
- We noted that consultants discussed options with patients; we witnessed one consultant showing a patient an x-ray of their fracture and providing a clear explanation, the consultant also explained to the patient that their follow up appointment would be with their GP.

Emotional support

- We saw staff treated patients with empathy and that they took the time to reassure patients.
- In the diagnostic imaging department, we saw that staff reduced patient's anxiety by fully explaining procedures and checking on the patient's wellbeing throughout.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- The trust's referral to treatment time for incomplete pathways was better than the England overall performance and met the trust's operational standard between January 2016 and August 2016.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral with symptoms of cancer.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis.
- Between January 2016 and December 2016 the percentage of patients, waiting more than six weeks to have a diagnostic test at the trust was better than the England average.
- Staff told us they tried to prioritise patients with a learning disability or dementia so that they did not have to wait for their appointment. Staff received feedback on complaints in quality improvement half days (QIHD'S).

However:

- Children had blood tests in the hospitals main phlebotomy department; we visited the department and found it was not child friendly.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- There was car parking, including disabled parking available on site for visitors and patients. A pay and display system was in operation with discounts available for people on certain benefits. One-time tickets valid for one visit of any length were available from the main reception desk. Nurses told us that they organised patient transport for patients with mobility problems.
- We found the diagnostic imaging department to be well signposted; patients we spoke with in the outpatient department told us they found the clinics easily.
- Information for patients such as how to rearrange appointments and outpatient clinic opening hours were clearly displayed on notice boards.
- There was sufficient seating and toilet facilities available for patients.
- Managers told us that the hospital did not complete skype appointments at the time of the inspection; however, they did facilitate some telephone appointments and virtual clinics. A virtual clinic is a planned contact by a healthcare professional for the purpose of clinical consultation, advice and planning.

Access and flow

- The trust had 824,097 first and follow up outpatient appointments between November 2015 and October 2016. Sandwell hospital had a total of 290,909 appointments.
- Between November 2015 and October 2016 the did not attend rate was higher than the England average for all sites for almost all of the time. Processes were in place for when patients did not attend their appointments. For example, the department would offer patients that did not attend another appointment if the patient contacted the trust within two weeks of being discharged to advise of the reason and to request a new appointment.
- Between January 2016 and December 2016, the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance with an average of 89%. The figures for December 2016 showed 88% of patients were treated within 18 weeks compared to the England average of 90%.
- The trusts referral to treatment time for incomplete pathways was better than the England overall performance and met the trusts operational standard between January 2016 and August 2016.The latest figures for December 2016 showed 88.9% of patients were treated within 18 weeks. This was slightly lower than the England average of 89.4%.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral with symptoms of cancer (average of 95%).
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis (decision to treat), the average percentage across the trust between January 2016 and December 2016 was 98%.
- During the inspection, we asked six patients or their relatives how long they had been waiting for their appointment. Patients or their relatives told us they had been waiting for their appointment between five and 30 minutes.
- We saw and a patient told us there was sometimes more than one appointment booked for the same time.
- Senior managers told us that the trust was beginning to gather information on late running clinics and told us and that they would be using the new in touch system to monitor and map patient flow in the future. The trust hoped this would be fully implemented by August 2017.
- Between January 2016 and December 2016 the percentage of patients waiting more than six weeks to have a diagnostic test at the trust was lower than the England average.
- Hospital data showed that diagnostic imaging staff had put effective systems into place to improve referral to reporting times of diagnostic procedures such as computed tomography (CT), magnetic resonance imaging (MRI) and Ultrasound (USS). For example In January 2017 the trusts pledge of referral/scan to report times being less than 14 days was achieved in 33% of cases in plain film (PF), 83% in MRI and 62% in CT. In February 2017, this had improved significantly when referral/scan to report times of less than 14 days increased to 91% in PF, 98% in MRI and 90% in CT. Scanner capacity, availability of a sub specialist radiologist to report on scans, the timeliness of the scan relative to the target date were the reasons the hospital were still not meeting their 100% target all of the time.

- We reviewed the topics discussed in the imaging directorates quality improvement half days and saw that the reasons for delays in the department were discussed.
- Staff in the diagnostic imaging department told us that they had blitz days when radiologists stayed in reporting rooms all day only completing reports, this helped to prevent workloads becoming unmanageable.
- We looked at the document "imaging performance" dated January 2017 and saw that the trust was implementing various changes to reduce waiting times; these included the introduction of a new reporting folder, a new x-ray machine in the emergency department, and plans to extend MRI opening hours at the city hospital.
- Senior staff from the diagnostic imaging department attended daily capacity meetings. Staff told us that requests for diagnostic procedures were prioritised according to clinical need.

Meeting people's individual needs

- The trust had implemented a self-service check in where patients could book themselves into outpatient appointments; additionally there was a member of staff on reception.
- We saw that volunteers were available to support patients with the new booking-in system. One of the self-service kiosks was suitable for patients or visitors who used a wheelchair.
- Restaurants and coffee shops were located near to the outpatients department, if patients attending appointments wished to purchase refreshments.
- We saw that there were a range of patient information leaflets available for patients in outpatient waiting areas.
- Staff told us that if a patient did not have an address, for example if they were homeless they could arrange for their next appointment before leaving the department.
- All areas we visited were wheelchair accessible, including all rooms in the diagnostic imaging department. A lift was available for patients in the outpatients department who were unable to use the stairs.
- Staff told us they tried to prioritise patients with a learning disability or dementia so that they did not have to wait for their appointment. Staff in the diagnostic imaging department told us that they had started a learning disability pictorial pack several years previous alongside the learning disability team; however, staff told us that that this had never been finalised due to time constraints.
- The diagnostic imaging department had a six-bedded bay for day cases where they provided after care for ward patients. Hot drinks and food was available to patients during their stay on the ward.
- The trust offered patients interpretation and telephone interpretation services in most languages including Punjabi, Polish, Mandarin and British Sign Language (BSL).
- Children had blood samples taken in the hospitals phlebotomy department; we visited the phlebotomy department and found it was not child friendly. Children waited with adults to have their bloods taken using a ticket system after walking from the children's outpatient department where they had previously had numbing cream applied. Children waiting for blood tests could see adults having blood taken as staff left cubicle curtains open. We saw that there were some toys available for children's use.
- The PLACE 2016 audit scored the hospital at 83% for the wards being dementia friendly, which was better than the comparative England average of 73%. Some of the failures on the audit were due to bays not having larger clocks or clocks with multiple faces to allow visibility from all angles.
- The PLACE 2016 audit scored Sandwell General Hospital at 82% for the environment being accessible for disabilities, which was better than the comparative England average of 77%.

Learning from complaints and concerns

- We saw that the trust had a policy in place for the handling of complaints and that staff knew where to find it. The policy included information on the definition of a complaint, roles and responsibilities, the health and parliamentary ombudsman service and complaints and disciplinary procedures.
- Between April 2015 and September 2016 there was 129 complaints referred to the parliamentary and health service ombudsman, this was across the whole of the trust. Of the 129 complaints referred, 38 were accepted for investigation; of those nine were fully or partially upheld. The parliamentary and health service

ombudsman makes final decisions on complaints not resolved by the NHS in England and the United Kingdom government departments and other public organisations.

- Staff we spoke with knew the process for making complaints and were aware of the patient advice and liaison service (PALS). Information on how to contact PALS was available in the main outpatient's area. PALS offers confidential advice, support and information on health related matters. The PALS service was based at City hospital.
- We saw there was a leaflet available for patients called "your views matter Compliment? Concern? Complaint?". The information leaflet contained information on patients advice and liaison service (PALS), a feedback form and how to give positive feedback.
- We saw there had been four complaints in the Sandwell hospital outpatients department between March 2016 and December 2016 and that there had been two within interventional radiology. Three of the complaints had been upheld, one was not upheld, one was partially upheld and one was withdrawn. Complaints included attitude of staff, cancelled appointments, breakdown in communications and being dissatisfied with treatment; there were no specific themes.
- We saw that senior staff investigated complaints, identified actions and gave apologies to patients. The diagnostic imaging department received a complaint which related to a staff member not wearing personal protective equipment (PPE). We reviewed the complaint and saw that the outcome of the investigation was that the staff member needed additional training. We saw evidence that a discussion had taken place with the staff member in relation to the complaint.
- We saw that staff discussed complaints in imaging clinical governance group meetings.
- Staff told us that they received feedback in relation to complaints and that staff discussed complaints during quality improvement half days (QIHD).We reviewed a QIHD agenda from January 2017 and saw this to be the case.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Leaders recognised the challenges to good quality care and were actively seeking solutions.
- Most staff felt their managers were approachable and that they could approach them with ideas and for additional support.
- Managers held quality improvement half days for staff where a variety of topics were discussed.
- Staff received regular trust updates and communications via the internet or by email.
- The diagnostic imaging department had a well-established IR(ME)R committee that met on a four monthly basis.
- Radiology work conducted through the Black Country Alliance had been nominated for a national award.

However:

- There had been a workforce review of staffing and this had led to significant changes at the trust, we saw pockets of low staff morale in the outpatients department caused by such changes.

Leadership of service

- The senior management team included clinical directors and managers. The directors for outpatient and diagnostic imaging services had been in post less than six months.
- Managers and staff worked across sites (Sandwell and City hospital).Staff in the outpatients department told us that they would like to have a manager on site at all times but that they knew they could contact them by telephone if they were needed.
- Most staff felt supported by their local leaders and felt they were visible. Staff made comments such as they were 'asked opinions on any new procedures being considered' and that 'their ideas were listened to'.
- Staff told us that information from the chief executive was available over the intranet. Some staff told us that the chief executive of the trust had thanked them personally for their hard work.

- Leaders could recognise the challenges to good quality care and how they could address this. For example, one leader told us there had been issues with recruitment so they had used social media and open days to assist in attracting new staff. Leaders also recognised that staff in the outpatients department had very little training in information technology (IT) so were looking to appoint IT literate staff to act as champions within the department.
- Staff told us they had been able to approach their managers to request additional training and support. One staff member told us they had been able to request specific equipment to enable them to carry out their role.

Vision and strategy for this service

- Most staff we spoke with were aware of some aspects of the trusts values but not so certain on the vision.
- We witnessed staff making time to listen, keeping patients involved and being polite, courteous and respectful, these were some of the nine promises set by the trust.
- We saw that staff displayed the trusts promises and values on a white board within the diagnostic imaging department.

Governance, risk management and quality measurement

- Staff were clear about their roles and responsibilities. Managers had given nurses additional responsibilities such as completing projects about risk, audit and infection control.
- Senior staff in the imaging department held monthly review meetings where staff discussed local risks such as performance, targets and outstanding actions.
- There were five main service level agreements (SLA's) in place within the diagnostic imaging and outpatient departments. These were within oncology, breast screening, on and off site imaging, MRI and nuclear medicine; we saw that there were governance arrangements in place to manage these.
- The diagnostic imaging department had a well-established IR(ME)R committee that met on a four monthly basis. The committee had both routine and ongoing work including training sessions for non-medical referrers, monitoring, analysing and reporting of radiation incidents and reviewing of IR(ME)R procedures.
- We saw that there was a 'year of the outpatients programme, board' that met on a monthly basis. We reviewed the minutes from the meetings and saw that actions and outcomes were discussed and rag rated.
- Outpatient managers attended a clinical records design authority meeting (CRDA) on a monthly basis. We reviewed the minutes from January 2017 to March 2017 and found they contained topics such as healthcare records, policy and standard operating procedures, scanned notes quality assurance procedures in addition to QHID feedback.
- We reviewed the departmental risk registers and saw that there was one risk in relation to the outpatient department and seven risks in relation to the diagnostic imaging departments at the trust. Risks included the reduced ability to provide an interventional radiology service because of difficulties in recruiting radiology consultants and risks that specialist ultrasound services may not be provided by the trust due to lack of trained sonographers. The risk registers had review dates, control measures, actions and were rag rated.
- We saw that audits had been undertaken or were being developed in the outpatient and diagnostic imaging departments in areas such as availability of notes, resuscitation trolley checks, hand hygiene and the five steps to safer surgery checklists.

Culture within the service

- Staff were passionate about the service they provided, felt valued and wanted to do their best to support patients. Two allied health professionals we spoke with had worked at the trust for more than 15 years. We noted that staff were supportive towards their colleagues.
- There had been a workforce review of staffing and this had led to significant changes at the trust, we saw pockets of low staff morale in the outpatients department caused by such changes. Senior managers recognised this but felt morale was starting to improve. Staff felt cross-site working was difficult at times.

Public engagement

- We saw 'you said we did' information displayed on whiteboards in the outpatients department. Improvements noted included the introduction of patient Wi-Fi and hear all about it a ward to board programme in which patient's shared their stories.
- Senior managers told us that patient focus groups took place and that the trust had sought patients' opinions about the new self check-in kiosks.

Staff engagement

- Staff received monthly bulletins and newsletters by email or could access on the trust internet.
- The imaging service had a suggestion scheme where staff could give ideas to help the service to improve; staff did this online and it was anonymous.
- The group director for the diagnostic imaging department cascaded a monthly newsletter to staff. Topics in the newsletter included equipment, recruitment, sickness, governance and positive feedback.
- Staff told us that managers sought their opinions. One nurse in the diagnostic imaging department told us how they had been involved in the set-up of the interventional suite and of the recovery area at the new hospital which was being built at the time of our inspection.

Innovation, improvement and sustainability

- Radiology work conducted through the Black Country Alliance had been nominated for a national award. The imaging department had launched a seven-day interventional radiology nephrostomy service becoming the first trust in the Black Country Alliance to do this.
- Radiology staff had devised specific courses which were available nationally. This had generated income for the department which was used to purchase additional software.

Outstanding practice and areas for improvement

Outstanding practice

Medical Service at Sandwell site

- Newton 4 displayed a high-level person centred care approach. The staff on this ward were very enthusiastic and passionate about the care they delivered and the patients they served. There were a number of innovative practices developed on this ward, which included the breakfast therapy club to aid with patient rehabilitation, rewarded by the stroke association. The development and implementation of the JEL model for staff progression, the development of the delirium pathway and of the patient care bundles to aid patient progression and so patients could own their own goals.

End Of Life Care at Sandwell site

- The palliative and end of life care service ensured that patients and their families were involved in their care and their choices and preferences were upheld, including where they would prefer to be for their care and when they died.
- The palliative and end of life care service integrated coordination hub acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week 24 hours a day.
- The service reacted speedily to referrals by providing an urgent response team in order to meet patient's needs quickly.
- Staff went the extra mile to ensure patients received the right care in the right place at the right time.
- Staff showed great compassion, empathy and an understanding of patient's needs and preferences.

Areas for improvement

Action the hospital MUST take to improve

Emergency Department

- Storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- Improve the standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and increased risk to patients.
- Patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.
- There is a clearly agreed and resourced system in place for safely managing the condition of patients queuing on trolleys when the ED is very busy.
- Staff identify patients at risk of sepsis and follow the sepsis pathway in place.
- Doctors use the appropriate proforma in place for effective clinical pathways.
- Sufficient substantive registrar cover overnight for the safety of patients.
- There is a designated appropriately safe room available within which to care for patients with mental ill health
- The security and safety of staff working in the ED at all times.
- Unplanned re-attendance rate to the ED within seven days is reduced.

Outstanding practice and areas for improvement

- Information about patients' assessment and condition recorded by consultants and doctors is sufficiently detailed, precise and legible.
- Patients are treated within one hour of arriving.
- Patients are admitted, transferred or discharged within four hours of arrival in the ED.
- Take effective action to mitigate the increasing risks to patients from overcrowding in the ED.

Medical Care service

- All staff across medical services are up-to-date with basic life supporting training.
- Temporary staff being used are competent to fulfil the role.
- Resuscitation medicines and equipment are stored in a way to protect from tampering and that storage and availability is consistent across all areas within the medical service.
- Guidance from the Resuscitation Council (November 2016) is being followed.
- Sufficient storage for equipment on medical wards to avoid delay in relevant equipment being received by ward staff, and to avoid out of service and in service equipment being stored together.
- Sufficient staffing and skill mix to meet safe staffing requirements on medical wards.

Surgery

- Measures are in place to prevent further Never Events to protect patient's safety.
- Records of care and treatment provided to patients are accurate and complete.

Outpatient Department and Diagnostic Imaging

- Resuscitation trolleys are checked daily, medications and fluid bags are stored appropriately and trolleys are secure and tamperproof.
- All staff are up to date with their safeguarding mandatory training
- All staff undergo regular assessments to ensure they are competent and confident to carry out their roles.

Action the hospital SHOULD take to improve

Emergency Department

- Consider reviewing arrangements in place to support the number of newly qualified nurses allocated to the ED.
- Reviewing arrangements in place in order to successfully rotate staff between Sandwell Hospital and City Hospital ED sites.
- Consider reviewing arrangements in place for Human Resources support to the ED staff team and leaders.

Medical Care service

- Using a consistent approach for documentation across the medical service. We saw variations in fridge temperature documentation and patient records.
- Staff are knowledgeable and understand the policies in place to prevent and control infection.
- Updating the disinfectant solution log to ensure it reflects clearly how long a solution has been pre-made for.
- Staff are consistently completing relevant risk assessment documentation.
- All staff are confident with procedures and up to date with relevant training for emergency events, such as fires.
- All staff are clear about Deprivation of Liberty Safeguards (2007) and when it is appropriate to make an application to authorise a deprivation of liberty.
- Continue with improvements made to reduce waiting times and average length of stay for some specialities.
- Continue with improvements to gain JAG accreditation for the endoscopy unit

Surgery

- Review the system of pooling surgical patients to ensure that patients are not put at risk.

Outstanding practice and areas for improvement

- Identify a non-executive board member to champion theatres issues at board level and support the service.
- Repair work surfaces in theatres to comply with infection prevention and control guidance.
- All junior doctors are familiar with escalation process should patients treatment or discharge be delayed by imaging department issues.
- Safety thermometer information is displayed on the wards. Staff members should be aware of their ward scores.
- Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.
- Wider learning is promoted through complaint trends being shared across all areas of the trust.

Outpatient Department and Diagnostic Imaging

- System and environment for taking children's bloods is child friendly including a children's phlebotomist.
- Staff in the phlebotomy department confirm the time when numbing cream has been applied by the children's outpatients department prior to taking any blood samples.
- Patients are given the opportunity to be weighed in private.
- Prescriptions for controlled drugs (FP10's) are stored securely at all times in accordance with trust policy.
- Hand hygiene compliance is regularly monitored and recorded in the outpatients department.
- Staff have an understanding of their responsibilities in relation to the Mental Capacity Act, 2005.
- Patients' notes are kept securely at all times in the outpatients department.
- Staff know who the safeguarding leads are at the trust.
- Staff appraisals are up-to-date.
- Equipment and furniture in the outpatients department is moved regularly to enable a thorough clean.

End Of Life Care

- Updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.
- Mandatory training for mortuary staff includes infection control training.
- Medical staff document reviews of patients care on their specialist care plans when these are being used.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Measures to prevent further Never Events had been implemented to protect patient's safety. These newly implemented actions must be maintained, monitored and reviewed. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 - Safe Care and Treatment 12.— Care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks; • ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; • ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

This section is primarily information for the provider

Requirement notices

- ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;
- where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;
- the proper and safe management of medicines;
- assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;
- where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.
- Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent. Guidance from the Resus Council (November 2016) was not always being followed. There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- The standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and increased risk to patients.
- For February 2017, the ED showed only 66% compliance with the Royal College of Emergency Medicine (RCEM) recommended maximum time from arrival to receiving treatment.
- The system in place for managing the condition of patients when the ED was very busy and they were queuing on trolleys in the corridor was not clear.
- Staff were not always identifying patients at risk of sepsis and the sepsis pathway in place was not always followed.

This section is primarily information for the provider

Requirement notices

- Appropriate proforma were in place for effective clinical pathways but doctors were not always using them.
- The trust had identified lack of substantive registrar cover overnight was as a risk.
- There was no designated appropriately safe room within which to care for patients with mental ill health
- Security within the ED and timely access to security staff was an ongoing issue of concern for ED managers and staff.
- The trust's overall unplanned re-attendance rate to the ED's across both sites, within seven days was worse than the national standard of 5% and generally worse than the England average.
- During February 2017, only 12% of patients at Sandwell Hospital were treated within one hour of arriving.
- During 2016, Sandwell Hospital ED had rate of 83.3% of patients admitted, transferred or discharged within four hours of arrival in the ED. This fell well below the Department of Health's standard of 95%.
- Emergency resuscitation trolleys were not all secure, medication and fluid bags were not stored appropriately and there were no security tags on the drawers to alert staff to tampering with the contents
- 2(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.
- The provider did not ensure that all staff were up-to-date with basic life support training.
- The provider did not ensure that temporary staff were competent to fulfil their role.

2(g) the proper and safe management of medicines.

- The provider did not ensure that storage and availability of medicines required for resuscitation were consistent. There were no arrangements in place to

This section is primarily information for the provider

Requirement notices

manage the risk and protect medicines for resuscitation from tampering. Guidance from the Resuscitation Council (November 2016) was not always being followed.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014** **Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; C. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; **How this regulation was not being met:**

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Requirement notices

- Appropriate proforma were in place for effective clinical pathways but doctors were not always using them.
- There was a systemic weakness in medical note making and clerking. Information about patients' assessment and condition recorded by consultants and doctors was often scant, lacking in detail and precision or illegible.
- Further actions identified by senior trust managers to mitigate the increasing risks to patients from overcrowding in the ED, did not address the problem as a hospital wide systems issue and the ED leaders were left to manage it.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing HSCA 2008 (Regulated Activities) Regulations 2014, Regulation (18) (2a) Staffing. **How the regulation was not being met** Staff did not receive appropriate supervision as is necessary to enable them to carry out the duties they were employed to perform. **This was because:-** Staff in the outpatients department did not have their competencies assessed to ensure they were confident and competent to carry out their role. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

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Requirement notices

The provider did not always ensure there was enough staffing or appropriate skill mix. Some wards were reliant on the use of temporary staff to fulfil safe staffing requirements. The provider did ensure temporary staff had sufficient competency.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment HSCA 2008 (Regulated Activities) Regulations 2014, Regulation (13) (2) Safeguarding service users from abuse and improper treatment. **How the regulation was not being met** The provider was not ensuring systems and processes were established and operated effectively to prevent abuse. **This was because:-** We reviewed individual department data from the trust and saw that cross sectional imaging radiology, radiography and ophthalmology had only a 50% compliance rate in safeguarding adult's level 2.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 -Premises and equipment 15- 1. All premises and equipment used by the service provider must be—

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Requirement notices

b. secure,

How this regulation was not being met:

Staff working in the ED were vulnerable to aggression and assault from persons entering the premises through the unsecured ambulance admission doorway.

1(c) suitable for the purpose for which they are being used.

There was insufficient storage space for equipment in a number of areas throughout the medical service.