Care Quality Commission

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell General Hospital

Quality Report

City Hospital, Dudley Road,
Birmingham. B18 7QH
Tel:0121 554 3801
Website:http://www.swbh.nhs.uk/

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

Ratings

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

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. Serving a population of around half a million people. There are two main acute locations; City Hospital and Sandwell General Hospital, on the City site is also Birmingham Treatment Centre. The trust also provides community services in the form of inpatients at Leasowes Intermediate Care and Rowley Regis Community Hospitals. Alongside other community services such as district nursing and community palliative care. All community services are offered in the Sandwell area.

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 inspections visit took place between on 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.
- Incident reporting shared learning needed to be improved across the organisation.
- Infection control practices were good but with pockets of poor practice which needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, the safe storage of medicines was not as robust, which we saw across the trust. This was area in which the trust failed to meet its targets for 2012-2013.
- The trust has consistently not met the national target for treating 95% of patients attending A/E within four hours.
- Generally community services were good with the exception of safe which we rated as requiring improvement
- We were concerned about wards D26 and D11 at City Hospital which was not meeting basic care needs for patients.
- The trust had recognised that end of life care was an area for development for them the Bradbury Day Hospice
- The mortuary on both sites had longstanding environmental issues which needed to be addressed.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

- The trust must review the levels of nursing staff across all wards and departments to ensure they are safe and meet the requirements of the service.
- The trust must 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.
- The trust must ensure that all patient identifiable information is handled and stored securely.
- 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.

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

Summary of findings

Professor Sir Mike Richards
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 	Some practices were creating risk to patient safety. These included doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and for infection control. This was being inadequately managed by the trust and the trust must improve this situation to ensure patient safety. The unplanned re-attendance rate for the emergency department fell last year and the improved rate had been sustained. However we found there were gaps in some patient's assessment records and this should be addressed. We found that services were caring. Translation services were available but staff relied heavily on patients' relatives. The children's room was not open overnight however and these meant children were treated in the same area as adults. The trust was failing to reach the national four hour target for seeing, treating, admitting or discharging at least 95% of patients that attended. Departmental governance and operational meetings were often cancelled.
Medical care	Requires improvement 	The medical care service required improvement, as staff training was variable and not meeting the trust's targets in most areas. There were not always reliable documentation in place to record care interventions. Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. The service was addressing concerns regarding staffing levels, staff skill mix and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies. All wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors. The medical care service had higher rates (therefore performing worse) for the development of pressure areas than the trust targets. People we spoke to were, in the majority of cases, very complimentary

Summary of findings

about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Surgery	**Requires improvement**		The handover processes for both some nursing and medical staff were sub optimal. Infection control measures were largely ignored by medical staff. There was inconsistent security for storage of confidential patient records. The trust engaged with national surgical audits but local audits to further review these findings or explore rationale for results were not in place. Medical staff demonstrated a poor lack of understanding of the Mental Health Act and best interest decisions for patients. Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking. Local leadership in most wards and departments was clear and senior staffs were committed to act as positive and proactive role models.
Critical care	**Good**		There were effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. Patients received treatment and care according to national guidelines. We found there was good multidisciplinary team working across the unit. Both patients and their relatives were happy with the care provided. Staff felt well supported within an open, positive culture.
Services for children and young people	**Requires improvement**		Improvements are needed for the service to be safe, effective and responsive; improvements are also needed in the leadership of the service. The care received was compassionate care with good emotional support. There was not providing the level of paediatric consultant recommended between 5-10pm daily. Staff did not always feel supported and described an 'autocratic' management style in relation to the approach by senior managers. We found a culture of openness and flexibility at ward level which placed the child and family at the center of decision making processes.

Summary of findings

We observed shortfalls in nurse skill mix and staff told us they had had not received the necessary training and support required to care for children and adolescents with mental health needs.
We were not assured that incident management and learning at ward level was robust at Sandwell Hospital.
The service has some gaps which meant that children and adolescents with mental health needs did not receive the support they required.

End of life care

Good

The specialist palliative care team had developed tools, processes and training for generic staff in order to deliver, monitor and evaluate care in line with current best practice.
The patient had been involved in decisions, care was good and staff were respectful and kind. End of life patients were not always able to be in their preferred place of care as the discharge planning process was not fully effective. Ward staff valued the support, expertise and responsiveness of the specialist palliative care team.

Outpatients and diagnostic imaging

Inadequate

There was a system for reporting incidents, but this was not always being used in a consistent manner.
In some areas we saw practices that could compromise the safety, privacy and dignity of patients. The trust was struggling to meet the demand for outpatient appointments so overbooking of clinics was commonplace, causing delays for patients.
Staff were well regarded by patients who were overwhelmingly positive about the care they received.
The managers of outpatients departments were accessible and respected by staff.
Within diagnostic imaging services, there were concerns regarding staff training records. Reporting times for completed imaging were experiencing a backlog of weeks, when reporting should have taken days.
Forward planning and lack of strategy was not in place either, the trust were using an outsource consultancy to produce a toolkit to improve service in the future.

Sandwell General Hospital

Detailed findings

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

Contents

Detailed findings

Background to Sandwell General Hospital

Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is an acute hospital with 460 beds. Sandwell General Hospital is an acute teaching hospital, providing a wide range of general and specialist hospital services. The 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.

Sandwell General Hospital is in West Bromwich and along with City Hospital and the community services that is part of West Birmingham Hospitals NHS Trust serves a population size of 530,000 from across West Birmingham and cover six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

The population is in the 20% highest proportion of households in poverty. 23% of adults are in long term unemployment. The life expectancy for Sandwell is worse than the England average. Men's life expectancy in this area is 76.3 where the England average is 78.9. For women it is 81.4 and the England average is 82.9. (Public Health England 2010)

The trust provides care from two main hospital sites, City Hospital in Birmingham and Sandwell General Hospital located in West Bromwich. Intermediate care is provided from Rowley Regis Community Hospital and 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 and Finance Director and the trust has made application for Foundation Trust Status, but is at the early stages and would 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 out of 326 authorities.

Prior to the inspection the trust announced 1,400 job cuts and strike action was planned during the inspection but later postponed.

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 advisors to include: Consultants, Doctors, Matrons, Nurses, Midwives, Therapist, Student Nurses and four '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?

Detailed findings

• 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 on 14 to 17 October 2014 and unannounced visits on 25, 27 and 30 October 2014. 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 talked with people who use services. We observed how people were being cared for and 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

Sandwell and West Birmingham Hospitals NHS Trust serve 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, and 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 two main local populations Sandwell and Birmingham with a population of over 530,000. Sandwell and Birmingham local authorities have a significantly high level of deprivation compared to 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 five years).

The trust has annual revenue of £439 million. Each year the trust spends £430 million of public money, £25 million is spent on new equipment and service expansion. By 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 & dental staff and 1,990 qualified nurses.

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

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

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	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
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

<Notes here>

Urgent and emergency services

Safe	Requires improvement
Effective	Good
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. 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.

We visited the department at Sandwell Hospital over two days including on one evening. We spoke with 10 patients and their relatives including parents accompanying children. We spoke with approximately 20 staff including; the matron, nurses at different levels, doctors at different levels, reception, administration and domestic staff; consultants; the clinical director, the general manager, the head of nursing and the head of infection control. In addition we spoke with paramedics from West Midlands Ambulance Service.

Summary of findings

The trust had systems in place, including internal and national audit, to monitor patient safety. However some practices were creating risk to patient safety. These included some doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and for infection control. This was being inadequately managed by the trust and the trust must improve this situation to ensure patient safety.

Services were not as effective as they should be and required improvement. Care and treatment was provided in line with national and standardised procedures. The unplanned re-attendance rate for the emergency department fell last year and the improved rate had been sustained. However we found gaps in some patients' assessment records which the trust should address.

Professional relationships in the department were improved from 2013 after this was raised as an issue by West Midlands Deanery. The trust should continue to monitor this situation as it could impact on effective communication and care.

We found that services were caring. Patients and their relatives said they found all of the staff in the department friendly and helpful and staffs were visible and accessible.

Services were responsive but improvements should be made to ensure patient safety. The staffing reflected the diverse range of the community they served. Translation

Urgent and emergency services

services were available but staff relied heavily on patient's relatives. Arrangements were in place to support patients with complex needs including those who required mental health assessment. The children's room was not open overnight however and this meant children were treated in the same area as adults.

Waiting times for emergency ambulances had been improved by the trust but the department was failing to reach the national four hour target for seeing, treating, admitting or discharging at least 95% of patients that attended. The need to improve this situation had already been recognised by the trust but not all staff were confident that this was seen as a trust wide problem. The trust should address this as failing to do so could affect patient safety.

We found that services were not well led and the trust must improve this to ensure patient safety. Risks to patient safety that were identified were escalated up to the board through risk registers. Staff expressed a lack of confidence in mechanism in place for learning from incidents however. Departmental governance and operational meetings were often cancelled. The trust must improve its management of governance arrangements in the department in order for them to be an effective tool for helping ensure patient safety.

Staff at different levels and roles felt supported by local managers and by the trust in their learning and professional development. The chief executive officer was visible and accessible. The problem with professional relationships between nursing and medical staff in the department, recognised by the Deanery, had been improved but we saw at least one example of poor role modelling in this respect. The trust must continue to monitor and improve its management of these issues because poor or ineffective professional relationships can have an impact on patient safety.

Are urgent and emergency services safe?

Requires improvement

The trust had systems in place, including internal and national audit to monitor patient safety. However some practices were creating risk and the trust was not managing this effectively.

We found there was an open culture for reporting incidents including medication errors, but staff were not confident about the effectiveness of the systems in place for learning from incidents and errors and this meant they could recur. There was a risk of 'less serious' incidents being under reported by doctors and trends being missed and this was not being challenged by the trust. The trust must improve this.

The absence of some safety audit data such as hand hygiene spot checks and the negative findings from some audits such as storage of medication, were not followed through to improve patient safety.

Some important safety procedures such as isolation procedures to prevent spread of infectious disease were not fully put into practice by staff. There was a lack of a consistent system for safe medicine storage and the trust must improve this.

There were systems in place to assess and respond to patient risk including using nationally accredited systems to identify early any deterioration in a patient's condition. However we noted systematic gaps in some patient records. The trust must improve this.

The trust had greatly reduced the handover time from the ambulance service and put in measures to improve patient flow through the department. There were escalation processes in place for when the department had reached full capacity and breaches were monitored.

Staff were aware of their responsibilities with regard to safeguarding patients and potential safeguarding issues were addressed within a range of clinical training.

We did not observe any problems with nursing or medical staff cover at the times we visited the department. The trust had however recognised difficulties in recruiting suitably

experienced nursing staff and sufficient consultants to the department and was taking steps to improve this position. The department still depended heavily on agency and bank staff and to some extent on locum doctors.

Incidents

- The trust reported 2 serious incidents for its emergency care department across Sandwell Hospital and City Hospital since April 2014 one regarding slips/trips and falls and the other about suboptimal care of a deteriorating patient.
- 'Safety thermometer data' was submitted on a monthly basis in line with national practice. The NHS safety thermometer provides a monthly snapshot of safety and is a point of care survey instrument that allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. Urgent and emergency care across Sandwell Hospital and City Hospital for July 2013 to July 2014 indicated that the rates of pressure ulcers, falls and catheter association urinary tract infections were low with a number of months with zero reports as would be expected for this type of service.
- The urgent and emergency care department across both hospitals submitted data to the board via a nursing quality, safety and patient experience dashboard in 'real time,' and this allowed for immediate action to be taken by the trust where necessary. The dashboard data covered infection prevention and control, staffing, patient safety and patient experience.
- The trust used an electronic Datix system for staff to use to report incidents. This provided a system for incidents to be analysed, assessed and investigated as appropriate at a local and trust governance level so that lessons could be learned to improve services.
- Most staff that we spoke with at Sandwell Hospital confirmed that they knew how to make these reports and had access to computer facilities to do so. However our discussions with staff indicated that nurses were more likely to report incidents than doctors. This could result in trends being missed by the trust.
- Matrons at both sites looked at incidents each day and the clinical director for the emergency department told us that he looked at reported incidents each Wednesday. The clinical director said there was encouragement from managers for staff to fill out incident reporting forms and this had resulted in a steady increase in reporting for the emergency department across both sites.
- Staff at Sandwell Hospital told us that they did not always get feedback about incidents that they reported. The clinical director told us that the reporting system was 'long winded' and the emergency department across both sites was so busy that doctors would need to stay beyond their shift time to complete an incident report.
- We raised this with the general manager of the emergency department across both sites who told us the department was much better at its IRI (incident requiring investigation) system and said: "There is more work to be done with the doctors over this."
- This meant there was a risk of 'less serious' incidents being under reported and trends being missed. It also meant that opportunities to learn from near misses were being wasted.
- The trust had a policy and procedures in place for the confiscation of illegal drugs brought into the department by patients.

Cleanliness, infection control and hygiene

- The department was a clean environment in which to treat patients.
- The department had its own domestic and housekeeping staff during the day and access to the hospital's general team overnight. Cleaning staff we spoke with confirmed what their duties and responsibilities were and understood the importance of hygiene in infection control.
- Staff confirmed that the trust provided sufficient stocks of personal protective clothing such as plastic aprons and gloves.
- Hand cleansing gel dispensers were accessible around the department to patients and staff. Information on the importance of hand hygiene was visible on the trust's website with information for patients visiting the hospital.
- The department had an infection control champion. In line with trust policy nursing and medical staff were 'bare below the elbow' while working in the department.

- Consultants told us that doctors received hygiene and infection control training as part of their corporate induction and spot audits were carried out in practice.
- A nurse manager told us that the hand hygiene audit should be done monthly, but an audit had not been submitted from the department to the infection team for June or August 2014.
- This was confirmed by the quality and safety patient experience dashboard that was regularly submitted to the chief nurse.
- We noted that some staff had attended patients without following proper hygiene procedures. For example we observed one doctor taking a blood sample from a patient without wearing gloves; we saw a pair of used gloves left on top of a trolley and not safely disposed of. We noted that a consultant wore the same plastic apron to see numerous patients.
- The computer monitors and key boards across the nurse's station were dirty including with finger marks smeared across on the screens where staff had touched them. This equipment was in constant use by nursing and medical staff as it gave them access to patient's records. The nurse in charge told us that there was no arrangement in place to regularly clean this equipment that was in daily use by nursing and medical staff.
- The matrons across both sites carried out monthly audits of records to check that patients were routinely screened for MRSA. The department's dashboard showed that screening was done in 92% to 96% of patients since April 2014. No cases of Clostridium difficile (C. difficile) were recorded for that period.
- The trust had a policy on the care and management of patients with viral fever including Ebola. Nursing and medical staff told us they had training on these procedures, domestic and maintenance staff said they had no training relevant to their role, although their managers and supervisors had.
- Reception staff confirmed they had been told to ask patients if they have recently travelled from abroad. We observed that the staff shift handover report included whether there were any patients with known or suspected infection.
- There were boxes of personal protective clothing available to staff in stock labelled for low and for high risk situations.
- Staff told us which cubicles were allocated at that time for isolation. We noted however that isolation procedures were not being effectively followed.
- For example we were told that one patient was in an isolation suite because they had attended with a suspected infection and their recent travel history gave cause for concern. There was no signage put on the cubicle doors to warn people of an infection risk. There was no evidence of appropriate personal protective clothing in use or precautionary measures undertaken.
- Staff we spoke with were aware of the trust's infection control policy and told us these infection control measures would 'normally be taken' but could give us no reason why they had not been followed on this occasion.
- We saw no evidence of a timely deep clean/ decontaminated of those isolation cubicles after the patient left.

Environment and equipment

- The environment was modern and spacious with secure systems of patient flow. Toilets were easily accessible to patients in the waiting area. The nurse's station was a spacious workplace for the whole team on duty.
- There was a resuscitation room including a paediatric bed and the department had a room for relatives to wait in. The department was divided into pathways for minor, major cases and a children's room. It included some designated high dependency beds.
- Emergency equipment was in the resuscitation room. The children's room had specialist equipment including for managing emergencies
- Areas were well stocked, for example the ambulance triage bays and the eye examination room had good stocks of appropriate equipment.
- There was a system in place to check that equipment was in good order and functioning and that necessary supplies were available each day. We noted that checks in the resuscitation room were comprehensive and up to date.
- We noted however that not all equipment checking regimes around the department were being effectively followed.
- For example, we saw that a resuscitation trolley kept in the corridor was checked for equipment and a record made, but the check list had no date on it; supplies of intravenous fluids, although kept in a room behind the nurses station, were not locked away to prevent them being tampered with. Empty oxygen cylinders were

stored on a wet floor and some storage cupboards containing needles had broken locks. Suction equipment was trailing on the floor in a number of cubicles.
- We noted the 'patient's cleansing room' was being used as a store, including for a staff bicycle.
- Trust governance recognised in its September 2014 report for the department across both sites there was a lack of formal local health and safety inspection for key non-clinical risks. The trust had put in place an action plan to improve this.

Medicines

- Sandwell hospital had a well-established pharmacy team who supported the safe use and management of medicines.
- We found that the pharmacy team were actively involved in all aspects of a person's individual 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 told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times including an out of hour's pharmacy service.
- We found that the pharmacy team provided an efficient clinical service to ensure people were safe from harm.
- Although the trust had an online Safeguard 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 in order to learn and change practice. The learning from these incidents would help to improve patient safety.
- We were informed that a medication safety group had been set up across both sites to discuss medicine errors but this group was not always well attended by nurses.
- We found medicines requiring refrigeration were stored appropriately with necessary equipment to make temperature checks so the medicines' efficacy did not deteriorate.
- Medicines were not always stored securely for the protection of patients. This issue had been identified by the trust's own medicine storage audit, however little or no action had been taken.
- We also noted medicines in damaged packaging with their expiry date and batch number no longer visible, which should have been returned to the pharmacy; some unaccounted for stock; incomplete documentation in the controlled drugs register and unsafe arrangements for the disposal of some medicines.
- Stock items of medicines were not labelled in accordance with trust policy and good practice guidelines. We raised these matters with the matron who assured us that they would be addressed.
- There was a lack of a consistent system for safe medicine storage and the trust must improve this.

Records

- Electronic and paper record systems were in place to support care and treatment but there were some gaps and inaccuracies that the trust should address.
- We audited fifteen sets of patient's notes including for five children's and found that there were recording systems in use to assess and record the condition of each patient.
- We found some systemic gaps in records, for example for pain assessment. The trust had recognised this as a problem in March 2014 and put in place regular audits.
- However pain audit results dated from May to August 2014 showed that the situation had not consistently improved.

Safeguarding

- The trust had policies and procedures in place for safeguarding children and vulnerable adults.
- Nurses that we spoke with knew how to access the policies and procedures for safeguarding on the trust's intranet.
- Staff told us that all doctors and nurses in the emergency department accessed level 3 safeguarding training.
- The mandatory training matrix for the emergency department across both sites showed that all staff had up to date level 1 safeguarding training but the report for the October 2014 governance meeting showed that only 57% of nursing and medical staff at Sandwell Hospital had taken or updated their safeguarding adults level 2 training. Safeguarding children level 2 training was also below trust target at 77%

Urgent and emergency services

- Nursing and medical staff we spoke with were aware of their responsibilities with regards to safeguarding patients but some clerical and cleaning staff were not aware of what their role might be.
- We observed an ambulance transfer triage nurse raise a vulnerable adult safeguarding alert over a patient whose circumstances gave cause for concern.

Mandatory training

- All staff that we spoke with told us they were up to date with their mandatory training.
- Figures submitted to the October 2014 emergency care directorate governance meeting however showed that take up of mandatory training was at less than 77% on average.

Assessing and responding to patient risk

- Analysis of data provided by the trust showed emergency department time to treatment across both sites was better than standard and often better than the national average for this type of service.
- The number of handovers delayed by over thirty minutes was high in absolute terms but the emergency department is a large one across Sandwell and City Hospitals. The trust had achieved significant improvement in waiting time for ambulance handover since August 2013.
- The department at Sandwell Hospital had an ambulance assessment bay with four beds. Ambulance crew brought patients directly to this bay where a formal procedural handover was made between the paramedic and nurse.
- Hospital staff received information about patients enroute by emergency ambulance so they could alert specialists and teams as necessary. We noted this was a calm quiet environment where information could be exchanged clearly and assessment made.
- Ambulance staff that we spoke with said there was generally a 'quick turnaround' at the hospital and the department's response had improved considerably in the last two years.
- A triage nurse system was used for walk in patients. A GP service was integral to the department and patients were triaged first by the GP nurse at the reception desk and moved on to the emergency department services if appropriate. This helped to take the pressure off the emergency service and improved patient flow.
- Most patients told us that they did not wait long to be seen however parents of a child told us they had waited a long time to be seen in the children's room.
- Nursing staff confirmed that if a patients experienced mental ill health and challenged the service, nurses, health care assistants and security staff worked together to try to settle and give support to them in order to treat them.
- We noted that one patient with no spoken English and a suspected infection was in isolation in the department for a number of hours before staff established their nationality in order to get an interpreter. This meant the patient's description of their symptoms and staff explanation of isolation procedures could not be effectively communicated.
- The 'adult acute sites observation tool for the national early warning score (NEWS)' was available and used to identify deterioration in a patient's condition.
- Escalation processes were in place for when the department reached full capacity and, breaches were monitored.

Nursing staffing

- Other than nursing managers, the nursing team in the department was band 7 charge nurses, sisters and a dedicated team of emergency nurse practitioners. The department operated a team structure with a band 7 in charge of every team.
- New nursing staff were allocated a mentor and a team lead and they had a supernumerary status for four weeks.
- A shift co coordinator at band 6 or 7 attended the resuscitation room for all alerts and was to be notified of any patient whose condition was causing concern and informed of any problem that could affect patient care or nursing staff.
- Patients with complex needs were allocated particular cubicles, observed by 2 nurses and looked after by health care assistants.
- We observed a staff shift handover meeting and noted it was clear, detailed and competent.
- Nursing managers told us they had to rely heavily on bank and agency staff for nurses and health care assistants to provide one to one support to patient's with complex needs.
- The department had developed its own staff by appointing 25 registered nurses in 2012/13 across the Sandwell Hospital and City Hospital sites. It has

supported them with training and development to bring them up to the appropriate level of competence. Nurse managers expressed confidence in this approach and were optimistic that these nurses would stay on in the trust.
- We visited the Sandwell Hospital emergency department over two days including an evening (with 2 hours' notice) and we did not observe any problems with nursing cover at those times.

Medical staffing

- The trust told us that consultant cover across emergency services at both sites was an issue and that medical recruitment was on going. We noted that 'inadequate number of medical staff' was rated as an Amber risk on the emergency department risk register.
- The consultant in emergency medicine told us that across both sites 20 to 30% of doctors was middle grades, 20% were consultant clinical staff and most of the workforce was junior doctors.
- There were six full time equivalent consultants at the Sandwell Hospital emergency department covering 8am to 10pm Monday to Fridays, with a shift in the middle of the day.
- The clinical director told us that the trust was working towards providing an 8am to 9pm shift on Saturdays and Sundays.
- We visited the Sandwell Hospital emergency department over two days including an evening (at 2 hours' notice) and we did not observe any problems with medical or consultant cover.
- Medical staff managers told us they rely heavily on locums and locums have the same access to training within the trust that permanent doctors have.

Major incident awareness and training

- The Trust had a named lead for major incidents.
- Nursing and reception staff told us they have effective support from security staff.
- The department had some major incident training on site in August 2014 with support from estate facilities staff.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Evidence based care and treatment was provided in line with national and standardised procedures. The department contributed to national data collection and audit arrangements to improve patient outcomes.

The unplanned re attendance rate for the emergency department was higher than the national average but fell dramatically in June 2013. The trust was continuing to sustain a decline.

Patients were given sufficient food and drink as appropriate while they were waiting for treatment or transfer or admission.

Pain relief assessment was part of a standardised procedure but we found that it had not always been recorded in patient's notes. There were also some gaps in the early warning score records used to detect deterioration in a patient's condition. The trust should improve this situation as it could have an impact on patient safety.

Multi-disciplinary working within the hospital and with external professionals was effective. Nursing managers told us that there were now strong working relationships between doctors and nurses. Nurses commented positively on the good multi-disciplinary team work in the department.

Evidence-based care and treatment

- Staff we spoke with made references to appropriate national guidance and told us that trust policies and procedures were on the intranet where they could easily access them.
- The department across both sites was part of the Trauma Network and submitted data to the National Trauma Audit and Research Network (TARN.)
- We noted that a sepsis screening tool and care bundle was available and a fast track pathway for fractured neck of femur.
- We saw the notes of one recalled patient and noted that the trust policy had been followed for their assessment and treatment.
- The trust used the national early warning score (NEWS) as a standardised tool to asses and respond to acute illness. We noted there were gaps in notes that we

audited in NEWS recording for six out of 15 patients, for which it was appropriate. This could mean that deterioration in a patient's condition would not be accurately assessed.
- We saw evidence of local clinical audit activity and these audits were reported on in the monthly emergency care governance report.

Pain relief
- We audited 14 sets of patient's notes. We found that a pain score had not been recorded for 3 patients although trust policy was that all patients treated should be assessed for pain and a record made. This could mean that some patients were not receiving the level of pain relief that they needed.

Nutrition and hydration
- We observed care and treatment in the department over two different days. We found that people were offered food and drink by staff as was appropriate to their condition and the length of their stay.

Patient outcomes
- The trust was participating in the 2014/15 round of College of Emergency Medicine audits, and results for severe sepsis and septic shock had been provided. Having identified tackling sepsis across the trust as 'the biggest single improvement' it could make in its care, the trust designated September 2014 as 'sepsis month'.
- The unplanned re attendance rate for the emergency department was worse than the national average but fell dramatically in June 2013. The trust was continuing to sustain a decline.

Competent staff
- We noted the department across both sites participated in a staff nurse development programme through 2014, although records showed that fewer than 50% of the 25 participants were achieving 100% attendance.
- Staff told us they had an annual appraisal. Not all staff had one to one supervision meetings with their line manager but nurses and junior doctors told us they had as much support as they needed and felt able to ask for it.
- New nurses could join the department only when they had completed their preceptorship training and development.

Multidisciplinary working
- We observed nursing and medical staff working together with patients. Nurses told us that that relationships between doctors and nurses were good and many commented positively on the good multi-disciplinary team work in the department.
- Nursing managers told us that there were much improved and now strong working relationships between doctors and nurses. This had improved since the West Midlands Deanery visit last year when changes in the quality of professional relationships were required and an action plan developed.
- We observed examples of satisfactory external multi-disciplinary working, for example making patients safe and stable to make an effective treatment transfer to another hospital.
- In the minor injuries part of the department an emergency nurse practitioner treated and discharged patients. A GP service functioned within the emergency department at the 'front door' of the hospital. We observed this practice working in partnership with the department, by screening patient's needs and directing to other services where appropriate.

Seven-day services
- Senior medical managers told us that the trust was working toward achieving consultant cover in the emergency department across both sites for seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- We noted that when patients were being examined their clothing was not removed. The patient may not recognise the significance of other signs and symptoms and fail to draw staff attention to them. This could mean they were missed by staff.
- A dementia screening tool was available to staff in the department but we noted that there was no audit of its use recorded on the dashboard from April 2014.

Are urgent and emergency services caring?

Urgent and emergency services

Good

We found that services were caring.

Patients and their relatives said they found all of the staff in the department friendly and helpful and staff were visible and accessible to them. Nurses, doctors, reception and support staff treated patients with dignity and respect. Families were supported when they attended with their children and staff communicated well with patients, including children.

Compassionate care

- We spoke with eight patients and relatives during our visits across two days and each person said they had found all of the staff in the department friendly and helpful. The people we spoke with said that nurses and doctors had treated them with dignity and respect.
- Patients and relatives told us that staff were visible.
- We noted staff at all levels and in all roles treating patients with respect and kindness.
- There were vending machines positioned in the main waiting areas so patients and their relatives could access drinks and snacks.
- The Care Quality Commission national survey found that levels of satisfaction at the trust's emergency department across both Sandwell Hospital and City Hospital were average and about the same as for other trusts.

Patient understanding and involvement

- We noted that nursing staff offered support continually to parents attending with their children.
- Relatives that we spoke with who were supporting patients told us that staff included them.
- One patient told us they attended the department quite regularly when they got into difficulty with a chronic condition and that staff were always kind.

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

Requires improvement

We found that services were responsive but improvements should be made to ensure patient safety.

Hospital staffing reflected the diverse range of the community it served in Sandwell. Translation services were available but staff relied heavily on patient's relatives and this could have an impact on staff ability to respond appropriately to a patient's condition. The trust should improve this situation.

The department had arrangements in place to support patients with complex needs including those who required mental health assessment. The children's room was not open overnight and this meant children were treated in the same area as adults. The trust had already recognised the need to improve this situation.

The emergency department across both Sandwell Hospital and City Hospital had failed to reach the national target for seeing, treating, admitting or discharging at least 95% of patients within 4 hours of attending, for most weeks since 7 July 2014. The trust had already recognised the need to improve this situation. However doctors and nursing staff differed in their view about whether the trust acknowledged and acted on this as an issue for the whole hospital system or just the department's problem. The trust should improve this situation to bring about change that is effective.

Waiting times for emergency ambulance had been improved by the trust across both Sandwell Hospital and City Hospital. The trust closely monitored the time taken for patients to move from the ambulance arriving at the department, through to admission to wards or discharge. This was done in a way that provided up to date, real time data that managers could respond to.

Some patients we spoke with over two days told us that they did not have to wait long to be seen by a triage nurse when they arrived others said they did wait a long time.

The trust had a complaint policy and procedure but we saw no information about this on display to patients in the department. The trust should improve this as opportunities to learn from patients experience might be being missed.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- We noted over 2 days that patients were from the range of ethnicities and nationalities reflected in Sandwell's population. Department staff were also from a range of ethnicities.
- We observed that a number of patients did not use English as their first language. 'Welcome' signage and basic information was displayed in 5 languages on large sail board signs in the main waiting area.
- Most staff we spoke with were unclear of the trust's translation policy and interpreter arrangements and communicated with patients through relatives.
- For example, we noted that a patient in isolation because of a suspected infection and with a recent travel history that gave some concern was unable to speak English. Staff had not identified the patient's nationality and we found the patient had been in the department for over 5 hours and an interpreter was not sought. This meant that isolation procedures to protect the patient and others could not be communicated to them effectively.

Access and flow

- The red phone situated in majors area of the department, answered by qualified nursing staff, enabled contact from the ambulance service to inform the department that a patient requiring resuscitation was on the way. Other specialist teams could then be mobilised by the nurse through contact with the hospital switchboard.
- We observed how incoming ambulances were tracked through an electronic communication system. This meant the ambulance bay triage duty nurse was able to anticipate the department's response before the patient arrived.
- The emergency department was failing to reach the national target for seeing, treating, admitting or discharging at least 95% of patients within 4 hours of attending, for most weeks since 7 July 2014. Overall the department's performance was variable. We noted that this was on the emergency care directorate risk register as a red level risk.
- The clinical director and the consultant for emergency medicine told us that the trust 'owned' the problem of not meeting the 4 hour target and acknowledged that its causes were systemic, for example a high proportion of patients presenting with complex needs, and needed to be admitted and then waited for an appropriate bed.
- Not all nursing managers however expressed the same confidence in organisation's ownership of the problem of not meeting the four-hour target and they believed it was viewed as a departmental shortfall.
- The trust closely monitored the time taken for patients to move from the ambulance arriving at the department, through to admission to wards or discharge. This was done in a way which provided up-to-date, real-time data that managers could respond to.
- Patients we spoke with over two days who did not arrive via the ambulance service gave us varying accounts of the time they had to wait to be seen by a triage nurse when they arrived and then to see a doctor.
- Data to May 2014 provided by the trust, showed the average time spent in the emergency department was lower than the national average, at between 130 and 140 minutes for the first half of 2014.
- Trust data showed the percentage of people waiting for 4-12 hours from the time it was decided to admit them to when they were admitted to the hospital was lower than the national average during 2014 and consistently less than 1% of those admitted.
- The department's urgent care score card showed that the 15 minute target for waiting time for emergency ambulance handover to hospital staff had been met from to July to October 2014.
- The number of adult patients leaving the emergency department before being seen was consistently higher than the English national average between May 2013 and May 2014, at 3-4%. This score declined steadily in the second half of 2013 but it started to rise again from February 2014.
- We noted that the trust had taken some initiatives to improve flow through the emergency department. For example, the trust had skilled up senior nurse practitioners to prescribe medicines and health care senior assistants to carry out some basic procedures. Patients therefore did not always have to wait to see a doctor for their medication which improved the flow of patient's through the department.

Urgent and emergency services

Meeting people's individual needs

- We noted when staff were dealing with patients whose first language was not English, that they relied on communicating through relatives. One patient with no spoken English and a suspected infection was in isolation in the department for a number of hours before staff established their nationality. This meant the patient's description of their symptoms would not be fully understood by staff.
- Staff we spoke with confirmed the department made good use of the Rapid Assessment, Interface & Discharge (RAID) team, and this helped to avoid unnecessary admissions to hospitals for people with mental ill health.
- We noted there were four monitored cubicles for patients with complex conditions and needs, including supporting patients with mental ill health and dementia, while they used the emergency department services.
- Health care assistants confirmed that they worked one to one with patients with complex needs so they were not left alone. Health care assistants worked with the security team to support patients who challenged the service.
- The department had a children's room with its own triage facility and a side room designated for adolescents. The children's room however was not available between 10pm and 9.30am. The trust had recently added this to the department's risk register.
- We noted information posters about a wide range of issues on the wall in the waiting room, including drug and alcohol abuse services and forced marriage.

Learning from complaints and concerns

- The trust had a complaint policy and procedure, but we saw no information about this on display to patients in the emergency department. There was a comments box with cards for patients to complete if they wanted. We noted few cards in the box. Information about the Patients Advice and Liaison service (PALS) was available in the waiting room.
- Nursing managers and the clinical director told us that they used the incident reporting system to review all complaints.
- Nursing and medical staff told us that there was no formal system for learning from incidents.

Are urgent and emergency services well-led?

Requires improvement

We found that services were not well led and the trust must improve this to ensure patient safety.

The trust had recently launched a 'vision project' to 'try to change how it delivered safe care at ward level across the multi professional clinical team'.

Identified risks to patient safety were escalated to the board through risk registers. Not all items on the emergency department's register were reviewed and updated within the planned timescale. No formal mechanism was in place for learning from incidents. Leaders in the emergency directorate had not effectively challenged the practice of doctors largely 'opting out' of using the incident reporting system.

The trust had systems of audit in place to check regularly on the quality and safety of the service but the systems were not always used effectively. A structure of regular governance and operational meetings had been put in place for the emergency care directorate but meetings were often cancelled. The trust did not follow up and address these issues.

The trust must improve its management of governance arrangements in the department in order for them to be an effective tool for helping to ensure patient safety.

Although the chief executive officer was visible and accessible, some nursing staff told us other leaders including were not. A problem with professional relationships between nursing and medical staff in the emergency department had been brought to the attention of the trust by the West Midland's Deanery in 2013. Staff at Sandwell told us that professional relationships were improving.

The trust must continue to monitor its management of these issues because poor or ineffective professional relationships can have an impact on patient safety.

Staff at different levels and in different roles felt supported by local managers and by the trust in their learning and

professional development and underwent appraisals of their performance and development needs. Team meetings were frequently cancelled however which meant that opportunities for innovation may be limited.

Vision and strategy for this service

- The trust had recently launched a project called Ten Out of Ten to 'try to change how it delivered safe care at ward level across the multi professional clinical team'.
- We noted that this Ten Out of Ten project featured in the chief executive's August 2014 'Hot Topics' bulletin for trust staff. We saw a poster committing the trust to achieving the goals of the project posted on the wall in the emergency department waiting room where patients could see it.

Governance, risk management and quality measurement

- The trust had risk registers operating at different levels including at trust level. We found that not all of the items on the emergency department register were updated as planned. For example the amber-rated risk associated with having large numbers of newly qualified and new-to-the department staff had not been reviewed in the current quarter.
- The trust had an incident reporting system and procedures. However staff that that we spoke with across a range of roles consistently told us no formal mechanism was in place for learning from incidents. We noted for example, there was no evidence of action taken on the points raised from a controlled drugs audit in April 2014.
- Senior nurses and doctors across both Sandwell and City Hospital sites told us that medical staff were less likely than nursing staff to use the incident reporting system. Leaders did not effectively challenge the opting out of incident reporting by medical staff.
- The trust had systems of audit in place to check regularly on the quality and safety of the service. The clinical director of both Sandwell Hospital and City Hospital sites told us that he had improved the governance arrangements since recently coming into the post.
- We found that the system for checking the quality and safety of the service was not always effective and that this was not always followed up by the trust. For example where there had been gaps in the submission of hand hygiene audits and this was noted in the exception report that the emergency department submitted to the board, the trust did not follow this up or address it.

Leadership of service

- Staff at all levels and in all roles in the emergency department told us that the chief executive officer was visible at the hospital.
- The chief executive produced a monthly bulletin for trust staff called 'Hot Topics' and we saw copies of this in the department. The bulletin included reporting back on the previous months topics
- 'Hot topic' sessions were run and the chief executive held a series of open staff meetings during September 2014.
- Staff told us that risk registers were made available for them to see.
- We found that while senior nursing and senior medical staff agreed the breach of the target for seeing, treating, and admitting or discharging at least 95% of patients within four hours' was a significant risk; they differed in their perception of ownership of the problem. This would have an impact on measures agreed for its solution.
- A structure of regular governance and operational meetings had been put in place for the emergency care directorate which included reviewing and updating items on the risk register. A monthly report was produced. However senior nursing staff told us that they felt frustrated because these meetings were frequently cancelled when doctors were unable to attend. Beyond these meetings there was no formal system for adjusting and updating the risk registers.

Culture within the service

- Before our visit the trust had recognised a problem with professional relationships between nursing and medical staff in the emergency department. The outcome of a visit from the West Midland Deanery last year had prompted an action plan to improve inter-professional relationships.
- The clinical director told us that a lot of work had been put into creating a team environment in emergency medicine, and that the clinical leads worked across the two hospital sites (Birmingham City Hospital and

Sandwell Hospital). A clinical lead consultant told us that relationships were improving and doctors and nurses had interacted more over patients in the last 12 months.

- Nurses we spoke with told us that that professional relationships were good within the multi-disciplinary team at Sandwell emergency department and they felt proud of the team's effectiveness.
- We observed however that one consultant delegated to senior nursing staff to respond to our questions. This was not a positive role model in collaborative work for junior doctors.

Public and staff engagement

- The trust had a token box and a text message system in place for obtaining Friends and Family test data and we noted that some comment cards had been used and placed in the box.
- Low response rates to the Friends and Family test are common in emergency departments. We noted that some patients had used the response display in the waiting area and that the majority of the tokens were placed in the 'very satisfied' slot.

Innovation, improvement and sustainability

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Medical care (including older people's care)

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

Information about the service

Sandwell General Hospital's medical care service has nine wards, including two acute medical assessments wards (with combined total of 60 beds), a coronary care ward (with 10 beds), an acute stroke ward (with 28 beds), a stroke rehabilitation ward (with 25 beds), a haematology ward (with 15 beds), and three wards for general medicine, gastroenterology, step down cardiology, respiratory and care of the elderly. The hospital also provides an ambulatory care unit alongside the Acute Medical Assessment wards.

During our inspection, we visited eight out of the nine wards and the ambulatory care unit, and spoke with 15 patients, 22 staff, and six people visiting relatives. We also looked at the care plans and associated records of 20 people.

Summary of findings

The medical care service required improvement as staff training was variable, and not meeting the trust's targets in some areas. Some essential care documentation was poorly completed. Care was generally provided in line with national best practice guidelines and the trust did participate in all of the national clinical audits they were eligible to take part in. Performance and outcomes met trust targets in most areas.

Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet patients assessed needs. The service was addressing concerns regarding staffing levels, staff skill mix, and monitoring the condition of deteriorating people. Some staff said recruitment was in progress to fill staff vacancies. Wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors. People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Although we found the medical care wards to be clean and well maintained, we found that the numbers of nursing staff were variable, and staff generally said that they felt pressurised, due to high patient dependencies. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people. The introduction of the performance boards across the wards was seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Staff training was variable across the wards. We found variable record keeping with regard to people's observations. The systems for storing medicines were not appropriate on some wards.

Incidents

- Staff were aware of the trust's policy for reporting and recording incidents and accidents. Senior staff said there was a high level of incident reporting. Junior staff were aware of how to use the hospital's computerised system to report concerns. Performance, patient safety data and learning from incidents was discussed at monthly ward meetings.
- Newton 4 ward had reduced the number of critical incidents by half from July to September we were told. We saw that ward staff had learned from incidents by addressing the concern about the level of falls during the night; the ward leader had introduced a system whereby night staff would base themselves in patient bays as opposed to sitting at the nurses' station. This had reduced the number of falls by 37 % in the past three months.
- Lyndon 5 ward had 43 reported incidents in September mainly relating to incidents of verbal abuse from patients, falls and medication errors. Staff were now more aware of effective incident reporting and senior staff said learning from these incidents was cascaded to the staff team.
- Staff told us how incidents were recorded and reported via the trust's computerised incident reporting system. Most staff told us that they had had feedback about the incidents, but some staff told us that they did not know what happened to the reported information. Learning from incidents in other ward areas was not always shared across the trust.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.
- Senior staff told us that morning handovers (safety briefings) including risks and incidents and that learning from these was shared at these meetings.
- Across medical wards for the trust, there were 52 serious safety incidents between April 2013 and March 2014 in medical care wards, 20 were due to slips, trips and falls, and 15 were due to the development of grade 3 pressure ulcers.
- The trust integrated performance report showed 54 hospital acquired pressure ulcers grades two to four between July 2013 and July 2014.From July 2013 to July 2104, there were 28 falls reported, and 44 reported incidents of catheter-acquired urinary infections.
- Some staff were able to tell us of how people's falls were investigated, and what plans were in place to reduce the risk of further falls. However, not all staff across the medical care service had an understanding of falls' prevention, other than to refer to the trust's falls' advisory service. We saw some evidence that movement sensors or alarm mats had been used as a potential measure to reduce the risk of falls.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.
- 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 in order to learn and change practice. We were informed that a

medication safety group had been set up to discuss medicine errors however this group was not always well attended by nurses. We found that although one ward had developed a change in practice following a medicine error this learning had not been openly shared in order to prevent the error happening on other wards. Another ward we visited was developing their own system of learning from medicine errors which had not been shared. The learning from these incidents would help to improve patient safety.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care. Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (venous thromboembolism, VTE).
- Staff told us that summary information from the monthly Safety Thermometer audit was shared with them regularly via team meetings.
- Wards carried out local audits on a monthly basis, including the safety thermometer audit, which looked at prevalence of pressure ulcer, falls, urine infections associated with catheters and whether Venous Thrombo Embolism (VTE) assessments had been completed.
- In the trust's integrated governance report for August 2014, medical wards reported 99% compliance with blood clots (VTE) risk assessments being completed on admission, which was better than the trust target of 95%.
- In the trust's integrated governance report for August 2014, medical wards reported that there were 11 falls with serious harm in the year to date, out of the trust total of 220.
- The incidence and timing of falls was being monitored on all wards, and some wards had extended visiting times, so that visitors would be able to spend more time with their relatives in the afternoons, which was a peak time for falls on these wards.
- There were three grade 3 or grade 4 pressure tissue damage incidents reported in the month of July 2014 with a total of 11 in the year to date. This was above the trust target of zero."
- Not all staff with whom we spoke were able to explain clearly what actions were being taken to prevent pressure ulcer development.

Cleanliness, infection control and hygiene

- Wards and communal areas were visibly clean and odour free. Personal protective equipment (PPE) was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage, regarding hand washing for staff and visitors, was on display.
- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate that barrier nursing was in place.
- Generally, cleaning schedules had been completed as required.
- Housekeeping staff told us that there were sufficient supplies of cleaning materials available to use.
- Staff followed universal infection control procedures when we carried out observations.
- Cleaning store rooms were generally clean and tidy and we noted that Control of Substances Hazardous to Health (COSHH) information sheets for cleaning materials were available for staff.
- Green "I am clean" stickers were used to show that equipment had been cleaned and was ready for use.
- In the AMU B ward, we noted that one of the communal baths, which was in use, had parts of the enamel chipped away: this had been reported by the ward as an infection control risk and was on the risk register for the service.
- On Priory 5 ward, we found the sink in the sluice room had chipped enamel which could have presented as an infection control risk.
- We also noted on the same ward that the drain to the shower cubicle was broken and not visibly clean: we informed a senior nurse who reported the concern to the hospital's Estates' Management team.
- On this ward, we also noted that the underside to one of the male communal toilet seats was unclean: we reported this to the senior nurse who arranged for the toilet area to be cleaned.
- We also noted that one of four sink areas for patients to use on this ward did not have a paper hand towel dispenser so patients may not have been able to dry their hands immediately after washing their hands.
- Handwashing audits were carried out monthly on all wards. Lyndon 5 ward had had a recent audit which showed 97% compliance with handwashing protocols.

- Staff told us that wards had Band 6 nurses acting as a "champion" for certain key risk areas e.g. for falls and infection control.
- From October 2013 to July 2104, there were five reports of C.difficle infections in the medical care service which was better than the trust target. No Methicillin Resistant Staphylococcus Aureus cases had been reported in the year to date.

Environment and equipment

- The environment was generally clean and tidy, but the décor, particularly in some communal areas and corridors, was in need of redecoration. Clinical areas were generally well maintained.
- There were systems to maintain and service equipment as required. Firefighting equipment had been checked regularly. Hoists had been serviced regularly. Portable electrical equipment had been tested regularly, to ensure it was safe for use.
- In AMU B ward, we noted that three out of four communal sinks did not have plugs and that for one, the hot water tap was not working. These sinks were for patient use and in these areas, patients were encouraged to be independent for personal hygiene tasks including washing and shaving.
- We noted on some wards that sluice rooms were not always lockable, but staff were aware of the potential risks if people with cognitive impairments went into these areas. However, on Priory 5 ward, the sluice room was unlocked and we found a cupboard inside that contained highly flammable chemicals and bleach tablets had been left unlocked. These chemicals could have presented a risk to patients or visitors if they had accessed this area.
- Most store rooms in ward areas were locked, but we found the store room on Priory 5 ward open and contained a variety of medical equipment (including dressing packs) which patients or visitors could have accessed. On Lyndon 5 ward, we found some store rooms left open that had signs on them saying "keep locked".
- Oxygen cylinders were stored in accordance with trust procedures.
- Nurses on Priory 5 ward told us that protective bumpers were not routinely used to cover bed rails on beds, unless a risk assessment highlighted the need for them to be used.
- Daily check records of resuscitation equipment were carried out on wards and generally checks were carried out and recorded in accordance with trust procedures.
- The trust had appropriate systems in place to manage the risk from water-borne viruses, and regular tests had been carried out.
- A lack of appropriate storage areas in some wards, for example Lyndon 5 ward, meant that equipment was stored in the patients' day room.

Medicines

- All wards had appropriate storage facilities for medicines, and generally had safe systems for the handling and disposal of medicines.
- Medicine trolleys were locked and chained to the wall when not in use. The trolleys were visibly clean and the contents stored tidily.
- Medicines were not always stored securely for the protection of patients. This issue had been identified by the Trust's own medicine storage audit however little or no action had been taken. We found a medicine cupboard on one medical ward that was open and had no lock. The storage of controlled drug medicines which require extra security storage arrangements did not always ensure that controlled drugs were stored securely which is a legal requirement.
- We checked a random sample of ten medicines on AMU B ward and found all were within their expiry dates.
- In AMU B ward we found that there were no systems in place to monitor the ambient room temperatures where medicines were stored, and we found that some of the medicines in use needed to be stored below 25°C, for example antibiotics. Also, intravenous fluids that needed to be stored below 25°C were stored in this area again with the ambient room temperature not being monitored. We brought this to the attention of the nurse in charge. Newton 4 ward was not recording ambient room temperatures where medicines were stored.
- Wards were recording medicine fridge temperatures in accordance with trust policy.
- Nurses wore red tabards when administering medication, in accordance with trust procedures.
- Staff said they had had relevant training, and that their competencies for medicine administration were assessed regularly.
- Sandwell General Hospital had a well-established pharmacy team who supported the safe use and management of medicines. We found that the

pharmacy team were actively involved in all aspects of a person's individual medicine requirements. People's medicines were reviewed and checked for safety by a clinical pharmacist at the point of admission through to discharge. In particular people admitted to the hospital had their medicines checked by a pharmacist to ensure the information provided was up to date and accurate. Any concerns or advice about medicines were written directly onto the person's medicine records by the pharmacist or discussed with the prescribing doctor. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times including an out of hour's pharmacy service. We found that the pharmacy team provided an efficient clinical service to ensure people were safe from harm.

- In a trust report from April 2013 to March 2014, there were 446 reported errors in the medical care service, with the largest number of 197 being as a result of medicines being "omitted". Summary reports were produced by the trust to show performance across each service area and so that learning from the themes of these errors could be cascaded to staff teams.

Records

- Senior staff said that the hospital did not use an electronic patient record and manual patient records were maintained. However, the hospital used an Electronic Bed Management System (eBMS). This system had a multi professional function for notes and was used on the Board rounds and by the capacity, social care and community teams for communication daily.
- We looked at the documentation kept to record peoples' vital signs observations, fluid balance charts, food intake and repositioning charts. We found inconsistent recording on some of the wards that we visited.
- On Lyndon 5 ward, fluid intake and output records were not being filled in at the time, with some charts having gaps and running totals not recorded.
- On Lyndon 4 ward, we saw there was trust guidance on record keeping in the front of the four sets of patient records we looked at. The notes were organised so it was easy to refer to particular documents within the file.
- On Lyndon 4 ward, we found for four patients that their fluid balance intake was not being recorded accurately and that when these patients had had intravenous fluids (IV) this had not been recorded on the patients' fluid balance charts. That meant there was not an accurate record for the fluid that these patients had had each day.
- On Newton 4 ward, we looked at three patients' fluid intake charts and found gaps in two of the charts. Staff were not always recording the running total, as was the trust's procedure. One chart had no entries completed for 8 hours in one day, so it was not possible to evidence if drinks had given and offered during that period.
- On Newton 4 ward, out of three care plans looked at, one patient did not have their religion recorded.
- Most wards had lockable patient note trolleys but not all trolleys were locked when not in use. Some ward patient boards did respect patient confidentiality by using symbols to denote medical conditions.
- We also saw on some wards, for example Lyndon 5 ward, that patient care plans, assessments and charts were not kept in the bedholders at the end of beds, but were left on bedside tables, tables or left tucked in the end of beds.
- We noted that not all updates and amendments to nursing risk assessments and care plans had been dated or signed, so it may have been difficult to check who had made the entry if required.

Safeguarding

- Adherence to safety and safeguarding systems and procedures was monitored and audited on a risk basis, and necessary actions were generally taken as a result of findings.
- The trust reported that it generally took a proactive approach to safeguarding, and focused on early identification, so that people were protected from harm, and children and adults at risk of abuse do not experience abuse.
- There were effective safeguarding policies and procedures, which were generally understood and implemented by staff, including agency and locum staff.
- The trust had a safeguarding lead for the hospital. We found that there was effective multidisciplinary communication with safeguarding leads in other organisations, and all referrals and concerns were triaged by the local safeguarding authority. Staff told us that this worked quickly and efficiently to safeguard people from harm.

- We found that the majority of safeguarding investigations were carried out within the target timescale of 28 days, and we saw evidence of effective protection planning to keep people safe, apart from discharge planning. Monthly reports were produced on safeguarding activity for senior managers.
- Not all staff were fully aware of the trust's whistleblowing procedures. Some staff did not know which external agencies could be contacted with a whistleblowing concern.

Mandatory training

- Staff told us that they had had mandatory training events annually, which included infection control, moving and handling, and health and safety. Some staff told us that at times, covering the wards took priority over training. Domestic staff also had mandatory training provided they said.
- The stroke wards had introduced stroke core competencies and at the time of inspection, 13 out of 50 staff on these wards had achieved all the designated competencies, including diabetes management, wound care and palliative care.
- As of August 2014, 78% of staff in medical wards had completed mandatory training, which was below the trust target of 95%. Senior staff said priority was given to staffing the ward rotas so staff were not always able to attend training.

Assessing and responding to patient risk

- Some wards had implemented the trust's "Ten out of Ten" initiative in which the trust was focussing on 10 key things that must be done for each admitted patient to reduce the risk of harm, including ensuring patient identification identifiers were correct, the risk of pressure area damage was assessed and care plans put in place, and risk of falls was assessed and a care plan put in place. Other wards had not yet introduced this initiative. This was a new initiative with a programmed roll out to all wards across the trust which started in September 2014. Some staff were not sure when this initiative was to be introduced. AMU A ward had started this safety initiative, but AMU B had not at the time of inspection.
- We observed a morning handover between staff on one ward, and we saw that handover sheets were used, which listed people's conditions and treatment. Some staff gave detailed handovers, included the person's co-morbidities, but other staff gave a perfunctory verbal handover that did not give all the required information.
- The hospital used the trust's National Early Warning Score (NEWS) tool to record patient's observations at regular intervals and calculate an overall score designed to alert nursing staff when a patient was showing signs of deterioration. Based on the scoring matrix, a review by a doctor would then be requested.
- The hospital had now implemented an electronic system for recording patient observations based on the NEWS tool; this electronic system was used on all wards. Staff said they had had training on how to use the system and how to input patient observations onto handheld devices. All patients' electronic observations were accessible to senior nurses via a desktop computer at the nurses' station and this also showed when each patient was due to have the next set of observations taken and recorded. The electronic system data was available to doctors throughout the hospital; however this electronic system did not automatically make a referral to a doctor to review the patient if their NEWS score indicated a review was needed. Nurses would make the referral and record this on the patient's written notes.
- Wards carried out monthly local audits for the electronic recording system and learning from the audits was shared at team meetings.
- The hospital used the trust's Electronic Bed Management system (EBMS) to record clinical concerns and to flag up those patients that needed a review by a doctor and this was linked to the hospital at night team handovers.
- All patients had two reviews by a consultant daily during the week staff told us.
- In most wards, we saw that the majority of beds did not have protective bumpers in place for the use of bed rails. Bed rails risk assessments had been completed, but there was no reference to consideration of use of protective bumpers.
- The hospital following the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The group medical director was not aware if "sepsis boxes" were available in ward areas. These sepsis boxes would contain the appropriate range of antibiotics to

facilitate immediate antibiotic treatment for those patients with suspected sepsis. AMU A had a "sepsis cupboard" containing appropriate range of antibiotics for staff to use if a patient showed signs of sepsis.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if any shifts were not covered. Senior staff said they would carry out a risk assessment if their ward was short staffed and escalate to senior managers. Staff said at times nurses and Health Care Assistants (HCAs) would be asked to work on other wards to cover. Some wards reported an increase in short term sickness recently. Senior nurses were able to tell us their ward's staffing vacancy position and at what stage the recruitment process was at. Staff said recruiting new nurses was a lengthy process at times and was not always successful.
- Most wards, apart from the medical assessment units (AMU A and B) used the trust's tool to assess patient dependency and acuity. Staff said AMU A and B were looking to develop their own patient dependency tool as these wards did not formally assess patient dependency at the time of inspection.
- Wards used the trust's E-Rostering system to plan rotas but this was not yet linked to the trust's Nurse Bank. Shifts not covered by the Nurse Bank within 48 hours were then put out to the trust's preferred agency provider of staff. Senior nurses said requests for agency staff were never refused; although the booking process was overly long and risked wards not receiving the staff they required whilst waiting for approval from senior management.
- The NICE guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was used by the trust to report on its monthly safer staffing levels information.
- Lyndon 4 ward had a nursing establishment rota based on 28 beds; the additional 6 beds in the ward, which were used for escalation purposes, were not staffed by permanent staff when open, so the ward was reliant on bank and agency staff to oversee patients in these six beds. Some staff said that the continuity of care was variable given the ward was reliant on agency staff at these times.
- Newton 4 ward had 28 beds and had nurse ratio of 1:7 during the day and 1:9 at nights. The ward also had HCAs on duty at all times. Staff said the staffing levels were appropriate and if needed, they could escalate any concerns.
- Priory 5 ward had a nurse to patient ratio of 1:5 in the mornings, 1:7 in the afternoons and 1:12 at nights. Staff said they were using less bank and agency staff now compared to a few months ago and that staffing levels were generally appropriate to meet patients' needs, but it could be quite busy at nights at times.
- Staff told us that additional HCAs were provided when a patient with higher needs (for example a cognitive impairment) required 1:1 focused care. We saw that two high dependency patients on Newton 4 ward were having appropriate support on a 1:1 basis at the time of our visit.
- Staff told us that at times, the trust required staff to work on different wards if there were staffing shortages elsewhere; not all staff felt confident about working on unfamiliar wards, but most understood the need to maintain safe staffing levels across the entire hospital. Also staff told us as times it was "hard going" as wards were reliant on bank and agency staff.
- Some wards reported higher than average staff vacancies and sickness, and were reliant on bank staff and agency staff to maintain staffing levels. Staff told us that they tried to use the same staff, so there was consistency in the level of care for people.

Medical staffing

- Junior doctors worked from 8am to 4pm or 5pm. After 5pm, doctors would be on call on a twilight shift rota. The hospital had a hospital at night team which started at 9pm, including doctors and Clinical Nurse Practitioners. Consultants generally worked week days and would work an on call medical rota at the weekends.
- Staff told us that consultant cover was good during the working days in the week, but that consultant cover, out of hours and at weekends, was variable.
- Doctors told us of a lack of consultant cover at nights for some specialities.
- The hospital at night team included registrars, junior grade doctors, and senior nurses and was designed to

be a multi-speciality team, with both medics and surgeons attending the nightly handover meeting at 9pm each day. However, staff said it was not regularly attended by surgeons.
- Doctors said that there was a dedicated 'hospital at night' team for doctors, and that there were formal face-to-face handovers between day and night doctors.
- The trust provided an on call rota for consultants to respond to emergency gastro-intestinal bleeds.
- The cardiology wards had on site consultant cover at the weekends.
- Out-of-hours cover was provided by the hospital's on-call rota of doctors, who were from all types of different medical specialisms.
- Staff told us that not all wards had doctors working on them out of hours, and would therefore be reliant on the doctors' on-call system.
- Some staff on the care of the elderly wards told us that there were usually more doctors on the other wards.
- Some senior nurses said that there was a lack of junior doctors on the wards at times.
- Some wards reported that the doctor's cover rota was reliant on the use of locums.
- The medical handover that we observed was efficient, and there was effective communication displayed regarding people's conditions.
- A doctor we spoke to said that their induction was "very good" and that there was excellent support from senior doctors.
- The majority of people we spoke with said that when they needed to, they saw a doctor quickly.

Major incident awareness and training

- The provider had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents, such as bad weather or illness.
- Patient safety information was collated and audited, and feedback was given to ward teams on a monthly basis.
- Senior staff told us that the trust had business continuity plans in place, and had systems and processes in place, to be able to respond to major incidents.
- The trust had made available its business continuity plans on its internal computer system, for staff to access, but not all staff we spoke with were aware of this.

Staff were aware of emergency protocols and fire safety risks. Staff told us that fire drills were carried out routinely. We did note on AMU B ward that a designated fire door to the kitchen area was propped open, which was not in accordance with the trust's fire procedures.

Are medical care services effective?

Good

Care was generally provided in line with national best practice guidelines and the trust did participate in all of the national clinical audits they were eligible to take part in. Performance and outcomes met trust targets in most areas. There was evidence of progress to providing seven day a week services, but this had not been consistently achieved across the medical care service. Most staff said they were supported effectively, but there were limited opportunities for regular supervisions with managers. The medical care service was below trust targets for staff appraisals and plans were in place to address this. Care planning effectiveness was variable, and care plans were not generally person-centred.

Evidence-based care and treatment

- Staff carried out accurate, comprehensive assessments, which covered most health needs (clinical needs, mental health, physical health, and nutrition and hydration needs), and social care needs. They developed care plans to meet some identified needs. Care plans were mostly regularly reviewed and updated. People's care and treatment was mostly planned, and delivered in line with evidence-based guidelines. However, for all the care plans we looked at, they were not person-specific and did not always reflect the holistic needs of the patients.
- Care-planning for people living with a dementia was not personalised and care-plans did not provide staff with clear guidance as to how to manage difficult behaviours. We saw one patient on Lyndon 5 and two patients on Newton 4 wards that were displaying aggressive behaviours, but we found they did not have a care-plan in place for the management of their behavioural issues.
- The Trust's Hospital Standardised Mortality Ratio (HSMR) for the most recent 12-month cumulative period

is 85.2, which remained better than peer trusts. Sandwell hospital'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.

- For some people, the Patient Passport, an assessment form for family to complete about the patient's needs, had not been fully completed. Staff said they did get a clear handover daily about the patients' needs.
- On Newton 4 ward, we found that one person's wound care plan had not been reviewed for over a month, when it should have been reviewed at least weekly.
- On Newton 4 ward, one patient needed staff support and equipment for moving and handling, but the handling care plan did not give clear guidance for staff regarding which type of hoist and sling should have been used. This handling plan had not been reviewed weekly as was the trust procedure.
- Senior staff said the hospital did not generally have a culture of using clinical pathways in all instances and that clinical pathways were focused on certain conditions, for example, variceal bleeds. Senior staff were not clear if all clinical pathways were reviewed and updated regularly.
- Wards also carried out a weekly memory screening audit to assess whether these assessments had been done since the patient's admission and to inform how the hospital performed against the Commissioning for Quality and Innovation (CQUIN) goal.
- Wards carried out a monthly Nutritional audit and sampled 10 patient's nutritional records to check weight loss risk assessments and food intake charts had been completed accurately.
- Staff said the stroke and cardiology wards administered care in line with national (NICE) guidelines and staff said the stoke pathway was a successful model. Staff did not know what patient outcomes there were for stroke rehabilitation therapists.
- The average length of stay for neurological patients at Sandwell was higher than the trust's other hospital and senior staff said this was due to a slow discharge pathway but there were no formal actions in place to address this area of concern. The trust said the local commissioners were aware of the difference between the hospitals and said it was due to the complexity of some people's needs and how they could be managed safely.
- The cardiology wards had effective systems in place for assessment of patients' needs, and followed clear protocols for medical procedures.
- The Ambulatory Care Unit was newly established and had generic as opposed to specific patient care pathways.

Pain relief

- Generally, wards had effective systems in place to assess and provide pain relief for patients.
- One patient who was receiving end of life care told us sometimes they had to wait for pain relief medicine to be given in a timely fashion as the ward (Lyndon 5) was short staffed at times.

Nutrition and hydration

- Staff told us the hospital used red trays and red beakers to designate those patients that were at risk of malnutrition and dehydration and needed staff support to eat and drink.
- One patient on Newton 4 ward was using a red tray to denote a risk of malnutrition and was having their fluids thickened due to the risk of aspiration. Whilst this information was shown on the patient information board above their bed (called the "Bed board" by staff), it was not recorded on their nursing care plan. This patient had had a risk assessment for malnutrition completed but the care plan did not reflect the level of risk for this patient.
- We saw on Lyndon 5 ward that red trays were being used to denote those patients at risk of malnutrition. Red beakers were being used for those patients at risk of dehydration.
- All wards had protected mealtime arrangements and notices for visitors about these protected mealtimes were on display on all ward entrances. Mealtimes were protected within the ward areas we inspected. This meant that patients could eat their meals without interruption, and staff could focus on providing assistance to patients who were unable to eat independently.
- We observed that the detailing of nutritional intake and fluids was not always accurately recorded within patient's records.

Patient outcomes

- The trust had an effective system for monitoring patient 'free from harm care' that was delivered in each ward

area, and monthly feedback reports were cascaded to staff. The main performance issues and safety risks information were displayed on the wards' performance boards.

- The trust's hyper-acute stroke service was provided at Sandwell hospital. The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), and the overall SSNAP audit score had improved from December 2013 to March 2014 to be at Band C (the middle of the national average), and staff told us recent results showed further improvement to a Band B, although these audit results had not yet been published. Senior staff said following actions to address the concerns in the SSNAP audit, significant improvements had been made, especially regarding therapist interventions, and the most recent performance data showed the trust was now in the top 8% in the country
- Both of the trust's hospitals offered an on-site diabetic support service, but as there were fewer diabetologists at Sandwell hospital, the results of the national diabetes audit were poorer at Sandwell than at City hospital. For the National Diabetes Inpatient Audit (NaDIA) in September 2013, Sandwell hospital performed worse that the national average in 14 out of the 19 audit measures. Senior staff informed us action plans were in place to address this.
- For the care of patients who had had a stroke, the trust reported for July 2014 in the Integrated Quality and Performance, that 99% of patients who had had a high risk transient ischaemic attack (TIA) had been seen within 24 hours, which was better than the trust target of 70%.
- The trust also reported for the same period that 89% of patients who had had a stroke were treated on the designated stroke ward for 90% of their hospital stay. This was slightly below the trust target of 90% but the rolling year average was 95%, which was above the trust target.
- The heart failure audit for 2013/13 showed that the Sandwell hospital performed better than the national average in nine areas, and slightly worse than the national average in two areas.
- In the **Myocardial Ischaemia National Audit Project** (**MINAP**) audit for the years 2012/13 saw Sandwell hospital perform better than the national average in all three areas reported.
- Data from the year 2012 to 2013 demonstrated that the trust performed better than the national average for people with nSTEMI (a common type of heart attack) being seen by a cardiologist (with 100% on the audit results compared to the national average of 94%), and for those people who were referred for or had angiography.
- Also, for the same period, the hospital performed better than expected against the national average for those people with nSTEMI who were admitted to a cardiac ward (with audit results of 60% compared to the national average of 53%) The quicker a person is admitted to a cardiac ward, the better their prognosis would be.
- The stroke rehabilitation ward (Newton 4) had an average length of stay of four to six weeks. Patients were receiving 45 minutes a day of occupational therapist and physiotherapist input three times a week which did not meet the National Institute for Health and Care Excellence (NICE) recommended guidance of 45 minutes therapists' input five days a week (Stroke Rehabilitation: Long term rehabilitation after stoke: NICE guideline CG162 as published on June 2013). However following the inspection the trust leadership refuted this and informed us that as they had seven day services for which patients received 31 minutes of therapy daily, which was equal to the NICE guidelines.
- Senior staff said there was a lack of neuroradiology input as some patients needed complex neuroradiology imaging, which was not always available in a timely manner. This imaging service was provided by another trust and staff said the service level agreement was been reviewed to address this concern.
- Lyndon 5 ward was working closely with the trust's End of Life care tam and now provided four side rooms for patients requiring end of life care.

Competent staff

- Most staff told us that there were no formal systems in place for regular supervision sessions with their line managers, apart from annual appraisals, but that any issues were addressed via informal support from managers.
- Senior staff told us that they had regular supervision sessions which did include reviews of their training and development needs.
- Only a small proportion of qualified staff we spoke to said that they had opportunities for clinical supervision. However, there were supervision arrangements in place for newly qualified nurses.

Medical care (including older people's care)

- Most staff told us that they had had an annual appraisal, and their training needs were discussed, and individual development plans completed.
- Newly appointed staff said that their inductions had been planned and delivered well. Permanent staff were provided with induction packs, but not all ward areas had separate induction packs for agency staff.
- On Lyndon 4 ward, the staff member we spoke with, who was providing one to one support for a patient living with a dementia who was displaying aggressive behaviours, did not show an awareness of behavioural triggers and de-escalation methods for managing these difficult behaviours. The ward had sought the support from the trust's safeguarding lead.
- For August 2014, medical wards did not meet the trust target of 95% compliance for having an annual appraisal, as only 84% of staff had had an appraisal. However, many staff told us that their appraisal had been booked.
- Newton 4 ward had carried out appraisals for 97% of the ward staff.
- Staff on Lyndon 4 ward said they had had appropriate training for Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 training and we saw the training schedule for the staff with each staff member having had a two hour training session on these areas. Staff said this training had met their learning needs.
- Doctors told us that there was an effective system for assessment and revalidation. As of August 2014, 87% of revalidations had been completed which was below the trust target of 95%.

Multidisciplinary working

- There was a multidisciplinary collaborative approach to care and treatment that involved a range of professionals, both internal and external to the organisation. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date. Each ward had a daily board round in the morning. These were a multi professional review of all patients.
- Staff told us that multidisciplinary working on the stoke ward was excellent with clear handovers given that discussed the needs of patients and action points for staff. The two stroke wards held combined multi-disciplinary meetings once a week to facilitate effective communication. Staff also worked on rotation across these two wards.
- We saw that multi professional medical ward rounds were being held daily on Lyndon 4 ward to ensure patients' needs were reviewed daily.
- Staff told us the two stroke wards (Newton 4 and Priory 4) had two occupational therapists and one assistant occupation therapist working across both wards. The trust said during weekdays there were five or six therapy staff working across these wards including occupational therapists, physiotherapist and speech and language therapists. Therapists worked on a seven day rota. Specialist services were delivered for patients by therapists included Functional Electrical Stimulation and spasticity management via botulinum toxin injections to enhance early mobility after the stroke. The two stroke wards held combined multi-disciplinary meetings once a week to facilitate effective communication. Staff also worked on rotation across these two wards.
- Daily ward meetings were held, usually at 8.45am called the Board rounds, to review discharge planning, and to confirm actions for those people who had complex factors affecting their discharge.
- We saw that multi professional medical ward rounds were being held daily on Lyndon 4 ward to ensure patients' needs were reviewed daily.
- Staff told us that there was robust multidisciplinary working at ward level, but sometimes links with other departments was not always effective. Staff told us there was effective liaison between nurses and doctors. Doctors told us that nurses knew people's condition, and would report any changes so as to deliver best outcomes for people.
- The Ambulatory Care unit had effective liaison with the emergency department and the AMUs.
- A pharmacist told us they were very much included in the decision making process with the medical and nursing teams and attended MDT meetings regularly.

Seven-day services

- Staff told us Medical ward rounds were held on each ward during weekdays, but most did not have ward rounds at the weekends. The trust told us that two consultants worked a combined 10.5 hours at weekends and reviewed patients across wards as required.

Specialty consultant rotas were also in place including cardiology and stroke. Senior staff told us that not all patients were therefore routinely reviewed at the weekends. Staff would refer any concerns to the on call team of doctors at the weekends. Staff reported there were no difficulties in getting doctors to review patients promptly at the weekends. During the night, staff would refer patients to the hospital at night team for review.

- The hospital had consultants on site at the weekend in the stroke wards spending 8 hours per day on site and being on call for the rest of the 48 hour period.
- All wards had out of hours medical cover provided by the on call Medical Consultant and their team. Specialty cover included an on call Cardiology Consultant and team. Priory 5 ward had an effective consultant presence on the ward with daily ward rounds during the working week. At weekends, poorly patients would be reviewed by the duty medical registrar supported by the consultant on call.
- Staff said junior doctors were readily available at the weekends and out of hours and patients did not have to wait for medical reviews when needed.
- Staff told us that the process for having X-rays taken, and getting the results for people, could be slow at times, particularly in the evenings and at weekends, due to the out-of-hours cover rota.
- Staff told us that the level of cover by doctors in the evenings and weekends varied from ward to ward.
- Therapists worked on a seven day rota and Speech and Language Therapists worked on on-call rota at weekends. Staff told us access to therapists was variable in the evenings and at weekends. Pharmacists did not work at the weekends, but senior staff told us that patients' discharge medication could be arranged by using the on-call pharmacist.
- Some wards had a nurse acting as a discharge co-ordinator and patients appropriate for weekend discharges were identified before the weekend, in order to try and facilitate appropriate discharges.
- Staff told us arrangements for patients' medications for discharge was more co-ordinated now using the online computer system that linked to the trust's pharmacy department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Some assessments correctly recorded specific decisions and the reasons for the judgement made, whilst others did not. The involvement of family members or people's representatives was only recorded in a minority of cases.
- In one case, we saw that an urgent Deprivation of Liberty Safeguards (DoLS) assessment had been authorised previously and that the DoLS standard authorisation was in place. Staff were maintaining a safe environment for the patient and had ongoing contact with the trust's safeguarding lead to ensure the patient's needs were met safely.
- In another case, a patient was having one to one staff observations as this patient posed risks to themselves and others. We found that the appropriate DoLS authorisation was in place in accordance with trust procedures.
- Nearly 83% of medical ward staff had completed the training event for Mental Capacity Act awareness and DoLS awareness, as of July 2014, which was below the trust target of 85%. Staff told us that they had had training sessions regarding DoLS, and that this had met their training needs in this area.

Are medical care services caring?

Good

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care. Staff in all roles put significant effort into treating people with dignity. Patients generally felt supported and well-cared for. Staff responded compassionately to pain, discomfort, and emotional distress, in a timely and appropriate way.

Medical care (including older people's care)

- We saw that interactions between staff and people were positive, respectful and caring.
- Most people we observed were well presented, and appeared comfortable in their surroundings.
- People's dignity was respected whilst they were being supported with personal care tasks, apart from on one occasion, where we saw a nurse take a patient's observations without pulling the dignity curtain around the bed. This was in full view of other patients.
- Staff knew people's names, and spoke in an appropriate tone of voice when supporting people. A doctor told us that the nurses "know their patients and their needs". The majority of people were very complimentary about the staff, and the care they had received. One person said of the nurses "They are very, very good". Another said "the nurses are very friendly". One person on Lyndon 5 ward said "This is the worst service I have had" as they had been kept waiting for help to go to the toilet during the night.
- One set of relatives we spoke with said "we are so pleased with the way they are looked after. They are so good with them".
- The majority of people told us that nurses checked upon them regularly, and were polite and respectful. The relatives we spoke with were complimentary about the care and attention their relatives had received from staff. Some wards had extended visiting times, to allow people to see their relatives for longer and more easily.
- Most people told us that staff answered their call bells in a timely fashion, but two people told us that they had waited at times for up to 10 minutes.
- Staff were able to tell us how the needs of people from culturally diverse backgrounds were met.
- In the stroke wards, patients were encouraged to wear their own clothes when using the gym.
- Five patients we spoke with on Lyndon ward were all very positive about the level of care provided with staff and that they were treated with dignity and respect at all times.

Patient understanding and involvement

- Most care plans that we looked at were not personalised to the individual people, and most did not reflect their involvement in agreeing to the plan of care.
- The majority of patients we spoke with across all wards visited said they were not aware of their care and treatment plans.
- In AMU B, patients did not have one named doctor but all three of the team of consultants for this ward were listed as the patient's named doctor. Staff told us all three consultants would be equally responsible for the patient's care and treatment. There was no individual consultant accountable for an individual patient's care on the AMU ward but senior staff told us the speciality lead or group director would have overall accountability.
- Four out of five patients we spoke with on Lyndon 4 ward were not able to tell us about their longer term individual treatment plans beyond the current day. One patient said "I keep asking what is going to happen. I know I am having an operation but nothing beyond that."
- The majority of staff had an understanding of the Mental Capacity Act, and how assessments of a person's capacity were needed if there were reasons to doubt their level of understanding. Staff told us that generally, capacity assessments were carried out by doctors.
- Relatives said they were generally kept well informed of how their relative was progressing.
- All wards had appropriate signs in place so that people would know which members of staff were their named nurse and doctor.
- Most care plans that we looked at were not personalised to the individual people, and most did not reflect their involvement in agreeing to the plan of care.
- On Priory 4 ward, relatives of a patient on a DoLS authorisation told us that were kept very well informed and that they had open access to the ward and shared in the care provided with the nursing staff.
- Some people had the trust's care for people with dementia document, 'Patient Passport', completed and available for staff to read; however, some did not. People's life stories and likes/dislikes included in the document had not been effectively transferred into the main care plan, especially regarding people's behaviours and known 'triggers' for aggressive behaviours.
- Most care plans and risk assessments we looked at had not been signed by the person or their representative.
- Some patients told us that they had not read their care plans, and did not know their treatment plans.

Medical care (including older people's care)

Emotional support

- Newton 4 ward worked with a volunteer patient befriending service called "Edna's Army" which offered support to those patients that did not receive visitors.
- A nurse on Newton 4 had been trained to be able to provide psychological support to patients when required. The ward was also considering setting up a clinic to help patients with their psychological support needs.
- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workload meant this did not always happen.
- Most staff said that an extra staff member could be requested if a person needed specific one-to-one support from staff, but that this did not always happen due to lack of available staff.
- People spoke highly of the hospital's chaplaincy service, and found it easy to access support.
- Staff told us that timely assessment and support was generally available for people from mental health practitioners.
- Some patients said that they had lost some independence whilst in hospital, but that staff kept them informed and did offer choices where appropriate.
- Visiting times met the needs of the relatives that we spoke to. Open visiting times were available to relatives if patients needed additional support from their relatives.

Are medical care services responsive?

Requires improvement

Some problems with the effective discharge of people were highlighted across the medical care service, from both staff and some of the patients we spoke to. Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning and staff training, to provide effective person-centred dementia care. The trust had systems in place to investigate complaints and compliments. The trusts' ambulatory care service was delivering an effective service to prevent admission or readmission to hospital. There was an elevated demand on bed availability at times, and the trust had escalation plans in place.

Service planning and delivery to meet the needs of local people

- Sandwell hospital delivered the trust's hyperacute stroke care service and would receive patients from City hospital if they had had a stroke. Sandwell hospital acted as the trust's single site service for patients needing assessment and treatment for neurological conditions.
- Senior staff said the Trust was planning a winter pressures plan to cope with increased demand for beds in the coming months. This plan included reducing the number of patients with a delayed discharged of care. The Trust was engaging with partner organisations, such as the local authority and Clinical Commissioning Group, to address this area of concern establishing a joint health and social care assessment for discharge team in the assessment units in the winter. The Trust had a comprehensive winter plan that included establishing 20 additional flexible intermediate care beds, increasing capacity for community in-reach service, transport, critical care and staffing. "During the period March 2013 to June 2014, the hospital was meeting the 18 week standards for referral to treatment times in all seven specialty groups (including cardiology, dermatology and gastroenterology).
- The trust had introduced a life history profiling document, 'Patient Passport', but we found that it had not been completed for all people with a dementia. We also found instances where a person's detailed life history had been received from family members, but was not reflected in that person's care plan.
- Staff told us that the translation service worked well when needed, and we saw posters on display in some ward areas. Wards also had access to independent interpreters when required.
- Some areas had patient information leaflets available in different languages (such as Spanish and Urdu).

Access and flow

- The Acute Medical Assessment Unit B (AMU B) had 20 beds and mainly took referrals from the AMU A ward. There was no designated length of stay for this ward but the average length of stay was 72 hours primarily catering for those patients needing a short term admission. The unit mainly catered for those patients with a urine infection, breathing difficulties or needed treatment for alcohol withdrawal. Patients were generally admitted to AMU B within 12 hours from

admission to hospital, usually via the AMU A ward. The unit had a Band 5 nurse acting as a discharge co-ordinator during the week, who liaised with the hospital's Complex Discharge team of nurses to facilitate safe and appropriate patient discharges.

- Newton 4 ward had employed a band 5 nurse to act as a discharge co-ordinator and the average number of monthly discharges had increased from 7 in April 2014 to 38 in September. This nurse worked weekdays and liaised with the Complex Discharge team to facilitate appropriate discharges for patients.
- On the day of our visit, 15 patients were medically fit for discharge and were classified as delayed discharges, mainly due to social care support reasons. Ward leaders told us they used the trust's Electronic Bed Management System (EBMS) and the bed co-ordinators for wards used this tool to communicate capacity and flow information between wards.
- The hospital had a matron on duty daily in the Capacity Team focusing on bed capacity and bed management across the hospital.
- The hospital had bed management meetings every two hours during the day from 8am to 8pm during the week to review and plan bed capacity and respond to acute bed availability pressures, for example in the AMU wards.
- Senior nurses said there was good strategic management of bed capacity across both hospital sites and effective liaison with the emergency departments to monitor patient flow and bed capacity.
- Senior staff said during each ward round during weekdays, there was a clear focus on effective discharge planning for patients. However, discharges at the weekends were half of what was achieved during the week and some wards did not always clearly identify patients for potential discharge routinely.
- Each ward did have daily Board Rounds at 8.45 am during the week with relevant multi-disciplinary professionals to plan potential discharges. These Board Round meetings had recently been brought forward from lunch times and the hospital was promoting a "home for lunch" discharge initiative.
- Ward leaders told us that 90% of patients were admitted to the correct medical ward for their condition and that medical outlier patients normally went to surgical wards. All medical outlier patients were logged on the EBMS system so it was clear where these outlying patients were. A search under a consultant's name would show all patients under the care of that consultant that were on outlying wards.
- The day prior to our visit, there were six medical patients outlying on other wards. Staff said the number varied each day but there were patients on outlying wards every day. The trust had a policy in place for the medical management of outlying patients.
- Ward leaders told us it was trust policy not to move patients after 10pm at night, unless their medical condition required it, for example transferring someone to intensive care. If patients were moved at night to alleviate bed capacity issues rather than for medical issues, senior nurses carried out risk assessments and would log the night move on the trust's incident reporting system. Staff told us 80% of moves at night were for medical reasons and 20% were for bed capacity issues.
- Staff on Newton 4 ward said patients were not moved at night and the latest time patients would be transferred to other wards would be 5pm.
- The average length of stay for the general medical wards was five days, which was below the trust average of six days. The average length of stay varied in each medical speciality, ranging from one day in cardiology to 21 days in neurology.

Meeting people's individual needs

- Not all wards were using the trust's symbols on patient information boards to indicate that a patient was living with a dementia.
- The hospital had a Rapid Response Therapy team that worked across the emergency department and Acute Medical assessment units so patients could have a physiotherapist and occupational therapist assessment quickly and this team liaised with adult social services so discharges could be co-originated and planned effectively.
- The AMU B ward had twice daily medical ward rounds carried out by consultant physicians during the week to review all patients on the ward. The ward had rolling consultant-led evening ward rounds.
- The stroke wards had set up a weekly Stroke Club on Wednesdays to promote patients' health and wellbeing. This club was well attended by patients.

- There was a lack of dementia friendly signage and of signs in alternative languages in ward areas, although we did see posters in different languages in some corridor areas.
- The care of the elderly wards were not specifically designed to provide an appropriate environment for people living with dementia, such as with dementia-friendly appropriate décor, flooring, and appropriate lounges for activities. Side wards used for patients who were at risk from falling were not always visible to the majority of staff.
- Not all wards had quiet or day rooms for patients and visitors. Priory 5 did have a quiet room but this room also doubled as an office, and had computer equipment in it for staff use.
- Care for people with dementia, particularly those who became agitated, and displayed challenging behaviours, was an area that the trust wished to improve. Behaviour charts were available for staff to use to help monitor and understand patient's difficult behaviours; but we found that these charts were not always being used, when they have been shown to assist with effective care planning.
- Dementia co-ordinators (Band 2 or 3 staff) were available to do activities with people living with a dementia in some wards. Ward staff said that whilst activity equipment and games were provided, there was little time for them to sit with patients to engage with them in meaningful activity.
- Newton 4 ward had effective processes for involving patients in their stroke rehabilitation plans and had available a detailed information pack for relatives and carers explaining the rehabilitation process.
- The hospital had access to a translation service, which staff told us was effective and met people's needs. Posters were on display about how to access this service.
- The trust was not meeting its target for providing single sex accommodation in the medical wards as there had been 93 breaches from April 2014 to August 2014. However, there had been no breaches in the past two months.
- Staff told us that they gave people's relatives the 'Patient Passport' document to complete, but they did not get many completed documents back. This meant that care and treatment was not always delivered to meet people's needs, as staff did not have appropriate guidance to follow.
- A stroke discharge pack was available for patients when leaving hospital, giving them appropriate contacts details of community support organisations. Stroke patients also received a copy of their stroke care plan for continuity of service in the community when they were discharged. All patients would be telephoned by the ward 48 hours after discharge to see how the discharge process had gone.
- Newton 4 ward had information leaflets for patients explaining the ward's ethos, staff roles and what stroke rehabilitation therapy was provided on the ward. This ward also encouraged family members to assist in the care for their relatives, such as supporting at mealtimes, if both parties agreed.
- The trust had a range of information leaflets available for patients and their relatives, to signpost them to other providers of support, including social services, and charities.

Learning from complaints and concerns

- People generally knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them, or their representatives, to provide feedback about their care, however, complaints procedure leaflets were not always readily available in ward areas. Not all areas we visited had posters on display regarding the trust's complaints procedures or the Patient Advisory Liaison Service (PALS).
- Some patients knew about the hospital's Patient Advice and Liaison Service (PALs), and leaflets were available in all areas we visited. We saw posters on display in corridor areas outside wards that gave information about the PALs service.
- People's views of the way in which the hospital dealt with complaints were mixed. One person told us that a concern had been dealt with "on the spot" and that they were happy with the resolution. Another person said "the complaint's procedure takes too long to get a response".
- Ward leaders told us how they were now working to achieve 'on the spot' resolutions to concerns where possible, and would hold meetings with people and their families to seek to resolve the concern.
- Senior staff on Newton ward said there had been one complaint in July and one in September and both had investigated and outcomes provided to the complainants.

Medical care (including older people's care)

- Newton 4 ward rarely received complaints staff told us but any issues of concern were resolved quickly and feedback discussed at team meetings.
- Priory 5 ward staff told us that some formal complaints had been dealt with slowly and that there was not an effective process for sharing learning from complaints across the hospital.
- The medical service at Sandwell hospital had had 93 complaints in the year ending July 2014 with the main areas of complaints being general medical care, gastroenterology and care of the elderly. The trust produced summary reports of the general themes of complaints so that learning could be shared with all departments.
- From April 2014 to August 2014, there had been 126 formal complaints about medical ward wards with 130 complaints shown as still being dealt with via the complaints' process.
- Staff told us that there had been a number of complaints regarding the discharge process, and that these were usually relating to ward discharges processes.
- Staff told us that learning from complaints was disseminated via informal staff meetings.
- We saw that all wards displayed the compliments they received.

Are medical care services well-led?

Requires improvement

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, and the implementation of information boards for staff to highlight each ward's performance. The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of recent initiatives. Not all staff felt able to contribute to the on-going development of their service. Not all junior staff were fully aware of the vision and strategy of the trust, and said work pressures, due to higher patient dependencies, was an area of concern.

Vision and strategy for this service

- Most ward leaders spoke positively about the vision and strategy that the board had for the ongoing development of the medical care service.
- Some staff were able to tell us about the "Ten out of Ten" initiative, and how this would lead to improved outcomes for patients in the planning and delivery of care. Some staff told us this initiative had only just been introduced into their wards, after a pilot in a few wards six weeks prior to the inspection. Half the wards we visited had not yet fully implemented this initiative.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.
- Some ward leaders felt that the pace of change in recent months was significant and the staff team needed clarification regarding the workforce reduction plans that were being implemented.
- Some staff were able to tell us about the trust's plans to review the nursing establishment at the hospitals with plans to provide a 1: 8 nurse to patient ratio on wards. Not all junior staff were able to tell us about the vision and strategy of the trust and their focus was on the areas they worked in.
- Staff told us that some new documentation was piloted, with feedback sought from staff to ensure that it was fit-for-purpose; however, at other times, new documents were introduced without a clear explanation to junior staff. Some staff said that the assessment documents and care plans were time-consuming to complete, and needed to be reviewed. Some had raised this with their managers.

Governance, risk management and quality measurement

- We were told by senior staff that CQC standards were incorporated into the quality assurance programme for the trust.
- Ward leaders were able to tell us about the ward's performance against the trust's targets and objectives, and were aware of the current risks on the risk register. However, junior staff were not always able to tell us how the ward was performing, or what actions were being taken to mitigate risks to people.
- The trust had in place regular governance meetings, and incidents, audits and complaints were discussed.

Formal reports about quality, safety and governance were produced, and made available to the public via the trust's website. Not all staff we spoke to had read these reports, but senior staff were able to tell us about them.

- Each ward had feedback findings from audits, complaints and areas of risk from audits, and information was cascaded down to all staff via team meetings. However, not all wards had displayed the findings of audits in public ward areas, with information available in staff areas only.
- Staff on Lyndon 5 ward said awareness of incident reporting had improved across the staff team and staff at all levels were now reporting incidents including verbal abuse and near misses, which may have not been reported previously.

Leadership of service

- Most staff told us that leadership at ward level had improved, with clearer communication. For example, performance boards that highlighted key issues and messages, and also recognised staff achievements, were available for staff to read. A few staff felt that there was a lack of consistency in ward leadership. Most staff felt well supported by local managers.
- Some staff told us that the board members and executive team were more visible and accessible to staff, whilst others said there had been little improvement. Some staff said the chief executive had visited their wards.
- Senior nursing staff said that the chief nurse lacked visibility and some had not met him. Staff did consider that the chief nurse was aware of the issues affecting staff on the wards.
- Some wards had established a senior clinical team comprising of a consultant, senior nurse and junior doctor to review and develop the ward's performance and accountability.
- Some ward leaders told us that leadership and management courses were much more accessible for them.
- Senior nursing staff and doctors said that the leadership from the board and the senior executive team had improved, and that two-way communication was more effective.
- Some senior staff said support from the Human Resources team could be improved and felt they were not getting enough support to manage the workforce reduction plans that were being implemented.
- Ward leaders and staff told us about most wards having weekly informal staff meetings that were held for staff, to share their issues, and also to get feedback from senior managers. Staff told us that generally, they were well supported by their managers.
- Some senior staff expressed concern about the length of time it took to get approval to use an agency staff member as applications to use agency staff had to be made 24 hours before the shift was needed and approval was not sometimes given until the "last minute". This impacted on the effective management of the ward rotas. This approval only applied to agency nurses, and wards were encouraged to use hospital bank staff to fill rotas up to eight weeks in advance in order to try and prevent the need to use agency staff.
- Some HCAs told us that they did not know what the ward performance boards were for, and some of the HCAs were not aware of the trusts' overall vision.

Culture within the service

- Senior staff reported an improvement in staff morale over the last few months, however, some staff reported feeling pressurised, and said keeping morale up was "a struggle", especially when staff were asked to work on different wards that they were unaccustomed to working on.
- Some senior staff expressed concerns about proposals to close beds on medical wards and to use these beds as escalation areas. This would effectively reduce medical wards bed numbers and the escalation beds may not have permanent staffing rotas so would be reliant on bank and agency staff when in use. The trust told us that their Clinical Group had escalation plans to open additional beds as part of winter planning. These were funded through winter pressures monies. Staffing was to be provided in part from the permanent staff pool and supplemented with bank staff. A matron would oversee the escalation ward.
- Most staff reported an improvement in effective communication to and from the trust's board.
- Some support staff felt that work pressure had increased, as the workload was rising due to the increasing dependency of patients.
- Some staff were concerned about the implications of the trust's workforce reduction plans being implemented and felt reducing staffing levels could compromise patient safety.

Medical care (including older people's care)

- Staff generally were very positive about the team working on their wards.
- Some wards reported a higher than average sickness absence rate; this was usually down to the impact of having staff off on long-term sick leave. Ward leaders told us of the trust's more robust approach to supporting staff with attendance issues. Medical wards had a sickness absence rate of 4.2% for August 2014, which was worse than the trust target of 3.15%.
- The majority of ward leaders were very positive, and spoke well of support from senior managers.

Public and staff engagement

- On Newton 4 ward, staff were encouraged to raise and discuss new ways of working to improve patient outcomes. Following on a staff member's idea, the ward had recently introduced a patient "likes and dislikes" sheet that staff completed with patients about their care needs.
- This ward was also working with a volunteer patient befriending service, which provided patients with peer support both in hospital and in the community if they wished.
- Some people told us that having the board meeting minutes available to the public online helped them to understand more about the hospital and how it was performing.
- Some HCAs told us that they were not well informed of the trust's plans to reorganise staff teams.
- Feedback from patients was regularly sought, and results displayed in ward areas.
- Wards had recent Friends and Family Test (FFT) results for the trust on display on their notice boards but the data was not always ward specific. For example, Priory 5 ward showed a trust FFT score of 76% for inpatients areas but was not individual to this ward.
- Friends and Family Test (FFT) results for the medical care service in July 2014 (for those wards with responses above 100) showed that from the nine eligible medical wards, five performed better than the national average of 70%.

Innovation, improvement and sustainability

- Innovation was encouraged, but staff told us that they were not always able to recommend changes, due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, whilst others did not.
- Senior staff said the service was under supported in terms of Information Technology and hospital informatics data and this was hindering innovation and redesign of services.
- Ward leaders felt confident about managing the pace of change if it were carried out in a planned fashion.
- Staff had objectives focused on improvement and learning as part of their appraisals.

Surgery

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

Information about the service

The surgical service is provided within surgery A and surgery B. This incorporates theatres and wards at both Sandwell and City Hospitals. Day surgery is provided at the Birmingham Treatment Centre on the City site and in a day surgery unit within the Sandwell site. From data the trust sent us, we saw that the surgical service at Sandwell Hospital treated 15,772 people 2014/15. We spoke with 14 members of staff including consultants, registrars and new doctors, nurses, matrons and healthcare support workers. We also spoke with 12 patients and their relatives on this site. We visited preoperative assessment, the day surgery unit, all theatre suites, and the orthopaedic, general and colorectal surgery wards.

Summary of findings

The surgical service had identified for itself some areas that required improvement, and had further identified that some plans to improve were not progressing as required. We found significant safety concerns and staff told us that improving safety was their main objective. Handover processes for some nursing and medical staff were suboptimal. Basic Infection control measures, such as cleaning hands on entering and leaving ward areas, were largely ignored by medical staff. There was inconsistent security for storage of confidential patient records.

Patients told us they received good pain relief. The trust engaged with national surgical audits, but local audits to further review these findings or explore the background to results were not in place.

Patients and their visitors were happy with the care they received and told us that staff were kind and helpful. Visiting times were clear and relatives told us, “Staff were polite but firm about this.”

Medical staff showed a poor understanding of the Mental Health Act 2005 and best interest decisions when patients lacked capacity to consent.

Consultants and nurses found being involved in the devolved complaints process helpful in understanding complaints.

Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the

Surgery

trust was undertaking, which in turn affected their morale and made it harder to engage proactively with further change. Some staff were confident about this 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 started consultations with staff early in October 2014. This did not match the views expressed by staff to us in conversation or in focus groups.

Local leadership in most wards and departments was clear and senior staff were committed to act as positive and proactive role models.

Are surgery services safe?

Inadequate

We assessed surgery as inadequate in the safe domain. The surgical service had identified for itself some areas that needed improvement, but were concerned that the plan did not cover all areas required for improvement. Staff told us that improving safety was their main objective.

The process for knowing what patients had been booked for theatres was not always effective or safe, this was due to a combination issues including IT systems. Incidents reporting feedback was not always received. In addition to this staff wanted to understand the trends in theatres but this information was not available to them at the time of the inspection.

The safety data collected was not used in such a way to encourage staff and display to staff and visitors the length of time since the last patient harm incident had occurred.

There was inconsistent use of the WHO surgical checklist. We observed a number of serious breaches in infection control practices within both the ward and theatre areas.

Patient records were not consistently stored securely, which put patients at risk of confidential information breaches. Medicine storage was inconsistent.

The handover processes for some nursing and medical staff were suboptimal.

Incidents

- Surgery across both sites had reported two 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the operating theatres (across all theatre suites) in 2013/14. Two had occurred at Sandwell General Hospital of which one had implications for operating theatres. We saw that recommendations had been made to resolve some of these issues and that difficulty with the information technology (IT) systems and procedural failures had been identified as a contributory cause and raised with the trust.

- Staff we spoke with told us that there were difficulties with IT systems and bookings for patients who needed theatre procedures. Orthopaedic surgeons, in both focus groups and one-to-one conversations told us it was still of great concern to them.
- Theatre staff confirmed that they still received an occasional unexpected patient because, out of hours, theatre lists were generated inconsistently and forms were handwritten in script. Senior theatre staff told us that they reported these as incidents. The clinical director for the area (who was new to the role) shared with us the action plan that senior staff had drawn up at the beginning of October to address some of these issues. The plan had sought to redress the difficulties at a local and practical level. It deliberately avoided the unresolved performance issues related to IT because these were outside the theatres' control. However, the clinical director was concerned that these essential changes to improve patient safety had not progressed and that the plan would need to be reviewed. For example, medical staff continued to handwrite emergency patient booking forms. It was not always clear what the expected operation was, and therefore a risk to patient safety.
- Within the theatre department, senior staff showed us emails that they had sent to governance leads within the trust to get better breakdowns of reported incidents, specifically by grade of incident and by month. At the time of our inspection, this had still not been actioned even though the trust had been made aware that monthly incident reports were important for the theatres and would enable timely safety improvements. This prevented learning from incidents in a timely manner.
- Nursing staff gave us mixed responses about incident reporting. Some staff told us it was important to keep reporting incidents even though feedback was limited. Others told us there was little point in reporting them because of the poor feedback. The trust told us they thought reporting across the trust was good and that they had taken positive steps to improve it. This view was not shared by the staff we spoke with.
- Senior medical staff told us that they shared learning from incidents within divisions and groups but were less sure that they received information about learning from elsewhere in the hospital' work. Middle-grade doctors told us that feedback was variable and that grading of the incident was dependent upon the subjective view of the person who had reviewed it. Grading was done centrally by the trust. However, the experience of middle-grade doctors was that the system used did not ensure that staff could be sure of consistent grading and responses from the trust.
- Nursing staff told us that there was limited opportunity to learn from incidents because feedback was poor and not timely.
- The trust system for reviewing hospital mortality and morbidity involved both the group director and the clinical director for the care area. A template for the review process had been reviewed earlier this year to ensure consistency and enable shared learning. These meetings were sometimes postponed and therefore did not always occur monthly as planned.

Safety thermometer

- We looked for information about the NHS Safety Thermometer (a national tool used to improve patient safety) on the wards we visited. Staff told us that they used to use a safety cross (to indicate safety level on the ward) but had now moved to internal and external measures boards. The internal measures board contained information about staff levels and sickness rates. One of the nurses told us it was for staff only. We asked staff when it had last been updated because the date on display was August 2014. Staff told us it did not get updated monthly as intended. The external measures board told us what the vision for the ward was. It explained visiting times and that meal times were protected. There was a section with graphs on it which was titled 'Monthly audits for harm-free care'. Written across this was 'NO DATA'. This meant that data about safety, although recorded by the trust, was not displayed. What was displayed could mislead people as there was sample data present and only on close inspection could you see the 'No Data' wording present.
- The theatre safety dashboard captured the current rate of staff sickness and theatre vacancies, which were within acceptable parameters. However, the board did not identify any safer surgery information about audit or completing checklists. It did not identify how many days there had been since the last event or incident, which could be helpful to staff committed to improving safety. There was information about a 'new' product that was not dated. Senior staff agreed the date the product was launched should be included on the board. The theatre

safety dashboard did not capture safety information. Senior staff told us that were working with the new clinical director to improve the safety dashboards at both hospitals.

- The trust had reported three pressure ulcers of grade 3 during the past year. We did not see any management information on any of the surgical wards to reduce the risk of this occurring again. For example, on one ward, a patient was assessed as at high risk of pressure damage, but no plan to reduce this risk was identified.

Cleanliness, infection control and hygiene

- We observed that most medical staff entering ward areas failed to follow the hand hygiene protocol. Nurses in training did not always apply gel to their hands immediately before or after patient contact. We reviewed the trust-wide infection control audit and found awareness of poor hand hygiene across the trust. The audit had been completed in April 2014, and the trust took steps to further review hand hygiene in July. Although we noted that the trust results showed some positive improvement, the audit tool had failed to ensure that all staff followed appropriate hand hygiene protocols within 6 months.
- Within the theatre departments, we found that all grades of staff from all disciplines failed to put on and remove face masks appropriately. We observed that most staff pulled masks off their faces and wore them around their necks during coffee breaks, and then pulled them back up. Some staff pulled their mask off, put it into a uniform pocket and then went for a break. We asked staff why they put the mask in their pocket and they told us they would take it out and wear again later. Failure to remove the mask and dispose of it appropriately when taking a break generates the risk of infection. The staff we asked about wearing masks around their necks told us that this was what they did in theatres.
- Senior theatre staff shared the infection control action plan for theatres with us. Part of which was based on the environment for two of the three operating theatre departments. Some of the newer surfaces in the first-floor theatres had become damaged and were resistant to cleaning, which could generate an infection risk.
- We observed that theatre staff entered theatres through an ante room, thus ensuring that the clean air flow was not directly interrupted. Medical staff told us about the importance of keeping theatre doors closed. Medical staff also knew how long the air cycle took to complete so that the emergency theatre could manage any type of case safely.
- Some scrub rooms were cluttered and untidy. Personal belongings had been placed in the sterile gowning area, thereby compromising the integrity and cleanliness of the gowns worn. Senior theatre staff assured us that lockers were provided and that personal items should not be placed in the sterile gown area.
- Each ward had dedicated domestic staff responsible for ensuring that the environment was clean and tidy. Domestic staff told us that they felt part of the ward or department team.
- Ward and department staff mainly wore clean uniforms with arms 'bare below the elbow'. On one ward, we observed one member of staff in an ink-stained and unclean uniform.
- We saw separate hand-washing basins, hand wash and sanitiser in the ward bays.
- We found hand gel available for visitors and staff at the entrance to wards, but not all side wards. However, at the entrances to some wards and departments, we found some of the gel dispensers empty.
- There had been no episodes of MRSA or Clostridium difficile (C. difficile) reported on the surgical wards during the past 6 months. The trust had reported three cases of C. difficile during the past year. This indicated that the preoperative screening measures for MRSA had been effective.
- From data the trust supplied to us we saw that it had a higher than expected rate of postoperative chest infections. We asked middle-grade and junior doctors if they routinely listened to chests postoperatively and they told us this was not a routine postoperative check, although this is not part of guidance from the Royal College of Surgeons or National Institute for Clinical Excellence. Nursing staff told us that sitting patients up was an important step in reducing the risk of a postoperative chest infection. Nursing staff also told us that they asked the physiotherapists for advice when needed. During our inspection, we did not have the opportunity to observe physiotherapists providing this support.

Surgery

Environment and equipment

- We saw that the surgical wards used the green label system, which helps to prevent healthcare-acquired infection. This showed that equipment was properly cleaned in between patients, and appropriately labelled, signed and dated as ready for use.
- Within theatres, emergency equipment was cleaned and signed for.
- Senior theatre staff had taken steps to improve the tray system and to ensure that an auditable process was in place for any instrument that required replacement or repair. We saw that this was clearly identified within the storage area.
- One of the anaesthetic machine clocks was set to the wrong time on the third floor of the Sandwell site. It is important to have an accurate time for the administration of analgesia or other medications needed during surgery.
- Ward areas had suitable records of daily checks for emergency equipment, and these were up to date.

Medicines

- We found inconsistency with medication storage in the surgical wards and departments.
- Medication administration records (MARs) were not always properly maintained. During the unannounced part of our inspection, we found a MAR chart damaged and unfit for purpose. It had become stuck together which meant it was unusable. We found that the name of a prescribed medication was obscured. This could cause a medication error of dosage or administration.
- We found contrast medium (a liquid containing a dye that shows up clearly on images such as CT scans) on a note trolley and not securely stored in a medicine cupboard. We asked staff about this and they described a process whereby the contrast medium arrived with the confirmation for a scan. Staff delivering the contrast medium did not ensure that it was given to the receiving ward staff. It could therefore be lost, dropped or broken, which could result in essential diagnostic tests being delayed and have a further impact on the wellbeing of the patient.

Records

- Emergency booking forms for patients needing emergency surgery were handwritten in script. This meant that it was not always possible to be sure what the intended procedure was. Theatre staff told us that they were trying to get emergency booking forms completed electronically to reduce this risk. As an interim measure, staff booking emergencies had been asked to print on the forms, but this was not being done.
- Some staff told us that they did not know how to use the electronic system for booking routine theatre patients. This could result in patients arriving for surgery when theatre staff were not expecting them.
- We found a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form filed in one patient's notes, but it had no patient's name or identifying details on it. We drew this to the attention of the staff nurse who told us it must belong to that patient because it was in their notes. This is unsafe practice and fails to meet the essential standards for record keeping.
- We reviewed three sets of notes on an orthopaedic ward and found that nursing entries were up to date and signed appropriately. However, medical notes in each set were either incomplete or had no medical signature. This failed to meet the expected standard for record keeping and this was a legal requirement. During our unannounced inspection, we found an improvement in medical signatures in notes.
- Preoperative assessments were supported with written protocols. There was anaesthetic support for the nurse-led clinic, information regarding how to prepare patients for surgery and postoperative instructions.
- Preoperative assessments were recorded. These contained decision-making information that included conversations with patients.
- We reviewed patient records on a variety of surgical wards and found that some risk assessments were incomplete, or no action had been taken when significant risk of developing pressure ulcers was highlighted.
- Medical notes were not always kept in secure note trolleys. We found an elective orthopaedic ward had floor-to-ceiling unlockable cupboards for note storage. They had a push-to-close mechanism and we observed that one cupboard would not close at all. Staff could not tell us whether or not this had been reported.
- The day surgery unit at the Sandwell site was visited out of hours. We were (as were members of the public) able to access the reception area and the endoscopy booking office because none of the doors were locked. We found four unlocked cupboards containing patients' notes within the reception area. The keys for these

cupboards were labelled and on a hook under the reception desk. There were patient letters on top of the desk and a further set of patient notes. There was a confidential shredding safe that was overflowing. We found that documents could be removed or easily read.

- The endoscopy booking office was unlocked. We found patient notes and letters on the desk. There was an unlocked cupboard with patient booking forms for endoscopic procedures. The confidential shredding safe was overflowing in this area too. Patients were identifiable from these unsecured details. We tried to contact the hospital manager but the automated system did not understand our request. We asked ward staff to bleep the hospital manager and explained our concerns about the day surgery unit. The hospital manager took immediate steps to secure the unit.
- Patient-identifiable records must be secured at all times in order to comply with information governance standards.

Safeguarding

- Safeguarding training for adults levels 1 and 2 had been undertaken by most staff working in surgical wards and departments. For new staff this was part of their induction.
- Nursing staff we spoke with told us about the trust intranet and the flow charts for safeguarding matters. Staff were confident about who they would contact and what they would seek support with if they had safeguarding concerns.

Mandatory training

- The trust provided us with a spreadsheet of mandatory training and the percentage of staff who had completed this. With the exception of medical staff (who had only achieved an average of 33%), 80% of all other surgical staff had completed this. Over 94% of theatre staff had completed their mandatory training. The trust needed to intensify its efforts to achieve compliance of mandatory training with medical staff.

Assessing and responding to patient risk

- The trust used the national early warning system (NEWS) for all patients and used electronic hand-held devices. This enabled them to promptly identify patients who became medically unwell. We saw that, when the outreach team was required out of hours, the bleep escalation process was to call the on-site hospital managers. These managers were clinical nurse practitioners and would support the night staff to reassess a patient before an anaesthetist was called.
- The trust used a bed ratio and dependency (BRAD) acuity tool daily to ensure that there were sufficient staff to safely meet the needs of the patients on the ward.

Use of 'five steps to safer surgery'

- We found that not all the World Health Organisation (WHO) surgical safety checklists were completed. We observed that staff in one anaesthetic room failed to carry out the WHOSC check. Most of the checklists we spot-checked had either not been signed by the whole team or had only been partially filled in.
- We observed variation in the way patients were checked into the operating theatre department. Some staff took time to ask people questions and repeat them when needed, so that patients could answer. Other staff leant against the wall and went through a checklist asking questions that patients were required to answer 'yes' or 'no' to.
- Some theatre staff had taken ownership of the 'safer steps' and ensured that all staff within the theatres checked the appropriate equipment, procedures and operation at required times.
- Senior staff we spoke with told us that they and the clinical director were involving theatre staff in a review of the checklist. This would ensure that band 6 staff had greater confidence and support to challenge medical staff when appropriate. The team brief should ensure that all staff are encouraged to ask questions about the surgical procedures to be carried out. This makes the operating theatre a safer place for patients.

Nursing staffing

- Wards and departments had expected and actual staff numbers on display. Nursing staff on most wards and departments worked 8- or 12-hour shifts. The Health and Safety Executive identified that long shift patterns could increase workers' fatigue levels and contribute to safety-related incidents. Most wards and departments had clear leadership with substantive leaders in post.
- Ward and department managers told us that they tried hard to ensure the skill mix was suitable to safely support the patients in their care.

- Nursing handovers did not always use the trust procedure for a printed handover list. Handovers on some wards took place in one bay area with patients present. Confidential patient details were disclosed, which was not appropriate.
- We observed another ward where patients were not acknowledged by the nursing staff who were talking about them. Again we noted that confidential information was shared in an open area and could be overheard.
- When agency or bank staff were needed, staff from all wards and departments told us that this could be a very difficult process.
- The trust had told us that, when bank or agency staff were needed, they were committed to ensuring that they were regular staff on a dedicated agency contract. Bank staff were the trust's own staff who were paid a premium rate to support shifts at short notice. Staff told us that the bank booking system closed at 6pm, which could be frustrating when extra staff were needed at short notice or overnight.
- The standards expected by the trust were not experienced by the staff requesting agency staff. We were told by staff on several wards and departments that the booking system was cumbersome, took an overly long time and was sometimes not responded to in a timely way, which resulted in the shift shortfall not being covered.
- Staff had to fill in a request, then send it to the matron, who sent it to the divisional nurse, who sent it to the executive nurse. Staff told us that sometimes they got a fast response for approval, which was 3–4 hours. Some senior staff told us they felt that the system was designed to be obstructive. More senior staff told us that the executive nurse did not understand the issue and should spend time with them to understand the problems. We observed that the current process prevented staff from getting the help they needed in a timely manner.

Medical staffing

- The trust had a higher number of registrars (middle-grade doctors) to consultants compared with the England average. This made the on-call arrangements for general consultants more challenging across both sites. The trust have told us that they have plans to reduce this burden on general consultants. However, some of these plans were in the early stages of development and consultants expressed concern about the on-call patterns they worked. The current pattern expected consultants to do more on-call work than trusts of similar size.
- There were always junior and middle-grade doctors on duty for the surgical service. Out of hours there were always two consultants on call. Some breast surgeons formed part of the general surgical on-call group (this is not recommended in the Association of Surgeons of Great Britain and Ireland guidelines) because there were not enough general surgeons to support the on-call arrangements. The trust told us that it knew about this issue and would work to resolve it.
- Consultants conducted ward rounds for all patients (that is, both planned and emergency admissions) on both Saturdays and Sundays.
- The surgical handover was well organised with a printed list of patients, working diagnosis and tests undertaken so far. At the handover, the team just going off duty went through each patient with the team coming on duty. Concerns were explored and further tests requested as part of the next team's job plan if needed. Patients for theatre or discharge were identified. A clear job plan was drawn up and surgical doctors knew where they were going on rounds and what surgical or medical interventions patients required.
- The trauma and orthopaedic handovers were not structured and there were no dedicated printed lists. From our observations, it was unclear which patients required theatre and which patients had been admitted during the last shift. From the information the trust had sent us about theatres, we saw that trauma and orthopaedic surgeons added steps to the process that could result in safety error. For example, there were three people involved in coding the operation before surgery for the list. We observed that the lack of organisation at these handovers could be a significant contributory factor in the safety issues with booking trauma and orthopaedic patients for theatre.

Major incident awareness and training

- Staff we spoke with were aware of the trust procedures for major incidents. Staff could tell us about the table top reviews they completed annually and that the trust intranet provided detail and information about these events. Staff told us that the last big rehearsal had been e years ago.

Surgery

Are surgery services effective?

Requires improvement

We assessed this domain to require improvement.

Fluid balance charts were not used in a planned way and were not reviewed to ensure patients who required the additional monitoring of fluid intake was achieved.

The general surgeons were in negotiation regarding their job plans, they were in place but were in dispute at the time of the inspection.. Medical staff showed a poor understanding of the Mental Health Act 2005 and best interest decisions when patients lacked capacity to consent.

The trust engaged with national surgical audits such as patient reported outcome measures for both hip and knee surgery. The results were in line with the England average. Patients told us they received good pain relief. We saw there was good multidisciplinary working within the department, and access to seven day services.

Evidence-based care and treatment

- The trust participated in a number of national audits. For example, the national neck of femur audit and the national bowel cancer audit.
- We saw that guidance was produced for preoperative assessments in line with best practice, including the National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland guidelines. This meant patients could be certain that appropriate assessments would be carried out to ensure that they were medically fit for their operation.
- Best practice guidelines were followed for the enhanced recovery programme for some elective surgery such as colorectal surgery. Enhanced recovery programmes are designed to enable patients to recover to full health as quickly as possible after surgery.
- We asked consultant surgeons if they had audited the rate of postoperative chest infections; they had not.

Pain relief

- The trust supported postoperative patients with patient-controlled analgesia, or epidural pain relief. We asked the trust about the entire audit processes completed during the past year and those that might still be in planning. We saw that the trust did not audit the benefit of epidural pain relief against less invasive and less labour intensive pain relief methods. Best practice guidelines for epidurals indicate that the decision to continue using epidural techniques should be guided by regular audits and risk–benefit assessment.
- The preoperative assessment for postoperative pain relief prepared patients to use patient-controlled analgesia. Patients told us that they felt well prepared especially when using patient-controlled analgesia. They also told us that they did not have to wait for pain relief.
- There was a dedicated trust-wide pain team available Monday to Friday ‘in normal working hours and that an anaesthetist provided this cover out of hours.

Nutrition and hydration

- Fluid balance charts within the surgical assessment unit on the Sandwell site were incomplete. We asked staff if they identified patients who would need a fluid balance chart. We were told that all patients in that area had a fluid balance chart. This meant that some patients who did not require a fluid balance chart were monitored. However, for patients who needed a fluid balance chart maintaining accurately, the lack of accurate measurement and proper completion could have an impact on the care they received.
- We found that patients had food and drink within their reach at meal times.
- Meal times were protected, which meant that wards had as few visitors and interruptions as possible when patients were eating.
- If patients needed help to eat or drink, staff were free to give this.
- Relatives and other visitors we spoke with told us that they were happy with the way this worked. Patients we spoke with told us that snacks were always available if they wanted them.

Patient outcomes

- The trust took part in the national bowel cancer audit. It had mixed results, which meant it should further explore some of these areas (for example, how many of the patients with bowel cancer were seen by a specialist nurse).
- The trust took part in 18 local audits for 2013/14.

- The trust undertook patient reported outcome measures (PROMs) for both hip and knee surgery. These were largely in line with England averages.
- The trust did worse in the national fractured neck of femur audit than the England average on 6 out of 10 measures assessed (for example, patients who developed pressure ulcers after surgery). This corresponds with our findings that people at risk of developing pressure ulcers did not have an appropriate management plan.
- Using the commissions latest methodology shared with the trust for the standardised relative risk of readmission, we found that Sandwell Hospital was worse than expected in all specialties except elective urology. We asked about further audits in this area. Staff we spoke with were not aware that they had a higher readmission rate for surgical patients across the trust.
- The hospital had an emergency department (A&E) at both Sandwell and City Hospitals. This meant that either site could provide emergency surgery. Sandwell Hospital had a staffed emergency theatre. National Confidential Enquiry into Patient Outcome and Death (NCEPOD guidance 2003 for non-elective surgery in the NHS) standards for unscheduled care require a staffed emergency theatre on a site where non-elective surgery could be needed.

Competent staff

- Surgeons told us that they had not had their job plans updated or reviewed for over three years. One consultant told us about a review of workload which had taken place but had asked for it to be signed off twice and senior management had failed to do so.
- The NHS Employers organisation and the British Medical Association (BMA) together produced a guide to consultant job planning. Consultant job planning would be an important part of organising resources effectively and efficiently.
- Surgeons took part in revalidation and were keen to explain the successes of the surgical department. The surgeons were positive and passionate about the improvements they had made to the quality of the service, but found not having a job plan an arduous burden.
- Nursing staff, healthcare support workers and ward clerks on surgical wards and departments all received annual appraisals. The document the trust provided us with recorded 100% of consultant staff as having completed an annual appraisal for the past financial year.

Multidisciplinary working

- There was some good multidisciplinary team working making the hospital team at night effective (for example, radiography staff were supportive if surgeons needed an opinion or further scan). However, there were concerns when surgical doctors required support from medical doctors. The surgeons told us that they were used to multiple teams supporting a patient when their condition needed input from more than one medical specialty. However, doctors from medicine did not engage as readily as other specialty groups, which put extra pressure on the surgeons.
- We saw that the colorectal team had a positive multidisciplinary approach to patient care. Records showed that the team communicated effectively and followed up patients in a timely manner.
- There were suitable arrangements in place for the transfer of patients between sites when this was required.

Seven-day services

- Consultants conducted daily ward rounds after each morning handover. After the evening handover, the middle-grade doctors conducted ward rounds.
- Consultants were on call for all out-of-hours periods and conducted ward rounds on both Saturdays and Sundays for all surgical patients.
- Arrangements were in place for out-of-hours imaging support. Middle-grade doctors told us that they did not encounter issues when urgent imaging was needed as part of the diagnostic process.
- Staff told us that there was no out-of-hours pharmacy support.

Access to information

- The day surgery unit provided leaflets about a large number of procedures and what to expect; this was an important part of preparation for surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical notes did not include suitable information about how decisions were reached if a patient did not

have capacity to consent. We saw that consultants recorded decisions without reference to the best interest decision process required. When learning disability specialists had been involved in the care for a patient, we saw that their advice had been ignored.
- Junior doctors we spoke with were not able to tell us about the requirements for consent when a patient lacked the capacity to make the decision for themselves.
- One junior doctor looked on the trust's intranet in response to our enquiry, and found the information required.

Are surgery services caring?

Good

Patients and their visitors were happy with the care they received and told us that staff were kind and helpful. Visiting times were clear and relatives told us, "Staff were polite but firm about this."

Compassionate care

- Patients and their relatives told us that they were happy with the care they received.
- One relative visiting at the Sandwell site told us that the care was good and had changed her mind about the hospital.

Patient understanding and involvement

- Patients and their relatives told us that they were happy with the care they received.
- One relative visiting at the Sandwell site told us that the care was good and had changed her mind about the hospital.

Emotional support

- Clinical nurse specialists were available for specialties including breast surgery, colorectal surgery and pain. This was to support patients including their emotional needs.

Are surgery services responsive?

Requires improvement

We found this domain required improvement.

Delayed discharge was an issue with patients waiting for medication causing them to be delayed in leaving the hospital.

Referral to treatment (RTT) time was worse than the national average in meeting the 18 week target.

Consultants and nurses found being involved in the devolved complaints process helpful in understanding complaints.

GPs were able to refer patients directly to the surgical assessment unit, which ensured that they did not have to wait in accident and emergency (A&E) before being seen.

Service planning and delivery to meet the needs of local people

- Patients could be referred directly by their GP to the surgical assessment unit or be admitted via the A&E. This ensured that patients did not have to wait in A&E before being seen or treated.

Access and flow

- We found that theatre sessions mainly started and ended on time.
- Patients needing to be transferred from the surgical assessment unit could be delayed because of a lack of available porters. Staff told us that porters did not come when requested and showed us a day-to-day log that indicated how long patients had waited to be transferred. They said they did not always bother to report this and sometimes took patients to other departments themselves. This took a nurse or healthcare support worker away from the assessment unit.
- Patients could be late being discharged because of a lack of available medicines. Staff told us that there was no out-of-hours cover from the pharmacy and that some patients were asked to collect their medications the following day.
- Patients needing treatment for fractured neck of femur were seen by a consultant and operated on within 48 hours of admission, as required by best practice pathways and guidance.

Meeting people's individual needs

- The trusts referral to treatment (RTT) time percentage within 18 weeks for three specialties was worse than the

England average with Trauma & Orthopaedics performing worst. The other two were general and plastic surgery. However, the other surgical specialties were meeting the RTT rate.
- On average the trust performs better than average on cancelled operations not treated in 28 days.
- The trust had a variety of translation services. These included pick and point cards, multilingual staff and a commercial translation service. The commercial translation service was accessed via a twin handset telephone. We saw that there were twin handset telephones available on most surgical wards and departments.
- The trust had a specialist nurse for learning disabilities who was able to provide advice and support to ward, department staff and patients when needed.
- Some surgical wards had taken steps to make the environment dementia friendly.

Learning from complaints and concerns

- The trust told us that it had recently changed the way it managed complaints. The new process was a devolved complaints system. This meant that clinicians involved in treating patients would investigate complaints about peers or neighbouring areas. Staff would not be able to investigate complaints that were about the care they had given.
- All complaints were overseen by a complaints manager to ensure that they had been answered appropriately and in a timely manner. The chief executive reviewed every complaint response before it was sent out to the person who had complained.
- Consultants told us that they found being involved in complaints useful as a learning tool.
- Nursing staff told us that they were sometimes involved in looking at complaints and that they tried whenever possible to resolve issues as they arose for patients.

Are surgery services well-led?

Requires improvement

We judged this domain to require improvement. Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking which in turn affected their morale and made it harder to engage proactively with further change. Some staff were confident about this review whilst others felt insecure.

Local management represented an area of improvement due to inconsistent or lack of departmental management in substantive posts. Although a new clinical director was in place and staff felt optimistic about this.

The culture was not one of team work; staff did not always feel their professional opinions were taken into account when raising concerns or when changes were being implemented.

There was a shared vision within surgery staff we spoke to mentioned the 6 C's care, compassion, competence, communication, courage, commitment.

Vision and strategy for this service

- Senior staff in theatres knew what the vision and strategy for the department were and that they involved the 'six c's': these were care, compassion, competence, communication, courage and commitment. Some staff understood that improving safety was the focus, and they too told us about the six c's, as did ward staff and those in other departments. This meant that all the surgical divisions shared and understood the vision and strategy for the service.

Governance, risk management and quality measurement

- We reviewed one of the 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) reported by the operating theatres.
- The information given to the patient should have been clearer about their procedure and related it to the expected surgery. Best practice consent processes would ensure that the patient received sufficient information about their surgery. This was the learning the trust took from the investigation and in no way makes the patient culpable.
- The consent process was considered to be part of the problem and a contributory factor in the root cause analysis. Changes to the consent process were included as part of the recommendations.
- We noted that the investigation did not identify one of the contributory factors, such that the same or similar incident could re-occur. This indicates that the root

cause analysis process was not sufficiently robust to correctly identify all contributory factors and system errors. Checking with the patient their understanding of the anticipated procedure is part of best practice in 'five steps to safer surgery'.
- This incident took place on one site and the learning from the review was shared across theatres on both of the Trust's acute hospitals.

Leadership of service

- The clinical director responsible for theatres had identified some areas for safety improvement, but there was no substantive or consistent directorate management in place to support these essential changes. This may be partly due to the fact that temporary management was in place at the time of the inspection. For example, the World Health Organization (WHO) surgical safety checklist was audited electronically and not directly. This enabled the audit to generate a positive result that did not account for omissions and members of staff who did not take the time to sign the document. The clinical director told us that they planned to make changes to how the WHO surgical safety checklist was managed. Some staff told us that they did not peer audit the checklist and that this had been considered as a possible development.
- The guidance does not need the checklist to be signed. However, if the decision had been made locally to require a signature on the checklist, then this would have been done. We found that the checklist in use at the trust required a signature.
- The new clinical director showed commitment to improving patient safety within the theatre environment and had drawn up a plan to address immediate issues.
- The clinical director was responsible for reviewing a current hospital death. There was a dedicated template and the trust sought to share learning through the mortality and quality meetings. The trust sent us minutes from mortality and quality meetings held during the year.
- Senior theatre staff told us that they felt supported by the new clinical director and were confident that changes would be made to further improve safety in theatres.
- Management of the surgical divisions had been destabilised by a lack of consistent senior management. The trust had either interim managers or vacancies within the surgical divisions' senior management structure. This meant that there was no consistent support for the general surgeons and their day-to-day management issues.
- Also, the lack of stable management support had caused stress for the general surgeons. In both focus groups and individual discussions, they told us how frustrated they had felt by the absence of consistent management within surgery. We could not find evidence that the trust had taken suitable steps to ensure that the surgeons felt supported while their managerial support was not substantive. The surgeons told us that they were committed to, and keen to work with, the trust, but the lack of stable divisional management had led to their feeling unsupported.
- Surgeons were in dispute with senior management regarding the job planning process. They had discussed this issue with senior management staff and requested a review of job plans. On one occasion, agreement had been reached but the job plan remained unresolved and unsigned at the time of the inspection.
- The consultant job plan is a key mechanism through which the shared responsibility of providing the best possible patient care with the resources available can be agreed, monitored and delivered. Management should not abdicate its share of the responsibility in this mechanism.
- Nursing staff in both focus groups and individual consultations across both sites told us that they were concerned about the process senior leadership had developed for requesting agency staff. Senior nursing staff expressed concern that this process was obstructive and time consuming. The length of time it took could result in shifts being understaffed.
- The management of the bank staff system could be a factor in the volume of requests for agency staff out of hours.
- Senior staff from both wards and departments told us that the executive nurse did not come and see them to understand their issues. They expressed the view that the executive nurse managed remotely and had not accepted offers to spend time on some wards and departments or with some senior staff to see the issues at first hand.
- Staff from surgical wards and departments told us that they had not seen the executive team on their 'First Friday' walkabout. However, we were made aware that one of the executive team works regularly in theatres,

and the CEO visited four times in 2014.The trust told us that it used the 'First Friday' initiative to see wards and departments at first hand. Information supplied to us following the inspection indicated that the executive team did visit the area.

Culture within the service

- We found that there were differences in the way that theatres undertook morning briefings and sending for their first patient. The discussion at the briefing should include each patient and any potential problems or challenges. Although this was trust policy, it did not always correlate with the distance between wards and theatres. Although there is no prescriptive guidance for when a briefing takes place, they are about informing the whole team about what is going to happen during the surgical list. The guidance advises that local policy should take account of the local geography and the distance from theatres of wards or admissions units. Staff told us that this led to a non-collaborative culture, which generated inconsistencies in practice, because the patient could arrive in theatres before they had finished the morning briefing. This added the risk that staff would cut short the briefing because the patient had arrived.
- Theatre staff told us that they found managing the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) theatre challenging out of hours. The emergency theatre was expected to have a risk-based protocol to enable emergency patients to take precedence over urgent patients. Theatre staff told us some consultants ignored the theatre utilisation policy that set out the criteria for determining whether or not a patient should be operated on in the NCEPOD theatre. Staff felt that this was a non-collaborative culture and did not enable the building of an effective team culture.
- Some staff told us that they had challenged some surgical consultants regarding the use of the NCEPOD theatre, and been supported by the anaesthetist. However, they expressed concern that consultants would sometimes behave inappropriately when a challenge was made. They would display defensive type behaviours. Staff told us that they felt uncomfortable about pursuing their concerns when challenge was unwelcome and not responded to in a collaborative manner.
- General surgeons told us about the tendency within senior management at the trust to email consultants about important changes. Although the consultants told us that they usually agreed in broad terms with the subject of the emails, they felt the tone and method disempowered and excluded them from being involved in seeking active solutions to surgical problems.
- The trust used a variety of printed and electronic methods to communicate, such as its news sheet, email, chief executive question and answer sessions and a monthly executive team First Friday' walkabout. However, general surgeons told us that they did not feel fully informed about changes to surgical on-call processes, and trust plans to separate breast surgery from general surgery for on-call purposes. General surgeons were concerned about on-call commitments and did not feel these had been addressed. The disconnect between the executive team and the management of the surgical division could have contributed to the surgeons feeling less informed than the trust believed they were. The trust confirmed to us that it was fully aware of this disconnect within the surgical division and executive management team.

Public and staff engagement

- The trust had set up a '10 out of 10' challenge. They explained to patients and visitors what this meant to them and encouraged these patients and their visitors to challenge staff about their treatment and experience at the trust.
- Some ward areas used an electronic hand-held device for the NHS Friends and Family Test. This enabled patients to record their views in real time once their care had been completed.
- The trust had an internal award scheme for staff. We saw that a number of staff from surgical wards and departments had received nominations for leader of the year. Staff told us that this scheme made them feel appreciated by the trust.

Innovation, improvement and sustainability

- The experience of general surgeons working without agreed job plans was not sustainable and could impede the development of the surgical department.
- The general surgical consultants would be keen to see consultant-led research clinics as part of their role. This could be both innovative and part of an improvement programme.

Critical care

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

Information about the service

The intensive care unit (ITU) at Sandwell and West Birmingham Hospitals NHS Trust has capacity to care for up to 14 level 3 patients across the two sites at City and Sandwell Hospitals. The unit provides both level 3 care, which is for patients requiring one-to-one support (such as those ventilated) and level 2 intensive care beds for high dependency care. The outreach team provides support in the care of critically ill patients who are on the wards. The critical care service has consultant cover 24 hours a day, seven days a week. The two units function as a single service to address capacity and demand.

We also looked at the coronary care unit at Sandwell General Hospital. It is a 20-bed unit.

As part of our inspection, we spoke with 28 staff, five patients and six relatives across both sites for critical care. Within coronary care, we spoke with four staff, seven patients and five relatives. We talked with a range of staff including nursing staff, junior and senior doctors, a physiotherapist and managers. We observed the care and treatment patients were receiving and viewed 17 care records (seven within coronary care). We sought feedback from staff and patients at our focus groups and combined listening events.

Summary of findings

There were effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. Medicines, including controlled drugs, were safely and securely stored.

Patients received treatment and care according to national guidelines. The intensive care unit (ITU) was obtaining good-quality outcomes as shown by Intensive Care National Audit and Research Centre (ICNARC) data.

We found there was good multidisciplinary team working across the unit.

Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were happy with the care provided.

There was strong medical and nursing leadership within the critical care unit. Staff felt well supported within an open, positive culture.

Critical care

Are critical care services safe?

Good

The intensive care unit (ITU) had effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. The environment was clean and staff followed infection control procedures. There were good systems for monitoring NHS Safety Thermometer data and improving practice. Medicines, including controlled drugs, were safely and securely stored.

Incidents

- There was a good system for learning from incidents. All incidents were reported and reviewed, and action plans developed. Staff were updated on the outcomes of incident reports via monthly emails.
- Mortality and morbidity meetings were held 6-weekly. All incidents of death and poor outcomes for patients were reviewed, and appropriate action was planned and implemented to improve outcomes.

Safety thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm. The audit covers the development of new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- Information from the Safety Thermometer was monitored alongside nursing documentation to ensure that specific ITU-related clinical checks were being made. For example, we saw monitoring of sedation scores and checking of endotracheal cuff pressure and other safety checks were undertaken.
- Action plans were developed whereby, if 100% compliance was not gained, learning was shared with staff to improve results.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission and throughout their stay, and prophylactic therapy was initiated for VTE prevention.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to. There were hand-washing facilities and protective personal equipment (PPE), such as gloves and aprons, available. We observed staff changing their gloves and aprons between patients. People entering the unit were asked to wash their hands.
- Since April 2014, there had been no incidences of MRSA. There had been one incident of Clostridium difficile (C. difficile) in the same timescale.
- There were effective arrangements for the safe disposal of sharps and contaminated items; these included dating when the sharps box had begun to be used. All sharps boxes we inspected had their lids closed.
- The latest hand hygiene audit, completed in October 2014, showed that the staff had achieved 95% compliance. This audit was repeated ahead of the monthly schedule if 100% compliance was not achieved.
- The Intensive Care National Audit and Research Centre (ICNARC) data reported low levels of infection rates in the ITU. ICNARC is a research centre that collects national audit data on clinical outcomes in critical care, so that units can benchmark themselves against similar units and ultimately improve patient outcomes.

Environment and equipment

- We found equipment was clean and fit for purpose.
- There were regular safety checks of medical equipment used in the ITU and these checks were signed by the individual doing them.
- Equipment was serviced on a routine basis by the medical electronics department. Specialist equipment such as ventilators, haemofilters and cardiac monitors were on a service contract with the respective companies.
- The resuscitation equipment was checked daily and records of these checks were maintained. However we noted a couple of days that did not have signatures. Although this was a minority it displayed an inconsistency in practice.
- The unit environment was bright and spacious and in good decorative order. There was adequate space between each bed area.
- There was a specific room for relatives to stay in, and also a sofa bed for them to use.

Critical care

Medicines

- Medicines, including controlled drugs, were safely and securely stored. The medication records we looked at during our inspection were found to accurately reflect the prescribed and administered medicines for the patients concerned.
- Fridge temperatures were monitored daily; this ensured that medicines were maintained at the recommended temperature. We saw that the staff doing the checks signed on their completion.
- There were arrangements for access to medicines out of hours. The ITU had its own dedicated pharmacist who visited the unit daily, Monday to Friday, and reviewed all medical prescriptions to ensure that sufficient stocks were available.

Records

- There was standardised nursing documentation kept at the end of each patient's bed. Observations were recorded clearly.
- All medical records were in paper form and followed the same format; this meant that information could be found easily.

Consent and Mental Capacity Act

- Staff we spoke with were aware of the Mental Capacity Act 2005 and how this related to the patients they cared for.
- The nursing documentation contained a specific section on mental capacity assessment, which ensured that each patient in the ITU was assessed on each shift.
- There appeared to be a lack of understanding of how Deprivation of Liberty Safeguards (DoLS) had an impact on critical care patients. Some staff we spoke with said they would appreciate more training on this.

Safeguarding

- Staff completed training on safeguarding vulnerable adults and children as part of their mandatory training and updates.
- Staff showed an understanding of safeguarding procedures and the reporting process.

Mandatory training

- The unit had a training plan for all nursing and medical staff to ensure that they met their mandatory training targets. Each month the governance team told the nurse manager which staff needed specific training.
- Ninety-four per cent of staff had completed their mandatory training.

Assessing and responding to patient risk

- There was an outreach team that provided support seven days a week from 7.30am to 8.30pm for the management of critically ill patients across both hospital sites as an integrated service. The purpose of the service was to assess acutely ill or deteriorating patients on wards, and to provide advice to the patients managing teams on monitoring, investigations and management plans. The aim was either to stabilise patients at ward level and so avoid the need for escalation to critical care, or to facilitate timely referral and admission to critical care when a higher level of care was required. The team also followed up patients after discharge from critical care, in order to optimise their recovery. There was also a hospital at-night team. The outreach service had submitted a business plan to provide a 24-hours service and was awaiting the outcome.
- The national early warning score (NEWS) of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. The hospital used a computerised system whereby all observations were electronically recorded. This enabled staff to access information from elsewhere in the hospital and where required could escalate appropriately.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patient's condition. This meant that deteriorating patients would be identified and action or escalation to the appropriate team initiated without delay.

Nursing staffing

- The staffing roster was planned and staff worked on a rotational basis of days and nights. All level 3 patients were nursed one-to-one and level 2 patients had one nurse to two patients.
- The nurse manager told us that they tried to cover staff shortfalls with their own staff, and the use of agency staff was being reduced. When agency staff were used, they were given an induction to the unit before starting work.

Critical care

- Nursing staff were moved across the acute sites to respond to capacity and demand. The staff we spoke with acknowledged that this was a requirement of their role.

Coronary Care

- Staff were concerned about staffing, but used bank and agency staff to cover shortfalls. No agency staff were in the unit on the day of our inspection.

Medical staffing

- Care in the ITU was consultant led and delivered. ITU Consultants provided cover seven days a week 8am to 6pm and were available on call at other times. They lived within 30 minutes of the hospital and were readily available and easily contactable. Staff said there were no problems contacting consultants or getting them to come to the unit out of hours.
- All admissions to the unit were discussed and admitted under a consultant.
- Comprehensive handovers were undertaken twice a day and each patient was discussed. They were in written format and kept by each patient's bed. Potential admissions from the medical assessment unit were also discussed at the morning handover.

Major incident awareness and training

- Major incident plans were in place and staff were aware of how to access information.
- Staff were aware of their roles and the procedures in the event of a fire.
- The trust had produced a Business Continuity Plan Policy to guide staff in the event of a major incident.

Are critical care services effective?

Good

Patients received treatment and care according to national guidelines. The intensive care unit (ITU) was obtaining good-quality outcomes as shown by the Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. However, the full multidisciplinary team did not attend all ward rounds.

Evidence-based care and treatment

- The Intensive Care Society guidelines were implemented to determine the treatment provided.
- There were care pathways and protocols in use (for example, a ventilator associated pneumonia (VAP) care pathway). These ensure that staff are following and delivering care in a consistent manner to ensure the best outcomes for the patients.
- Nursing documentation had not been reviewed since 2003. There appeared to be a disconnect between the descriptors used on the ITU charts and in the core care plans. The management was aware of this and the nursing documentation was currently under review.

Pain relief

- Patients' pain scores were assessed and documented. There were clear links between the pain scores and the level of analgesia administered.

Nutrition and hydration

- Staff in the unit used the malnutrition universal screening tool to assess the nutritional needs of patients.
- In the ITU, staff followed a protocol for the hydration and nutrition of ventilated patients, and initiated enteral tube nutrition. Support from a dietician was available Monday to Friday.

Patient outcomes

- There were low mortality rates in the unit.
- The ICNARC data outcomes compared well with national comparators. The length of stay was similar or better for all the measures when compared to the national average.
- Both measures for unit acquired infections in blood for ventilated patients were consistently better than the national average.
- Emergency surgical admissions patient outcomes were better than the England average for three out of the five measures for example unit mortality and length of stay.
- Out of hours discharges were slightly worse than the England average for the last quarter, but the previous two quarters it had been better than average.

Competent staff

- All staff received one-to-one supervision and appraisals. These processes covered training and development

needs and practices. Eighty-four per cent of staff in the directorate had completed their appraisal. Staff we spoke with said that their appraisal had been well conducted and linked to training plans.
- All nursing staff new to the unit had a comprehensive 6-week induction, during which they were supernumerary.
- Over 60% of the nursing staff had the post-registration award in critical care nursing. All staff were working towards the national ITU competencies and were being assessed by a mentor.
- There was one paediatric stabilisation bed in the unit. These patients were always accompanied by a registered children's nurse from the ward. Staff in the unit had in-house training on caring for these patients.
- Medical staff had weekly two-hour education sessions. All junior medical staff were allocated to mentor.
- 84% of staff had received appraisals in the last year.

Coronary Care

- New staff to the unit were given competencies that they had to achieve within an 18-month period to ensure that they had the skills and experience to support patients in the unit.
- Once staff had completed 18 months in the unit, they had the opportunity to undertake a coronary care course; 40% of the staff had done this.

Multidisciplinary working

- There was a multidisciplinary team that supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff. The lead nurse attended the doctors' ward rounds. The pharmacist attended them when possible. Patients told us that the unit's team worked well together: "They support each other and don't bicker."
- There was adequate support and input from dietetics and physiotherapy, whose staff obtained patient updates from the nurses caring for the patients. This would include their clinical condition and plans made on the ward round. Microbiology staff did a daily ward round and were available for advice at weekends.
- Within the ITU there was an outreach team that was fully integrated and provided valuable support in the care of the critically ill patients. Members of the team obtained daily updates from the nursing staff on patients' planned discharges from the unit.
- There was a 'follow-up service' that monitored patients' physical and psychological needs after discharge from the unit. Staff from the service held weekly focus groups for past patients to return to the unit to discuss their experiences.

Seven-day services

- There was consultant cover for patients in the unit from 8am to 6pm, and an on-call service out of hours.
- There was 24-hour consultant cover. The consultants carried out twice-daily wards rounds and were available for advice and support at other times.
- Pharmacy, dietetics and microbiology staff were available Monday to Friday and physiotherapists 7 days a week. Pharmacy and microbiology staff were available on call at weekends.
- There was an outreach team that provided support 7 days a week from 7.30am to 8.30pm for the management of critically ill patients in the hospital.

Are critical care services caring?

Good

Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were happy with the care provided.

Compassionate care

- We observed staff caring for patients in a kind and professional manner. Care was compassionate in its nature. We saw that patients were treated with respect and dignity at all times. Nurses were attentive and had a good rapport with patients.
- One patient told us, "Staff are exceptionally caring, very attentive even though busy."
- Patients had scored the unit between 85% and 100% in the NHS 'Friends and Family' audit over the past few months.

Patient understanding and involvement

- Patients and relatives spoke very highly of the staff. Relatives told us that they felt they were kept informed and treated sensitively with understanding.
- One relative told us, "Care has been excellent. Staff have been very attentive."

Critical care

Emotional support

- Documents supplied by the trust indicated that counselling was available to patients. We did not speak to anyone who had used the service.

Are critical care services responsive?

Good

We judged this domain to be good. The ITU was run in such a manner that ensured both planned and emergency admissions were accommodated.

Translation services were in place for people whose first language was not English. However complaint signposting literature was only available in English. Staff felt that where complaints had been received they were updated on feedback which could have an impact on their practice.

Service planning and delivery to meet the needs of local people

- The number of patients admitted was based on the number of available nurses, worked out on a points system over the two critical care unit sites based at Sandwell and City Hospitals. This allowed them to be flexible in managing capacity over the two acute sites. It appeared to meet the demand of the local patient population, except during periods of unpredictable activity. Critically ill patients could be looked after on the wards by outreach staff until a bed became available.
- Staff ensured that patients were cared for in gender-appropriate areas of the unit using single rooms if possible. The unit had 10 single-sex breaches during the period April–September 2014. The staff tried to arrange timely discharge out of the unit whenever possible to prevent gender breaches. This was because as a patient became well and were classed as level 1 they needed to be cared for in none mixed accommodation.
- The staff were assessing their potential unmet need (for example, high-risk surgical patients and deteriorating patients).
- The bed occupancy for adult critical care beds was 85% across the trust, which was similar to the England average. The Department of Health has found that bed occupancy rates exceeding 85% in acute hospitals are associated with problems dealing with both emergency and elective admissions. However, scope for flexibility to meet demand had been identified by the trust as a current issue and was red (high risk) rated on a risk register (02/09/2014 Surgery A Risk Register – Group Level – August 2014). Although the trust had identified control measures, it had not reduced the risk.

Coronary care unit

- There had been no single-sex breaches in the coronary care unit in the past 6 months.

Access and flow

- The length of stay in the ITU was similar to that for similar units compared with the national average of around 3.8-4.6 days.
- Early readmissions that were admitted to the unit within 48 hours of discharge were similar to the national average of 2%. Of the last three quarters Q4 of 2013 was very slightly elevated.
- Out-of-hours discharge delays (that is, patients' discharge between 10pm and 7am) were below those for similar units compared with the national average.
- Delayed discharges were below those for similar units compared with the national average.
- Non-clinical transfers out (that is, patients discharged to a level 3 bed in an adult ITU in another acute hospital), were lower or similar to the national average of less than 1%, however in the last quarter result there was a spike of 2%. The timeframe for this was 01 January to 31 March 2014.

Meeting people's individual needs

- The unit had access to translation services. Staff could contact the NHS interpretation service by telephone.
- Staff were aware of how to support people with learning disabilities. For example, they told us how they would use people's learning disability passports within their plan of care. The passports contain information about the person with learning disabilities which staff use to support the person appropriately. There was a lead nurse for learning disabilities who provided support to staff on the unit.
- There was a lack of staff training for caring for people with dementia. This meant that staff did not feel confident in caring for people with this diagnosis.

Learning from complaints and concerns

- Information on how to make a complaint was available to patients and carers. However, we noted that the complaints leaflet and other information leaflets were

only available in English, whereas the hospital cared for a multicultural population. This meant that patients who did not read English may not have been able to make complaints.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings.

Are critical care services well-led?

Good

There was strong medical and nursing leadership within the critical care unit. Staff felt well supported within an open, positive culture.

Vision and strategy for this service

- The matrons and the clinical lead were involved in the development plans for the critical care services in the new hospital, the Midland Metropolitan.
- Both the matrons and the clinical lead felt that the constant change and reduction in middle management had led to a lack of communication between the clinical teams and the executive team.
- Staff said the executive team was not visible within the unit.

Governance, risk management and quality measurement

- There were 6-weekly multidisciplinary governance meetings and morbidity and mortality meetings.
- The unit had a risk register with clear action plans that were regularly reviewed. Items for inclusion on the risk register were identified by senior clinical staff. Some items had been identified by analysis of incident reporting.

Leadership of service

- There was strong leadership from the matrons and the clinical lead.
- The matrons were very visible within the clinical environment. Staff we spoke with articulated their respect for the matrons.
- The staff felt valued members of the team and this was reflected in the low turnover of staff in the unit.
- All the staff we spoke with said they were well supported by their managers.

Culture within the service

- Staff spoke of being proud of the open, supportive culture in which they worked.
- One member of staff told us, “It is a privilege to be an ITU nurse; there is a supportive, family atmosphere.”

Public and staff engagement

- During our inspection, we saw a number of cards and letters from patients and their relatives expressing their thanks for the care they had received in the ITU.
- Staff within the unit monitored the results of the NHS ‘Friends and Family audit’. They also conducted their own patient and relative feedback survey. Results of these surveys were shared with staff to improve practice.

Innovation, improvement and sustainability

- Staff were proud of their bereavement and follow-up services, which provided valuable psychological support to relatives and patients.
- The outreach team was keen to develop its service further to provide 24-hour cover for its patients.
- Band 6 nurses were encouraged to attend leadership development programmes once they had completed their ITU course.
- Staff were supported to attend conferences to improve their practice.

Services for children and young people

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

Information about the service

The children's service is managed as a single integrated provision across the Sandwell and West Birmingham Hospitals NHS Trust, and is the largest paediatric department in the West Midlands.

The main children's wards are situated at Sandwell Hospital, where there are 44 beds; which include 10 beds for short-stays and day surgery, and eight in the Adolescent Unit.

During our inspection of Sandwell Hospital we visited the following children's areas: Children's Outpatient Department (COPD), Priory Ground, Lyndon Ground and Lyndon One. We spoke with four medical staff, 16 nursing staff, one student nurse, two children and 13 parents.

Summary of findings

Services for children and young people at Sandwell Hospital were caring. However, improvements are

needed for the service to be safe, effective and responsive; improvements are also needed in the leadership of the service.

Safety issues were identified which were serious, regarding incidents, infection control and emergency processes, all of which had the potential to result in poor outcomes for children using the service.

Children, young people, parents, and one carer told us that they had received compassionate care, with good emotional support. Parents felt that they were fully informed and involved in decisions relating to their child's treatment and care. Improvements to care and treatment were identified by audit findings, or in response to national guidelines.

A clear leadership structure was in place within the Women and Children's Health Group . The Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' standards for staff had not been met, because the trust did not provide the level of paediatric consultant cover recommended, however other mitigation action had been undertaken.

We received mixed responses from staff with regard to nursing and management leadership. Staff did not always feel supported, and described an 'autocratic' management style by senior managers. We saw that the

Services for children and young people

acting ward managers struggled with some management tasks associated with their work, such as risk management, and in ensuring consistency of clinical practice.

The nursing establishments have been reviewed within the children's service in 2014, which resulted in staff roles being redesigned. The trust is not following the Royal College of Nursing (RCN) staffing guidance identified in 'Defining staffing levels for children and young people' (2013).

Since the inspection the trust has informed the CQC that the children's services have a five year strategy and two year plan. Governance processes were in place, and known clinical risks monitored. Public and staff engagement processes captured feedback from both groups.

We were not assured that incident management and learning at ward level was robust at Sandwell Hospital.

The children's service provided good access and flow to its services, which met most children's and parents individual needs. Aspects of the children's service had been recently reviewed, which had resulted in initiatives being implemented to improve both provision and access.

The service has some gaps in health provision, which has meant that children and adolescents with mental health needs have not received the support they required. During the inspection, CQC raised these concerns with the trust at executive level.

Following the inspection the trust has informed the CQC that since Dec 2014, the CCG has commissioned CAMHs cover up till 8pm.The issue around the shortage of tier 4 beds is nationally recognized and out of the control of the Trust.

Good transitional arrangements were in place for adolescents. We saw that joint consultant working within the trust had enabled further expansion of transition arrangements with adult specialities, to the benefit of young people.

Are services for children and young people safe?

Requires improvement

We have rated this service requires improvement because there needed to be improvements in safety for patients. We were not assured that incident management and learning at ward level was robust throughout the children's service. This was because we did not see evidence confirming that all actions and outcomes from the incidents we reviewed had been acted upon and monitored for on-going compliance. Staff told us they had not always received feedback from the incidents they had reported.

We observed that there was not always robust attention to infection prevention and control practices, despite appropriate measures being in place.

Resuscitation equipment although checked single use and out of date equipment was not removed from the trolley, which presented as a risk to children in an emergency situation. We also found that not enough nursing staff had undertaken advanced paediatric life support. Since the inspection the trust have provided us with additional evidence confirming that 100% of medical staff had under taken advanced paediatric life support training.

The environment was not seen to be conducive to the needs of the child or young person with mental health needs. We observed that the environment was not safe, as risks such as 'ligature points' had not been recognised. Robust risk assessments were not in place for this patient group.

Training arrangements for level three safeguarding was not adequate, with not enough of staff having received the training, identified in best practice guidelines.

The nursing establishments have been reviewed within the children's service - in 2014, which resulted in staff roles being redesigned. The trust was not following the RCN best practice guidance. We observed shortfalls in nurse staffing, and were told that staff had not received the necessary training and support required to care for some categories of children admitted to the service.

The Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' standards for staff had not been fulfilled,

because the trust did not provide paediatric consultant on site cover between the hours of 5pm and 10pm. However, since the inspection the trust has provided additional information relating to consultant cover which identifies that there is an experienced Registrar on site and that the consultant is available for verbal advice 24 hours and lives within 20 minutes travelling time. There have been no reported serious incidents or near misses related to the lack of consultant presence out of hours. In the event that the registrar is required in another area, the escalation policy would be activated and the Consultant on call would be called to attend, thus preventing children being left without senior medical input.

Incidents

- The hospital had systems in place to make sure incidents were reported, investigated and learnt from. Incidents had been discussed at monthly matron and paediatrician risk meetings, and a monthly risk newsletter was circulated within the paediatric service across the trust. Staff demonstrated an awareness of how to report incidents. We noted that there had been no serious incidents reported in children's services.
- We were not assured that incident management and learning at ward level was robust within the children's service at Sandwell Hospital. This was because, for the two incidents we reviewed, we found limited evidence confirming that the actions identified had been completed as indicated. We were told that ongoing monitoring was not in place and we saw no evidence of staff learning from these incidents.
- Unexpected infant and child death guidance was in place for staff, parents and carers in Sandwell Hospital. We saw that staff were given opportunities for discussion following the instance of a child's death; this showed that learning had taken place following this incident. The minutes of the 'Paediatric Directorate Mortality Report' (Sept 2012-Aug 2013) confirmed that discussions relating to morbidity and mortality had taken place at trust level.
- The clinical areas displayed information for patients and members of the public to see. Each clinical area had a 'Confident & Caring Board', which displayed information such as staff sickness, hand hygiene audit results, clinical incidents and mandatory training attendance.
- 'Never events': These are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented. Information indicated that there had been zero 'never events' in children's services at this trust.

Cleanliness, infection control and hygiene

- An integrated infection prevention and control service led by a director of infection prevention and control. Staff told us that the infection control nurse visited the wards which meant that professional advice was available to staff.
- Staff told us they had a ward infection control link person. This person attended quarterly infection control updates, and had been responsible for communicating infection prevention information back to the clinical staff.
- The areas we visited had appropriate infection prevention and control guidance and hand washing facilities available. Additional infection prevention measures such as wall mounted hand gels were in place. However, we observed that one hand gel dispenser was empty on Lyndon Ground. We observed that staff adhered to the trusts 'bare below the elbow' policy.
- We saw examples which identified that cleanliness within some clinical areas was an issue. On Lyndon Ground, in one cubicle within the Adolescent Unit, we observed blood stained curtains; the floor was dirty, and hair was in the sink. In room 10, in the main ward area, we saw that the ceiling tiles were discoloured.
- We saw an example of poor infection prevention practices. On Lyndon One we observed a member of untrained staff walking in and out of isolation rooms turning off monitors. This person took no infection prevention precautions. Discussion with two members of staff confirmed that infection control and isolation procedures had not always been followed. One senior member of staff said that they were not sure how they could ensure staff compliance in infection control measures. These observations showed poor infection prevention practices, which could put people at risk of infection. Having spent time observing staff infection prevention practices, it was apparent that retraining of staff should be identified as a priority.
- Infection control training: Staff told us that they received infection prevention and control training at induction,

and as part of the trust mandatory training programme. The Lyndon One training matrix confirmed that 81.48% of staff had completed infection control training up until 16 October 2014.

Environment and equipment

- The children's unit was seen to be child-friendly; with colourful cartoons on the walls and designated play areas. We did notice, however, that the unit decoration looked tired.
- Access to the ward was secure with access through a call bell and / or swipe card system.
- Discussions with a registered mental health nurse, who was temporarily assigned to the unit, identified concerns relating to the environment in which children and adolescents with mental health issues (CAMH(S)) had been nursed. These concerns related to the presence of ligature points. This was raised with the acting ward manager who arranged for the removal the ligature points. This included the removal of curtain rails and curtain hooks.
- We saw equipment suitable for children and young people in all clinical areas. We undertook random checks on clinical equipment and found that most equipment had been serviced. However, we did observe that some equipment, including a Dinamap continuous blood pressure monitor, had reached its service expiry date, which on the blood pressure monitor was identified as August 2014.
- Systems were in place to remove broken or faulty equipment. We saw an 'Equipment maintenance log summary for paediatrics and neonates', which showed some shortfalls in equipment maintenance throughout the Directorate. The highest shortfall in maintenance appeared to be equipment on Lyndon One.
- We undertook random checks of the paediatric resuscitation equipment located in each clinical area. We found evidence on Lyndon Ground and Lyndon One of sealed resuscitation equipment being out of date, or undated, and single use ambu bags not being stored in sealed plastic bags. This could pose a potential risk, because daily resuscitation equipment checks had not been completed, which had resulted in equipment, which should have been replaced, still being present in the resuscitation trolley.

Medicines

- The trust adhered to National Institute for Health and Care Excellence (NICE) guidance in relation to medication management. We observed that pharmacy controls were in place. However, we observed on Lyndon One that the treatment room was unlocked and open, and a cupboard containing Milton and Hibiscrub was easily accessible. We also found that some medication products had expired on Lyndon One and Priory Ground. The inspector alerted the relevant staff member of the clinical area. This meant that these drugs were removed immediately to reduce the likelihood of a future medication incident from occurring.
- Staff had received medicines management training on induction. For example, the doctors trust induction programme included a 30 minute training programme on paediatric prescribing. Training information provided by the acting ward managers from Lyndon One and Lyndon Ground confirmed that trained nursing staff had completed medicines management training and medical devices training. Minutes of staff meetings confirmed that issues associated with medication had been discussed.
- We reviewed drug charts, and saw that they had been signed, dated and reviewed by the doctor where necessary.
- Auditing of medication errors had taken place. The audit excel report 'Medication Errors – April-Sept 2014' identified a total of 87 medication errors recorded for the Women and Children's Health Directorate. We saw that communication of drug errors had been included within the trust's monthly 'Risk-E-News' newsletter. The October 2014 newsletter identified actions for staff to take should medication be omitted. Discussions had taken place following paediatric medication audits at key forums within the trust.

Records

- The children's service had both paper and electronic patient records. In some clinical areas, records had been locked away in a lockable cupboard and / or cabinets. On Lyndon One and Priory Ground some patients' records had not been stored securely.
- We reviewed five sets of children's notes in each clinical area whilst at Sandwell Hospital. We found that some children's notes were incomplete. For example, drug chart height and weight sections had not been completed. Three baby growth charts were reviewed, and we found that the information was incomplete. We also observed that there was no reference to cultural preferences. This meant that staff may not have had the

full information required for the child in order to make informed decisions. Pre-printed, standardised care plans were in use throughout the children's service. These care plans identified limited, if any, nursing interventions and evaluations. We also observed that the care plans we had reviewed had not always been dated and timed.

- We were unable to identify the roles of the medical staff against some medical entries in the child's notes, as these were not present. This meant that we were unable to determine whether the child had been seen by a paediatric consultant within 24 hours of admission. However, following the inspection the trust made us aware of the process they adopted to ensure children were seen by a consultant, which involved the coded handover notes so staff could identify that a consultant review had been undertaken.
- Records audits had been completed on 24 July 2014 and in September 2014 and the results of these audits were communicated to staff by the ward matron, or clinical service manager. No actions were necessary, as no concerns had been identified.

Safeguarding

- The chief nurse was the trust executive lead for safeguarding. The trust had clear governance reporting arrangements in place for safeguarding which meant that children's safeguarding and associated processes had been monitored closely by the trust.
- The trust had child protection systems and partnership working arrangements in place. Partnership working and communications took place when the chief nurse and deputy chief nurse attended meetings at the Sandwell Local Safeguarding Children's Board (LSCB) and the Birmingham Local Safeguarding Children's Boards. We were also told that named leads represented the trust on some LSCB sub-groups.
- The trust's safeguarding child protection policy had recently been reviewed, and was awaiting ratification. This policy was also used in combination with other trust policies, such as the whistleblowing policy, responding to domestic abuse, and child death overview guidelines.
- The trust met the statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the trust undergo a DBS check prior to employment, and those working with children undergo an enhanced level of assessment.
- We were told that referrals had been made to the children's safeguarding team via telephone Monday to Friday between 9am to 5pm. The trust policy contains guidance for staff who need to make a referral out of hours.
- NICE safeguarding guidance recommends that permanent staff should be trained to a Level 3 standard. Trust training statistics identified that 74% of nursing and midwifery staff, and 67% of medical and dental staff, within the Women and Children's Health Directorate, had completed Level 3 training in safeguarding children. This meant that there were training shortfalls in Level 3 safeguarding training. This meant that staff awareness of child safeguarding issues and processes may be limited, therefore, leading to a reduced recognition of those children most at risk.

Mandatory training

- Staff confirmed that they had received a range of mandatory training, and training specific to their roles. Discussions with one acting ward manager confirmed that staff had not completed refresher mandatory training for 2013-14, as staff had not been able to be released from the ward due to staffing issues.
- The trust's mandatory training information for the Women and Children's Health Group confirmed administration, nursing and medical staff in attendance at identified mandatory training sessions. There were shortfalls in staff attendance at mandatory training. Trust training statistics for nursing and midwifery, and medical and dental staff, confirmed attendance at 80% and 62% year to date.
- One acting ward manager we spoke with confirmed that RCN best practice guidance had not been followed as the trained nursing staff had only completed paediatric intermediate life support (PILS) training. Only one nurse had been trained to advanced paediatric life support level (APLS). However all the medical staff had undertaken the APL course. APLS is the Advanced paediatric life support course.
- The trust corporate induction, included guidance relating to equality and diversity, NHS counter fraud, customer care, and governance. Middle grade doctors attended a separate induction programme. We saw a copy of the September 2014 induction programme for middle grade doctors. The induction programme ran from 1.30pm to 4.50pm on the Sandwell Hospital site, and included topics such as paediatric prescribing,

safeguarding and blood gas training. This meant that new middle grade doctors and staff had received a service-specific induction prior to working on the children's unit.

Assessing and responding to patient risk

- We saw a series of incidents which put the child at risk. These incidents included alarms on intravenous fluid pumps alarming for 20-30 minutes, and oxygen saturation monitor machines alarming to inform of altered oxygen levels and heart rates. Staff had taken no notice of these alarms, which could have put the child at risk.
- The trust had identified guidelines and protocols to assess and monitor in real time, and react to changes in risk level.
- Trust wide the children's service used an early warning system called the 'paediatric early warning score' (PEWS). This system is used to monitor children and to ensure early detection of deterioration. We reviewed a sample of PEWS observation charts, and found that these were completed in detail by members of the nursing team. However, one child's PEWS chart, which showed an increase in the PEWS score, identified that PEWS escalation had not been documented.
- The 'Kids Intensive Care and Decision Support (KIDS) Retrieval Service' worked in collaboration with the trust when transferring sick children. This service is a children's acute retrieval and advice service, which specialises in the management of critically ill children requiring intensive care in the Midlands.
- We saw training records confirming that some staff had completed trust paediatric high dependency training and competency assessments
- Two risk registers were seen. The Sandwell and West Birmingham Hospitals NHS Trust Risk Register: Women and Children's' identified four risks relating to children's services. Whilst, the 'Appendix A: Trust Risk Register (version dated 27 August)' identified two risks relating to children's services. This meant that the higher level risks in children's services had been identified at board level on the trust risk register.

Nursing staffing

- The trust risk register (version as at 31 July) identified the children's high dependency unit (HDU) staffing levels as an issue. Discussion of these risks took place at trust board level on the 5 June 2014 and 7 August 2014.
- The paediatric service has a 'Paediatric Staffing and Capacity Escalation Guideline' (Implementation date – July 2013), which provides instruction on how to manage capacity or reduced staffing levels.
- The acting head of services for paediatrics and gynaecology told us that the RCN best practice guidance had been used to inform the children's service staffing levels. Children's staffing levels were described as 'ok' and we were told that staff had not been asked to compromise on staffing levels.
- We were told that annual skill mix and staffing reviews had taken place; reviewed September 2014 and signed off by the Chief Nurse.
- We were not assured that staffing levels or skill mix were always safe following discussions with staff who told us that 'staffing levels had not always been safe.' We reviewed the Lyndon Ground duty rotas for week commencing 30 June 2014 and 27 October 2014 and found shortfalls in experienced staff (band 6 nurses and above). Some shifts on the adolescent unit had also been led by a band 4 and 5 nurse. This did not follow the RCN best practice guidance. This meant that the staff may not be sufficiently skilled to provide care for children and adolescents admitted into the unit. Staff told us that the unit had admitted a lot of children with mental health problems, and that they felt they did not have the skills or knowledge to care for these young people.
- We were told that unqualified band 4 staff were being used in qualified staff roles, and band 2 health care assistants ran the majority of children's outpatient's clinics at Sandwell Hospital. Staff told us that these staff had not received any training prior to commencing in their new roles.
- On 16 October 2014, we observed two health care assistants working alone, without trained children's nurse support, in the Sandwell Hospital children's outpatient service. The outpatients was situated next door to the ward area, so that qualified staff could assist where necessary. However untrained staff agreed they could ask for help but sometimes the nurses were too busy to respond in a timely fashion.
- Senior staff confirmed staffing establishment for Lyndon One ward was funded for 26 beds, although operating on 18 beds. The acting head of services confirmed that

the service budget did not currently include high dependency unit (HDU) funding. The trust informed us following the inspection that the lead nurse working in this area had attained HDU competencies.

Medical staffing

- The lead clinician told us there were 12 consultants providing acute care for children's services. They were supported by 33 junior medical staff, which included 12 specialist registrars.
- Trust wide the Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' standards for staff had not been fulfilled. This was because the trust did not provide paediatric consultant cover from 5pm until 10pm, on each site. However, since the inspection the trust has provided additional information relating to consultant cover which identifies that there is an experienced Registrar on site and that the consultant is available for verbal advice 24 hours and lives within 20 minutes travelling time. There have been no reported serious incidents or near misses related to the lack of consultant presence out of hours. In the event that the registrar is required in another area, the escalation policy would be activated and the Consultant on call would be called to attend, thus preventing children being left without senior medical input.
- We were told that locum doctors had been used in the last six months due to registrar vacancies. Since September 2014, there had been a 0.5wte (whole time equivalent) vacancy.
- A consultant anaesthetist told us that the trust had up to nine anaesthetic consultants with a paediatric interest, who are confident in treating children over the age of one year. For babies less than one year of age, neonatologists assisted with the care of these babies.
- Staff told us that there had been some difficulties getting support from other specialities, and knowing which doctor was on-call. The outcome is that the surgeons are now moving towards a 'consultant of the week' model.

Major incident awareness and training

- A trust major incident plan was in place, which set out actions to be taken for major incidents and other similar events.
- We asked what winter and summer management plans were in place. We were told that the ward capacities could be increased through opening additional beds. One manager told us that Lyndon One was budgeted for 26 beds; it is currently operating on 18 beds. The extra eight beds would be opened as long as sufficient staffing capacity was available. We were told that bed capacity on Lyndon Ground could also increase, from 14 to 18 beds in the winter.

Are services for children and young people effective?

Good

We assessed that this domain to be good. We found that transition services were in place for young people transitioning into adult services. Pain management was effective, despite a new pain control tool being introduced, for which staff said they lacked training.

Children's services made improvements to care and treatment where these had been identified by audit findings, or in response to national guidelines.

The majority of staff had received their annual appraisal for 2014. Staff identified a range of views regarding the support and personal development they had received. There was evidence of multidisciplinary working across various disciplines and specialities.

Not all assessments were undertaken for the nutritional status of children. We found a lack of Nil by Mouth policy could lead to inconsistencies in the preparation of children and young people for surgery.

We found that the consent process did not adequately take account of if a parent / guardian fully understood if English was not their first language.

Evidence-based care and treatment

- Clinically-endorsed guidance, from authorities such as the Royal College of Paediatrics and Child Health (RCPCH), and the National Institute for Health and Care Excellence (NICE), had been used to inform children's care. In addition, RCPCH guidance had been used to develop local policies.
- There was a designated lead consultant for each medical condition.
- The trust has some transition services in place for young people. These services include allergy, haematology, rheumatology, epilepsy, diabetes, palliative and continuing care, and neurodisability services. The first

joint endocrinology transition clinic was due commence in October 2014. The trust identified that some gaps exist in their transition services. These gaps include improving the holistic aspect of the transition process.

Pain relief

- Children and young people had access to a range of pain relief should it be required, including topical, oral analgesia, and intravenous analgesics where this is required.
- The trust has a dedicated pain management team. We were told by staff that the team will provide support when necessary.
- The service used an evidence-based pain scoring tool to assess the impact of pain. A new pain management tool had been launched. This tool was displayed in two clinical areas. Staff told us that there had been no formal training delivered in the use of this new pain tool. Despite this lack of training, we did not see or were told of, children's pain not being controlled effectively. Lyndon One had identified a link nurse, who attended the pain management meetings, and whose role had been to share information from the pain meetings with other ward staff.

Nutrition and hydration

- We saw that a varied menu was offered to children. The children's notes we reviewed contained no evidence of completed nutritional assessments.
- We saw that guidelines were in place for the management of referrals to the paediatric dietetic service.
- Specific information was available for children and young people who were required to fast because of their recommended treatments / surgical interventions. The information was presented in leaflet and booklet form. We saw that both documents were informative, and had been directed at the child's / young person's level of understanding.
- The acting ward manager from Lyndon One was not able to show us a children's 'nil by mouth' (NBM) policy and we observed in our conversations that they did not really know what to do. We were told that staff "relied on their experience" when children needed to be put on NBM.

Patient outcomes

- We saw evidence that the trust had a robust system of audit in place to ensure effective patient outcomes were achieved. The trust's audit dashboard identified a list of the audits that had been completed, and the progress that they had made against them. From the 16 audits submitted, the trust identified that recommendations from 14 of the audits had been effectively implemented. Ten future clinical audits had also been identified in the paediatric clinical audit forward action plan for 2014/15.
- Additional trust audits which had taken place in paediatrics included the 'Re-audit of Parental Satisfaction with Pre-operative Anaesthetic Information' and a 'Review of epilepsy related admissions'. Both audits identified conclusions and / or recommendations. The 'Acute Paediatric Team Meeting Agenda' dated 24 June 2014, confirmed that the epilepsy checklist was one of the agenda items for discussion. The lead clinician told us that a business case had been put together following this audit, to recruit an epilepsy nurse specialist.
- Monthly audits included paediatric asthma and healthcare records audits. The completed dashboard of the asthma audit identified compliance against identified areas within asthma management. The outcome from this audit had resulted in the development of a new asthma pathway, and funds to develop an e-module to educate health visitors in the community to improve asthma management.
- Minutes from the monthly paediatric speciality meetings, clinical effectiveness, and paediatric governance meetings confirmed that patient outcomes and clinical effectiveness issues had been discussed, and improvements noted. We also saw that quality, safety and performance were standing agenda items on the trust board report.

Competent staff

- Formal processes were in place to ensure that staff had received training and an annual appraisal. We saw trust statistics confirming that 100% of staff had received appraisals in 2013/14. All but one staff member we spoke with confirmed they had completed the appraisal process.
- We were told that staff skills had been enhanced through a three-month rotation programme, every three years.

Services for children and young people

- Some staff raised concerns about the lack of training they had received in caring for children and young people with mental health needs. The trust policy for 'the management and prevention of deliberate self-harm in children and young people' (Implementation date – July 2013), had not been followed in equipping staff with the right knowledge and skills to be able to care for a C&YP with mental health needs.
- The trust made us aware following the inspection that the Directorate employs a chartered child psychologist who specializes in managing children with chronic illness and medically unexplained illnesses. The Directorate holds monthly psycho social meetings where cases were discussed.
- We spoke with two medical staff who were at different levels within their training. They told us that there had been teaching four times a week, on alternate weeks, from Monday to Thursday. Both were very praiseworthy of the teaching they had received. One was a senior house officer, and the other was a registrar.
- Staff told us that they had been given time to attend the paediatric HDU course through Birmingham University. The 'Lyndon One training matrix' confirmed which nursing staff had completed their competency assessments to enable them to work with children requiring high dependency care.
- We spoke with a member of staff who told us that clinical supervision took place. This nurse said that they had received yearly clinical supervision.

Multidisciplinary working

- Staff told us how they worked in partnership with other health care professionals, such as dieticians and health visitors to ensure positive outcomes for children and their families.
- The lead paediatrician told us that there was effective cross-speciality working. Every quarter, a paediatric surgical meeting had taken place. The meeting was used as a forum to discuss services, guidelines, protocols and measurements against joint Royal College guidelines. Governance and risk had also been discussed. One example of this joint working related to an audit which identified gentamicin prescriptions intra-operatively for appendicitis patients.
- The paediatric department had a strategy 'away-day' for doctors and nurses. One of the discussions at this meeting related to the format of the paediatric assessment unit (PAU) at Sandwell. Following this meeting, the layout of the PAU was changed. This showed that service needs had been reviewed, and changes had been made to accommodate current service needs.
- During the inspection, we observed a medical handover between a consultant and a registrar. These medical handovers took place three times a day. This process meant that medical staff were able to make effective clinical decisions regarding children's medical care.
- The lead consultant paediatrician told us that multidisciplinary working existed between Sandwell Hospital and the Birmingham Children's Hospital (BCH). Yearly meetings had been held with the BCH KIDS Team, where discussions of learning and issues affecting children's care had taken place.

Consent

- Trust training statistics identified that 71% of medical and dental staff had completed training in 'Consent - Basic Consent'. Nursing staff we spoke with confirmed that training in consent and mental capacity had been incorporated within their safeguarding training.
- We saw evidence that written consent had been obtained prior to certain procedures. One example of written consent was seen for a child who was undergoing a scan. This meant that parents / carers had been informed of the procedure and any recognised risks prior to the procedure taking place.

Seven-day services

- There is 24 hour paediatric consultant support at Sandwell Hospital. Junior medical staff and nursing staff said that they could access consultants out of hours, and described the consultant team as supportive. We were told that out-of-hours consultant staff would arrive at the hospital within 20 minutes of being called. Additional medical cover overnight comprised of one registrar and one senior house officer (SHO).

We were told that out-of-hours investigations could be accessed, such as imaging and urgent lab tests. We were also told that pharmacy access and support were available.

Are services for children and young people caring?

Services for children and young people

Good

Children, young people, parents and one carer told us that they had received compassionate care, with good emotional support. Parents felt that they were fully informed and involved in decisions relating to the child's treatment and care. Some concerns had been raised by parents with regard to high car parking charges and, at times, the noise levels on the ward at night.

Compassionate care

- Throughout our inspection we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of the child, young person and parents.
- We spoke with two children and 12 parents at Sandwell Hospital. They told us that they had generally been happy with the medical and nursing care received in the inpatient and outpatient areas. They told us that clinical teams liaised well, and had kept them informed on treatment plans. Patients said that they had been treated respectfully; staff listened, and were caring, responsive and reassuring.
- Concerns raised by some of the parents we spoke with related to the level of noise experienced on the wards at night, and not being sure which nurse was providing the care for their child which meant they had not felt fully supported or knew who to approach with any concerns.
- The parents we spoke with made suggestions in which to improve the current service provision. These included making more constructive activities available, improving the timing of meals, and providing parents and children with an initial orientation of the ward. These comments meant that parents recognised gaps in current service provision which the trust should consider.

Patient understanding and involvement

- We saw information boards throughout the children's service, and photo boards of staff to say who's who.
- We spoke with 12 parents about their experiences. They told us that generally, the medical and nursing care that their child had received had been satisfactory, that most treatment plans had been explained, and that clinical teams liaised well. We observed members of staff who talked with children and young people at an appropriate age-related level of understanding.
- We observed part of a ward round, and noticed that the staff had a very good rapport with a father. The doctor was seen to take time talking with the father, so that the father understood what was being said about his child's condition, and the father was given opportunities to ask questions.

Emotional support

- Generally, parents and children told us that they had been supported during their visits to the children's service. However, one young person commented on some failings in communication and support during their stay. They identified that their plan of care had not always been explained, and they did not always know who was looking after them.
- The trust told us they employed four play specialists. Staff told us they thought one was employed and that previously more play specialists were employed by the trust. Following the reconfiguration of the overall service, the play staff were re-deployed into new roles. The play specialist we spoke to told us that they split their time between the Birmingham City and Sandwell hospital sites.
- Paediatric specialist nurses, such as diabetic and child protection nurses, were available for parents and staff to access for support.

Are services for children and young people responsive?

Requires improvement

The children's service had recently reviewed its services, which had resulted in initiatives being implemented to improve service provision and access to the service.

The children's service provided good access and flow to its services, which met most children's and parents individual needs. The trust had good support from tertiary centres, such as the Birmingham Children's Hospital (BCH).

During the inspection, CQC raised concerns about service provision for children and young people with mental health needs with the trust executive.

We found good transitional arrangements in place for adolescents.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The children's service had recently reviewed its services, which had resulted in a number of initiatives being implemented to improve service provision and access to the service.
- The service had no formal agreement with the local children and adolescent mental health services. The trust had also identified this area as a 'red' risk on their risk register, which meant that the trust had recognised this as a high risk area. We saw statistics confirming that the number of children and young people requiring mental health support admission had increased in the last year.
- Staff said that they received limited support when caring for this vulnerable patient group. Concerns were raised at the lack of tier-four beds for children and young people with mental health concerns, which is a national issue. The team were unanimous in feeling that the paediatric service was not the right place to care for this vulnerable group of children and young people. During the inspection, we raised concerns, about children's and young people's mental health care, with the trust at executive level. Following the inspection we were made aware of the additional support offered by the clinical psychologist where monthly psycho social meetings took place where individual cases are discussed.
- Service planning in children's services involved both medical and nursing staff. A paediatric department strategy 'away-day' was held on 16 May 2014. Staff discussed outpatient improvement, improving the acute wards, the day unit and community services, and also improving the urgent care service, and support for GPs.

Access and flow

- The children's service at Sandwell Hospital provided good access and flow to its services. The 14-bedded paediatric assessment unit (PAU), Lyndon Ground, was located on the ground floor next to children's outpatients and the surgical day ward, Priory Ground.
- Service reconfiguration had resulted in a number of initiatives to improve service provision and access to the service. One example was the 'Keep it Moving' action plan, developed to streamline processes and systems to facilitate effective patient flow, and assist with the early discharge of patients. We did not see evidence confirming that a follow-up review had taken place, which would have identified the success of the initiative.
- The children's outpatient service hosts specialist clinics, which were attended by specialist nurses to support the doctor and child / family. The clinic timetable confirmed that children's clinics had been run by a variety of specialities, therefore assuring access for children and their families to services which could support them, such as physio, dietetics and surgical clinics.
- We were told that children requiring urgent appointments had been seen in children's outpatients, or on Lyndon Ground.

Meeting people's individual needs

- We were told that children had not always been seen daily by the CAMHS team. We were given conflicting information about the availability of a child psychology service. However the trust have confirmed that a child psychology service to support children with long term conditions and medically unexplained conditions.
- One band 5 nurse told us of their experiences on the previous days shift. They told us that they had been looking after three young people who had mental health needs, and one acutely unwell child. This nurse said that ''sometimes you concentrate on the medical case due to urgency of intervention and end up ignoring the children and young people (C&YP) with mental health needs out of default''. This nurse expressed how they felt uncomfortable with the set up, but were not sure what could be done.
- We looked at the care planning in place for C&YP with mental health needs. The acting ward manager showed us a pre-printed care plan and risk assessment used for this patient group. We were told that each patient had been given the same care plan. This meant that the individual care and support needs of C&YP with mental health issues had not been recognised; consequently, potentially all their needs may not have been met.
- We were told that the clinical commissioning group funded registered mental health nurse one-to-one care. However, staff experiences identified that this cover may be provided by a health care assistant in the first instance. The mental health assessment was

undertaken by CAHMS who directed the type of supervision required for the child with reference to the type of nurse (registered or healthcare assistant) and the number required (1:1 or 1:2).
- The trust had provided staff with training to assist their understanding of people's needs, through attendance at training sessions in equality and diversity, safeguarding, and managing conflict.
- We observed that some staff lacked cultural awareness, such as not knowing that fish was allowed for Muslim patients. This was despite equality and diversity training being available within the trust.
- We observed that Nintendo Wiis had been provided for children to play with. One asthmatic child was observed to be playing with it, which distracted the child from his symptoms. We observed an anaesthetic assessment of a young person by an anaesthetist whilst on Priory Ground.
- We observed that the mother was asking the child questions when the anaesthetist was not present, as Punjabi was her first language. This meant that the parent had only understood a proportion of the conversation between their child and the anaesthetist. The inspector escalated this incident to the nurse in charge.
- Good transitional arrangements were in place for adolescents. The trust told us that they were especially proud of their young people's diabetes service, allergy management, and the way in which acutely ill children were cared for. We saw that joint consultant working within the trust had enabled further expansion of transition arrangements with adult specialities, to the benefit of young people.

Learning from complaints and concerns

- Parents and visitors raised concerns, either locally at ward level, with the Patient Advice and Liaison Service (PALS), or through the trust complaints department. The trust also identified and responded to concerns through individual patient surveys, an example of which we saw had been undertaken on Lyndon One in May 2014.
- The head of services told us that parent's feedback and complaints had been reviewed monthly, and trends fed back to staff. We were told that quarterly unit meetings had taken place on both sites. We saw some minutes of these meetings, which confirmed that they had taken place, and that complaints had been discussed.
- We saw that learning from complaints had been communicated back to staff through unit meetings.
- Complaints had been discussed at senior management meetings within the trust. Meeting minutes confirmed that complaints had been discussed at paediatric clinical governance, and at the Women and Child Health Governance Board Meetings.
- The trust complaints data identified nine complaints in total for all of children's services. The complaints report dated 2013/14, was incomplete, in that information relating to date of reply, action taken, and date reply sent to complaints, had not been identified. We were unable to judge how effective the complaints process had been due to this missing information, and because not all action plans were completed.

Are services for children and young people well-led?

Requires improvement

We judged this to require improvement. There was a leadership structure was in place, however the management had not addressed the serious safety issues. Children's services were well-led at ward level; however, we recognise that at times, staff perceived that they had not been supported or involved in decision-making processes in relation to the new ways of working. Some staff described an 'autocratic' management style in relation to the approach by senior managers.

The trust does have an identified paediatric clinical lead of acute children's services, and the chief nurse is the trust executive lead for safeguarding.

The trust has informed us that a five year children's strategy is - in place. Staff told us that the paediatric service also has an annual plan which, had been monitored bi-monthly.

Governance processes were in place, and identified clinical risks had been monitored but not completely actioned. Public, parents / or carers, children's and staff engagement processes were in place to capture feedback.

Vision and strategy for this service

- We were told by the children's services management team that there was no children's strategy; however, the service had an annual plan in place relating to service improvements. The trust has since informed us that a

five year children's strategy was in place. The acting paediatric matron had been involved in developing the annual plan, and ward managers had been given the opportunity to identify ideas for this annual plan. The children's plan fed into the trust business plan which had been discussed at board level. We asked if we could have a copy of this plan and some minutes confirming the progress made against the plan, but have not received this information.

Governance, risk management and quality measurement

- We saw that the trust had a clear decision-making pathway in place in relation to governance, risk management, and quality measurement.
- We were told and saw documented systems in place to enable clinical and management interface to occur. These included monthly paediatric directorate meetings, and directorate operational meetings, departmental risk and governance meetings, and directorate risk and governance groups. We saw random minutes from these meetings.
- We observed that effective and supportive medical leadership was available, and that there had been medical involvement in recent service improvements, 'away-days', and multidisciplinary team (MDT) working.
- Minutes seen from the ward meetings confirmed that staff had been kept informed of issues and updates relating to patient safety, patient experience, clinical effectiveness, health and safety, cleanliness and infection control, workforce and area-specific quality issues. Staff members we talked with confirmed that information had been regularly shared with them.
- The trust 'Risk Register: Women's and Children's' identified four risks for children's services. Meanwhile, the 'Appendix A: Trust Risk Register (version dated 27 August)' identified two risks relating to children's services. This meant that the higher level risks in children's services had been identified at board level on the trust risk register. Discussions with some staff confirmed their knowledge of what risks were identified on the risk register, and what involvement they had had with this process.

Leadership of service

- There was a clear leadership structure within the women and children's health clinical group. The clinical group comprised of four directorates; each had a head of service and clinical director, with the exception of the community children's directorate, which had a clinical director.
- The head of service for paediatrics and gynaecology services is responsible to the group director of operations, and is accountable to the chief nurse. A key role is the responsibility for supporting management and clinical performance of both directorates. The head of service has a paediatric background.
- Staff told us they had not seen the chief nurse. One staff member said that they felt a 'bit left behind in paediatrics'.
- We received some mixed feedback about the level of support that the acting matron had given the children's clinical areas. Junior medical staff said they had been supported by consultant staff.
- There was a clear leadership structure within the various children's wards, paediatric assessment unit (PAU) and children's outpatient departments. Staff we talked with on all children's clinical areas told us that they had felt supported by their immediate line manager. We observed that there appeared to be limited management support within the children's outpatient department and day surgery unit. However, the trust has informed the CQC that a dedicated ward manager manages the units.
- We directly observed leadership at ward level within the clinical area. We were told that changes identified by senior management had been cascaded down to the ward areas. Staff told us that these changes had been implemented; however, the style of senior management leadership had been 'autocratic'.
- We were told by staff that the trust would support them to top up their nursing degree by undertaking a leadership and change management module. One acting ward manager told us that they had not had any training in the last 18 months, other than mandatory training.

Culture within the service

- We found a culture of openness and flexibility amongst all the teams and staff we met within the children's clinical areas. Staff spoke positively about the service they provided.
- Staff were very honest about their current feelings. We observed that staff morale was low, and conversations with some staff confirmed this. Staff told us that they

had not felt supported or had been engaged in the reconfiguration which had resulted in their roles being redesigned. As a result, these staff said they felt vulnerable.

- Discussions with the acting head of service for paediatrics identified that they recognised staff morale was low; staff felt their skill sets had not been recognised, and staff felt left out in relation to the changes implemented following the nursing establishments review. Monthly discussions of the supervision of junior medical staff by consultant staff took place. To assist consultants within their supervisory role, they had completed a 'train the trainers' course.
- We saw that staff worked well together, and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of acute health services. We were told that paediatricians and the nursing staff from the children's service had supported staff in other areas, such as the adult intensive care unit, when a child was admitted to that area.

Public and staff engagement

- The trust had a Patient Advice and Liaison Service (PALS), which offered help, support, information and advice to patients and their relatives, friends and carers.
- We saw that the trust had captured patients, family and friends comments and concerns. We observed that the majority of complaints related to process and communication issues. Actions had been identified which responded to the issues raised.
- An alternative system had been introduced, which asked parents and children to provide feedback about the service. Children's services have a paper-based survey, which asks parents and children to provide feedback about the service. Two surveys had been completed on Lyndon One during May 2014, which were aimed at the parents of babies and children up to four years of age. The survey results identified that the care received had been excellent.
- The trust has a whistleblowing policy, which staff could use to assist them when raising concerns.
- The acting ward manager on Lyndon One told us that the chief executive officer had occasionally visited the ward.

End of life care

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

Information about the service

End of life care was delivered where required by ward staff throughout the hospital. There was a specialist palliative care team who provided support and advice to staff for those patients who had complex care and/or complex symptom management. Support was also provided to relatives of end of life patients. The specialist palliative care team consisted of 1.4 whole time equivalent (WTE) consultants and seven WTE nurses (one vacancy). In addition there were two WTE occupational therapists. The team was accessible 24 hours day, providing support and advice across the two trust acute sites; Sandwell General Hospital and City Hospital. Ward staff understood how to make a referral to the specialist team and reported the team responded promptly.

We visited five wards and four specialist departments at Sandwell General Hospital. We met four patients, spoke with four relatives and reviewed five care records. We talked with 18 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, allied health professionals, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

The specialist palliative care team had developed tools, processes and training for generic staff in order to deliver, monitor and evaluate care in line with current best practice. They regularly reviewed the complex care needs of patients to promote coordinated, safe and effective end of life care and clinical practice. Ward staff were familiar with the trust's end of life care plans. Records showed potential problems for patients were identified and planned for in advance.

The patient and relatives we were able to speak with told us they had been involved in decisions, care was good and staff were respectful and kind. End of life patients were not always able to be in their preferred place of care as the discharge planning process was not fully effective. We were told recent reviews of the chaplaincy service would impact on the ability to be fully responsive to patient needs. Ward staff valued the support, expertise and responsiveness of the specialist palliative care team.

End of life care

Are end of life care services safe?

Good

The specialist palliative care team provided safe care and advice for patients, relatives and staff throughout the trust. Equipment, medicines and other resources were available and used to assess and manage patients' pain and other symptoms safely. The team demonstrated how they learned from incidents and shared learning with others. There was damage to flooring in the mortuary which had been reported for repair. No date had been given for the repairs which were necessary to reduce infection control risks.

Incidents

- There had been no Never Events in the specialist palliative care service (a serious, largely preventable patient safety incident which should not occur if the available preventative measures have been implemented).
- 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.
- We looked at records of the last specialist palliative care governance meetings held during December 2013 and May 2014. These documented discussions, learning and action plans regarding general risks identified across the trust and specific incidents reported. For example; through incident reporting the team discussed actions taken to improve staff communication and terminology used with families during a patients last hours of life.

Cleanliness, infection control and hygiene

- In one room in the mortuary we saw a crack in the concrete floor. This damage was under one of the examination tables and continued approximately ten feet to the edge of a wall. Staff confirmed this damage had been previously reported approximately a year ago but no repairs had been scheduled. This presented an infection control risk. This did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- 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. However on one ward we observed when a group of medical students leaving the ward, four did not wash or disinfect their hands. A nurse also observed this and had to ask the medical students repeatedly to return in order for them to complete their hand hygiene.

Environment and equipment

- The National Patient Safety Agency recommended during 2011 that all Graseby syringe drivers should be withdrawn by 2015 (a device for delivering medicines continuously under the skin). The Graseby syringe driver had been withdrawn from the hospital and staff throughout the trust had been retrained to use the McKinley syringe driver.
- We looked at hoists used to assist with moving patients on two wards and observed they were well maintained and serviced.

Medicines

- Written guidance was available for doctors to prescribe appropriate end of life medicines to manage patients' pain and other symptoms.
- Staff on the wards we visited all told us they routinely kept stocks of palliative medicines for symptom and pain relief.
- Records showed those patients referred to the specialist palliative care team had their medicines reviewed by the team. This was done in consultation with other medical staff involved with the patients' care.
- 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.

Records

- We reviewed five sets of patient records. We saw detailed discussions between clinical staff and patients and relatives were recorded sensitively. Records were legible and illustrated clear plans detailing current and planned care which was regularly reviewed.
- We saw clinical staff used the trust's 'end of life care tools'. These 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, non-essential medicines and documenting the patient's preferred place of care.

End of life care

- The trust's end of life care plan included risk assessments of patients' nutrition, mobility and skin integrity. The five patient care records we looked at showed these risk assessments had been regularly reviewed.
- We looked at nine Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. These had been completed in line the national guidance published by the General Medical Council. Except one in which the form did not indicate that family had been spoken to.
- A patient transport DNACPR form was completed for patients being discharged via hospital transport. This was completed and signed by a doctor and ambulance crew. This meant the ambulance crew understood the care required before the patient was formally discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt.
- Relatives told us they had been involved by staff with decisions when patients were no longer able to make decisions independently.

Safeguarding

- Staff were knowledgeable regarding their role and responsibilities to safeguard vulnerable adults and children from abuse and understood what processes to follow.
- Most of the specialist end of life team were in date with the trust's mandatory safeguarding training.

Mandatory training

- The specialist palliative care team provided records of mandatory training completed by the nurses in the team. This training included health and safety, infection control and safeguarding children and vulnerable adults. The records showed seven nurses were in date with more than 90% of the mandatory training. No mandatory training information was available for the two palliative medicine consultants.

Assessing and responding to patient risk

- The trusts end of life care tool incorporated regular reassessments of patients needs to minimise risks and maximise symptom control. We saw risk documents had been reviewed.
- The reverse of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms documented limits of treatment plans. These recorded the maximum level of interventions patients would or would not have in the event of deterioration in their condition. For example; whether or not to implement dialysis or ventilation.
- The management of deteriorating patients' care was documented in care records. These showed patients and their relatives were involved with decisions about care.

Nursing and medical staffing

- The specialist palliative care team provided support, advice, training and care to patients and staff trust-wide. The team consisted of 1.4 whole time equivalent (WTE) consultants and 7 WTE nurses (one vacancy). In addition there were two WTE occupational therapists. The team said this was adequate staffing and were reviewing skill mix as vacancies arose.
- The team responded to all referrals from clinicians throughout the trust for adult patients who had complex support and/or complex symptom management needs during end of life care. This included support to families of patients referred.
- The specialist palliative care team screened and allocated all new referrals on a daily basis. Current work and new allocations were reviewed every morning by the team and work was allocated based on patient need and urgency.

Major incident awareness and training

- Mortuary staff had additional facilities available in the event that the mortuary became full.
- The specialist palliative care team had not been included or involved in any major incident planning or training.

Are end of life care services effective?

Good

End of life care was provided in line with national guidance. Patients identified with end of life care needs had their needs assessed and reviewed and had pain and other symptoms managed effectively. Wards had identified end of life champions who received additional training by the

End of life care

specialist end of life team. Ward staff recognised end of life care related to a range of conditions and had training and additional resources to respond appropriately to patients' individual needs.

The specialist end of life team was valued by ward staff. The team were reported to be accessible, responsive and effective in supporting patients with complex end of life care needs and staff training needs.

Evidence-based care and treatment

- The specialist palliative care team had developed an end of life tool/pathway based on the recommendations in the Department of Health End of Life Care Strategy 2008. This provided a framework across the trust for non-specialist end of life practitioners to structure care for patients during the last year of life. This included guidance on end of life medicines and symptom management and where and how patients could be supported in their preferred place of care.
- End of life care was well embedded in Childrens services. The children had plans in place and the paediatric staff worked closely with the palliative care team.
- End of life care followed other national guidance; for example, the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. For example standards were being met with the provision of a specialist palliative care team who provided seven day working and could be contacted in person or by telephone during all out of hours. Staff on the four wards we visited said the accessibility of the specialist team had improved the consistency and effectiveness of end of life care for patients
- The specialist palliative care team provided written audit evidence relating to end of life tools developed by the team. These included continued evaluation of action plans related to the five year end of life strategy. For example, a retrospective audit of deceased patients' records (December 2013) had been completed to ascertain how optimum end of life care had been achieved.

Pain relief

- We spoke with the relatives of four patients who told us pain relief had been provided in a timely manner.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.
- We visited five wards and on each staff told us they always kept stocks of commonly prescribed end of life medicines. Staff said they did not experience significant delays getting alternative or additional stocks from pharmacy.

Nutrition and hydration

- Patients' records showed those identified as being in the last hours or days of life had had their nutrition and hydration needs evaluated and appropriate actions followed. These records documented subsequent discussions with relatives. Two relatives of patients we spoke with confirmed ward staff had clearly explained all changes in care, including those related to nutrition and hydration.
- The trust's end of life tool included ongoing medical review of patients' nutrition and hydration needs. We looked at five patient care records and saw individual nutrition and hydration needs had been assessed and reviewed and actions clearly recorded.
- We observed patients had drinks and snacks available. Relatives and staff said these were replenished throughout the day.

Patient outcomes

- The hospital contributed to the National Care of the Dying Audit, Royal College of Physicians, 2014. This scored participating trusts against seven organisational and key performance indicators. The hospital had fully met three of the indicators, almost met two indicators, partly met one indicator and not met one indicator. The specialist palliative care team had identified actions, responsible clinicians and timescales required to improve levels of compliance. This included working with other colleagues to develop shared practice guidelines and training.
- The specialist palliative care team audited records to see if patients had achieved their preferred place of care (Palliative Care Team Annual Report 2013-2014). During October, November and December 2013 the percentage of patients who achieved their choice was; 72%, 78% and 79%. The figures for January, February and March 2014 showed the percentage of patients who achieved their preferred choice of care had decreased to 67%,

49% and 53%. The specialist palliative care team had documented a range of training and education events for trust staff in order to improve these patient outcomes.

Competent staff

- We saw evidence 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.
- All wards had identified end of life care champions for the benefit of patient care. The specialist end of life team provided a rolling programme for identified staff to develop eight core end of life care competencies. These included; diagnosing dying, care plans, communication, comfort, modifying care, symptom control, meeting spiritual needs and care after death. Evaluation records showed staff who had already attended, valued the programme, reporting information was relevant, clear and well delivered.
- Ward staff knew who their end of life champion was and said the additional advice and support given by this person helped to maximise patient care and gave staff increased confidence with sensitive situations.
- The specialist palliative care 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.
- Four of the specialist palliative care nurses showed evidence of advanced continued professional development in end of life care.

Multidisciplinary working

- The specialist end of life team had a weekly multidisciplinary meeting to discuss end of life patients in more detail and depth and review care and treatment plans.
- The specialist palliative care 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 70% of meetings.
- The specialist palliative care team said they would attend other multidisciplinary meetings on an ad hoc basis when requested by other teams.
- The specialist palliative care team said they supported other health professionals to recognise and consider when patients may be approaching the need for terminal, end of life care.

Seven-day services

- The specialist palliative care team provided a seven day service at Sandwell General Hospital. The nurses worked Monday to Sunday 8am to 4pm. The nurses provided on call telephone advice from 4pm to 8am. The consultants worked 8am to 4pm Monday to Friday and provided out of hours telephone advice during the weekend.
- All ward staff we spoke with said the palliative care team responded promptly to referrals, with many patients being seen the same day or within 24 hours.
- Care records documented end of life patients had care anticipated to meet needs during the night and weekends. This included medicines and equipment.

Are end of life care services caring?

Good

Compassionate end of life care was provided to patients by ward staff. The patient and relatives of end of life patients we spoke with told us they felt involved with care and were treated with dignity and respect. However, relatives said they were given limited practical support when visiting end of life patients for extended periods of time. The specialist palliative care team had action plans in place to improve the experiences of end of life patients and their relatives.

Compassionate care

- Two of the patients we spoke with said staff had been attentive and they had no complaints about care they had received. We observed patients and relatives were treated kindly and with compassion.
- Ward staff told us where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Relatives of end of life patients told us ward visiting restrictions had been lifted and drinks were occasionally offered to them.
- Relatives of end of life patients said limited practical support was available when visiting for long periods. For example, relatives were offered a pillow and blanket but slept in high backed chairs and were not routinely

offered any food. Also, despite accessing reduced car parking fees, parking costs had mounted up when it had been necessary to stay at the hospital for extended periods.

Patient understanding and involvement

- We spoke with four patients and four relatives of end of life patients who told us they felt involved and informed with decisions and care.
- We reviewed 5 care records and saw detailed recordings of discussions with patients and relatives. This included discussions relating to medical treatments, prognosis and actions staff should take in response to patients' and relatives' wishes.
- The specialist palliative care team provided written resources for patients and families which were provided by the team or accessible via the trust website. This included information about a range of end of life medicines and information and advice about the last days of life.

Emotional support

- Emotional support for patients and relatives was available through the specialist palliative care team, ward based nurse specialists, the chaplaincy team and patient affairs offices (bereavement services).
- Training by the specialist palliative care team was available to ward staff on communication and end of life care.
- The trust had a dedicated bereavement service. Staff provided support and guidance to the families. Condolence cards were sent to bereaved families.
- Once a year there was a critical care unit memorial service for families of patients who had died. This was a multi-denominational service held within the hospital chapel.
- Families gave positive feedback regarding the bereavement service provided.

Are end of life care services responsive?

Requires Improvement

The discharge process was not effective as staff reported frequent delays, with assessments, planning and transport, including for those patients identified for fast track discharge. The chaplaincy service had been reduced which we were told would impact on the ability to be responsive to patient needs. Patients' individual needs were effectively responded to by ward staff. The specialist palliative care team were responsive to requests to support patients with complex end of life symptoms and care needs.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with community palliative care services and the clinical commissioning group (CCG). Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.
- One consultant from the specialist palliative care team was part of the end of life strategy group for the local CCG. A key function of this group was to develop service planning and delivery to meet the needs of local people.

Access and flow

- End of life care was delivered where required by ward staff throughout Sandwell General Hospital. The specialist palliative care team was accessible 24 hours a day for support and advice regarding patients who had complex care and/or complex symptom management.
- Referrals to the specialist palliative care team were made by ward staff using the trusts IT system or by telephone. The specialist palliative care team met every day to review current work and allocate new referrals, which were prioritised and allocated based on urgency and need.
- Ward staff understood how to make a referral to the specialist team and consistently reported the team responded promptly, usually seeing patients within a few days of referral.
- Patients receiving end of life care, who wished to transfer their care home or to an alternative service and, patients identified for fast track discharge, had their individual needs assessed by the discharge liaison team. The team said the service was always busy and unpredictable. Recent reorganisation of these services had resulted in reduced staffing levels. The discharge liaison team said this had resulted in delays in assessments for end of life patients wishing to be discharged from hospital. No audit or evaluation information was available regarding the effectiveness of the service. We spoke with the specialist palliative care team and ward staff who confirmed end of life patient discharges could be delayed for days or weeks.

End of life care

- Ward staff said further discharge delays of days or weeks impacted on end of life patients. Staff said this was due to the time taken by the local authority to arrange the appropriate care packages for patients.
- Staff said end of life patients with completed hospital discharge assessments and plans in place, did not always get transferred home for their preferred place of care. This specifically affected end of life patients being discharged home via ambulance. Patients whose home included steps or stairs required three ambulance crew. Ward staff said if the ambulance crew assessed the steps or stairs as having health and safety implications the end of life patient was taken back to the hospital A&E department. Staff said the patient would then be admitted to a ward where there was a bed vacancy.
- Planning and effectively responding to an end of life patients' choice for their preferred place of care and death is part of national best practice guidance. This includes; One Chance to Get it Right, Department of Health, 2014 and the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013.
- There was a policy in place for the rapid release of a deceased patient from the mortuary. Medical and mortuary staff demonstrated an understanding of the processes to follow. This enabled the cultural wishes of families to be respected.
- The National Care of the Dying Audit, Royal College of Physicians, 2014 identified quiet spaces were not available in all areas for relatives and friends of dying patients. The specialist palliative care team had action plans to encourage the trust with the development of new quiet spaces.

Meeting people's individual needs

- The specialist palliative care team was accessible 24 hours a day for support and advice for patients who had complex care and or complex symptom management.
- The chaplaincy service responded to the spiritual needs of end of life patients and their families. This included providing last rites services. The chaplaincy service had a multi-faith prayer room and provided multi-faith services and individual spiritual support and guidance as required.
- The chaplaincy service said recent reviews meant the chaplaincy service had recently been reduced. The team said they were considering how to manage this reduction but it would impact in the loss of one of the full time chaplaincy posts or the entire out of hour's service. This would not meet the standards set in the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. This says patients approaching end of life should be offered spiritual and/or religious support appropriate to their needs and preferences and receive care whenever they need it (day or night).
- Translation services were available for end of life patients and relatives.
- We saw patients and relatives had been frequently consulted and their wishes had been clearly recorded in care plans.

Learning from complaints and concerns

- End of life complaints were reviewed as part of the quarterly specialist palliative care governance meetings. Minutes from the last meeting dated May 2014 showed complaints and patient feedback had been discussed and actions planned to make end of life service improvements.
- The specialist palliative care team said any patient concerns or issues were dealt with at the time they were reported. Staff said concerns were also discussed during the team's daily morning meeting and if necessary were discussed in more depth and detail at the monthly multidisciplinary meeting. Staff said they learnt how to improve practice by sharing experiences.
- Information was available throughout the hospital to inform patients and relatives how to make a complaint.

Are end of life care services well-led?

Good

The staff we spoke with on wards valued the expertise and responsiveness of the specialist team. The specialist palliative care team was enthusiastic and passionate about the quality of end of life care provision and developing the skills of others. There were governance processes in place to monitor the quality of end of life care strategy. The specialist palliative care team demonstrated learning and changes in practice as a result of audits and complaints.

End of life care

Vision and strategy for this service

- We spoke with 18 staff on five wards at Sandwell General Hospital. This included doctors, nurses and health care assistants. Staff demonstrated a good understanding of the trust's end of life care pathway and how and when it should be used with patients.
- The specialist palliative care service had clear strategy and work plan priorities for the present and future. Palliative care priorities were discussed and recorded by the specialist team during their monthly business meetings.
- An end of life strategy group had also recently been coordinated by the specialist palliative care team. One meeting had been held during June 2014 with further meetings planned on a quarterly basis. The trust's chief nurse was nominated as chair and membership was being extended to include other disciplines and services. For example; a geriatrician, patient and carer representatives, a surgeon and district nursing lead. Staff said the aim of this group was to monitor, evaluate and plan and progress the trust's end of life strategy. In addition standing agenda items were documented to include; audits, key performance indicators, complaints and incidents, education, communication, the Mental Capacity Act and ethics. The last meeting minutes documented the intent to share outcomes from the meetings with different hospital directorates, GP's and the local clinical commissioning group (CCG).

Governance, risk management and quality measurement

- The specialist palliative care team reviewed clinical standards and risk and quality indicators as standing agenda items during the monthly business meeting. These included incidents, audits and quality improvement programmes. Staff said they adjusted practice as a consequence of incidents and complaints. This included the way in which they shared their learning and clinical practice with others. This information was documented in meeting minutes. For example, how to improve the transfer of end of life patients to alternative services during out of hours.
- End of life patient care was monitored by senior staff on wards. If staff learning needs were identified they requested support or training from the specialist palliative care team.

Leadership of service

- The senior specialist palliative care staff were described by colleagues as knowledgeable, supportive and passionate about end of life practice. Several staff members of the palliative team said the team was the best they had ever worked in because of team's good communication and excellent peer support. The specialist palliative care team had regular informal and formal supervision during daily and weekly meetings.
- Staff throughout the trust said the specialist end of life team were visible, approachable and accessible. Ward staff we spoke with valued the expertise and responsiveness of the specialist team and said patient outcomes and clinical practice improved as a result of the support provided.

Culture within the service

- The specialist palliative care team was passionate about the quality of end of life care for patients and relatives. The team said they felt supported by the trust board.
- The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others. This was done on a one to one basis, small groups or during larger training or end of life awareness events.

Public and staff engagement

- The specialist palliative care team was evaluating ways to more effectively collate the views of patients and bereaved relatives.
- Staff who attended training courses facilitated by the specialist palliative care team were asked their opinions of both content of the training and style of presentations. The majority of this feedback was positive. The specialist palliative care team said feedback was used to plan and improve future training sessions.
- The specialist palliative care team worked collaboratively with other services to improve end of life care for patients. This included community end of life and primary care services including district nurses and hospices.
- The specialist palliative care team conducted a bereavement survey using a questionnaire with bereaved relatives between May 2013 and November 2013. This resulted with the completion of 165 questionnaires. Most relatives of deceased patients were satisfied with the end of life care provided. For example, 77% of relatives felt the patient's wishes had been considered and 78% felt they were given enough

information after the death. An action plan was in place to address areas identified as requiring improvements. This included staff communication skills and how information should be collected in future from bereaved relatives.

Innovation, improvement and sustainability

- The specialist palliative care team was using national guidance to plan, improve and sustain the end of life services provided in the hospital.
- The specialist palliative care team provided a range of ongoing end of life training programmes for staff. This had been done and continued to be planned for the future in order to skill up increasing numbers of staff throughout the hospital to be able to provide good end of life care for patients now and in the future.
- One of the specialist palliative care consultants was a member of the end of life group for the local clinical commissioning group (CCG). This included engaging with local people and planning end of life services.
- The specialist palliative care team said their ability to follow and deliver on action plans identified within the trust's end of life care strategy was dependent upon maintaining the current skill mix.

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

Sandwell and West Birmingham NHS Trust runs a range of outpatient services from Sandwell Hospital, City Hospital and in the community. At Sandwell Hospital the outpatient clinics are on the ground and first floors, with reception desks on the ground floor and waiting areas in each clinic area. During our inspection we observed a range of outpatient clinics including haematology, ophthalmology, diabetes, respiratory medicine, orthopaedics and trauma, children's, endoscopy, and oncology.

The trust operates a diagnostic imaging department across both sites that undertakes x-rays, computerised tomography (CT) scans, interventional imaging, fluoroscopy, ultrasound and nuclear medicine. Management and some staff rotate across both acute hospital sites (City and Sandwell General). MRI scanning on the Sandwell site is undertaken by an on-site private provider. We did not inspect their facilities during our visit.

We met with 38 staff, including receptionists, nursing staff, healthcare assistants, radiology staff and consultants. We spoke with 15 patients and relatives. We looked at the patient environment and observed waiting areas and clinics in operation.

Summary of findings

In some areas we saw practices that could compromise the safety, privacy and dignity of patients. The trust was struggling to meet the demand for outpatient appointments, so overbooking of clinics was common, causing delays for patients. The impact of this was not being monitored locally.

Within diagnostic imaging services, we saw serious breach of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000).

There were issues with staff training records and reporting times for completed imaging. There had been a recent reconfiguration of the service, which had put pressure on an already short-staffed department.

We observed patients were cared for in a clean and hygienic environment. There was a system for reporting incidents, but this was not always being used consistently.

Management was still under development, with some managers recognising their limitations. Forward planning was not in place either, but the trust had recognised this and was using an outsourced consultancy to produce a toolkit to improve service in the future.

Staff were well regarded by patients, who were overwhelmingly positive about the care they received.

The managers of the outpatient departments were accessible and respected by staff.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

We assessed this domain to be inadequate. There was a system for reporting incidents, but no incidents had been reported in last 12 months. Staff were aware of how to report an incident.

Staff had an awareness of the Mental Capacity Act, but did not have a working knowledge and confidence to implement the requirements of the act.

Staff had received safeguarding training and were familiar with reporting systems.

Patient records were not always held securely.

Within the imaging department incidents had occurred and been reported appropriately. Training records for staff had not been adequately maintained.

There was long term sickness, which was impacting on service provision.

We observed patients being cared for in a clean and hygienic environment

Incidents

- There had been 22 incidents reported over the last 12 months. Staff were aware of how to report an incident. In some clinics staff reported that they were reluctant to report incidents as they did not receive any feedback.
- There had been no 'never events' (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) reported in the outpatient department.
- An electronic incident recording system was in place. In the general outpatient department, the two senior nurses were trained to use the system. Staff informed us that they reported any concerns or issues directly to the senior nurses.
- Patients told us they felt safe in the hospital.

Diagnostic Imaging Department

- 58 radiation errors were recorded across Sandwell General and City Hospital in the past year, this was about average when compared to other trusts. Over half were due to incorrect/unnecessary referrals and lack of robust identification procedures by the imaging staff. Where required under the IR(ME)R (Ionising Radiation [Medical Exposure] Regulations 2000), exposures reaching a nationally agreed threshold for external reporting were notified to the inspection team and appropriate investigations were being carried out. These included firm action plans and a governance structure surrounding the wider learning brought about following incidents.
- All staff spoken with were aware of the need to report incidents, concerns and near misses. These incidents were investigated and staff involved were included in this process. All incidents were documented on the trust software system for reporting and outside organisations were informed when applicable.
- We received information that indicated that one report contained a syndrome definition that had come from an inappropriate information site on the internet. Although this was one incident we felt it was sufficiently concerning to require clarification from the trust. We spoke with senior management, who were aware of which staff member had done this. Action had been taken to prevent this from reoccurring. Reporting was conducted for both sites, therefore we were not aware what site the patient attended.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Clinical areas appeared clean and there were systems in place to monitor checks of cleanliness.
- Toilet facilities were clean.
- Hand-hygiene gel dispensers were located at the entrance to each clinic, and were prominently signposted. Checks were in place to monitor hand hygiene. We saw the results from these checks.
- Patients told us they considered the hospital was clean.

Environment and equipment

- The service was delivered in a building which lacked space compared to the City Hospital site. Although we saw no direct detriment to patients due to the age of the building.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas. When the general outpatient department needed a hoist, they used one that was stored in the day unit.

- Resuscitation trolleys were located in each outpatient department. In the general outpatient department, the defibrillator was kept in a separate room to the trolley. The defibrillator was stored in a room where echocardiograms were carried out, so access to it could potentially impinge on the privacy of a patient having investigations. The Trust reported that the placing of the defibrillator in the cardiology area was due to the greatest likelihood of a defibrillator being required. From April 2014 the defibrillator has not been used.
- All resuscitation equipment was checked on a daily basis. We also saw evidence of audits undertaken by the resuscitation team.
- All staff had basic life support training and some had received intermediate life support training.
- We saw evidence to confirm that checks were in place to monitor the safety of the environment.

Diagnostic Imaging Department

- Equipment was regularly maintained and records of maintenance were kept. These records were in relation to medical physics equipment servicing and maintenance.
- Radiographers did not perform additional quality assurance on a regular basis. This was confirmed by the trust radiation protection advisor, who informed us that radiology staff were being worked with closely to improve compliance in this area. The equipment, however, always met its annual maintenance and safety checks and therefore there was no concern that equipment may be faulty or unsafe in any way.

Medicines

- All drugs used by the outpatient department were stored in a locked cupboard. No controlled drugs were stored in the department.

Records

- In some outpatient areas, records were held appropriately in a consulting room, nurses office or reception area.
- In the general outpatient department we observed patients' notes on trolleys outside consulting rooms. Staff were not always in the vicinity so records were vulnerable to theft and unauthorised access. This issue was not identified as an information governance risk in the department's risk register. The risk register is a record of risks identified within the department and actions identified to mitigate the risks.
- Staff told us when they did not have the full set of a patient's notes they made up temporary sets of notes by obtaining copies of recent letters that are stored on the database, but these did not contain all of the patient's records. When doctors or nurses do not have access to complete patient records it can compromise their ability to make robust decisions about care and treatment.
- In fracture clinics, patient's x-rays were seen in public areas without any staff nearby, leaving them open to unauthorised access.

Diagnostic Imaging Department

- There were no staff training or development records available to view except in the CT department. This included a lack of IR(ME)R update training or equipment competencies for any operator for all other modalities. This equipment included newly installed direct radiography and fluoroscopy image intensifier. The understanding was that all staff were adequately trained in the safe use of x-ray units, but there was no documentary evidence for this. This applied to all duty holders as cited within IR(ME)R.

Safeguarding

- There was a good awareness of adult and children's safeguarding. Staff stated they were well supported by the trust's safeguarding team, whom they could contact for advice.
- Information on safeguarding was displayed in some clinic areas.
- No safeguarding referrals had been made by the general outpatient department in the last 12 months.
- Safeguarding training was included as part of the mandatory training package. All staff received level one and two safeguarding children training. All staff received level one adult safeguarding training but only the senior nursing manager (band 7 and above) received level two adult safeguarding training. The trust have recognised that, "band 6 staff, with their managers, should consider the relevance of the training (level two) to their working environment" (safeguarding adults policy, August 13). Due to the level of autonomy the trained and untrained staff have within the department, level two training should be offered to staff.
- All staff we spoke to were aware of their responsibilities in safeguarding children and adults.
- The safeguarding policies were available for staff via the intranet.

Outpatients and diagnostic imaging

Mandatory training

- The mandatory training records for the general outpatient department identified who was up to date with their training and where there were gaps. This allowed for managers to address any shortfalls with individual staff members.
- The majority of mandatory training was up to date.

Diagnostic Imaging Department

- We saw records that demonstrated that mandatory training of all imaging staff was currently at 90.9% for the previous 12 months. This was below the trust standard but considered to be better in comparison to other hospital departments. Of the radiographic staff, 86.8% had undertaken a personal development review, which is a 12 month rolling programme. At the time it was below the trust recommended level of 95%, however following the inspection the trust confirmed this was a year to date figure.
- Medical appraisal and revalidation rates were 100% for medical radiologists. This meant that medical staff had the required skills and qualifications to maintain their registration.

Assessing and responding to patient risk

- A member of the trust board had recently undertaken a 'patient safety walkabout'. The subsequent report identified actions to improve patient safety. For example, the disabled toilet had a hand drier that blocked the way for people in wheelchairs due to its position.
- There was a risk to patients' privacy and dignity as staff were carrying out routine checks such as height, weight and blood pressure in the corridors next to waiting areas. Therefore results of these tests could be overheard by other patients and members of the public, which could have embarrassed the patients.

Diagnostic Imaging Department

- No exposure factors or diagnostic reference levels were listed in any x-ray room apart from the CT room. It is viewed as best practice that these are available and used clinically for guidance. Automatic exposure factors were used in all x-ray rooms viewed. It is acceptable practice to use automatic exposures as long as the exposure parameters have been optimised, which they were. This was discussed with various members of staff who informed us that they were aware of the correct range of exposures for each examination and the expected dose for standard patients and projections.

Nursing staffing

- The general outpatient department had a full staff complement. However, they had been told that the number of trained staff was to be reduced by two across both the Sandwell General and City Hospital sites. There would also be a reduction in the number of healthcare assistants but it was not known by how many.
- Bank and agency staff were not used in the general outpatient department. When extra cover was needed, existing staff would work additional hours.
- At busy times or when clinics overran, staff worked extra hours to ensure adequate cover was maintained.
- The children's outpatient department did not provide nurse cover for all clinics. In the month of September 2014 there had been eight occasions when the clinics were staffed by healthcare assistants only. On four of these occasions the nurse had left the clinic before it was completed. This does not comply with Royal College of Nursing guidelines requiring a nurse to be present within the specialist clinic.
- At times the general outpatient department was asked to provide staff for the specialist outpatient department to prevent clinics from being cancelled.
- Volunteers were not used in the outpatient departments.

Diagnostic Imaging Department

- There was a 4.45% sickness absence recorded for imaging staff across sites, which was considered high within the trust. However the trust was monitoring and managing via regular updates with staff and managers.
- There had been an increase in agency nursing usage during this financial year due to long-term sickness.
- At the time of the inspection there were three vacant radiographer posts and two vacant radiologist posts. These had not been advertised, as senior management in the department stated the need to make substantial savings and the biggest spend was staffing. The impact of this decision was not fully known. However, we did see that a recent decision to extend the hours of the service had resulted in a reduction of rooms able to be staffed to carry out imaging.

Outpatients and diagnostic imaging

- Due to the five outstanding posts and the long-term sickness rate of 4.45%, we considered the additional pressure on the remaining staff could not be maintained in the long term without reorganisation of the service. Both departments were undergoing a staff review at the time of the inspection. Patient safety could be compromised if this situation is allowed to continue in the long term.

Major incident awareness and training

- Outpatient managers stated that they were involved in major incident planning when necessary. They found this arrangement effective and efficient for their area of work.
- Allied health professionals reported that the trust "sorted things out before it is a problem", particularly in relation to winter pressure planning.

Diagnostic Imaging Department

- We noted there was a major incident procedure for imaging, which was also part of the whole hospital major incident procedure.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There was effective multidisciplinary working in the hospital and community settings to provide joined-up patient care.

Patients were positive about the outcomes of their treatment and felt they had been involved in making decisions about their care.

Although staff underwent an assessment of their performance, they did not have an opportunity to reflect and review their own practice.

The diagnostic imaging department were not working within guidelines on reporting timescales. This had resulted in the department having to use third party organisations to decrease the backlog, and their own staff were being paid a premium to reduce the backlog of unreported examinations.

Staff had a good system in place enabling them to compare previous images with the most recent for reporting purposes. All radiologist reporting sessions cover examinations undertaken at both hospitals within the trust.

Evidence-based care and treatment

- The endoscopy clinic had achieved the nationally recognised Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has the competence to deliver national endoscopy standards. This ensures that the unit provides the highest quality, timely, patient-centred care.
- The unit also used the two-stage consent process, which follows the Department of Health model consent processes, and we observed this is use. This ensures that the patient has all the necessary information they need to make an informed decision about their treatment and care.
- The endoscopy clinic had adapted a World Health Organisation safety checklist that ensured the safe pathway of patients through their treatment. During our visit we saw the checklist in use.
- The diabetic clinic has recently won the Quality in Care Programme award for the best primary care and/or community initiative with their Community Pathfinder Diabetes Project, which promotes the devolving of care from the hospital to the community.

Diagnostic Imaging Department

- The national two week wait timeframe for cancer patient examinations was adhered to. However, the reporting of these examinations did not comply with usual report turnaround times, which should be five days. Instead there was a four to five week turnaround time for routine reports.
- All ultrasound examinations were reported within 24 hours by the advanced practitioner sonographers and radiologists.
- All interventional imaging is reported within 24–48 hours by the radiologists.
- Extra reporting sessions were being undertaken by the radiologists as part of waiting list initiatives and they received extra payment for this work. This meant they could reduce the backlog.
- Standards of reporting were discussed with senior management as were the number of examinations reported per session. We were told that the number of

examinations reported was low and that management was trying to increase the number of reports to reduce the backlog. The additional consequence would be a reduction in spend on the extra sessions.

- The radiologists were not completing the recommended number of reports per four hour session. For example, they reported on 45 x-rays when the Royal College of Radiologists suggests 75 examinations in a four hour session. An outsource company were being used to undertake some of the plain film reporting.
- The outsource company was not being used for CT or magnetic resonance imaging (MRI) reporting. This enabled staff to maintain their skills in these two modalities.
- The trust used the services of another provider to review all of the complex head examinations undertaken. These were discussed during a twice weekly multidisciplinary team meeting. There was no radiologist representation from the trust at these meetings. This means that any changes to reports were not discussed with the Sandwell or City radiologists or changed on their radiology computer system. No learning and development was therefore taking place at this level. Also, any report changes made by the other provider were only made in patient notes.
- The management told us that the neurology department at Sandwell had grown recently. However, the neurologists within the trust found it challenging that the level of expertise was not as high as other providers for the specialised CT/MRI service.
- All accident and emergency (A&E), ultrasound, nuclear medicine and interventional examinations were reported within 24–48 hours.
- Two weeks after the inspection, the trust informed us that some of the reporting times had reduced, namely CT and MRI scans. Six per cent and 8% of CT and MRI unreported scans remained unreported at five weeks, respectively. The trust had identified that by November this would have improved further to a two week delay in reporting.
- Electronic vetting of all request forms was in place throughout imaging and worked well. Standard procedure was that previous images were viewed during justification and this was routinely undertaken.

Pain relief

- Staff told us that they could give Paracetamol to patients if they were in pain. Patients took their own medications that had been prescribed for them.

Patient outcomes

- Patients we spoke with were positive about the outcomes of their treatment. Patients told us that treatment was effective and met their needs.

Competent staff

- There was a structured induction programme in place for new staff, but no new staff had been recruited to the general outpatient department for some years.
- In the general outpatient department there was an appraisal system in place and records showed an appraisal completion rate of 100%.
- In the general outpatient department the last team meeting had taken place six months ago. Managers stated that due to clinic commitments it was difficult to hold meetings more regularly. Notes of staff meetings were available to staff who did not attend.
- Staff were kept up to date by trust-wide communications. Nurse managers sent out emails when key messages needed to be communicated.
- In the general outpatient department clinical supervision did not take place. As a result there was no opportunity for staff to reflect on and review their practice, discuss individual cases in depth, change or modify their practice or identify training and continuing development needs.
- Senior managers had suggested that a trust-wide 'governance day' would be arranged when individual staff and teams could have dedicated time to reflect on their practice, but this had not yet happened.
- Staff in the general outpatient department reported that access to training was sometimes difficult due to staffing levels.
- Allied health professionals reported they had regular supervision and appraisals, and good access to competency-based training using national and local competency frameworks.

Diagnostic imaging department

- There were three advanced practitioner radiographers who reported on A&E-generated examinations, and staff

told us they were encouraged to develop their skills. The trust was unable to demonstrate that training or competency checks had been undertaken because they had not maintained records of them.
- There was no clear guidance available in the x-ray rooms for new staff regarding exposure parameter guidance or information on expected dose values. It is a regulatory requirement that diagnostic reference levels are established and audited with regular review. Although a dose audit programme was established, the reference levels were not displayed and therefore not available to staff to refer to within the x-ray department.
- They were all general radiologists with a subspecialty interest; we saw three were increasing their knowledge and skills of neuroradiology as they were performing complex head CT and MRI examinations.
- Some senior managers stated a lack of knowledge about the radiation regulations and were aware that they needed to familiarise themselves with IR(ME)R.

Multidisciplinary working

- Some clinics were jointly run by consultants and nurses and some by clinical nurse specialists only.
- Patients told us that where they received care from different services in the hospital staff were aware of this.
- All staff reported good working relationships with community teams. We saw examples when staff engaged with allied health professionals, general practitioners and community teams. The respiratory nursing team was an integrated service across both hospital and community settings to ensure seamless care. A social service liaison officer worked in the eye clinic, ensuring that appropriate referrals were made to the sensory impairment team at Sandwell Social Services.
- Allied health professionals stated that effective integrated working took place across departments.

Seven-day services

- All clinics were held on weekdays with some additional clinics organised to meet demand and waiting time targets. A chemical chemistry clinic was held once a week outside core business hours. Family planning clinics were also run once a week outside core business hours at Rowley Regis Hospital.

Access to information

- Patients we spoke with stated they felt that they had been involved in decisions about their care.
- Patients told us they had received information about their conditions.
- There was a wide range of relevant information displayed in the chest clinic, in the reception area of the general outpatient department, and in the endoscopy clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall, outpatients staff had an awareness of the Mental Capacity Act, but did not have a working knowledge and confidence to implement the requirements of the Act. This could result in staff not ensuring patients either had a best interest assessment or had persons appointed to act on their behalf if a patient did not have appropriate capacity.
- Training on the Mental Capacity Act was only provided for the senior nurse manager in the general outpatient department.
- Allied health professionals had a good understanding of the Act and its implications in their work.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with dignity and respect. Over time, many staff had built trusting relationships with some patients.

Staff were well regarded by patients who were overwhelmingly positive about the care they received.

Compassionate care

- Throughout our visit we witnessed patients being treated with compassion, dignity and respect. A patient in the endoscopy clinic said “staff made an unpleasant experience as good as it can be”.
- Most outpatient departments had suitable rooms for private consultations.
- The eye clinic did not provide sufficient privacy for consultations, as they were conducted in cubicles where doctor patient conversations could be overheard. This matter was recorded on the trust risk register and potential solutions were recorded and design plans had been agreed by the Trust.

Outpatients and diagnostic imaging

- Patients we spoke with all felt the hospital staff were very caring and were complimentary about the service. A patient in the trauma and orthopaedic clinic said, "The staff were brilliant and I always felt looked after".
- Patients told us they felt they had treatments and procedures explained to them.
- Clinic consultations took place in rooms with the door closed.
- In the genitourinary clinic there were separate male and female waiting rooms. If mixed sex couples attended they had the option to ask their partner to wait in a single sex waiting room or wait together in the reception area.
- Chaperoning arrangements were in place. Doctors and nurses decided if chaperoning was necessary. When patients requested a chaperone, one would be provided, but patients were not informed of their right to a chaperone, either before or during a consultation.
- Staff were said to be professional, compassionate, polite, kind and helpful.

Diagnostic imaging department

- We observed the reception staff during the inspection, they were pleasant and informative and began the identification process to ensure the correct patient would receive the correct examination. There had been a problem with the patient identification procedure earlier in the year and the new six point identification procedure recommended by the Care Quality Commission (CQC) IR(ME)R inspectors had been successfully adopted. Staff felt that it was helping to reduce errors.
- The radiographic staff interaction with patients we observed during this visit was professional, informative and compassionate at all times.

Understanding and involvement of patients and those close to them

- Patients stated they felt that they had been involved in decisions about their care.
- We saw nurses seeking consent from patients before they carried out any interventions.
- Patients told us they had received information about their conditions and medications.
- Patients also told us that relatives or carers were included when they wanted them to be. This included joining them in the clinic rooms.

Emotional support

- Many staff had worked at the hospital for some years and were known to some of the patients. This helped them to build a trusting relationships with staff.
- We saw examples across most departments where patients were referred to a clinical nurse specialist. A number of clinical nurse specialists regularly held their own clinics across the outpatient departments.
- In the general outpatient department a quiet room was available for patients who had received difficult news. Additional information was provided along with access to a clinical nurse specialist and follow-up contact details.
- Clinics have access to the ESTEEM programme. This is a private sector collaboration with a mental health/ psychology team. Patients with personal or psychological difficulties are referred to the service, and then signposted on to appropriate therapies. Patients had received laughter therapy, one to one counselling and group treatments. We spoke with one doctor and one patient who had used this service who reported that it had made a big difference to the patient's quality of life.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We judged this domain to be inadequate. Patients were happy with the treatment and care they received but were often kept waiting beyond their appointment time. The trust was struggling to meet demand for appointments. There was no mechanism in place to measure access and flow in the department. There was no structured support in place for people with dementia and learning disabilities.

General outpatients did not information available in any language other than English

There was a backlog of four to five weeks for the reporting of computerised tomography (CT) scans. This was unacceptable as usually it took five days.

Service planning and delivery to meet the needs of local people

- Patients receive written notice of their appointment that informed them where to go when they arrived at the

hospital. Contact numbers were provided if patients were uncertain of anything before their visit. It also informed them what they would need to bring with them or if they were required to visit another department for tests.
- There was no use of pre-booked x-rays to reduce the length of waiting time in the x-ray department or the outpatient department.
- The planning of clinics was mainly founded on historical practice, based on the availability of consultants and the drive to achieve the 18 week referral-to-treatment target. Following the inspection the trust supplied evidence which demonstrated that monitoring of the service provision was undertaken along with stakeholders.
- To ensure that each clinic had a limit on the number of patients booked in, a template was used for booking appointments. However managers reported that this was not always used and that clinics often exceed the prescribed numbers. This regularly resulted in clinics over-running. This led to patients experiencing long waiting times and staff working over their prescribed hours.
- The number of patients who were seen within 18 weeks of referral was better than the national average.
- Outreach clinics were provided at Rowley Regis Hospital, Neptune Health Park in Tipton and Neptune Health Centre in Smethwick.

Diagnostic imaging department

- Staff hours had been changed recently to improve accessibility to the service for patients. The working days had been elongated to a 12 hour shift pattern during the day. Staff told us this resulted in rooms needing to be closed due to staffing level safety issues. This was because there were gaps in the number of staff available during the core hours of the working day. This put more pressure on staff to undertake the same workload in fewer rooms across both sites, but more often at Sandwell. Evidence of staff rotas and room capacity and demand were seen as part of the inspection.

Access and flow

- Patients told us that they were happy with the treatment they received but were usually kept waiting beyond the time of their appointment. Most patients we spoke with were tolerant and accepted when they were not seen at their scheduled appointment times.
- In the children's outpatient department, staff informed us that morning clinics can run over into the afternoon with children waiting in excess of one hour.
- In the general outpatient department, clinics were late running on the day of our inspection. Staff told us this was normal. For example 'new' patients were often booked in first. They would have to have investigations such as blood tests and x-rays before they saw the doctor. When they returned to the clinic they would be slotted in, but this created delays for other patients.
- In the genitourinary clinic, people were waiting for up to one hour. There were recent examples where patients left the department without being seen by the doctors due to the excessive waiting time.
- Waiting times were only displayed in the children's outpatient department. In other clinics, nurses would inform patients of the waiting time every 30 minutes although patients were not told the reasons for any delay.
- In the haematology clinic we were told that the doctor does not deliver any bad news in the clinic due to only having 15 minute appointments. The doctor will request the patient to return to the ward where sufficient time can be spent on supporting them.
- At the time of our visit the clinical chemistry clinic had cancelled 19 patients at short notice due to unavailability of the doctor. Staff tried to make contact with patients who had their appointment cancelled, but if people did attend they were seen wherever possible.
- The number of patients who did not attend their appointment was higher than the national average. A change programme was currently in place for outpatients called 'The year of the outpatient' that the trust hopes will improve this situation.
- Access and flow within the outpatient department was not being adequately measured. Waiting times and the numbers of clinics that started late or overran was not systematically measured by the trust.
- The trust provided patient transport services. Staff reported that appointments were sometimes cancelled

due to patient transport reasons, for example if patients were not ready for transport. The diabetic clinic reported some patients could wait up to 4 hours for transport home.
- In the general outpatient department, weight and height measurements were taken in the corridors, which compromised patients' dignity and confidentiality. The trust is aware of these issues but there were no confirmed plans in place to rectify the matter.

Outpatient clinics were made up from the separate directorates within the trust such as chest, ophthalmology and children's, alongside general outpatients including surgery, medicine and oncology. Diagnostic imaging department

- There was a backlog of routine computerised tomography (CT) scan reporting of examinations of between four and five weeks. The usual turnaround time for reporting is five days. Senior management thought this was the imaging department's greatest risk.
- Within the staff rota we were able to confirm that there were two general radiographers plus one CT-trained radiographer working through the night from 8pm to 8am. There was also a radiology registrar on site for reporting CT examinations throughout this time frame as well. We verified this.

Meeting people's individual needs

- Overall there was good access to interpreters. The trust had its own bank of interpreters that could be accessed by the department for patients. The genitourinary clinic ensured that interpreters were the same gender as the patient. If GPs flagged the need for an interpreter in referral letters then one could be booked in advance.
- Allied health professionals reported some difficulties in accessing interpreters across the hospital.
- The equalities and diversity team had a dedicated noticeboard in the trauma and orthopaedic clinic that provided public information on the work the trust was carrying out to fulfil its equality and diversity duties.
- The children's outpatient department and the chest clinic had a range of books and leaflets in different languages. However, patient information was only available in English in the general outpatient department despite the department serving a multicultural community.
- In the children's outpatient department we observed a clinic session involving a child with sensory impairment where appropriate language was used and written information given to support the child and parent.
- In the general outpatient department we observed the cupboard where dressings were stored was left unlocked and unattended. Staff stated that this was due to the difficulty in finding the person who has keys. The cupboard was left open for 45 minutes.
- Staff informed us that patients with complex needs were fast tracked through the department to avoid any delays.
- In the endoscopy clinic all patients with dementia were pre-assessed by a consultant before they received their treatment.
- Dementia awareness training was not mandatory. The trust has a network of dementia coordinators and champions. There is no dementia coordinator for the outpatient department. Staff would contact the trust dementia leads if they had any concerns.
- Staff told us there was no learning disabilities awareness training or screening for dementia, although there was an information pack for people with learning disabilities available in the genitourinary clinic.
- In the endoscopy clinic, single sex accommodation had been improved. However, patients may have had to walk past patients of the opposite sex to go to the toilet. This is a breach of single sex guidelines.

Diagnostic imaging department

- There were a number of information notices for patients in different languages in the waiting areas. All staff were aware of the interpreter service offered within the hospital, which was used frequently.
- There were separate changing cubicles for male and female patients in CT department and patients in other areas were provided with dressing gowns and were encouraged to remain in the changing cubicles until called into the imaging rooms.

Learning from complaints and concerns

- There had been no formal complaints about the general outpatient department. Managers informed us that any issues were dealt with at the time they arose. No record was kept of these incidents so learning opportunities may have been lost.

Outpatients and diagnostic imaging

- There were some leaflets available in the outpatient departments including comment cards, which patients could, completed and posted.
- Most patients we spoke with were not familiar with the complaints process but said they would raise any issues directly with staff.
- Conflict resolution was included in the mandatory training programme, which all staff in the general outpatient department had completed.
- Only the senior nurse manager in the general outpatient department had completed investigation of incidents, complaints and claims training. This meant that investigations and complaints should have been investigated thoroughly and fairly.

Diagnostic imaging department

- All incidents were discussed at clinical governance meetings and changes were made to the service if necessary. Action plans, review and revision of policies and procedures were seen during the inspection, and minutes of IR(ME)R governance and clinical governance meetings were also inspected.

Environment

- Car parking was available, but some patients we spoke with said it was expensive, particularly for short stays. There was no system in place to give concessionary passes if patients experienced delays in appointment times and they incurred additional car parking costs.
- In the waiting areas in the children's outpatient department, there was a range of toys and books available to help keep children occupied, and décor was bright with pictures on the walls. There was a television showing a children's film and space for pushchairs.
- There were sufficient seats in all outpatient areas. In the entrance of the general outpatient department there was a large seating area that was not used during our visit. This area housed a television that was showing information about the trust's performance alongside general health information. We were told that this information was for patients attending the department, but we found the information difficult to read from the seats in this area.
- There was a wide range of leaflets in this area as well.
- A café was located near to the front entrance of the outpatient department, run by a private company.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We assessed this domain to be inadequate. Communications across the trust had recently improved but messages about workforce changes were not always clear. Targets for improvements had been missed and senior staff felt that they were unrealistic and over simplified.

Service governance systems were not strongly established.

Staff morale was being affected by the change programme. Staff did not always feel valued by the trust.

The managers of the outpatient departments were accessible and well regarded by staff.

Within the imaging department, leadership needed to be developed further to enable all staff to be supported to deliver effectively. The management needed to develop their analysis of service delivery, to ensure future plans meet the needs of patients and staff.

There was no vision or strategy and changes had been made to improve access to the service, but due to staffing this had not been fully achieved. Issues such as vision and strategy and forward planning had been outsourced to a third party company.

Management within the service felt they required more experience to manage the service well.

Vision and strategy for this service

- Not all staff were able to describe the vision and strategy for the future of the trust.
- A change programme was currently in place for outpatients, called 'The Year of the Outpatient'. This project aimed to improve patient experience of using outpatients, by modernising the systems and processes currently in place. A survey of patient opinion had been completed. Progress on the subsequent targets within the change programme had not been achieved. Senior managers reported that the rate of change was not always realistic, and plans did not fully reflect the complexity of the outpatients service.

Outpatients and diagnostic imaging

- Progress on the first targets in the change programme had not been achieved. Senior managers reported that the rate of change was not always realistic and plans did not fully reflect the complexity of the outpatient department.
- Not all staff in outpatients were aware of the change programme. This is despite of the Trust newspaper outlining the aims and work streams of the project.
- Alongside the change programme a workforce review had also been undertaken. The outcome of this review had identified the need to reduce the number of trained nurse posts by two across both the Sandwell and City hospitals. The reduction in the number of healthcare assistants was not yet known. Staff spoken with reported fearing for their jobs, which was adversely impacting on morale.

Diagnostic imaging department

- There was no clear vision or strategy in the imaging department. The senior managers were waiting for a productivity review report, which was being produced by an outsource consultancy to bring about changes in the departments. Following the inspection the trust were clear that the consultancy firms role was to review demand and capacity.

Governance, risk management and quality measurement

- Although there had been 22 incidents reported over the last 12 months, staff were aware of how to report an incident. In some clinics staff reported that they were reluctant to report incidents as they did not receive any feedback. Allied health professionals reported that over the last 12–18 months they had started getting feedback from incidents.
- Staff in the general outpatient department were not receiving clinical supervision, so there was no formal monitoring of their practice.
- Staff were not familiar with the potential implications of the mental capacity policy in their work due to the lack of training offered.
- There were no governance procedures to monitor the frequency of overbooked or late running clinics or waiting times. Therefore, the impact was unknown and no actions were taken to address the issues.
- The general outpatient risk register did not capture all risk issues, for example, information governance breaches, which we saw on inspection.
- During April and December 2014 all patients attending the outpatient department were asked about their experience. The majority reported their experience had been very good. A parents' and children's survey was undertaken in the children's outpatient department in August 2014. Overall the results were positive, particularly in relation to the care provided.

Diagnostic imaging department

- One senior department manager stated there was no forward planning in the department. This meant room lists could be cancelled at the last minute due to radiologists taking planned leave. Within Sandwell Hospital there was only one fluoroscopy room which meant that any cancellation would have a negative impact on patients. It was also stated that this was being examined by an outside consultancy firm as the department was undergoing a productivity review, and they expected to receive an imaging toolkit which incorporated forward planning and standards of working.

Leadership of service

- All staff we spoke with told us their immediate line managers were approachable. All outpatient managers told us they had an open-door policy.
- All staff reported feeling well supported by their managers.
- Staff did not always feel valued by the trust.

Diagnostic imaging department

- Some of the managers were newly in post and described an absence of leadership in the department for 18 months previous to their employment. One of the managers told us they thought this was the main reason for the current position of the department.
- Some senior managers stated they could benefit from training and support to improve their management styles. They felt this was needed if they were to make the service more responsive to the needs of patients and other clinical colleagues. The trust has an ongoing leadership programme in place to support management on which the imaging management were represented.
- During the group discussions with radiographers, leadership was one of the topics and the staff felt they were not well-led. Although they had good working relationships with the radiologists, they did not feel the clinicians took responsibility for the service.

- The staff stated during the focus group that the managers were not visible on the 'shop-floor' but were approachable in their offices. They felt the band 7 radiographers ran the departments, producing the working rotas and were around for advice and support when needed.

Culture within the service

- We observed staff culture that was respectful and advocated for patients. Staff offered a caring service.
- Staff in outpatient departments spoke positively about the service they provided for patients. They were proud of their 'customer service' and the way doctors and nurses worked as a single team.
- Staff we spoke with were aware of the whistleblowing procedure. They told us they would report any concerns they had.
- Staff were receiving annual appraisals that included a review of completed training.

Public and staff engagement

- Staff reported that communications across the trust had been improved over the last 12–18 months. However, communications about the workforce changes were often confusing and contradictory.
- Allied health professionals reported that they were well informed through their manager, the regular newsletter 'Hot topics', and they had experience of emailing the chief executive and receiving a response.

Diagnostic imaging department

- A token system for patients to describe their experience with the imaging department was in use. The various imaging departments had different coloured tokens, which were given to patients before their examination. The patients then placed the tokens in the relevant sections of the wall boxes provided that best described their experience in the department. The distribution of the tokens were analysed weekly and any required changes to the service and/or department identified by patients were put into action.
- We saw documentary evidence that information within the radiography department was relayed at weekly staff meetings by the band 7 staff. Staff stated that the morale of the department was low, but the staff tried hard not to show this to the patients. This was observed during the walk around the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

A&E

Action the hospital MUST take to improve

- 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.

Surgery

Action the hospital MUST take to improve

- 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

Action the hospital MUST take to improve

- 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.

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Action the hospital SHOULD take to improve

A&E

Action the hospital SHOULD take to improve

- The trust should consider what the systemic gaps in the use of patients' early warning score records are indicating about usage of this tool.
- The trust should consider some analysis of staff practice of relying on patients' relatives for language interpretation, and what impact this has on the accuracy of assessment of a patient's condition.
- The trust should consider how to better promote its complaints policy and procedure in the A&E department.

Medicine

Action the hospital SHOULD take to improve

- The trust should take action to improve the compliance with staff's mandatory training targets
- The trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion

Outstanding practice and areas for improvement

- The trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.
- The trust should ensure all patients are aware of and in agreement with their treatment plan.
- The trust should ensure all medicines are stored in accordance with trust procedures.

Surgery

Action the hospital SHOULD take to improve

- The trust should ensure that a safe system is in place, which all surgical staff have received appropriate training in, to safely book patients into the theatre suite and record same.
- The trust should ensure that the World Health Organisation (WHO) surgical safety checklist and preoperative briefing follow the WHO guidelines. The trust should ensure that staff know what is expected of them and that the checklists are assessed and monitored for quality.
- The trust should consider improving the environment in the pre-assessment unit at City Hospital because it is not patient friendly, has inadequate staff facilities and does not promote patients' dignity.
- The trust should consider reviewing its process for booking bank and agency staff. The current system does not flow as the trust expects it to, and it obstructs staff in ensuring that shifts are staffed safely.

EOLC

In addition the trust SHOULD:

- The trust should schedule repairs to the previously reported cracked concrete floor in the mortuary. This presented an infection control risk and did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- The trust should review the hospital discharge processes. These have an impact on patients' ability to achieve their preferred place for end of life care and fast-track discharges. This is contrary to national best practice guidance including One chance to get it right, Department of Health, 2014.
- Review how the reduced chaplaincy services can continue to provide a caring and responsive service to patients when required. The reduction in these services is contrary to national guidance including the NICE Quality standards for end of life care, 2011, updated 2013.

OPD

Action the hospital SHOULD take to improve

- The trust should ensure that communications to staff about workforce changes are timely, clear and consistent.
- The trust should ensure that the outpatient risk register captures all known risk issues.
- The trust should ensure that support for people with dementia and learning disabilities is available in the outpatients department.
- The trust should ensure that the planned review to assess the current and future capacity in outpatients is undertaken urgently so that the findings can inform the current change programme.
- The trust should ensure that, when complaints about outpatients are resolved at the time they arise, records are kept so that lessons can be learned from the incidents.
- The trust should ensure that urgent action is taken to improve the privacy of patients in the eye clinic.
- The trust should ensure that urgent action is taken to improve the confidentiality of patient records in outpatients, and that patients' privacy and dignity are maintained at all times.
- The trust should ensure that all staff have a working knowledge of the Mental Capacity Act 2005 and understand its implications for their practice.

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 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.**

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.**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services 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.

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	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.