Sandwell and West Birmingham Hospitals NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Sandwell and West Birmingham Hospitals NHS Trust is a provider of both acute hospital and community services for the west of Birmingham and six towns in Sandwell. It serves a population of around half a million people. There are two main acute locations: City Hospital and Sandwell General Hospital; there is also the Birmingham Treatment Centre on the City site. The trust provides community services in the form of inpatients at the Leasowes Intermediate Care Centre and Rowley Regis Hospital, alongside other community services such as district nursing and community palliative care. All community services are offered in the Sandwell area. The Birmingham and Midland Eye Centre based on the City site is a specialist service which will be scheduled for a full inspection separately. Please note we did look at its outpatient department as part of the outpatient core service.

We carried out this comprehensive inspection because the trust is known as an aspirational trust wanting to become a foundation trust. The inspection took place between 14 and 17 October 2014, and unannounced inspection visits took place between 25 and 30 October.

Overall, this trust requires improvement. We rated it good for caring for patients and effective care but it requires improvement in being responsive to patients' needs and being well-led. We rated the safe domain as inadequate.

Our key findings were as follows:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Shared learning from incident reporting needed to be improved across the organisation.
- Infection control practices were generally good but there were pockets of poor practice that needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, across the trust, the safe storage of medicines was not robust. This was an area in which the trust had failed to meet its targets for 2013/14.
- The trust had consistently failed to meet the national target for treating 95% of patients attending the accident and emergency (A&E) department within 4 hours.
- Generally community services were good, but required improvement for safety.
- We were concerned about wards D26 and D11 at City Hospital, which were not meeting the basic care needs for patients.
- The trust had recognised that end of life care was an area for development for the Bradbury House Day Hospice.
- The mortuary on both sites had long-standing environmental issues that needed to be addressed.

We saw several areas of outstanding practice including:

- The iCares service within the community and the diabetic service. These were outstanding and had received national recognition. Critical care services were good overall, with both staff and patients feeling well supported.
- The compassionate and caring dedication for end of life care with regard to a minor, which was rated as outstanding, especially how the service used the wider healthcare team to meet the needs of the individual. We were confident that this level of support would be repeated in a similar situation.

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

Importantly, the trust must:

- review the levels of nursing staff across all wards and departments to ensure that they are safe and meet the requirements of the service;
- ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised so that service development and learning can take place;
- ensure that all patient-identifiable information is handled and stored securely;
- follow through from findings of safety audit data, and follow up absence of safety audit data;
- address systemic gaps in patient assessment records;
- take steps to improve staff understanding of isolation procedures.

Summary of findings

There were also areas of practice where the trust should take action, and these are identified in the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS Trust serves a population size of 530,000 from across West Birmingham and six towns in Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

The trust provides care from two main hospital sites: City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. Intermediate care is provided from Rowley Regis Hospital and the Leasowes Intermediate Care Centre, which is where the trust's stand-alone birthing centre is located.

The trust is an integrated care organisation and by self-admission there is more work to be done. The executive team has seen newly appointed members over the past 18 months to include a Chief Executive Officer, Chief Nurse and Director of Finance The trust is considered a likely future applicant for foundation trust status, but this is at an early stage and the trust will use this report as part of their evidence.

The trust provides acute and community care to a diverse population of Sandwell and Birmingham with a high level of deprivation, ranked 12th and 9th, respectively, out of 326 authorities.

Over two years ago the Trust published a long term financial model indicating major pay savings. With the announcement of the proposed new Midland Metropolitan Hospital in July 2014, public attention focused again on these issues. The Trust commenced internal discussions with staff in August 2014 about workforce changes, roughly equivalent to the loss of 1400 jobs over a five year period.

During the week of our inspection an NHS wide strike was planned.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

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

The team included 15 CQC inspectors, 27 specialist advisers including consultants, doctors, matrons, nurses, midwives, a therapist, student nurses and 4 'experts by experience'. Experts by experience have personal experience of using, or caring for someone who uses, the type of service we were inspecting. The inspection team was supported by CQC analysts, planners and recorders.

How we carried out this inspection

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?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits between 14 and 17 October 2014 and unannounced visits on 25, 27 and 30 October 2014. During our visits, 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,

Summary of findings

healthcare assistants and senior clinicians. We talked with people who used the 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 used the services. We met with people who used services, as well as carers, who shared their views and experiences of the core service.

What people who use the trust's services say

A public listening event was held on 25 September at City Hospital and 8 October 2014 at West Bromwich Town Hall. Feedback from people who used acute and community services was mixed including many who were happy with their care. People were happy with overall care from ward staff and out-patient appointments, but dissatisfied with complaints management and care from both accident and emergency (A&E) departments because of staff rushing and not having enough time to provide safe and effective care.

Focus groups were held with three black and minority ethnic community groups to include people who are homeless, blind or visually impaired, Asian females and mothers of young children.

Main themes to emerge were concerns about waiting times and poor staffing levels at both City and Sandwell Hospital A&E departments, and poor management of complaints.

Facts and data about this trust

Sandwell and West Birmingham Hospitals NHS Trust serves a population of over 530,000. It provides acute services from City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. The trust provides community services across the Sandwell area. It has a community hospital at Rowley Regis and an intermediate care service at Leasowes in Oldbury. The trust's community services merged with the acute trust in April 2011.

The trust serves the two main local populations of Sandwell and Birmingham with a population of over 530,000. Sandwell and Birmingham local authorities have a significantly high level of deprivation compared with the England average, ranked 12th and 9th out of 326 authorities. There is a high level of health inequality between the most deprived and least deprived areas in Sandwell and Birmingham (a difference in male life expectancy of more than 10 years, and in female life expectancy of more than 5 years).

The trust has annual revenue of £439 million. Each year the trust spends £430 million of public money, £25 million of which is spent on new equipment and service expansion. In 2018/19, the trust plans to open the Midland Metropolitan Hospital (Midland Met), which will be built close to the boundary between Birmingham and Sandwell.

The trust employs around 7,500 members of staff, including around 760 medical and dental staff and 1,990 qualified nurses.

The trust has 764 acute beds, including 70 maternity beds and 19 critical care beds. It has a further 44 beds in its community services.

In 2013/14, 5,586 women gave birth across the sites and 564,395 people attended outpatient clinics. There were 736,852 community contacts made within the 'same time frame; 176,496 attended both accident and emergency (A&E) departments and the trust's eye casualty centre, called the Birmingham and Midland Eye Centre, which was not inspected during our inspection. The trust conducted 82,295 emergency and elective operations, of which 47,431 were on a day-case basis.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Inadequate 

Summary

We judged safety to be inadequate for the trust overall. The safe domain for both acute sites was rated inadequate. On the Sandwell General Hospital site surgery and outpatients department were rated inadequate. Within the City Hospital site the core services of medicine, surgery and outpatients were rated as inadequate.

Within outpatients we found that essential training records were missing for the imaging department they were unable provide proof of staff competency. Within surgery they had been a 'never event' for which the control measures identified were still not being used consistently. Within children and young people's service we found infection control practices, resuscitation equipment and the environment for children and adolescents with mental health issues was required improvement.

Safety concerns we found on D26 at City Hospital was the main reason for the inadequate rating in medicine on that site. The trust had identified issues on this ward, but at the time of the inspection had not taken effective action to address these.

It was clear that the drive to improve safety was potentially at cross purposes with the trust's planned reduction of staff numbers. The Trust were sighted on this. The current situation resulted in some cases of staff not being able to attend training because of staffing constraints, or offer services over extended hours, also due to lack of staff.

Learning from incidents was not well embedded beyond a local level. This presented a risk to the organisation because staff were not always learning from incidents and 'near misses'. We also noted reluctance on the part of some staff to raise concerns because they felt that the feedback process was ineffective. Where serious incidents had occurred the control measures put in place to address them had not been adhered to.

A number of environmental and equipment issues were not dealt with in a timely fashion; although staff told us they had reported them, they remained unaddressed.

Medication storage and security was inconsistent and we found the trust needed to improve this across both acute sites and within the community. This was despite failing to meet its agreed improvement target with commissioners in the last year.

Summary of findings

Duty of candour

- Duty of candour is a new part of the regulations that providers have to comply with. This came into force for NHS providers in November 2014. However, although our inspection took place before this, providers needed to be aware and prepare their organisations for this regulation change.
- The trust's senior executive team was aware of its responsibilities with regard to this.
- During the inspection, we saw evidence of the spirit of the regulations to be open with patients when care did not meet best practice. We observed this within the accident and emergency (A&E) department.

Incidents

- The trust reported 5 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in 2013/14. There has been another reported event in 2014/15. These included two wrong site surgeries. We noted that current processes still placed patients at considerable risk of this occurring again. The staff within surgery had recognised the potential risk and had put control measures in place; however, these were not being routinely adhered to.
- The trust had an average number of serious incidents given its size.
- Widespread learning from incidents outside staff's own wards or departments was limited, despite the trust using different communication platforms to share learning with the operational staff. This was acknowledged by representatives of the executive team. Staff felt they required more learning from outside their own wards or departments. Currently no audit of staff attendance of ward or department meetings had been undertaken.
- Previously staff had graded the incidents and if re-grading had occurred, the person reporting the incident was to be informed but this had not always happened. At the time of our inspection incidents were assessed by senior management for grading after 24–48 hours. Management used the review of all incidents and their personal experience to determine the grading.
- The trust had good processes in place for the analysis of incidents. A review of all incidents reported was undertaken daily by trust senior management. Investigations were also undertaken by relevant staff but it was recognised by senior trust staff that those undertaking the investigations would benefit from root cause analysis training.

Summary of findings

- New pressure ulcers were reported as incidents; this enabled learning to be shared so that the number of occurrences could be reduced. Though we noted that in some areas of the trust, although staff had identified that preventable pressure ulcers had occurred, there were no management plans in place to prevent future occurrences. However, figures provided by the trust do show the prevalence of pressure ulcers to be falling.

Cleanliness, infection control and hygiene

- The arrangements in place regarding infection control were well planned. There were procedures for audit and reporting. Staff had a good understanding of best practice and were well supported by infection protection control (IPC) staff. Regular audits showed that most staff, wards and departments used good IPC. However, we saw a few staff not using IPC as set out in the trust policy, and in some of these cases local audits had not identified this as an issue. This indicates that this was an on-going issue and that the trust must continually remind staff of their responsibilities. The practices in place revealed that this was being done, but extra local focus would be constructive.
- Across both community and acute settings, 72% of staff had attended infection control training. The trust understood that it needed to improve the attendance of training, aiming for 95% compliance by March 2015.

Environment and equipment

- Resuscitation equipment checks across both acute sites needed to be improved; we found numerous incidents were checks had not been maintained on a daily basis of this emergency equipment. This was against the trust's own policy. We also saw that some equipment was out of date, missing or faulty, which put people at risk.
- Most areas of the trust environment were fit for purpose, enabling staff to undertake their roles safely. We also found that equipment was readily available and safe to use. However, we noted that, despite the need for some repairs being escalated appropriately, some remained unaddressed for extended lengths of time. Examples were cracks in the flooring in the mortuaries and, in a number of areas, broken chairs not suitable for patients to use. We saw that issues raised within the community remained unaddressed for extended lengths of time, such as a room where medications were stored being too warm. This could compromise the integrity of the medicines stored there. Also, the environment of the Bradbury House Day Hospice adversely affected the activities that patients could undertake.

- Some elderly care wards had areas designed for patients living with dementia; unfortunately these were not used because staff could not see patients using these spaces if they were unsupervised.

Medicines

- We found that the pharmacy team was actively involved in all aspects of an individual's medicine requirements. People's medicines were reviewed and checked for safety by a clinical pharmacist at the point of admission through to discharge. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and that, if they had any medicine queries, they had access to pharmacist advice at all times, including an out-of-hours pharmacy service. We found that the pharmacy team provided an efficient clinical service to ensure that people were safe from harm.
- Although the trust had an online 'incident-reporting' system in place to record and report medicine incidents or errors, we found that learning from these errors did not always take place. There was an open culture of reporting medicine errors. However, nursing staff were not always informed of the overall outcomes and thereby able to learn and change practice. Learning from such incidents would help to improve patient safety.
- Arrangements for the safe storage of medicines remained an issue for the trust. We found numerous breaches where medications had not been stored either correctly or securely.
- Two wards on the City site were placing carrying cases with handles on top of a metal dressing trolley to take medicines to people during medication rounds. This system had not been risk assessed for safety or security.
- We found chaotic medicine storage in the A&E department, with medications out of their original packaging and stored in a haphazard manner.
- There was no consistent system for safe medicine storage, despite the trust failing to achieve its Commissioning for Quality and Innovation (CQUIN) for the Safe Storage of Medicines 2013-14. We would have expected additional efforts to improve, but we did not see that during the inspection.

Records

- Information governance was an area of concern. During an unannounced visit, we found serious breaches of unsecured patient notes. During an announced visit, we noted in various documents that information vital to delivering good-quality care was missing, such as records within notes with no

information to identify the patient concerned. This could lead to confusion because staff would not know if the record applied to the person in whose notes it was found. We alerted appropriate hospital staff in all instances we found.

- When reviewing Do Not Attempt Cardio Pulmonary Resuscitation documents we found incorrect or missing information for patients which put patients at considerable risk of not having their wishes adhered to.
- Data supplied by the trust showed that 76% of staff had undertaken information governance training at the time of our inspection.
- The imaging department was not operating to expected levels in some areas; these included the lack of training records and safety guidelines for staff. This had resulted in the department being judged as in breach of Ionising Radiation (Medical Exposure) Regulations 2000. This meant the trust would be issued with an improvement notice, and would need to make improvements within an agreed timescale. This would improve both the working conditions for staff and outcomes for patients using the service. This seriously compromised the ability of the department to demonstrate staff competency around the equipment they were using.

Safeguarding

- The trust had a good reporting structure and staff knew how to access the appropriate person for support. The chief nurse was the safeguarding lead for the trust.
- The trust had adult and children's policies in place, although we noted the safeguarding children's policy was due for renewal at the end of August 2014 which at the time of the inspection was still the case. We note that the trust took an active decision to work with an out of date policy until the feedback from the CQC safeguarding review was received.
- Safeguarding adults training received by staff was not based on best practice. Not all staff whose position brought them into contact with vulnerable patients had received training to the appropriate level. This was because the trust had taken a decision to only offer level 2 adult training to senior staff (band 7 and above) or to more junior staff if their roles demanded it. However, within the outpatients department, only senior staff had been trained to level 2, despite junior staff being responsible for clinics.
- When we were aware of safeguarding issues during our inspection, we alerted the trust to these so that appropriate actions could be taken.

Mandatory training

- Mandatory training for 2013/14 was reported by the trust in its annual report as completed by 87% of staff.
- Documents supplied to us by the trust showed that across all the staff groups and departments mandatory training (including statutory training) was 77% at the time of our inspection. We did note that the document was undated, but we assumed that it was the latest version for 2014/15 supplied to us as part of the information requested from the provider before our inspection.
- We noted a considerable difference in compliance between the professions of nursing and midwifery and medical and dental with mandatory training. Nursing and midwifery attendance completion rate was 77% and 54% for medical and dental staff. The trust needed to ensure the same amount of importance was applied to medical and dental staff attendance as to nursing and midwifery staff.

Nursing staff

- We saw that nursing staffing numbers was an issue for some areas of the trust. For example, within the community at the Leasowes Intermediate Care Centre, they had serious issues regarding the number of qualified staff on duty at night. There was one nurse working over two floors totalling 20 patients, which included two palliative care beds. Documents supplied corroborated this. The trust recognised this as a safety issue and had put an interim control measure in place, although a permanent solution had not been addressed. There were similar issues within both the acute and community settings where staff were working over and above their contracted hours to cover vacancies and sickness.
- There was reconfiguration taking place within the trust. Over the next five years, the Trust will be reducing its all professions workforce by 17%. Some estimates suggest that this will be in the face of rising demand, although local commissioners dispute this. During our visit, the Trust was part way through a consultation to change some workforce roles. Although this was to improve access to the service for patients, the extra strain on existing staff to cover the additional hours without more staff was noticeable. We found this resulted in poor morale and staff were concerned for their job security. The process for accessing both bank and agency staff was overly complicated and resulted in staff sometimes not receiving the cover they needed. However, the trust had identified that overspend on both agency and bank staff represented a risk and needed extra controls. It was clear that, although a robust process was required, the current situation was not effective, being lengthy,

for staff making requests, and may not have been the best use of time for the chief nurse. At the time of our inspection, there were additional measures pertaining to the one to one process which had been in place a few weeks.

Medical staffing

- The trust had a higher (worse) ratio of middle-grade doctors to consultants than the England average. The trust had 235 whole time equivalent doctors with 33% at consultant level, which was worse than the national average of 38%.
- Doctors we interviewed and who attended focus groups gave mixed views regarding the proposed changes within the trust. It was felt that some decisions made by the trust were arbitrary and they had not had the opportunity to give their opinions. The trust informed the CQC that the trust has an active and well attended medical staffing committee and a regular Local Negotiating and Consultation Committee (LNCC).
- Some doctors expressed frustration at the current level of their workload, particularly across two hospital sites. When we spoke with the trust leadership about this, they thought the reconfiguration of services and new hospital opening would reduce this.
- The Postgraduate Medical Education Training Board (PMET) review findings report summary dated 9 October 2014 from Health Education West Midlands gave a positive review of trainee doctors' education and training at Sandwell and West Birmingham Hospitals NHS Trust.

Are services at this trust effective?

Good

Summary

We judged that this domain to be good. We found that evidence-based treatment was delivered and patients were mostly pain free. Although audit of all pain relief procedures was not undertaken.

Identified treatment pathways were used across the trust. We noted that identification of deteriorating patients was used to good effect in most instances, but we found some wards were not undertaking observations when due and in some cases staff were not escalating concerns to medics when results demonstrated this was required.

The trust was performing well against their targets for commissioning for quality and innovation. These targets are put in place to improve services for patients.

Care planning within the acute sector was not always personalised. The trust used pre-printed care plans and we found that some patients did not have care planned for all their needs, even when a

risk assessment had identified that extra support was required. The trust also needed to improve arrangements about mental capacity because some junior medical staff did not know how to discharge their duties in this area.

Evidence based care and treatment

- The trust used identified treatment pathways to deliver care across all the services we inspected.
- Identification of the deteriorating patient was used to good effect within the trust.
- The trust took part in 31 national audits in 2013/14, which represented 100% of the audits the trust could take part in. However, in some cases where the trust had not performed well, re-audit had not been undertaken to see if improvements had been achieved.
- The hospital had not yet implemented the British Thoracic Society's care bundle for community-acquired pneumonia as recommended by NHS England earlier in 2014 which aims to improve administration of antibiotics within 4 hours of admission to hospital.

Pain relief

- Generally pain relief that patients received was good. They reported that they received analgesia when they needed it.
- Staff used recognised tools to identify pain levels in patients, although within acute children's services a new tool had been introduced for which staff said they lacked training; however, no child was seen or reported to be in pain.
- The use of anticipatory prescribing was well embedded across both acute and community end of life services.
- We did note that, within maternity and surgery, epidurals were used as pain relief. Within surgery, the use of epidurals was not audited for effectiveness against less invasive and less labour-intensive pain relief methods. The trust supported postoperative patients with patient-controlled analgesia or epidural pain relief. Best practice guidelines for epidurals indicated that the decision to continue using epidurals should be guided by regular audits and risk–benefit assessment.

Patient outcomes

- Care plans in use were pre-printed documents that lacked personalisation.
- Some patients did not have care plans in place for known conditions. Also, after risk assessments that identified that extra support was needed, patients did not always have care plans to support the outcomes of the risk assessments. This put patients

at considerable risk, because professionals delivering care used these documents as tools to identify care requirements. It also showed that care was not always discussed with patients or their relatives. Finally, having pre-printed care plans deterred staff from personalising them, although with good leadership staff could have been encouraged to personalise the care plans.

- The outreach service was effective in supporting patients appropriately and accessing timely care.
- The Hospital at Night team of doctors and senior nurses were not using the Royal College of Physicians' Toolkit for handovers as recommended in 2011. This toolkit gives clear guidance and structure to ensure effective handovers are completed that address patient's needs and conditions.
- The Trust's Hospital Standardised Mortality Ratio (HSMR) for the most recent 12-month cumulative period is 85.2, which remains below that of peer trusts. The City hospital site HSMR was below the national average with 70.4, and the Sandwell hospital site's HSMR was 99.7, which was within the expected range for the most recent 12-month cumulative period, as reported in the trust's Integrated Quality and Performance report for the second quarter of 2014.
- The Integrated Quality and Performance report for the second quarter of 2014 showed 100% compliance with the 90% target set by the Commissioning for Quality and Innovation (CQUINs) payment framework for July 2014 form dementia screening.
- The trust reported meeting the 62 day cancer standard (from urgent GP referral to treatment) in Quarter 2 2014-15, with overall performance of 88.6%, which was higher than the trust target of 85%.
- The trust was meeting its target for carrying out mortality reviews within 42 days by achieving 89% compliance above the trust target of 86% as of June 2014.
- Use of hand-held devices, as well as other tools, was well embedded to identify a deteriorating patient.

Nutrition and hydration

- Access to food and drink was good. Patients reported they could obtain snacks and drinks when they needed them.
- We noted that, when patients needed encouragement with fluids, their fluid intake and output were monitored. However, this was not done consistently the completion of these records was patchy and no targets had been identified for patients. Local audit of the quality of the completion of these documents was missing.
- There was no specific policy to support staff and children and young people regarding Nil by Mouth (NBM). This resulted in

staff relying on past experience to determine when and for how long a child should be NBM for prior to surgery. This meant the practice was inconsistent and contained elevated risk to the child.

Competent staff

- The trust had improved the appraisal rate to 100% of staff receiving appraisals in 2013/14. Staff we spoke with agreed they had received appraisals.
- Induction practices across the trust were good; within each ward or department, new staff were supported to achieve competencies to deliver their new roles.
- Attendance at mandatory training was well supported and encourage. The trust reported 86% for the period 2013/14. Other undated documents shared with us by the trust showed that 77% of staff had completed their mandatory training.
- There was a widespread lack of staff supervision throughout the trust. Staff told us the reason was staff shortages, which prevented them from supporting staff with supervision on a regular basis.
- Bank nurses told us that there was not an effective system for their supervision or their appraisals.
- Medical staff within Emergency medicine, General surgery and Gynae-oncology needed clearly agreed job plans. These would enable them to plan their duties, responsibilities and objectives for the coming year. They also covered all aspects of their professional practice. Without these in place, it was difficult to assess the performance of each individual. Following the inspection the trust informed us that job plans were in place for general surgeons but they were in dispute.

Multidisciplinary working

- Allied healthcare professionals were used to ensure that patients' outcomes were optimised. Across the trust we saw good examples of cross-professional work. The community services appeared to work well within the local healthcare community, and worked hard to overcome obstacles to ensure that patients received the service they needed.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- A letter dated 29 May 2013 had been sent to trust medical staff from the trust medical director identifying the importance of obtaining consent for the provision, withholding or withdrawing of a medical intervention. There had been a previous 'never event' where the investigation had identified consent as a contributory factor.

Summary of findings

- Mental capacity issues were not embedded within all the staff groups as well as they should have been. Junior doctors' knowledge and skills needed more support and training to allow them to be more confident. However, we noted that passports were in use for people with learning disabilities and the trust provided specialist support for both staff and patients in this area. Passports are documents produced by the patient and family, which details their likes and dislikes, especially if the patient has difficulty communicating.

Are services at this trust caring?

Good

Summary

We judged the trust to be caring. In all the services we inspected across the whole of the trust we found staff and patient interactions to be good. All levels of staff who had patient contact were polite and treated patients with dignity. We observed interactions across the trust and spoke to patients, most of whom said they were treated well. They were also made aware of their treatment plans and felt well supported throughout the process.

Compassionate care

- Most patients received compassionate care from staff. We witnessed many interactions that showed that staff were respectful and kind to patients.
- We saw on some occasions that patients' dignity had been compromised, but these were in the minority. One particular incident we observed involved staff not removing a person to use the bathroom while meals were being eaten; this resulted in other patients not wanting to finish their meals. It also showed a lack of dignity and respect for the other patients in the vicinity.

Emotional support

- In most instances, staff involved patients in their care and emotional support to patients was forthcoming.
- Patients spoke very highly of the staff, notably in the intensive care unit (ITU; they said the staff were patient and attentive).
- The identification of empathetic staff was part of the recruitment process, which senior staff told us had resulted in good-quality staff being recruited to the trust.

Are services at this trust responsive?

Requires improvement

Summary

We judged responsiveness to patients' needs to require improvement. We saw that the trust provide services to meet the

needs of the local people, but these were not always well planned or implemented (for instance, the extending of hours of service in imaging with no related increase in staff, which effectively meant one room could not be staffed). However, the provision of a GP service in the accident and emergency (A&E) department was responsive to patients' needs.

The translation services were not uniform: some areas did not have information readily available in different languages, and some procedures had to be cancelled because of a lack of interpreters to support patients' needs. Whereas other areas did have information available not in English, and age appropriate.

The complaint process had been devolved to local level, with support from the central complaints team.

The trust needed to ensure that it made inroads into the local community to gather the views of the diverse population it served.

Service planning and delivery to meet the needs of local people

- The trust had implemented a number of initiatives to ensure that patients received the care they needed close to home. The community pathfinder diabetes project was a planned and delivered service that had devolved the traditional outpatients appointment into the community, making it easier for patients to access the service.
- We also noted that the trust had reconfigured some services to be delivered across extended days. However, the common theme of concern was the inability to staff the extended hour's services appropriately.
- We saw that GPs were in the A&E department so that patients could access primary care if that was more appropriate than emergency treatment.
- Before the inspection, we spoke with a group that supported homeless people, some of whom had issues with alcohol. They told us they felt able to access the services of the trust and had been well supported in most cases.
- The trust has community services which aim to address the needs of local people. Notably services delivered within schools which was child and family centric. Therapists empowered parents to deliver therapy to their children.

Meeting people's individual needs

Summary of findings

- The community that the trust served was culturally diverse but the trust did not have a universal response to this. We saw that in some areas information was accessible in different languages and formats, but in others it was lacking.
- Overall, access to interpreters was good; the trust had invested in interpretation services, although we noted that the service was not universal in its accessibility. Community staff told us they adhered to trust policy regarding not using relatives as interpreters; however, acute staff continued to do so, especially in emergency services. Because it was emergency services, there was some level of mitigation; however, the use of third-party interpreters should always be preferred. We were made aware that on occasion patients' appointments or procedures had been cancelled because of a lack of translators.
- The trust served an ageing population with patients displaying dementia-type illnesses. This put extra strain on the service to deliver safe and responsive care. The trust used to have a lead for dementia services but had taken the decision not to re-recruit to that role. There were dementia champions within the trust. However, we observed, and staff told us of, many instances where they were required to support patients with this kind of condition, but felt unprepared to do so.
- The trust employed a lead for learning disability, whom staff found to be very supportive. However, during our inspection, we saw that the learning disability advice for one patient was disregarded by a medic.

Access and flow

- Delayed discharge had a significant impact on the trust's ability to have beds available for patients. An area where the impact was felt deeply was in end of life care. Patients were given the choice of where they wanted to end their lives and, because of the nature of their condition, this had to be undertaken in a timely fashion. Reorganisation and staffing were sighted as reasons for delayed in transfers.
- In the trust's Integrated Quality and Performance report for the second quarter of 2014, it reported Delayed Transfers of Care increased during the month to 4.3% (from 3.7% in June).
- Patients did not always receive their medicines promptly on discharge. We were told that sometimes people were discharged or transferred without their prescribed medicines, which were then sent on later using hospital transport. Discharges were often delayed because of the need to wait for medicines to come from pharmacy. There were many reasons

discussed for the delay. These included the time taken for a doctor to write up the discharge prescription and changes made to a person's medicines, which resulted in further delays in dispensing new medicines.

- Patients attending outpatients regularly experienced delays and extended waiting times. The department appeared to appreciate this was a problem but at the time of the inspection it had not been resolved. The outpatients department was part way through the "Year of the Outpatients" initiative, with one of the objectives to improve patient flow.

Learning from complaints and concerns

- We spoke to a number of medical and nursing staff in a variety of areas who told us about the changes to the complaints process. The trust told us that their new complaints process was a devolved system. This meant that staff of all grades were involved in investigating and responding to complaints made by patients and their carers about their care and experience while at the trust.
- One of the changes made by staff in response to complaints was sleep packs, which included eye shields and ear plugs to help patients get a good night's sleep.
- Consultants who had been involved in responding to complaints told us they had found it a useful experience and were pleased to be involved in responding to complainants.
- Senior management at the trust told us that they shared patients' stories and complaints at the board meeting so that the whole trust could understand patients' experiences.
- We met with trust representatives who told us that the trust had just started to monitor the numbers and trends of locally resolved complaints. These were complaints that staff dealt with as they arose and resolved for patients immediately.
- Most complaints were received from Caucasian people and those of Caribbean origin. Trust board members we spoke with admitted that they needed to improve the links to other communities that they served, because the voice of those communities was under-represented. The trust had just started some work to become more involved with the local community, but it was too soon for us to judge this during our inspection.
- Complaint resolution time was improving within the trust, averaging 40 days to resolution previously it had been up to 70 days. The trust wanted to improve on this further.

Are services at this trust well-led?
Summary

Requires improvement

Summary of findings

We judged leadership to require improvement. Although we saw many arrangements that showed good management, we observed issues that needed further management input. The tools which the board used to be aware of risks within the organisation did not always contain the all risks to the organisation.

Staff knew the chief executive, but did not recognise other members of the trust board. The workforce transformation was presenting major problems because it adversely affected morale within the trust with staff citing lack of communication about their roles as a major contributor.

Innovative practice was taking place, notably iCares (which is a service which supports patients with long term conditions working closely with the acute hospitals to maintain patients within the community) and the community pathfinder diabetes project, a planned and delivered service that had devolved the traditional outpatients' appointment into the community, making it easier for patients to access the service. both of which had received national recognition for good service.

Vision and strategy

- The trust had a vision it was working towards, which was to be known as 'the best integrated care organisation in the NHS' by 2020.
- The medium-term vision and strategy was to have completed and moved into a new hospital, the Midland Metropolitan.
- The trust has to achieve a staffing reduction of 1,400 in the next five years.
- The trust had set six strategic objectives for 2014/15. The first was safe high-quality care and the main initiative for this was 'Ten out of Ten care'. This required staff to always undertake 10 actions, with the aim of reducing harm, for every patient admitted. During our inspection, we found that a considerable number of staff were not aware of this initiative. However, when we spoke with members of the trust board, it became clear that it was a pilot being trialled on a limited number of wards and departments. We also noted in trust board papers that the '10 out of 10 care' initiative had been launched in September 2014.
- Also as part of safe high-quality care strategic objectives, an extra priority was 'the year of the outpatients', although, when we visited staff in outpatients and asked about this, not all staff were aware of this initiative. Some were aware that systems and processes were being reviewed and updated.

- This showed that, although the trust had many devices available to share information, key messages were still failing to reach operational staff. Also, we were not clear on the ability to achieve this strategic objective for 2014/15, when the pilot phase started 6 months into the delivery year.
- Four-hour A&E department breaches are another indicator of safe high-quality care and identified as another priority for 2014/15. Documents supplied by the trust showed that, since April–July 2014, the A&E department had breached the 4-hour wait times three of the four months. Although this was a strategy identified for the 'front door', it had implications for the whole hospital: if there were insufficient beds available, this could have an impact on the A&E department's ability to transfer patients to a ward and result in a breach occurring. Staff had expressed concern that this issue was seen only as theirs, when it was a wider trust issue.
- The trust board was aware of delayed transfers of care and these were discussed in the quality and safety committee in August 2014. The trust had regular contacts within the community to try and address the need for more social care support to help with the discharge processes.
- Within services such as critical care and focus groups of the wider staff group, staff expressed their dissatisfaction with the instability of middle management. This was also noted in minutes of committee meetings and presented to the board. As middle management was essential to ensuring that operational staff understood the vision and strategy of the organisation, this uncertainty put the organisation at considerable risk.

Governance, risk management and quality measurement

- The trust had to make changes in the workforce that would result in 1,400 whole time equivalent posts being lost. This resulted in staff undergoing consultation for some roles and management reviewing establishment numbers. The trust confirmed the statutory consultation process began in October 2014.
- Trust executives confirmed that the identification of risks and how they were presented on the risk registers needed further work. Staff required extra support and training to present the risks and control measures in a uniform fashion. However, we saw risk registers having future control measures applied to reduce the current risk. This did not appear to be a safe practice because the trust board was looking at residual risk ratings associated with current control measures. Therefore, if a residual risk was lower but the appropriate control measures were not in place; this was falsely reducing the risk. We spoke

with a member of the trust board who did not see this as an issue. However, as the trust was already aware that the quality of the risk registers needed to improve, 'it should also consider the control measures that should be applied.

- We found that not all departments had a robust system in place for reviewing risks on a regular basis to monitor if the control measures had reduced the levels of risk. This was notable in the A&E department.
- The process for accessing additional bank or agency staff was time consuming and at times inadequate to meet the needs of the units needing the extra support. It was clear from our conversations with executive staff and from documents supplied by the trust that the additional monitoring of bank and agency staff use was required to ensure spending controls. However, the system in place at the time of the inspection was convoluted and created barriers between staff requests and executive management approval. This meant that sometimes no staff were available even when approval had been granted.
- The trust's 'Safer staffing' document was produced and published every month on NHS choices. This showed the number of expected nursing and healthcare assistant staff compared with actual, by those who had attended in the past month. We spoke with the chief nurse about these figures because they showed the percentages achieved. The overview demonstrated that, for the past 3 months (as presented to the trust board) the staffing was more than that expected in most instances. However, the experience of staff did not reflect these results. The figures presented had associated explanations; however, the explanations failed to address the largest anomaly within the report. For instance, the report presented to the trust in September 2014, which related to July 2014, showed that on ward D5 the fill rate for healthcare assistants was over 2,000% for night-time. When we asked for an explanation regarding the fill rates which were considerably over 100% we were told it was a data error, which had not been challenged.
- The IT systems in place were presenting issues for staff. These occurred across many different departments both in the acute hospital setting and in the community. Within maternity, we saw two different systems for updating records for a mother and her baby, requiring staff to log out of one system to add information to another. Also within the community, because of the number of different systems in place, information that staff relied on was not readily available to staff, and showed the NHS number and if admitted the hospital identity number which staff found problematic at times. The trust was helping staff

with IT support and champions to try and reduce the difficulties, but not all had been resolved. The trust recognised this as a current risk, but it needed sharper focus to resolve it as a matter of urgency.

- We noted in documents supplied by the trust that the procurement process had begun to replace the trust's electronic patient records. The trust informed us the implementation is due October 2017.
- The workforce delivery plan had cost improvement plans (CIPs) and quality impact assessments (QIAs) associated with it. Members of the trust board told us that there were 451 projects and 390 of them needed QIAs, of which 264 had been completed at the time of the inspection. We were sent a selection of QIAs to review, but these lacked detail as to how the impact was assessed.
- The trust's governance arrangements were comprehensive with clear responsibilities. Sub-committees fed into committees, which fed into the clinical leadership executive, which fed into the trust board. The non-executive directors were also responsible for committees such as the quality and safety committee, which fed into the trust board. This arrangement should have meant that the trust board was well aware of the issues affecting the trust.

Leadership of the trust

- The chief executive was very visible around the trust and used many communication platforms to interact with staff. He was well recognised by all staff groups. Some staff described him as dynamic and inspirational. However, the rest of the executive team were less visible. Nursing leadership was cited as less visible by the nursing staff, which led to their believing that the local pressures they faced were not understood at executive level.
- The trust did not have a director of organisational development at the time of our inspection. This would be a strategic role to help with the workforce reconfiguration and also to support the leadership in its development to meet the future needs of the trust. Shortly after our inspection the trust appointed to this post.
- According to the trust's 5-year plan, the trust was investing in leadership across the organisation. Given the amount of transformation, the leadership's ability to lead was paramount to its success. The trust recognised that offering a leadership development programme was required.
- The trust board accepted that middle management was suffering from low morale, and this was attributed, in part, to

the workforce changes. Middle management felt they lacked the information needed about the forthcoming changes to support their staff adequately. Some of their roles were under consideration, which meant they could not be part of the planning and so could not effectively support their staff.

- We noted that the trust no longer had a lead for patients with dementia-type illnesses. They had chosen to use dementia champions. However, staff felt they required the support of a person with appropriate extended skills.

Culture within the trust

- Relationships between professionals within the trust were mostly good, but we found that the nurses' influence was not as prominent as it might have been. In both surgery and emergency medicine, we noted nursing staff not being recognised as equal partners in delivering care. This issue is recognised by the executive management team of the trust.
- We found that staff wanted to do the best for their patients, and they showed that they were prepared to work beyond their contractual obligations to meet the needs of patients. However, this, coupled with the workforce transformation, meant that staff were beginning to feel that this was too much, and could not be sustainable in the longer term.
- The leadership took part in 'First Fridays', which meant that they worked with operational staff on the first Friday of every month. They could then see first-hand how staff worked, and share information about the trust.

Public and staff engagement

- The trust undertook NHS Friends and Family Tests for 2012/13, and identified a target for inpatients of over 60%. For that period, the trust averaged 73%, a few percentage scores below the NHS England average of 76%. The trust had made a target to improve the response rates, notably within maternity services.
- For the period April 2013 to July 2014, the trust's Family and Friends Test score response rate was an average of 26%, below the trust average of 33% and the national average of 30%.
- We noted that, on some wards and departments, patients were helped to give feedback in real time, either using iPads or tokens. This information was collated and reviewed to improve the service.
- Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking; this in turn affected their morale and made it harder to engage proactively with further change. Some staff

were confident about the review while others felt insecure. The view expressed by most staff was that they had not been adequately consulted about what the changes meant for them. The trust had sent us an overview of the changes and confirmed they had begun consultations with staff early in October 2014. This did not match the views expressed by staff in conversation with us and in focus groups.

- The trust used an online survey tool called 'Your voice', which aimed to get a whole trust response over a 3-month period. The response rate was 21%. The survey tool had a number of open questions, such as "What top two things could we introduce or improve to make you more positive about working in the trust?" This enabled staff to give their feedback regarding working within the trust.
- Feedback had been captured from staff through the staff survey. We saw the results for January, April and July 2014, and observed a reduction in % scores relating to engagement, advocacy, involvement and motivation. For example, 34% of staff felt involved and 41% felt engaged this corroborates the high numbers of staff expressing low morale during our inspection.

Innovation, improvement and sustainability

- The trust had staff who were keen to take part in research and innovation. They have been commended for services such as iCares and the community pathfinder diabetes project, both of which received recognition and awards nationally. Both were good examples of how the trust had provided a service that not only met the needs of patients by making services easily accessible and closer to home, but also demonstrated sustainability. For instance, the community pathfinder diabetes project took place within local GP practices with both a hospital doctor and patient's GP present. This enabled the GP to manage the patient without the need of the hospital input if the patient or others presented at the practice with the same or similar issues.
- The trust took part in 250 clinical research trials for 2013/14, covering areas such as cancer, rheumatology, neurology, dermatology and surgery.

Overview of ratings

Our ratings for City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Sandwell General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Requires improvement	Good	Good

Overview of ratings

Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Sandwell and West Birmingham Hospitals NHS Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate the effectiveness of Outpatients.
2. We were unable to collect sufficient evidence during this inspection to rate Community children, young people and families services fully. They will be subject to a further inspection. This is not a reflection on the Trust, nor of the service; but of an internal CQC difficulty.

Outstanding practice and areas for improvement

Outstanding practice

The iCares and diabetic service within the community had received national recognition for the level of service offered to people. Also end of live care for a minor during our inspection was also notable for the level of commitment compassion and care offered to a minor.

Areas for improvement

Action the trust MUST take to improve

A&E

- The trust must put in place an effective system for learning from incidents and errors, and address the risk of 'less serious' incidents being under-reported by doctors, and trends being missed.
- The trust must follow through from findings of safety audit data and follow-up absence of safety audit data.
- The trust must address systemic gaps in patient assessment records.
- The trust must take steps to improve staff understanding of isolation procedures.
- The trust must provide a consistent system for safe medicine storage.
- The trust must review its governance arrangements in relation to supporting the A&E department to more consistently achieve the national 4-hour target.
- The trust must improve its management of governance arrangements in the A&E department.
- The trust must continue to improve its management of inter-professional relationships within the A&E department.

Medicine

- The trust should ensure all medicines are stored in accordance with trust procedures.
- The trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion

Surgery

- The trust must take action to ensure that general surgeons have up-to-date job plans.
- The trust must take action to ensure that hand hygiene is carried out appropriately by all members of staff across the trust at all times.
- The trust must take action to ensure that a suitable system is in place to ensure that patient records are kept secure at all times.
- The trust must take action to ensure that a suitable system is in place to regularly assess and monitor the quality of postoperative surgical care.

Children &Young People

- The trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed. Staffing skill mix and support on some shifts within the clinical areas were not always meeting national best practice guidance.
- The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.
- The trust must ensure that staff receive appropriate training including mandatory training updates and supervision.
- The trust must ensure that all records are kept securely for the purpose of carrying on the regulated activity.
- The trust must ensure that there is an accurate record in respect of each child that includes appropriate information and documents in relation to the care and treatment provided to each child.

OPD & Diagnostics

Outstanding practice and areas for improvement

- The trust must maintain adequate records regarding the qualifications and training of imaging department staff.
- The trust must ensure guidance be available for imaging staff regarding exposure parameter guidance or information surrounding expected dose values.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1) The registered person must take proper steps to ensure that each service users is protected against the risks of receiving care and treatment that is inappropriate or unsafe, by means of- (a) the carrying out of an assessment of the needs of the service user and (b) the planning and delivery of care and, where appropriate, treat in such a way as to- (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user. All people receiving the service should have a plan of care in place for all their treatment needs.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to- (1) (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations. (1) (b) identify, assess and manage risks relating to the health, welfare and safety of service users and other who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Compliance actions

The provider must ensure that all systems to identify risk and audits are completed to assure itself that improvements are gained and maintained.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control (2) (a) The registered person must, so far as reasonably practicable, ensure that the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection. The provider must ensure that people are not put at risk of receiving unsafe care due to infection control practices not being followed.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for this purposes of the regulated activity. The provider must improve its processes to ensure that in particular all medications are stored appropriately and administered safely.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Compliance actions

(1) The registered person must ensure the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of maintenance of-

(a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user;

(2) (a) kept securely and can be located promptly when required.

The provider must ensure that all patient identifiable materials are kept secure so no information breaches can occur. In addition to this documents must be accurate relating to care and treatment of people.

Regulated activity

Diagnostic and screening procedures

Nursing care

Personal care

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified and skilled and experienced person employed for the purposes of carrying on the regulated activity.

The provider must ensure that sufficiently skilled and experienced staff are available to meet peoples needs.

Regulated activity

Diagnostic and screening procedures

Nursing care

Personal care

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

23 (1) The register person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by –

This section is primarily information for the provider

Compliance actions

1. Receiving appropriated training, professional development, supervision and appraisal;

The provider had not ensured that staff had received appropriate training, including mandatory training updates and supervision.