Walsall Healthcare NHS Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Walsall Healthcare NHS Trust provides local general hospital and community services to around 260,000 people in Walsall and the surrounding areas. The trust is the only provider of NHS acute care in Walsall, providing inpatients and outpatients at the Manor Hospital as well as a wide range of services in the community.

Walsall Healthcare NHS Trust is working in collaboration with the Royal Wolverhampton NHS Trust under the leadership of a joint chair and chief executive.

Between 20 September 2022 and 10 November 2022, we carried out an unannounced inspection of three of the acute services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We inspected Children and Young Persons services using our focused inspection methodology. We also inspected Medical and Surgical services. We inspected these services, at Manor Hospital, as our intelligence suggested there may have been a deterioration in the safety and quality of care provided. In addition, in Medical services, we needed to follow up a section 29a warning notice, issued to the trust in March 2021, as we found significant improvement was required to the nurse staffing of the service, the governance of the service and how they provided patients with a safe discharge.

We did not inspect any other services at Walsall Healthcare NHS Trust because our monitoring process had not highlighted any concerns. We will re-inspect these services as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed ‘is this organisation well-led’. We inspected the well-led key question between 9 and 10 November 2022. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England. There was not a separate ‘Use of Resources’ assessment in advance of this inspection.

Our findings

Following our core service inspection, we served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided by Walsall Healthcare NHS Trust in relation to the management of medicines, including prescribing, administration, recording and storage, in Medical services required significant improvement.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring as outstanding.
- We rated two of the trust's acute services as good and one as requires improvement.
- In rating the trust, we took into account the current ratings of the five acute services and four community services not inspected this time.
- Safe processes and systems were not always in place to manage the prescribing, administration and storage of patients' medicines and medicine related documents. Services did not always control infection risk well. Care records were not always complete. In the Surgery service staff did not always assess risks to patients in relation to venous thromboembolism (VTE).
- In the Medical Care service, arrangements to ensure assessment of patient's mental capacity or deprivation of liberty were not robust.
- Services for children and young people did not always take account of patients' individual needs.
- Service leaders did not always run services well and information systems were not always reliable.

However:

- We found improvements during our inspection of how well led the organisation was.
- Services mostly had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff mostly assessed risks to patients and acted on them. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided kind care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information. Key services were available seven days a week.
- Across all services staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Although people could not always access the service when they needed it, the trust was working hard to ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- Services planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Our findings

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Trust Wide

- The trust had worked with system partners to increase employment opportunities for people in the community who were long term unemployed and people from ethnic minority groups.
- A team effort to ensure gold standard care for patients with hip fractures had resulted in a national award for the trust which was now rated as second best in the region for its service.
- There was exceptional performance in the emergency department at Walsall Manor Hospital where the trust had some of the highest same day emergency care (SDEC) rates in the country and consistently the lowest ambulance handover delays in the region.
- Patient, carer and public engagement and involvement was exemplary.

Manor Hospital

Children and Young Persons

- The patient experience used the 15-step challenge tool to improve patient experience. This included children in developing the tool and participating in order that their views and contributions were heard and valued.

Medical

- The diabetes service had received several awards for improvements for care of people admitted to hospital with diabetic emergencies.

Surgical

- The service received a clinical audit award from the healthcare quality improvement partnership for work on the trust's neck of femur (NOF) pathway. This was an improvement as the trust had recently been a (NOF) outlier.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Our findings

We told the trust that it must take action to bring services into line with three legal requirements. This action related to two core services and trust wide.

Manor Hospital

Trust Wide

- The provider must ensure all levels of governance and management function effectively and interact with each other appropriately and there is a risk management framework in place that ensures there are assurance systems in place, and performance issues are escalated appropriately through clear structures and processes. Regulation 17: Good Governance.
- The provider must ensure they act in an open and transparent way with people receiving care or treatment from them and apply the duty of candour for notifiable safety incidents. Regulation 20: Duty of candour.

Medical

- The provider must ensure safe process and systems are in place to manage the prescribing and administration and storage of patients' medicines including medicine related documents. Regulation 12: Safe care and treatment.
- The provider must ensure there are appropriate systems in place to ensure infection control risk is minimised. Regulation 12: Safe care and treatment.
- The provider must ensure the design, maintenance and use of facilities and premises keep people safe. Regulation 12: Safe care and treatment.
- The provider must ensure staff identify and quickly act upon patients at risk of deterioration. Regulation 12: Safe care and treatment.
- The provider must ensure records of patients' care and treatment are complete, clear and are stored securely and provide all required information for staff providing care. Regulation 12: Safe care and treatment.
- The provider must ensure patients who lacked capacity to make their own decisions or were experiencing mental ill health were appropriately supported and measures to limit patients' liberty were appropriately applied. Regulation 11: Need for consent.

Surgical

- The provider must ensure that venous thromboembolism assessments are carried out. Regulation 12: Safe care and treatment.

Action the trust SHOULD take to improve:

Trust wide

- The provider should ensure work continues to increase the uptake of training developed and released by the National Guardian Office (NGO).
- The provider should ensure work continues to progress the digital agenda.
- The provider should ensure a quality strategy is in place to provide a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience.

Our findings

- The provider should ensure work continues to increase compliance with the duty of candour regulation.
- The provider should ensure work continues to strengthen the work of the sub-committees and non-executive directors in order to ensure all levels of governance and management functioned effectively and interacted with each other appropriately.
- The provider should ensure work continues to develop supplementary plans to give assurance that the financial plan would be delivered.
- The provider should ensure work continues to develop a risk management framework that would ensure there were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes.

Manor Hospital

Children and Young Persons

- The provider should ensure all staff recovering paediatric patients in the theatre recovery area are trained in either paediatric immediate life support (PILS) or, European paediatric advanced life support (EPALS).
- The provider should ensure the voice of the child is consistently captured in the records.
- The provider should ensure the outpatient's department has an appropriate number of nurses available to staff the outpatient's clinics.
- The provider should ensure patient records are consistently completed on all wards.
- The provider should ensure systems and processes are in place on ward 21 to safely store medicines.
- The provider should consider engaging staff in safeguarding supervision.
- The provider should consider reviewing outpatient appointments for children and young people to avoid appointments late in the evening.
- The provider should consider reviewing the environment in the outpatient's department to make it child-centred.

Medical

- The provider should ensure doctors, nurses and other healthcare professionals work together as a team to benefit patients and support each other to provide good care.
- The provider should ensure staff use an appropriate tool to help assess the level of pain in patients who are non-verbal.
- The provider should ensure to ongoing checks on the effective management of venous thromboembolism assessment.
- The provider should ensure the sepsis audit includes all key management measures for sepsis as identified within the trust policy.
- The provider should ensure timely psychosocial assessments and risk assessments are completed for patients thought to be at risk of self-harm or suicide.
- The provider should ensure there are appropriate arrangements in place when a patient is transferred between wards and other clinical staff to keep them safe.

Our findings

- The provider should ensure the policy which includes the management of younger people between 16 and 21 years is reviewed and is shared with staff to ensure best practice is followed.
- The provider should ensure the programme to complete mandatory training which includes safeguarding adults and children level 3 and basic life support is completed.

Surgical

- The provider should ensure that patient weights are consistently recorded on drug charts.
- The provider should ensure all staff adhere to infection prevention and control practices.
- The provider should consider safe storage of equipment in theatres.
- The provider should ensure there is a robust system in place to improve monitoring of post-operative complications.
- The provider should ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line with national standards.
- The provider should ensure enough suitably qualified nursing staff are available on every shift to keep people safe.

Is this organisation well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

- Not all leaders had the necessary capacity to lead effectively, succession planning was in its infancy and the stability of the board was under development.
- There was no quality strategy in place providing a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience. This was planned to be in place by January 2023.
- Work was underway to ensure all staff felt knowledgeable, encouraged and supported to raise concerns and the culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents.
- Governance processes were in place throughout the trust and with partner organisations. However, these were in their infancy with some leaders not yet clear about their roles and accountabilities.
- Systems to manage performance effectively were under review. Relevant risks and issues and actions to reduce their impact had been identified but there was work to do to ensure they reflected the strategic objectives realised through the group strategy.
- Work was underway to ensure the board collected reliable data and analysed it. Technology improvements were in their infancy, with some not yet realised meaning staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

Our findings

- Overall, leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders had regular opportunities to meet, discuss and learn from the performance of services.
- The trust had plans to cope with unexpected events. The board were clear that their decision-making avoided financial pressures compromising the quality of care.
- Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The trust collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leadership

Overall, leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, not all leaders had the necessary capacity to lead effectively, succession planning was in its infancy and the stability of the board was under development.

The trust was run by the chair and a board of directors made up of 13 executive (ED) and nine non-executive directors (NED). Of these, five executive directors and six of the non-executive directors were voting members of the trust board.

Leaders described the board as a unitary board with the EDs and NEDs making decisions as a single group and sharing the same responsibility and liability. However, during some of our well led interviews we found a lack of clarity regarding roles and responsibilities of some board members and an element of discord between some board members. In addition, the stability of the board was uncertain with several new appointments under the semblance of a group appointment and seven NEDs due to end their tenure of appointment in 2023.

Overall, leaders had the skills, knowledge and experience that they needed, both when they were appointed and on an ongoing basis and were united in their understanding of the challenges to quality and sustainability. Leaders were in the process of identifying the actions needed to address challenges.

Leaders understood and managed the priorities and issues the service faced. There was a good understanding of the challenges of mental health needs in the population and work was underway with local mental health partners to respond to the increased demand for mental health support in the population.

Our findings

In 2021/22, the directors individually updated their declarations to confirm continuing compliance with the Fit and Proper Person test. The trust had implemented the current required standards for Fit and Proper Person checks, including declarations, periodic Disclosure and Barring Service (DBS), periodic fit and wellness checks, appraisals and cross-checking with other information in the public domain.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of three executive directors and three non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found all files were fully compliant with FPPR.

Leaders were visible and approachable in ward and department areas. During our core service inspections, we heard many examples where EDs and NEDs had visited clinical areas. Recently the senior nursing teams had introduced an idea called #BackToTheFloorFriday across both organisations, Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. The ask was that senior nurse leaders cleared their diaries on Fridays wherever possible to be out and about in clinical areas, visiting, auditing or undertaking a clinical shift and overseeing care and listening and supporting patients and staff.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership including for example, development programmes in place for leaders at all levels across the organisation and regular board development days.

A succession plan was in place however, this was in its infancy. A number of NEDs were coming to the end of their term in 2023 and the trust was actively recruiting to replace them.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. While there was no quality strategy currently in place, this was planned to be in place by January 2023.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The trust was guided by four strategic objectives which combined to form the overall 'vision' for the organisation. Underpinning these were the trust's values, a set of individual behaviours that were in place to guide staff in order to deliver effective care for all.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners. Senior leaders engaged with staff to agree the values and individual behaviours that they wished to project in their working environments. During our core service inspections, staff told us they knew and understood what the vision, values and strategy were, and their role in achieving them.

The trust recently revised their vision 'to deliver exceptional care together to improve' to reflect the trust's ambition for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations.

There was a strategy for achieving the priorities and delivering good quality sustainable care. The trust's five-year strategy (2022-2027) was a joint strategy for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). It reflected the closer working relationship between the two trusts under the leadership of a joint chair and

Our findings

chief executive. The strategy was based around four strategic aims, referred to as the Four Cs: Care, Colleagues, Collaboration and Communities and incorporated feedback from colleagues working for both organisations as well as the public and external stakeholders. For example, the integrated care board and other providers. The strategic aims were underpinned by strategic objectives; more specific measures used to measure achievement.

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The trust had recognised that the communities of Wolverhampton and Walsall often had poorer health outcomes than the nation as a whole and were characterised by some of the highest levels of deprivation. Life expectancy was generally lower and many risk factors associated with poor health (for example, physical inactivity) were higher. Through the strategy the trust was committed to positively contributing to the health and wellbeing of the communities served and delivering action on health inequalities.

There were systems in place to monitor and review progress against delivery of the strategy and local plans. It was to be the role of the sub-committees to routinely monitor the achievement of the strategic aims and objectives, reporting into the trust board.

There was no quality strategy in place. We were told this was under development and there were plans to have a quality strategy in place by January 2023. A quality strategy would provide a framework to build, standardise and innovate in order to deliver high quality, safe and effective care, and a positive patient experience.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. Work was underway to ensure all staff felt knowledgeable, encouraged and supported to raise concerns and the culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents.

Most staff felt supported, respected and valued and felt positive and proud to work in the organisation. We saw during our core service inspections, there were cooperative, supportive and appreciative relationships among staff. Feedback from staff was largely positive with staff speaking highly of the executive leadership team. The inclusivity and leadership culture, whilst improved from our last inspection, still had a way go and there was a framework in place to deliver this.

Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. We saw improvements had been made with the safety culture, with staff feeling encouraged to report patient safety incidents. This included knowing what to report and feeling confident to report. However, there were still improvements to be made in relation to ensuring systems were used effectively and that staff understood and learned when things did not go to plan.

The culture centred on the needs and experience of people who use services. People who used the service and others were involved in regular reviews of how the service managed and responded to complaints.Complainants were given the option of being involved in actions identified as part of their complaint and going forward this was to be an "opt in" as part of the trust's final response letters. Complainants were also given the option of sharing their story as a "lived experience" and becoming a part of the Patient Involvement Partner (PIP) programme, which was led by the patient experience team.

Our findings

In August 2021 the trust enrolled in the Parliamentary and Health Service Ombudsman (PHSO) early adopter scheme, as part of which, they were given access to the PHSO model complaints handling policy, as well as a maturity matrix to help the trust identify areas for improvement.

During 2021/22 a total of 4082 contacts were received by the patient relations team which included a total of 361 written complaints. This included nine informal to formal complaints and four Member of Parliament (MP) letters (an increase of 81 complaints overall for the year compared to 2020/21) and an average of 16 contacts per working day.

The total number of complaints resolved was 371, with 27 complaints upheld, 116 not upheld and 213 partially upheld. Seven complaints were withdrawn within this period.

The patient relation team were committed to 'getting it right first time' with their complaint responses, this was evidenced by their low numbers of reopened complaints; 27 complaints were re-opened between April 2021 and March 2022 which equated to 7.2%.

During our inspection of well led we reviewed five complaint responses. All responses were clear and transparent throughout. We noted that responses to complaints were very empathetic and compassionate. It was clear from our review of complaints that there was a definite focus on the patient and/or their loved ones.

Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Sickness absence was monitored and reported each month through the governance framework. Particular challenges were addressed through bespoke support and through management and human resources interventions.

Through our well led interviews, we heard some examples of excellent working to secure the future workforce of the organisation. We saw examples of an innovative and sustainable approach, working with partners, which had brought benefits to the community and economy.

The culture did not always encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.

For the reporting period October 2021 to September 2022, compliance with the duty of candour regulation had been variable (stage one compliance 69%, stage two compliance 38%). The board was sighted on the improvement work which was required in record keeping for duty of candour and accessibility of the data for audit. Professional duty of candour was required to be recorded in the patient medical records, making this a mandatory field on the new governance risk and compliance system which was in the implementation phase and was to be functional from January 2023.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken as a result of concerns raised. The trust had 1.8 whole time equivalent Freedom to Speak Up Guardians (FTSUG). Trained through the National Guardian's Office (NGO), the FTSUG service supported colleagues to escalate patient and staff safety concerns which when appropriately addressed contributed to establishing a culture of openness and safety. A FTSUG coordinator and nine confidential link staff supported the team.

Our findings

The Freedom to Speak Up (FTSU) index is a metric for NHS trusts, drawn from four questions in the NHS annual staff survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The 2021 FTSU index score for this trust was 74.4% and below the national average of 79%. The FTSUG team felt this score may well have been attributed to a new executive leadership team and increased activity following the COVID-19 pandemic.

A new speaking up question was included in the 2020 NHS Staff Survey. The question asked respondents whether they feel safe to speak up about anything that concerns them in their organisation. The results of this question also showed a strong positive correlation with the FTSU index. In this trust, 59% of staff responded positively to the question. These cultural metrics indicated the organisation would have to improve speak up culture in order to contribute to establishing a culture of openness and safety.

The number of concerns raised through contact with the trust's FTSUGs for the period 1 April 2022 to 30 June 2022 was 23 of these, 20 cases related to a behavioural element. For example, worker safety/wellbeing, bullying or harassment and other inappropriate attitude or behaviours).

Two training modules had been developed and released by the National Guardian Office (NGO). This e-learning package was available to all NHS trusts. The purpose was to raise awareness of and the value of speaking up in improving the safety culture within an organisation. In this trust, the modules had been included in a suite of training that could be accessed via mobile devices however, only four per cent of the workforce had undertaken the Speak Up or Follow Up training as recommended by the NGO. Leaders had oversight of training compliance and significant work was in progress to increase the uptake of this training.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. However, no area had achieved the trust target of 90% compliance. Overall trust performance for appraisal (PDR) compliance as of September 2022 was 81%, compliance in three areas was 50% or less. These included, the governance directorate, the operations directorate and transformation and strategy.

There was a strong emphasis on the safety and wellbeing of staff. In November 2021 the trust was successful in being awarded £25,000 from the NHS England and Improvement (NHSE/I) Voluntary Services Fund. The funding was granted on the basis that the trust supported staff wellbeing through volunteer roles and involvement. The NHSE/I team reviewed the range of projects funded and had selected the volunteering projects at Walsall Healthcare NHS Trust as an area to celebrate and highlight.

Equality and diversity were promoted within and beyond the organisation. The trust's aim was to ensure the diverse needs of patients, partners, communities, service users and staff were provided for and that patient involvement and experience when using services and the reputation of the trust as a place to work was improved. The board was committed to further improve workforce performance and culture and had signed up to a pledge:

"We, your Trust Board, pledge to demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you".

Our findings

The trust's equality, diversity and inclusion (EDI) plan described the vision and direction when implementing equality and diversity and inclusion within the trust both for service users and workforce. Developed in 2021, the plan set out aims and objectives and key priorities for the trust. The plan was continuously reviewed to align with the trust's improvement programme. The next step was to work with stakeholders to co-create the action plan that would support the delivery of EDI outcomes.

The governance and accountability frameworks in place within the trust were used to measure and evaluate performance on the action plan developed to support the EDI plan. This took place through the EDI Group which was a multi-disciplinary staff group including EDI champions, patient experience lead, staff side representatives and executive lead and was chaired by a non-executive director (NED) of the trust board. The people and organisational development committee which was a sub-committee of the trust board had oversight and reviewed progress on a regular basis in order to provide assurance to the trust board.

The trust had made significant improvements in the workforce indicators of the Workforce Race Equality Standard (WRES). Workforce demographics as of April 2022 showed, 32% of the workforce were from ethnic minority groups. This was currently higher than the ethnic minority population in Walsall which was approximately 23.1%. In addition, the trust had made significant improvements in relation to workforce representation of colleagues from ethnic minority groups at a senior level (Band 8a and above). This had significantly increased overall within the trust over a two-year period from 18.0% in 2020 to 25.5% as of 31 March 2022.

However, not all staff, including those with particular protected characteristics under the Equality Act, felt they were treated equitably. WRES data showed, in all four of the National NHS Staff Survey indicators, staff from ethnic minority groups were treated less favourably than their white counterparts. To continuously improve the trust's approach to EDI, the trust had identified key areas of focus and included for example; increased focus on improving the WRES /WDES (Workforce Disability Equality Standard) staff survey cultural indicators (reducing incidences of bullying, harassment and abuse and discrimination).

Governance

Governance processes were in place throughout the trust and with partner organisations. However, these were in their infancy with not all staff clear about their roles and accountabilities. Leaders had regular opportunities to meet, discuss and learn from the performance of services.

Governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were in their infancy. During our interviews with executives, it was clear there was an understanding of what needed to be the focus to drive assurance at board.

Leaders were enthusiastic about the direction of travel, not only for the trust but for the system as a whole and had taken steps to address shortfalls and had started to put arrangements in place that would provide the information and assurance needed. This included system-wide training across the Integrated Care System (ICS) ensuring staff at all levels were clear about their roles and understood what they were accountable for, and to whom and ensuring the right people were in the right role.

NHS England and Improvement had carried out a trust wide review of accountability and governance in March 2020 and a limited scope governance review of the Surgery division in September 2021. The themes (structures, data / technology, leadership / accountability / strategy, culture / engagement, risk and improvement) from the two NHS England and Improvement reports had local action plans that had been mapped and were included in previous CQC requirements as well as local action plans and the governance function repurposing work that was underway.

Our findings

The governance function had been reviewed in the last ten months with a co-design and engagement process including representatives from NHS England and Improvement and commissioners, The Royal Wolverhampton NHS Trust, the trust's central governance team, and divisional leadership teams. This had resulted in a redesign and business case.

The improvements included a complete governance team restructure, technology improvements with an electronic governance risk and compliance system and patient safety system for quality standards monitoring, audit, quality Improvement and policy management.

There were also plans to create 'golden thread' dashboards at five levels, department, care group, division, trust, and the two trusts (group). This would ensure that consistent data was collected, interpreted, acted upon, and escalated for decision with clarity from floor/ward to board.

The alignment work between the trusts was to result in a group assurance function incorporating governance and risk. The previous governance frameworks for each trust were to be replaced by a group wide assurance framework which was currently under development and consultation, this was to ensure uniform delivery and oversight across both organisations. A Gantt chart, project management tool, was in place to monitor and review progress.

Throughout our well led interviews we were told further work was needed to strengthen the work of the sub-committees and non-executive directors in order to ensure all levels of governance and management functioned effectively and interacted with each other appropriately. Much of the scrutiny of performance and quality of care was undertaken through meetings of the board's sub-committees; performance and finance, quality and safety, people and organisational development and research, digital and innovation. In addition, committees in common were in place ensuring scrutiny of performance at a group level.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust worked in partnership with 14 other health and care organisations as part of the Healthier Futures Integrated Care System (ICS) serving 1.5 million people in the Black Country and West Birmingham. Working with other key partners, people and communities, the partnership aimed to improve the health and wellbeing of local people by working together. Working as part of the ICS was Walsall Together; a partnership of health, social, housing, voluntary and community organisations that were working together to improve physical and mental health outcomes, promote wellbeing and reduce inequalities across the borough.

Financial Governance

The trust had set a financial plan to break even in 2022-23. The achievement of this plan was recognised as being a challenge and risks had been flagged, although there had not yet been agreement to change the forecast. The trust was developing supplementary plans to give assurance that the financial plan would be delivered.

The finance team appeared well-embedded in the trust's operational divisions and relationships both internally and at place level were said to be good. The term 'place' refers to the geographical level below an ICS at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen. The team leveraged their ability to respond by working in collaboration with group colleagues at the Royal Wolverhampton NHS Trust.

The trust had a private finance initiative (PFI) and also a large retained estate. It had a significant backlog maintenance requirement for its size at more than £27m; and limited capital resources for rectification. In addition, we were told that the trust was in active debate with its PFI provider about structural works to give assurance about fire safety.

Our findings

Management of risk, issues and performance

Systems to manage performance effectively were under review. Relevant risks and issues and actions to reduce their impact had been identified but there was work to do to ensure they reflected the strategic objectives realised through the group strategy. The trust had plans to cope with unexpected events. The board were clear that their decision-making avoided financial pressures compromising the quality of care.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions however, arrangements were under review at the time of our inspection. A risk management strategy was in place however, this was an interim strategy and whilst it articulated the direction of travel for the trust, there was very little detail to support how the strategy was to be achieved. Despite this, there was a shared understanding of risks across the organisation and alignment between recorded risks and what staff said was 'on their worry list'.

Work was underway to develop a risk management framework that would ensure there were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. Development of non-executive directors was recognised as key to holding risk owners to account and ensuring risk assurance systems were regularly reviewed and improved.

A trust risk register (TRR) was in place that identified relevant risks and actions to reduce their impact. The TRR was a combination of both local risks and corporate risks. There were 752 risks within the TRR, broken down as:

- Level 1 - Departmental Risks = 315 risks
- Level 2 - Care Group Risks = 252 risks
- Level 3 - Divisional Risks = 156 risks
- Level 4 - Corporate Risks = 29 risks.

All risks were to be reviewed at least once annually to ensure the details captured accurately reflected the current position of a captured risk and the details of its; controls, assurances, and actions. Our review of the TRR (dated July 2022) showed a number of risks were out of date for review. The board were fully sighted on this and a robust TRR improvement plan was currently in place. As part of this improvement plan the head of risk management and compliance, as well as the four divisional governance advisers, were working with the divisions to complete a data cleanse as the trust moved to a new risk management system. January 2023 was currently the provisional date for the trust to go live with the risk management system.

As of 13 October 2022, there were 116 risk that had not been through a data cleanse within the last 12 months (down from 504 out of 881 risks), and 189 risks overdue a risk review (down from 443 risks out of 881 risks).

Additional actions in the improvement plan included for example, dedicated risk management support and risk review meetings at divisional level, revision of risk management tools and templates and training of the new system to applicable trust users.

A board assurance framework (BAF) was in place that brought together in one place all of the relevant information on the risks to the board's strategic objectives. We found the BAF to be very detailed and were unable to see when, or if, risks had been reviewed and/or updated. For example, one risk had been identified as 'high risk', we could not see where action had been taken to reduce this. We were told, during our well led interviews, that the BAF was to be refreshed, using a new template and reflecting the group strategic objectives. In the interim, the board had agreed to stick with the current BAF as they transitioned to the group strategy.

Our findings

There were processes to manage current and future performance. These were under review to align to the new strategy and group structure. Current processes were recognised by the board as producing unreliable data that did not always provide the board with the required level of assurance. An example of which was a failure to identify the medicines management concerns we had identified though our core service inspection. Technology improvements, system-wide training and development of the board were all seen as key in managing performance going forward. Throughout our well led interviews, it was clear the board were fully sighted and had started to implement changes to ensure that quality of care and patient experience were driving future plans.

Benchmarking data (including NHSE/I published data, Model Hospital and GIRFT (Getting It Right First Time)) was also routinely included within committee and board reports to further add context to the trust-reported performance.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. During 2021/22, there were a number of national clinical audits programmes and national confidential enquiries covering NHS services that the trust provided that were suspended due to COVID 19 subsequent waves.

During 2021/22 the trust participated in 100% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had an overarching emergency preparedness, resilience and response policy (EPRR). This policy set out the strategic framework for the management of emergency planning, business continuity, response and recovery within the trust. It was linked to the trust's vision, strategy and values in which readiness in the face of incidents, emergencies and disruptions and organisational resilience were key components. The aim of the policy was to ensure that the trust had high quality, strong performance and standards for EPRR with robust arrangements and governance.

The trust also had a specific business continuity management policy. This business continuity policy facilitated the rapid and efficient mobilisation of trust services in the event of an incident disrupting normal service delivery. This policy was complemented by business continuity plans (BCPs) detailing how individual services performed in the event of disruption by defining and prioritising its activities and services, detailing contingency arrangements during the disruption and, when the disruption has passed, how all services would be restored.

Governance for EPRR arrangements were managed through the EPRR steering group. The purpose of this Steering Group was to facilitate the trust's preparedness, overall resilience and ensure response capability was in place to these types of incidents and emergencies.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. The performance, finance, and investment committee provided a forum for the trust board to seek additional assurance in relation to all aspects of financial and general performance, including performance against nationally set and locally agreed targets.

Information Management

Work was underway to ensure the board collected reliable data and analysed it. Technology improvements were in their infancy, with some not yet realised meaning staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Our findings

The board had an understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Information was used to measure for improvement, not just assurance. However, the quality of data presented to the trust board was collected manually and therefore subject to human error and not wholly reliable. Board members relied on other sources and professional curiosity to support this data.

Key performance indicators that were monitored through the National contract and those metrics that the trust measured for operational efficiency and patient safety were reported in the integrated quality and performance report. Reviewed through the quality, patient experience and safety (QPES) committee, the report was presented monthly to the trust board.

There were clear service performance measures, which were reported and monitored, and we saw work was in progress to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. We were told this would enable action to be taken when issues were identified.

A digital strategy had been developed in collaboration with external stakeholders and would focus on using technology to improve trust performance. Currently in draft, the strategy was due to be presented at board at the end of November 2022.

Work was underway to progress the digital agenda with a direction of travel evident. Current information technology systems were described as ineffective in monitoring and improving the quality of care. Technology improvements and plans to create 'golden thread' dashboards were already underway to enable better ward to board assurance. However, significant risks remained in relation to patient records and medicines administration, which were both currently in paper format. The aspiration to have an electronic patient record across the integrated care system (ICS) had yet to be realised and was reliant upon a full business case and significant investment. In addition, funding for an electronic prescribing and medicines administration (ePMA) system had not yet been secured.

It was clear from our review of board papers and meeting minutes that quality and sustainability both received sufficient coverage in relevant meetings at all levels. All staff had sufficient access to information. However, work was underway to ensure there was appropriate challenge at board.

Arrangements were in place to ensure that data or notifications were submitted to external bodies as required. This included, but was not limited to, the Care Quality Commission, commissioners and the local authority.

The Data Security and Protection Toolkit (DSPT) is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care (DHSC), notably the 10 data security standards set out by the National Data Guardian in the 2016 Review of data security, consent, and opt-outs.

All organisations that have access to NHS patient data and systems must use this Toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Organisations either achieve a status of 'standards met' by providing evidence against the mandatory requirements, or 'standards not met'. The 2021/22 DSPT for this trust was submitted on 30 June 2022 and achieved a status of 'standards met'.

Our findings

There were robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches. The trust had a framework in place to manage personal data incidents that utilised subject matter expertise from information governance, digital services, informatics, data quality, health records and systems administration.

Risks to personal data were managed and controlled in accordance with the trust's data protection policy and the incident reporting and management policy. Incidents were reviewed by the information governance steering group (IGSG) which was chaired by the chief finance officer, who had been appointed as the senior information risk owner (SIRO). Membership also included the trust's chief medical officer who had been appointed as the Caldicott guardian, the director of assurance and data protection officer. During the period 2021/22, four incidents were referred to the Information Commissioner's Office as meeting the criteria for external reporting.

All staff received data security training as part of their corporate induction upon joining the trust, with annual data security awareness and information security training mandated for all staff. Ongoing knowledge, skills and training requirements were supported by a comprehensive suite of policies, and guidance was provided to users to ensure access to personal data was appropriate.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The trust collaborated with partner organisations to help improve services for patients.

Patient, carer and public engagement and involvement was exemplary. People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. The trust listened and acted upon the views of its patients, relatives, and carers with protected characteristics. The introduction of the programme of the Patient, Carer, and Staff Experience Stories to trust board allowed patients with a protected group and staff to attend the trust board to give accounts of their experience of care. This had been extended to the quality and patient experience committee (QPEC), clinician forums, and frontline teams. The chaplaincy team also introduced an encounter form to capture the type and frequency of support provided. The SPaRC (Spiritual, Pastoral and Religious Care) form was introduced alongside faith profiles and was initiated following a patient story regarding access to chaplaincy, particularly from the Sikh faith.

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. This included people in a range of equality groups. The patient partner programme was introduced in 2021. Workstreams, where partners had expressed interest in involvement, included the end of life steering group, the Acute Medical Unit (AMU) Improvement plan, the oncology nurse specialist out-of-hours survey and the patient experience group. The patient partners were broadly representative of the nine protected groups.

Patient partners had been involved in the development and codesign of new ward Information boards. A patient partner was actively involved in a faith-based improvement arising from a poor patient experience. This resulted in the purchase and distribution of 30 hand-held, pocket-sized devices with pre-enabled microchips that were programmed to play a range of Sikh prayers and hymns. They assisted with daily worship at a time when patients were unable to visit their normal place of worship and found it difficult to attend the trust chaplaincy sacred spaces, or when visiting was restricted.

Our findings

The patient relations and experience team increased opportunities for patients to provide feedback and for trust staff to respond to the 'near time feedback with real time action'. In addition to the Friends and Family Test and complaints, concerns and compliments, the Mystery Patient Scheme was initiated. The mystery patient feedback was collected via a bedside/departmental poster which also included a link to provide friends and family feedback via a QR code linked to the area.

The Mystery Patient Scheme was introduced to the organisation in August 2021 and provided patients with the opportunity to share their experience of their recent visit and support staff to improve the services provided. The scheme was anonymous which enabled the patients to provide honest feedback about all areas of their visit.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. This included those with a protected equality characteristic. The trust had established a number of staff networks for race, gender and lesbian, gay, bisexual, and transgender (LGBTQ) equality. The aim and purpose of these was to ensure that staff with a protected group had a voice and could influence decision making across the organisation with regard to equality, diversity and inclusion (EDI). Each staff network had an executive sponsor and met regularly to progress activities related to race, gender and LGBTQ matters. The chairs of the staff networks also attended the trust's EDI steering group (EDIG) which reported into the people and organisation development committee (PODC); a subgroup of the trust board.

The trust had worked with system partners to increase employment opportunities for people in the community who were long term unemployed and people from ethnic minority groups.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust worked in partnership with health, social, housing, voluntary and community organisations as part of 'Walsall Together', an integrated care partnership between organisations that planned and delivered health, mental health and social care services locally.

Healthwatch Walsall had regular contact with the trust and in 2021/22 provided feedback reports on patient views regarding communication and end of life care. The report on communication was shared with the patient experience team and changes were made to the telephone system within the Patient Advice and Liaison Service (PALS) to accommodate concerns regarding call handling.

A member of the Healthwatch team sat on the trust learning matters editorial group throughout 2021/22 and contributed via independent scrutiny to the inclusion of articles that shared learning from feedback and actions arising from complaints, incidents and mortality reviews.

Healthwatch Walsall was commissioned by Walsall Together to undertake patient, service user and residents' engagement to ensure they were fully represented in the decision-making process on the future delivery of services and service change.

There was transparency and openness with all stakeholders about performance. A Walsall Together partnership board, with senior representation from each organisation, met on a monthly basis to provide strategic oversight and operational coordination for the services in scope. All organisations had signed an alliance agreement which set out how they would work together to deliver sustainable, effective and efficient services.

Our findings

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There were systems in place, across the group structure, to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Group working had impacted positively on long-standing issues for staff and was seen as improving services for patients. An example of this was the exceptional performance of the emergency department at Walsall Manor Hospital, which had consistently high performance. The trust had also benefitted from moves to reduce use of agency staff.

A change in culture had enabled leaders and staff to strive for continuous learning, improvement and innovation. The trust had embraced quality improvement (QI) and had a well-established QI academy and training programme delivering Quality, service improvement and redesign (QSIR) training and more recently, Healthcare Systems Engineering.

There were standardised improvement tools and methods, and staff had the skills to use them, and staff were encouraged to regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance. Organised training sessions had taken place for the two boards (in the group structure) on quality management systems and making data count. Training had been made available to staff from across the trust, integrated care system (ICS) and wider and specific training programmes had been set up for staff groups such as for example, regional anaesthetics trainees, intensive care and theatre staff, pharmacy and senior nursing teams.

The trust's QI strategy set out how staff were supported to improve the services and care they delivered to patients. Recognising that everyone had a role in quality improvement, the strategy was in place to help develop sustainable improvement changes through the embedding of a recognised programme of training across the group structure and continued support of QI in the wider context.

The continuous QI team at The Royal Wolverhampton NHS Trust and QI academy at Walsall Healthcare NHS Trust had been integrated to become the 'Quality Improvement Team'. As a result, QI had become central to the group strategy.

There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Throughout the trust, we felt a palpable energy for QI and saw staff were committed to continually learning and improving services. We heard of numerous examples of projects that had significantly led to improvements and innovation for the benefit of patients. Examples included, but were not limited to:

The division of surgery contributed 73 projects to the latest QI annual awards. The winning project came from within Surgery, based on improving prompt mobilisation post femur fracture.

A team effort to ensure gold standard care for patients with hip fractures had resulted in a national award for the trust which was now rated as second best in the region for its service. Reduced hospital stays, less time in theatre for patients, a decrease in mortality rates and improvements in the timeliness of pain relief had all been achieved as a result of the QI work carried out by the neck of femur team at Walsall Manor Hospital.

Our findings

Funded through the trust and Walsall Together, virtual wards set up to help people manage COVID-19 patients at home, as well as support those with long COVID, were being expanded in Walsall to include patients with respiratory conditions and Chronic Obstructive Pulmonary Disease (COPD). More than 1,800 people had been cared for through virtual wards that were put in place to reduce the length of time people were in hospital or prevent them from having to go in at all.

The group structure had received praise from executives at NHS England and Improvement for their innovation in community services resulting in, developing a national community nursing plan and delivering a community nursing safe staffing tool.

There was a recognition of the importance of research and the trust were working collaboratively across the group structure and wider ICS to maximise impact. This included participating in appropriate research projects and recognised accreditation schemes. Successes included, the introduction of an electronic patient record in the emergency department (ED) during the pandemic, achieving Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation standards for endoscopy services, leading research in Dermatology, the community Nephrology service pilot, to deliver Chronic Kidney Disease (CKD) services differently across Walsall through development of a cohesive, integrated primary and secondary care pathway for patients with CKD, Ask EARL electronic interface in ED, some of the highest same day emergency care (SDEC) rates in the country, a strong advanced clinical practice (ACP) model in Emergency Medicine and growing model in Acute Medicine, winner of the Rowan Hillson Inpatient Safety Award for participation in the Diabetes DEKODE Project and runner up in the Health Service Journal awards for the Covid Safe at Home Pathway.

Participation in and learning from internal and external reviews was effective, including those related to mortality or the death of a person using the service. Learning was shared effectively and used to make improvements. Deaths at the trust were recorded using the Clinical Outcomes Review System (CORS). This enabled review and discussion at service and directorate morbidity and mortality meetings. A proportion of deaths also went through a more detailed review. Detailed case record reviews were undertaken using the Royal College of Physician's Structured Judgement Review (SJR) methodology for any death meeting one of 11 defined categories.

Specialties could also undertake additional detailed case record reviews as part of their own mortality review processes and feed any lessons learned from these into the mortality surveillance group. Paediatric and maternal or neonatal deaths were reviewed using the Child Death Overview Panel (CDOP) and MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) tools respectively.

As part of this inspection we looked at the trust's processes for reviewing deaths. The trust used the structured judgement review (SJR) methodology. We reviewed five cases where a SJR had been carried out. We saw the care received by patients who had died had been effectively reviewed, areas of learning had been identified and the reviews supported the development of quality improvement initiatives when problems in care were identified.

Learning from reviews of deaths, including those reviewed by detailed case record review, was discussed, and shared through local specialty and directorate mortality meetings. Themes from these meetings were shared at the trust mortality surveillance group.

As part of this inspection we reviewed the Root cause Analysis (RCA) Investigation reports for five serious incidents. It was clear from our review that significant work needed to take place to ensure RCA investigations were robust and effective. This was confirmed through our interviews at this inspection. We were told an improvement plan was

underway that had already identified our concerns following an external review conducted in January 2022. We found, two different RCA templates in use, a lack of clarity around the time afforded to individuals to carry out investigations and support given to staff who had been involved in the incident and limited indications of whether there had been patient, family or carer involvement.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Jan 2023	Requires Improvement →← Jan 2023	Outstanding →← Jan 2023	Requires Improvement →← Jan 2023	Requires Improvement →← Jan 2023	Requires Improvement →← Jan 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community	Requires Improvement	Good	Outstanding	Good	Outstanding	Outstanding
Overall trust	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Outstanding ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Manor Hospital	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023
Overall trust	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Outstanding ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ↑↑ Jan 2023	Requires Improvement ↑ Jan 2023	Requires Improvement ↑ Jan 2023
Services for children and young people	Good ➔➔ Jan 2023	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023
Critical care	Good Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and diagnostic imaging	Good Dec 2017	Not rated	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Surgery	Requires Improvement ➔➔ Jan 2023	Good ↑ Jan 2023	Good ↑ Jan 2023	Good ➔➔ Jan 2023	Good ↑ Jan 2023	Good ↑ Jan 2023
Urgent and emergency services	Requires improvement Nov 2020	Good Jul 2019	Good Jul 2019	Good Nov 2020	Requires improvement Nov 2020	Requires improvement Nov 2020
Maternity (inpatient services)	Requires improvement Oct 2021	Requires improvement Oct 2021	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Oct 2021	Requires improvement Oct 2021
Maternity	Requires improvement Nov 2020	Good Nov 2020	Good Jul 2019	Good Jul 2019	Requires improvement Nov 2020	Requires improvement Nov 2020
Overall	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023	Requires Improvement ➔➔ Jan 2023

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Good Dec 2017
Community health services for children and young people	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Community end of life care	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017
Overall	Requires Improvement	Good	Outstanding	Good	Outstanding	Outstanding

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Manor Hospital

Moat Road
Walsall
WS2 9PS
Tel: 01922721172
www.walsallhospitals.nhs.uk

Description of this hospital

Walsall Manor Hospital is an acute general hospital that serves a population of around 270,000 across Walsall and surrounding areas.

The hospital has 550 acute beds and provides a wide range of services including a 24-hour accident and emergency department.

Medical care (including older people's care)

Requires Improvement  

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

The service provided mandatory training in key skills to staff and most staff had completed it.

Most staff received and kept up to date with their mandatory training. Mandatory training was provided both by eLearning and face to face. Information provided identified overall 85% of staff were up to date with mandatory training which was below the trust target. Ward managers and senior managers matrons told us whilst most staff had received mandatory training, some new staff required basic life support and safeguarding adults and children level 3. Ward managers and senior managers told us all remaining staff were booked to complete mandatory training modules by the end of November 2022.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were required to complete mandatory training in a range of topics including safeguarding adults and children, information governance and data security, equality and diversity, conflict resolution, fire safety, health and safety, moving and handling, dementia awareness and infection prevention and control.

Clinical staff completed training on recognising and responding to patients with mental health needs, and dementia. More than 90% of staff had received training in dementia awareness. Senior managers said additional training would also be provided for new international staff in dementia awareness.

A senior manager said the medical and long-term conditions (MLTC) division had the highest number of patients admitted with a mental health condition in the previous month. Mental health training was not mandatory; however, training modules were available. Information provided identified 43% of eligible staff within MLTC division had undertaken level 1 mental health awareness training. De-escalation and breakaway training were also available and 50% of AMU staff had received this training with plans for this training to be available trust wide. From November 2022 further training had been arranged to include caring for complex mental health patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they received email alerts and could access the electronic system to check so they knew when to renew their training. Local managers had oversight of their staff completion of mandatory training. Staff compliance with mandatory training was also part of the regular care group review meetings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, compliance with level 3 adult and children's safeguarding training was below the trust target

Medical care (including older people's care)

Staff received levels 1, 2 and 3 adult and children's safeguarding training which met national safeguarding training guidance. More than 90% of staff had received safeguarding adults and children level 1 and 2. However compliance with level 3 adult and children's safeguarding training was significantly below the trust target (46% of staff safeguarding children and 71% for safeguarding adults). Managers said all staff had this training booked to be completed by the end of November 2022.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff said they made safeguarding referrals for patients who had been admitted with pressure sores or there were other similar concerns.

Female Genital Mutilation (FGM) training was included in the safeguarding training. Nursing staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Trained staff knew how to make a safeguarding referral and who to inform if they had safeguarding concerns. Some health care assistants said if they had any concerns, they would ask the ward manager or trained nurse to make the referral on their behalf if needed.

A senior manager said the safeguarding level 3 training included training in learning disabilities and autism.

The service had a safeguarding adult at risk policy and a safeguarding children and young people policy. Both of which were in date, version controlled and reflected national guidance. Staff were supported by ward managers, matrons the senior management team and the safeguarding leads to raise issues and report safeguarding concerns. Staff made safeguarding referrals to the local authority.

Whilst staff understood the importance of maintaining confidentiality about patients care and treatment, care records were not locked on most wards we visited.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. However, staff did not always clean equipment and or use control measures to protect patients, themselves and others from infection.

The trust had monthly infection prevention control audits, these were divisional wide and provided scores for individual wards. Dependent on the score the areas were either rated red (lowest scores), amber (some improvements required) or green (meeting targets). Based on the scores given action points were created. Wards in the MLTC division had 90% compliance with infection control and prevention standards. This included areas of the environment, sharps, personal protective equipment, linen, waste, hand hygiene and isolation. Ward managers shared improvements when needed during staff meetings.

There was an extensive refurbishment programme in place however some areas were in a poor state of repair including missing ceiling tiles, torn flooring, damage to door frames and walls which compromised effective cleaning and infection control. Some wards faced challenges with the environment which compromised infection control requirements.

Ward areas were generally clean and housekeeping staff regularly cleaned ward areas. However, bed spaces on wards 1, 2 and the acute medical unit were not always cleaned after being used by covid patients. Toilets outside of covid contact bays were not restricted to covid contact patients only increasing the potential risk of cross infection to other patients.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. Covid patients on ward 1 within the covid contact bays used toilets on the wider ward. There was no cleaning of these toilets in between patients and no signs to restrict usage to covid contact patients only. The recent infection control audit (August 2022) identified insufficient commodes were available on most wards to ensure sole use for designated patients to reduce the risk of cross infection.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed some staff not wearing appropriate PPE when handling infectious patients or adhering to infection and prevention control methods including 'donning and doffing', gloves, masks and hand washing. In addition, rooms with infectious patients were not always labelled to alert people to the risk of infection or to wear appropriate PPE.

The most recent quarterly hand hygiene audit in June 2022 identified 97.5 % compliance with hand hygiene. A further audit identified improvement was required with staff compliance around 75% which was below the trust target of 90%.

The trust screened all patients within 24 hours of admission for MRSA. The MLTC division was 80% compliant with MRSA screening.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

The design of the environment did not always follow national guidance. The trust had an extensive refurbishment programme in place which included medical wards and departments. During our inspection wards 16 and 17 were being refurbished and had moved on to other wards until November 2022. The new acute medical unit was due to open in February 2023.

However, whilst there was a refurbishment programme in place day to day issues compromised patients, staff and the visitor's safety. Blocked fire exits were seen on several wards with adhoc nursing stations, medical equipment and ward televisions. Door frames were split with sharp edges posing a health and safety risk and items of broken equipment had been left in windows alcoves. We also observed several electrical leads crossing floors that posed a significant trip hazard.

Staff carried out daily safety checks of specialist equipment for example resuscitation trolleys.

Patients could reach call bells and staff responded quickly when called. All patients throughout the inspection had their call bells within easy reach and call bells were answered in an appropriate time. We did see a broken staff call bell in one toilet on the acute medical unit which had been left to dangle over a toilet cistern.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, records did not always confirm staff identified and quickly acted upon patients at risk of deterioration. Staff used a nationally recognised tool to identify deteriorating patients. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. Records seen showed early warning scores were recorded as part of

patient's electronic observations. A score of above 5 triggered to the outreach team on the electronic system and the team would contact the ward to discuss patient's management. Information provided by the trust identified for the last three months no medical ward met the trust target for timely patient observations. This increased the risk of patients not having timely review and treatment by a doctor if they deteriorated.

The trust used a red stamp in the patients notes which identified possible deterioration and what escalation had been undertaken. Several patients' records seen did not include the red stamp, confirm when the patient early warning score had triggered or actions (and timing of those actions) undertaken. Calls from the outreach team were not always recorded in patients notes to confirm patient's management.

Staff completed risk assessments for each patient on admission or arrival to a new ward using a recognised tool, and reviewed this regularly, including after any incident. Staff completed assessments for the risk of pressure ulcers, falls and nutrition. Generally, doctors completed venous thromboembolism (VTE) although there was some confusion whether this was a medical or nursing task. Risk assessments were repeated when anything changed with the patient.

Staff knew about and dealt with any specific risk issues. The MLTC division had identified VTE assessment as a matter of concern and had a quality improvement project in place. An audit had been undertaken of all patients who did not have a VTE assessment during the first two weeks of September 2022. The audit identified 60% who did not have a VTE assessment had been discharged the same day. The division also identified a discrepancy between the electronic VTE assessment and prescriptions for prophylactic treatment. The audit confirmed patients did receive the correct treatment when required to reduce the risk of venous thrombosis.

The trust had a sepsis information campaign with posters highlighting sepsis and its treatment on all wards. Staff said part of the outreach team included one person dedicated to sepsis management each day who contacted them when patients triggered for potential sepsis and advised them on patient treatment and management. The trust performed well when compared with other trusts for antibiotic therapy within the hour, which had improved consistently since the initiation of the sepsis team. However other key information about sepsis management was not reviewed including the timeliness of observations and escalation of potential sepsis.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The mental health team included a lead nurse for mental health (Monday to Friday), a matron for mental health and clinical nurse specialists who worked over seven days (including twilight shifts). Mental health staff could be contacted by an urgent bleep between 8am and 6pm. Out of hours staff were able to access mental health advice by contacting the local mental health trust switchboard.

Staff did not always complete or arrange timely psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We spoke with two patients who had previously self-harmed. They were anxious and could potential self-harm again, but no psychological assessment had been completed. We escalated our concerns to the trust who took appropriate actions to support these patients.

Staff did not always share key information to keep patients safe when handing over their care to others. Several staff reported a need to improve patient handovers (from one ward to another). Several staff said things were often not handed over and meant patients may not receive timely care and treatment.

There was a nurse handover at each shift change when key information was shared. We did see one handover /safety huddle which included doctors and other staff but was largely doctor driven with little interaction from other staff.

Doctor handovers were undertaken over the phone or in person at the end of the day to the on-call team.

Staffing

Nurse staffing

The service had recruited enough nursing and support staff with the right qualifications, skills, training and experience to meet patients' needs keep patients safe from avoidable harm and provide the right care and treatment. However, not all staff were in post at the time of the inspection. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff. Staff said staffing had improved although short term sickness rates meant they were frequently short staffed. Wards did not always have enough staff to care for all patient's needs. Ward managers said staffing had been reviewed and increased and as a result there appeared to be a shortage until new (additional) staff were in post. During the inspection, we observed an incident on ward 14 where a patient was identified in their notes as requiring 1:1 care to keep them safe and reduce their risk of falling. However, despite staff requesting this, an additional member of staff was not allocated to provide 1:1 care.

We reviewed staffing rotas (for the wards we inspected) for 27 June 2022 to 2 October 2022. We found mostly wards were staffed with the required staffing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Ward managers and matrons reviewed nurse staffing every morning reviewing the actual versus the planned required staffing. When needed staff were moved from one ward to another to mitigate against and provide safer staffing. The trust used a "red flag" system to identify staffing risks and concerns. There were twice daily staffing reports with a 72-hour forecast report for the weekend staffing to identify if additional staffing would be required.

Ward managers discussed staffing concerns with their matrons and any concerns were escalated to the staffing hub meetings. Matrons joined the trust virtual staffing hub (across all divisions) where any gaps in staffing and/or additional support were discussed. If staffing was not met this was escalated to the director of nursing to support a request for specialist agency staff. However, during the inspection, several wards we visited reported staffing shortfalls with the greatest concerns highlighted on wards 1 and 14, it was not evident if this had been appropriately escalated.

Ward managers could adjust staffing levels daily according to the needs of patients. Ward managers on several wards told us a review of staffing levels had recently been undertaken against patients' needs and staffing had been increased.

The trust provided a summary of actual against required staffing within the medicine and long-term conditions (MLTC) between 27 June 2022 and 2 October 2022. Information identified registered nurse staffing was generally below the actual staff requirement whilst clinical support workers staffing was above the required numbers.

The service had reducing vacancy rates. The trust had recruited to most of its vacancies. In May 2022, a business case for additional nurses had been agreed and as a result vacant positions had increased, although there were more staff employed. Ward managers confirmed successful recruitment and with ongoing recruitment overall vacancies would continue to decrease.

The service had reducing turnover rates. The divisional board review identified staff turnover as improving in August 2022.

Medical care (including older people's care)

Sickness rates were largely aligned to the waves of covid infection in the local community with staff sickness deceasing and increasing alongside community covid infection rates.

The service had reducing rates of bank and agency nurses. Staff absences were covered, when possible, with existing staff, staff from other wards or bank staff. The number of bank and agency staff had reduced with the recruitment of additional staff. Information provided by the trust confirmed agency staff use as minimal.

Managers limited their use of bank and agency staff and requested staff familiar with the service. If there remained a need for additional staff, regular agency staff who were familiar with the service were requested. Information provided identified agency staff use was agreed as to support specific requirements for example mental health patients requiring 1:1 care, additional bed capacity, restrictions due to a covid outbreak or to ensure the safe external transfer of patients.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

There were appropriate arrangements in place to ensure the service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The trust had historically struggled to recruit but had successfully increased the number of doctors and consultants. Most of the posts had been recruited to however not all staff were in post at the time of the inspection. Recruitment of doctors included international recruitment and included additional training opportunities, a buddy scheme and support with accommodation.

Actual medical staffing had increased, information showed an increase of filled shifts for all grades of doctors in the last three months.

There was an AMU consultant of the day to support junior doctors to provide them with an identified point of contact. They had changed the roles of the two on call registrars to fairly distribute workload. The trust had recruited new clinical fellows and redesigned the rota for on call for AMU doctors.

The service had reducing vacancy rates for medical staff. There had been extensive recruitment of all grades of doctor in the last twelve months. This had been achieved by providing additional support for doctors, reduction in workload and increased teaching opportunities for junior doctors.

The service had reducing rates of bank and locum staff. The division had four bank locum consultants and the remainder were on the NHS locum contracts all of whom were seeking specialist recognition via the certificate of eligibility for specialist registration route. The trust identified by the end of November 2022 they hoped to significantly reduce their reliance on locum doctors. The junior doctor agency spend was expected to increase over the next three months as temporary cover was needed to cover rota positions which had not yet been filled substantively.

Managers made sure locums had a full induction to the service before they started work. New international doctors had six weeks supernumery before they started.

Medical care (including older people's care)

The service had a good skill mix of medical staff on each shift and reviewed this regularly. AMU was staffed by the AMU consultants until 5pm with an on-call medical consultant in the evening. There was additional consultant cover in both the ambulatory care and frailty units until 8pm. Consultants were supported by registers and junior doctors.

Records

Records of patients' care and treatment were not always complete, clear or stored securely and did not always provide all required information for staff providing care.

Patient notes lacked detail and did not provide all information about the care and treatment. The trust mostly used paper records with patients' observations recorded on the electronic system. On most wards records of the patient current admission was available in ring bound folders. However, we found paper records from within the folder frequently fell out and had not been put in date order and in some cases were in the wrong patient's folder. This meant it was difficult for staff to identify patients current and previous treatment needs and there was a risk they would not receive the care they required.

When patients transferred to a new team, records were not always available or complete. The temporary folders accompanied the patient to their new ward and included a handover sheet which summarised their care needs. However, several staff on different wards said information provided was frequently incomplete, not available or inaccurate.

Records were not stored securely. Records were not always stored securely in lockable cupboards on all wards. The ward manager on the acute medical unit said new patient records trolleys which were lockable had been ordered and would be available soon. The lockable 'fob' trolleys were available on some wards however they also were unlocked. Records of patient's current admission on ward 4 were in the locked trolleys although their medical records were kept unlocked under the lockable trolleys.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not follow systems and processes to safety prescribe and administer medicines. Some prescriptions charts seen on inspection were illegible and we could not be assured of the accuracy of administration of medicines records.

We found that some prescribed medicines were not available to administer to patients. Preventer inhalers (those used to prevent a patient having breathing difficulties) were not available for four patients.

Medicines used in the treatment of glaucoma were not available for administration to a patient. Failure to manage glaucoma will lead to sight loss.Patient weights were not recorded on prescription charts. Additionally, the nurse assessment record for four patients recorded mid upper arm circumference (MUAC) and not the actual patient weight. There was a risk of having insufficient medicine dose to have the required effect or too much medicine which would cause side effects.

Poor diabetes management resulted in a patient experiencing extreme hyperglycaemia (high blood sugar levels).

We found that one patient had been without their pain-relieving medicines or an alternative for 6 days

Medical care (including older people's care)

Wards did not always store and manage all medicines and prescribing documents safely. We were not assured that medicines were stored within manufacturers recommended temperatures to maintain effectiveness. For example, the fridge on one ward was over filled with medicines and assurance was not available to show that medicines stored at room temperature were kept within the manufacturers temperature range.

We found that some medicines were out of date and available to be administered to patients on two wards. This included medicines used to treat infections. The date of opening was not in place for some shortened shelf-life liquid medicines once open. There was a risk these medicines would not be as effective once past their new expiry dates.

On one ward we saw the administration of a controlled medicine was not witnessed by a second person as required by trust policy.

Pharmacists reviewed the patients' medicines on admission to the hospital. However further follow up was not evident to ensure required medicines were prescribed and available with required changes made.

We were not assured about the robustness around sharing alerts and reported incidents due to the significant concerns identified around medicines. Some wards were able to tell us how medicine errors had informed change. For example, AMU had developed a teaching programme for management of ketoacidosis and use of sliding scale insulin.

However, the allergy status for patients were completed appropriately on the prescription charts checked during the inspection. Oxygen was prescribed appropriately, where it was being administered to patients.

Registers for monitoring controlled medicines were completed regularly and found to be accurate during the inspection.

Emergency medicines were stored on resuscitation trolleys in accessible areas with required checks on content and expiry dates.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

No never events had been reported within the medicine division. Managers shared learning with their staff about never events that happened elsewhere and learning was shared trust wide.

Staff reported serious incidents clearly and in line with trust policy. In the last 12 months there have been a total of 55 serious incidents reported across all categories. This also included ward closures and infection outbreaks. There was a process to review all serious incidents, these investigation reports reviewed identified areas of good practice and areas for improvement. Staff we spoke with were aware of serious incidents within their own division.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent, and mostly gave patients and families a full explanation when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence changes had been made as a result of feedback. Following reported medicine errors additional training had been provided on management of patients requiring sliding scale insulin and management of ketoacidosis. In oncology additional actions had been implemented to ensure timely identification of potential infection in a peripherally inserted catheter (PICC) which is a specialist line and may provide intravenous fluids, blood transfusions, chemotherapy or other medicines. The learning had been shared trust wide and included trust wide education and a PICC passport which provided additional assessment of the site area.

Managers investigated incidents. The trust had a framework for investigation of incidents and depending on the incident and potential harm would determine the type of investigation and level of seniority required for final sign off the incident and investigation.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. However, managers did not always ensure effective checks were in place to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver care according to best practice and national guidance. Clinical practice guidelines were available and reflected guidance.

There were some systems in place to check patients received services and evidence-based care which met best practice. However, these systems were not always effective. The trust did undertake sepsis audits. However, information provided only included compliance with antibiotics administered within 60 minutes. No information was provided to confirm timely escalation of potential sepsis or other key management aspects of sepsis treatment.

The policy which included the management of young people between 16 and 21 had been identified for review in May 2020 but had not been reviewed. The current policy identified young people between 16 and 18 particularly if they were vulnerable should be accommodated on the children and young people's ward. We observed this was not the situation and young people were not given a choice about being placed on an adult's ward.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. There were no adults admitted under the MHA to the wards we visited at the time of our inspection. However, staff told us how they worked closely with the mental health team if a patient required assessment or treatment under the Act. Staff working with people who were detained also had support from the safeguarding team to ensure patients' rights were protected.

Medical care (including older people's care)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered a choice of food at each mealtime. Patients said they had plenty of food choices and the food was mostly good. Staff confirmed cultural diets were available on request. The trust performed well in comparison to other trusts in the CQC Inpatient audit 2021 (published September 2022) for staff providing enough help to patients (who required assistance) to eat their meals and patients describing the hospital food as good.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded totals of food and fluid regularly throughout the day to ensure timely identification of patients whose fluid or dietary intake was insufficient. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The nutritional screening tools we looked at were accurately completed and when needed included additional action such as referral to a dietician.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and generally gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff said the trust currently had no pain tool for patients who lacked understanding or were unable to communicate verbally. Staff said the end-of-life team were currently looking at alternative suitable pain tools.

Patients received pain relief soon after requesting it. Staff were prompted to ask patients about pain when recording their observations electronically. Patients were asked on a scale 1 to 10 to describe their pain with 10 being the highest. Staff said they would go back to the patient 30 minutes later to check the pain relief had been effective.

Staff prescribed, administered and recorded pain relief accurately. Generally, patients received pain relief as prescribed. However, we found one patient who was without their pain-relieving medicine for 6 days.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Audits included the National Audit for End-of-Life Care, National Lung Cancer audit, National Bowel Cancer audit and National Oesophagastric audit

Outcomes for patients were similar to other similar services. When audits identified a need for improvement this was undertaken. For example, a cancer clinical nurse specialist had been appointed to ensure increased patient access to a cancer nurse special. The trust also provided new services and increased diagnostic sessions for earlier detection for bowel and lung cancers.

Managers and staff used the results to improve patients' outcomes. A new service which followed British Thoracic Society guidance was in place. The new service had increased early detection of lung cancer by increased and regular monitoring of the patients with pleural tumours. Pleural tumours are found in the pleural space; the cavity between the lungs and chest wall that contains lubricating pleural fluid. The service provided a training programme for pleural procedures. Data from the new pleural clinic identified 66 hospital admissions were avoided in the last year.

A procedure called endobronchial ultrasound (EBUS) that allows doctors to investigate patients' lungs and take samples was now available within the trust. This had resulted in shorter waiting times for patients and patients getting histology results quicker. This ensured those patients who required further treatment received more timely treatment.

The diabetes service had been part of a project called Digital Evaluation of Ketosis and Other Diabetic Emergencies (DEKODE) to review the management of diabetic ketoacidosis and other diabetic emergencies. Ketoacidosis is a serious complication of diabetics which can be life threatening. Over the last 12 -18 months, the hospital had identified improvement in the management of diabetic emergencies. The study identified the hospital patients performed well compared to its peers. The length of stay was shorter by one day at the trust (2.3 days as opposed to 3.3 days for other hospitals) in the study.

In addition to the DEKODE project the diabetic team have identified a 50% reduction in the number of diabetic patients who have had amputations in the last three years.

Information about patients who received same day emergency care (assessment and treatment) within the medical division was identified as 23% of patients which was stable. Information identified 23% of patients had returned directly to their usual place of residency.

The service had a low risk of readmission. Managers monitored information for patients readmitted to hospital within 48 hours and seven days. The information provided showed readmission rates were stable and minimal.

The divisional board discussed readmission rates for the division compared to other similar services and found the service performed well.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and when required used information from the audits to improve care and treatment. For example, documentation, risk assessments, consent, management of deteriorating patients and discharge. Managers shared and made sure staff understood information from the audits and implemented changes in practice when required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust had reviewed staffing and increased availability of more experienced nurses including more ward sisters to provide additional support to other junior staff.

Managers gave all new staff a full induction tailored to their role before they started work. The trust had recruited to a large number of posts. The induction for new starters was a structured and supportive introduction to the trust and ward or department. It included an introduction to the trust values, policies and procedures in addition to an introduction to their role and their immediate work area. All newly qualified staff had access to a preceptorship programme and specific learning opportunities to support them in their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust reported current appraisal rates for staff in the MLTC division as 82% at the end of August 2022 which was below the trust target. The trust identified there was a delay in uploading appraisals onto the electronic system but compliance with appraisal continued to increase. There was a plan in place to ensure at least 90% of staff had an up-to-date appraisal by the end of December 2022.

The practice education facilitators (PEF) supported the learning and development needs of staff. Ward managers said the PEFs had a key role in supporting the new international and newly qualified staff. However, they were limited availability of the PEFs to support other staff. We did see the number of more experienced nurses (band 6 and above) on wards had increased which gave additional support and teaching opportunities for nursing staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Wards had weekly safety huddle for all staff and most wards also had monthly team meetings. Notes of the both the safety huddle and ward meetings were available for staff who were unable to attend. Staff said key information from the weekly safety huddle was shared at each staff handover for the following week.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity for learning through clinical skills workshops and leadership sessions and staff could apply for formal courses through the training needs analysis process.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff in several areas spoke positively about the support they had been to develop their careers and improve patient care provided.

Managers made sure staff received any specialist training for their role. Nurses had identified link or champion roles in specialist subjects. This included clinical and non-clinical subjects, such as infection control, tissue viability and safeguarding.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored staff performance and when required ensured additional training opportunities were available. However, if performance failed despite additional support and training a more formal process would be instigated.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work effectively as a team to benefit patients and their care.

Staff held regular and mostly effective multidisciplinary meetings (MDT) to discuss patients and improve their care. Staff of different grades and specialities attended regular safety huddles which were mostly weekly except for AMU which held daily safety huddles. We observed one safety huddle on AMU however it was mainly doctor focused and provided little discussion from other professionals present. Staff told us the room they had previously used was no longer available and their current room was too small making attendance difficult.

Medical care (including older people's care)

Multidisciplinary meetings were held daily (Monday to Friday) to discuss oncology cancer patients for each including breast, lung, bowel and skin cancers. There were additional weekly multi-disciplinary team meetings to discuss patients with pleural nodules which may develop into lung cancer.

Staff did not always work effectively across health care disciplines and with other agencies when required to care for patients. We observed doctors and nursing staff in some areas worked separately and were unclear of roles and responsibilities to ensure patients received high quality and effective care. For example, there was a lack of clarity around roles to ensure patients mental capacity or risk of venous thrombus was appropriately assessed.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants the trust was supported by visiting oncology consultants from another trust who were available Monday to Friday and were available to provide advice and support to other clinicians. However, doctors in AMU were not aware of these arrangements and were unclear who to ask for advice on patient management.

Seven-day services

Most key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds including at weekends on most wards. Most patients were reviewed by a consultant daily. However, in some areas such as respiratory and oncology a consultant was not available seven days a week but were available to provide telephone advice.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Allied health professionals (physiotherapists, occupational therapists, dietitians and speech and language therapists) covered core hours between 8.30am to 4.30pm from Monday to Friday. In addition, the physiotherapy and occupational therapy service was available on an ‘on-call’ basis and could offer support at weekends for more urgent cases such as in the respiratory speciality.

Doctors said there had been delays in receiving some laboratory results since the pathology service had been centralised. Radiography services were available 24 hours a day.

The oncology service was nurse led. Whilst the current service was Monday to Friday there was a business case to increase it to six and eventually seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff displayed healthcare literature. For example, the respiratory wards and oncology displayed information about smoking cessation.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Nurses gathered information concerning the patient's individual physiological, psychological, sociological, and spiritual needs. The assessment identified current and future health care needs of the patient. The alcohol screening and referral tools and smoking cessation tools were completed for all patients.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Patients who lacked capacity to make their own decisions or were experiencing mental ill health were not appropriately supported. Measures to limit patients' liberty were not appropriately applied.

Staff did not fully understand how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. However, staff did not always complete 'best interest' paperwork and frequently no capacity assessment had been completed to confirm the patient did not have capacity to consent to an aspect of their care or treatment.

Staff did not always assess patient's mental capacity appropriately. Some records identified the patient had capacity, but this was contradicted in other records with no mental capacity assessment completed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However, staff did not always follow the Mental Capacity Act 2005 or deprivation of liberties safeguards (DoLS) when caring and treating patients who lacked capacity and needed some form of physical intervention in their best interests. We found not all patients who had a Deprivation of Liberty safeguards in place had their mental capacity appropriately assessed. This meant patients were being deprived of their liberty unlawfully.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) however they were not completed appropriately. Information provided by the trust identified good compliance with the completion of MCA and DoLS. Information was over a three-month period and included 26 patients of which 25 patient records were appropriately completed. We did not find MCA assessments were appropriately completed and this meant DoLS were not appropriately completed.

Staff told us oversight of DoLS was undertaken by the safeguarding team whom they could contact if they required any support. However, the majority of DoLS records we saw during the inspection were not completed accurately or were incomplete for example not dated or no mental capacity assessment recorded. We were not assured current arrangements for oversight were effective.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw staff gaining verbal consent to undertake tasks with patients, such as providing personal care or taking vital monitoring readings.

Staff made sure patients consented to treatment based on all the information available. Staff sought patient's permission before they received any type of medical treatment, test or examination. This was done based on an explanation by a clinician.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they were required to complete training as this was part of their mandatory training. Compliance was over 90% for staff having received this training at the time of the inspection.

Medical care (including older people's care)

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The safeguarding team did undertake ward visits to support staff in mental capacity and DoLS records and were also available to give telephone support. One ward sister told us they were working with junior staff to show them how to complete the DOLS applications.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Most staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff mainly had conversations with patients about their care behind closed curtains and as discreetly as possible to maintain their privacy.

Several patients on the acute medical unit (AMU) told us the care they received was “fantastic” and staff had been “brilliant”.

The trust performed well in comparison to other trusts in the CQC Inpatient audit 2021 (published September 2022) for patients saying they were not bothered by noise at night from staff or other patients and they were able to discuss their condition or treatment with hospital staff without being overheard.

Staff were compassionate and caring with patients who were at end-of-life care. A patient had passed away during the inspection and staff were seen comforting the family and making appropriate arrangements for privacy and dignity.

The discharge team had a robust set of criteria to ensure patients were still able to be discharged appropriately and safely. The staff ensured patients were suitably dressed for their discharge and gave food parcels to patients where appropriate. Staff also followed up patient discharges 72 hours later via a third party who signposted them to additional agencies where necessary.

Some younger patients and their parents said they did not feel comfortable or safe on an adult ward and their individual needs were not considered particularly around autism and mental health. Staff mostly spoke to patients in a respectful or dignified way. However, we observed one patient with dementia spoken to in a patronising manner regarding them wanting to go to the toilet.

Staff mostly respect patients personal, cultural, social and religious needs of patients. However, another staff member undertaking a meal round was observed being disrespectful to a patient which was perceived by the patient to be because of their social situation and/or culture.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff sat with patients who were emotionally distressed to calm them and to give reassurance. One patient receiving end of life care said staff had been “lovely and supportive” whilst they had received uncomfortable tests.

Understanding and involvement of patients and those close to them

Staff supported patients and their loved ones to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Records confirmed patients who required end of life care and their loved ones were given choices about treatment options. Where it was identified patients lacked capacity there was evidence of family or next of kin being involved in patient care and involvement in end of life wishes.

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The numbers of inpatients within the MLTC division had increased in the last 12 months, the trust had increased bed capacity in response and particularly in areas such as AMU to ensure the needs of the local population was met.

The service had access to areas such as the ambulatory care unit which had reduced hospital admissions. The ambulatory care unit had four senior advanced nurse practitioners and two trainee advanced nurse practitioners assessing patients and providing treatment to avoid a need for a hospital stay.

The service worked with others in the wider system and local organisations to plan care. The trust had increased investment in community support services which included rapid response services, community nursing and virtual wards for covid and respiratory conditions to reduce readmission rates within the medical service.

The frail elderly service provided acute medical support in order to avoid inappropriate admission to hospital and to facilitate a safe discharge from the emergency department. During the covid19 pandemic a unit which was part of the respiratory ward to provide additional respiratory support had been developed.

There had been a business case to increase the provision of consultant oncology advice, diagnosis and treatment capacity to ensure patients had access to timely cancer care. The business case included an oncology service that was accessible 52 weeks per year and capable of consistent delivery of cancer treatment within 62 days of referral.

The oncology and haematology day services had been upgraded and moved away from inpatient wards to minimise the risk of cross infection of their vulnerable patients with reduced immunity. If a patient, however, did require treatment, they would be admitted to a ward with that specialist such as the respiratory or gastroenterology wards with support from the oncology nurse specialists. The service had a business case in place to increase the number of specialist chairs from 14 to 22 to ensure patients had more timely access to treatment.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were clear they would be supported by managers whenever possible to avoid mixed sex breaches. The trust reported 13 mixed sex breaches during August 2022 within the coronary care unit (CCU) at a time of extreme capacity pressure on the service. The patients all required a cardiology bed, not a CCU bed and as there was no clinical need were reported as mixed sex breaches.

Facilities and premises were appropriate for the services being delivered. The trust had an extensive refurbishment programme in place to ensure facilities and the premises safely and appropriately met patients' needs. The new acute medical unit was to bring further improvements and was identified as an exciting time for the team. The plans for the new AMU included two higher monitoring bays with increased nursing support.

Meeting people's individual needs

The service was inclusive but did not consistently take into account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Arrangements were in place to support patients living with mental health problems and dementia. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems and dementia. Whilst the trust had arrangements in place to support mental health patients there was a lack of arrangements in place to support patients who had a learning disability. The safeguarding lead identified this was an area of focus.

Patients who were 21 years and under and had a learning disability were not always placed in an appropriate care setting for their needs or given a choice between an adult or a younger person ward area. Information provided by the trust identified there had been 366 patients under 21 years admitted to an adult ward. The trust policy had been due to be reviewed in May 2020 but with changes in a matron this had not been undertaken.

The policy identified all young people under16 years and those who were identified as vulnerable until their 18th birthday would go to ward 21 (the paediatric and young person ward). The trust policy identified patients between 16-18 were given the choice about whether they went to an adult or young person's ward. During our inspection, we found this was not the situation. Doctors and nurses said patients over 16 were admitted onto adult wards. One patient told us they felt unsafe and scared on AMU due to their age, developmental disability and mental health condition. We did not see any recognition of vulnerable patients under 21 years asked about choice about going to a children/ young person's area or an adult ward.

Medical care (including older people's care)

Wards were designed to meet the needs of patients living with dementia. Ward 2 was designed to be the dementia care ward and provided additional support for patients living with dementia. Staff used reminiscence therapy to assist patients (particularly with memory impairments) in recalling and sharing events from their past through listening to music, watching news reports of significant historical events, playing games and karaoke and watching films.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff working in cancer services worked closely with Macmillan to ensure patients received additional advice and support when required.

The service had information leaflets available in languages spoken by the patients and local community. The population of Walsall was ethnically diverse. Staff had electronic access to leaflets in other languages which could be printed off when required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to access interpreters or signers when needed and were able to use a translation service for patients for whom, English was not their first language.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could mostly access the service when they needed it and usually received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Waiting times for cancer review and treatment had been problematic since the covid-19 pandemic. However, information provided for the three months between June and August 2022 showed improvement with cancer waits. The trust performed better than other similar services in meeting cancer waiting time targets.

More than 90% of patients were seen within two weeks for a skin and upper gastrointestinal cancer review whilst there had been some improvement previously for lung cancer no information was available for August 2022.

Gastroenterology had an efficient process for triaging all referrals called the Referral Assessment Service (RAS). A business case had been submitted for an extra consultant and middle grade doctor which would further address the demand and capacity issues for endoscopy services.

The gastro service was achieving the standard for the 62 day wait from referral to treatment. The dermatology service had consistently met the 62 day wait although problems with pathology results had delayed treatment to patients for August 2022. The 62 day wait for lung cancer was not met as treatment was dependent on another local trust. The specialty was moving this service to another local trust from October 2022 to address the delays.

Dermatology had commenced tele-dermatology and recruited to all consultant vacancies which had resulted in the specialty achieving the 2 week wait for August 2022 following a sustained improvement.

Medical care (including older people's care)

Waiting times for oncology treatments from initial GP referral to commencement of first treatment did not meet national targets. Information for August 2022 showed 83% of patients requiring chemotherapy and 42% for hormone treatment received their initial treatment within 62 days.

Decision from the time seen to commencement of treatment within 31 days was met for all types of oncology treatment (excluding surgery which was provided by another local trust). Cancer services within the trust were supported by consultants from another local trust and a team of oncology nurses which had improved waiting times for oncology services.

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior managers spoke proudly of work undertaken to reduce the length of stay for patients and in September 2022 this was nine days. Average length of stay within MLTC division over the last six months compared favourably with other similar services.

The service moved patients only when there was a clear medical reason or in their best interest. One of the primary reason's patients were moved was due to infection prevention and if patients were identified as covid positive on non-covid wards. Generally, patients were moved to one of the covid wards with most patients going to ward 3. Managers monitored patient moves between wards and services and ensured patients moves were kept to a minimum.

Staff did not move patients between wards at night. In 2020 the trust identified a need to improve patients being moved at night as a quality indicator. As part of the quality improvement initiative the opening hours of the discharge lounge were increased with the closing time extended from 5pm to 10pm. This reduced the number of out-of-hours transfers taking place in the division from an average of 24% to 18%. In addition, the MLTC division had expanded the junior doctor rota in August 2022 to increase medical cover and enable tasks to be completed earlier in the day to enable timely discharges and transfers. This has resulted in 14% of patients out of hours transfers between wards in August and 13% in September.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. Managers in oncology services said only in extreme situation were appointments and treatments cancelled. For example, they had a recent failure of the specialist pharmacy room where chemotherapy was prepared. This meant chemotherapy treatment was not available and appointments were cancelled or were delayed. Ongoing delays in receiving chemotherapy from pharmacy meant patients had to wait for their treatment to be available. Managers said where possible they would make other arrangements but sometimes, they had to cancel patients. When patients had their treatments cancelled at short notice managers made sure they were rearranged as soon as possible and within national targets and guidance.

Patients who were ready for discharge were sent to the discharge lounge. Staff in the discharge lounge said they checked discharge arrangements for all patients including a check all required tests had been undertaken; social circumstances and suitability of the discharge destination, patients' medicines were available and correct and checks to ensure intravenous lines or canula needles had been removed.The trust increased the opening hours of the discharge lounge following a quality improvement initiative identified patients experience had improved. Staff said there were times wards were unable to discharge patients to the discharge lounge but 99% of patients were. Staff said it was much better for patient's safety and flow for them to go to discharge lounge and was better for the ambulance patients to go to the discharge lounge.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Care group meetings discussed length of stay on each ward and identified actions to address increased length of stay when required.

Staff supported patients when they were referred or transferred between services. Staff acknowledged it was often difficult for patients who required treatment at another hospital as they had to wait for an available bed within the speciality service.

Managers monitored patient transfers and followed national standards. Staff transferred patients when they needed access to a specialist service or procedure not available at the trust. This would involve trust staff confirming the transfer with the physicians at the hospitals where the patient was to be transferred to.

Managers worked to minimise the number of medical patients on non-medical wards (referred to as medical outliers). The MLTC division had embedded the 'red line' that no medicine patients should be accommodated on a non-medical ward without serious considerations of all other options available. This policy ensured patients receive their care in the right place. The trust had significantly reduced the number of medicine outliers in other divisions with just 17 medical patients accommodated on other division wards in the last 12 months.

Suitable arrangements were not in place to ensure managers and staff started planning each patient's discharge as early as possible. When patients were admitted their medical and nursing records detailed home arrangements and any existing care received. However, records seen did not identify potential needs and a plan identified for discharge including referral to other professionals such as physiotherapists or occupational therapists.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Information asking patients and their visitors to share their experience of care were available all patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to advise patients on how to make a complaint in line with the trust's policy and procedure. Patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There had been 96 formal complaints about medical wards between April 2021 and March 2022. The highest number (53) were about care, assessment or treatment. There was a process to investigate complaints locally, it was investigated by the manager and overseen by the quality matron. Complaints were recorded in a dashboard so were available for review by trust managers. Complaint investigations were shared at the monthly matron and care group meetings and potential themes discussed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. The oncology service said they had improved assessment procedures for patients who had a specialist intravenous needle called a peripheral inserted central catheter (known as a PICC) line. The trust had changed the visiting policy to ensure patients who were vulnerable or had communication difficulties could see their loved ones. Arrangements identified nominated agreed visitors who were covid tested and were issued with visiting passes which were handed to the ward staff when they visited.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders understood the priorities and issues the service faced; however, these had not been managed effectively. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical services which included all medical wards, accident and emergency, the acute medical unit, ambulatory care unit, frail elderly assessment unit and community services were part of the Medicine and Long-Term Conditions (MLTC) division. Oncology and haematology services were a separate care group and part of the surgical division. CQC methodology includes oncology and haematology as part of the medicine core service. For more information about leadership please see the surgical core service report.

The division was split into care groups such as respiratory, elderly care, acute and diabetes. Each care group had a management team which included a consultant, nurse and manager who were responsible to the senior management team of the division. The MLTC division senior leadership were a triumvirate: a divisional medical director, divisional nurse and divisional senior manager. This leadership team were supported by deputy directors for medical, nursing and managerial. Operational and clinical leadership worked to support quality patient care, the trust's sustainability, and to effectively engage more fully in external partnerships.

Several of the MLTC wards had new ward managers, matrons and additional senior nurse roles. Ward managers and qualified staff we spoke with were highly motivated to provide high quality patient care but were clear of the challenges of their ward and areas for improvements.

The service supported staff to develop their skills and take on more senior roles. One ward had a recently appointed matron. Staff said whilst they were without a matron, they had been supported by the deputy director of nursing for the division. They said this support had continued from the deputy director of nursing, whilst ensuring support was also available for the newly appointed matron.

Leaders and managers said they have been supported to engage in further leadership training. One senior manager told us they have been supported to undertake a leadership course and felt had helped them to better understand compassionate leadership and enabled them to bring this to their day-to-day work.

During our inspection, we saw leaders were present on the ward and staff approached them for advice and support. Staff said matrons for their areas were visible, supportive and prioritised the right issues within their areas of responsibility.

Staff felt the chief executive and senor leadership team were supportive and gave examples of improvements made to the service particularly increased staffing and the refurbishment plan and improved services.

Medical care (including older people's care)

The trust had processes in place to ensure equality and diversity was promoted within and beyond the organisation. During our inspection, no staff members voiced concerns over the way in which they were treated from an equality and diversity perspective.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a set of values developed with its staff, the values underpinned everything staff did and included Respect, Compassion, Professionalism and Teamwork. Staff knew and understood what the vision, values and strategy were and actions to achieve them.

The trust strategy of the "4 Cs" was supported by the division: This was:

C- Excel in the delivery of care.

C- Support our colleagues.

C- Effective collaboration.

C- Improve the health of our communities.

Managers and staff were enthusiastic about the plans for their service which was aligned to the trust strategy and gave several examples of improvements to the services including staffing, skill mix and the developments of the service which were also part of both the division and trust strategy.

The MLTC division included community services and whilst community services were not inspected the division senior leaders identified community services as central in the support their strategy. The division's plans were in line with integrated care systems (ICSs) and the needs of the local population. This demonstrated senior leaders and managers worked effectively with the wider health economy. Staff told us they were on a journey and were in a much better place but acknowledged they were still not where they wanted to be.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

Staff spoke positively about the improved culture in the trust. Staff in cancer and oncology services said they were "Very proud of the service they offered now". The staff culture in AMU had improved with staff feeling more supported and improved feedback from patients.

Staff and managers said they were listened to and able to put views and suggestions forward for service improvement. Staff said if they had a concern, they would not hesitate to raise it.

Medical care (including older people's care)

Staff and managers were enthusiastic about their service and were proud to tell us of their achievements and plans although acknowledged the trust was on a journey. One senior manager said ‘we're not where we would like to be yet, but we are going in the right direction, but it's a journey’

Senior staff acknowledged challenges remained in improving culture, trying to get doctors and nurses to work better together but identified huge improvements. Several workshops (some off site) had been held supported by two external people. The workshops had assisted improved communication and people's understanding of each other’s roles for example an Ambulatory care workshop helped to highlight the role of advanced nurse practitioners.

Staff spoke positively about career development opportunities. Several staff we spoke with said they had been appointed to their new position in the last six months. Staff spoke enthusiastically about their role and ensuring patients received high quality patient care. They said they had been supported in their new roles by matrons and senior managers.

Governance

Governance systems were in place but were not always effective. Staff were not all clear about their roles and accountabilities but there were regular opportunities to meet, discuss and learn from the performance of the service.

The trust had identified improvement was required to governance processes and were beginning to implement them with increased governance support to the MLTC division. The new governance structure commenced in April 2022 to assist the service to support improvement and embed positive change.

The service held a range of meetings to share learning and monitor performance with middle and senior managers. There were monthly Divisional Quality Board (DQB) meetings held with divisional directors and senior managers. The monthly meeting included standard agenda items such as staffing, financial situation, review of risks, service delivery and care group highlight reports. Actions were identified for named staff with actions identified to improve service delivery when required and included an action log. Actions were discussed and reviewed at each meeting. However some information provided to the care group meetings was not always robust and challenged the effectiveness of the systems to provide assurance.

Managers had not effectively monitored how well the service followed the Mental Capacity Act. Whilst we saw new documentation for mental capacity assessment was available it was mostly incomplete. The service had undertaken audits of completion of DOLs applications which identified satisfactory compliance. However mental capacity assessments we saw were not completed appropriately.

The MLTC division was split into care groups with each care group having meetings with the division senior management team, as a minimum quarterly or more frequently when needed. The division used a standard agenda for all meetings with records available and included staffing, risks, complaints service performance (patient numbers and length of stay), incidents.

Ward managers completed monthly reports about the ward and had monthly meetings with their matron to discuss the ward performance. Ward managers were clear about actions required to improve the service and identified actions to review staffing, staff mandatory training, staff appraisals. However there was a lack of clarity of roles and responsibilities for some staff for example to reduce medicine errors and ensure VTE assessments were completed.

Meetings were chaired by the most appropriate person, with clinical leads and the director present. We saw a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended and multidisciplinary, and actions were highlighted and reviewed at each meeting. Service leads confirmed that they met with the board regularly to discuss performance.

Each area had a weekly staff safety huddle except for AMU which had daily staff huddles, staffing and key information about the safety and performance of the service were discussed. Notes were taken at each huddle for reference for those staff who were unable to attend. It was noted meetings observed were not collegiate and were focused around doctors rather than a full team approach to fully benefit patient care. There was a weekly multidisciplinary (MDT) review of all moderate harm or above incidents to enable any required immediate actions to ensure safety. All moderate harm and above incidents were investigated, and a report completed of the findings and actions required with any associated learning shared with staff. Information was shared through meetings, minutes, and newsletters with other staff.

AMU senior leadership had appointed a governance facilitator to ensure they shared examples of good practice.

Management of risk, issues and performance

Leaders and teams used systems to manage performance however, these were not effective. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Matrons and managers did undertake regular audits of patients care for each ward such as patient's records completion, medicines management and completion of mental capacity assessment and DoLS. However, these audits did not fully identify the failing which we found during the inspection.

There were departmental, care group, division and trust risk registers. Risk registers were monitored and updated within the department care group and the division quality board. The governance team were reviewing all risks alongide the divisional team to ensure appropriate actions were in place. Each risk identified was recorded on a register and summarised: a description of the risk, its cause and impact, the existing controls for the risk, an assessment of the consequences and likelihood of the risk happening with the existing controls, the risk rating: low, medium, high or very high and the overall priority of the risk. The governance senior team met monthly with the divisional management team to discuss divisional risks. A monthly risk report was taken to divisional quality board. Divisional risks and risks requiring escalation to the corporate risk register were discussed at a divisional performance review and taken to the risk management executive. The risk register reflected the risks staff, managers and we identified.

Leaders said financial pressures did not compromise patient safety and gave examples of increased investment to ensure patients safety. Information provided within business cases to improve service identified any potential harm to patients if the business case was not accepted or a failure to meet required standards.

The division had regular morbidity and mortality meetings for each care group as an opportunity for learning and reflection both within the care group and more widely in the trust. These provided a forum for staff to explore the management patients who had died and if patient care and treatment pathways were appropriately followed.

Information Management

The service collected data and analysed it. The quality of data was not always robust. Staff could find the data they needed and were able to understand performance, make decisions and improvements when needed.

The service had improved information management systems. Managers said they were more assured of the accuracy of the information and data they received. However there remained some gaps particularly in the quality of some audits which did not provide accurate information about the service provided.

Managers reviewed all information to give them a picture of the quality of care provided. For examples they had systems to review identified incidents / complaints including patient falls and pressure ulcers against staffing. They were able to identify when staff required additional training for example in medicines management. Whilst audit results such as medicines audits, patient record audits and mental capacity assessment audits did not always reflect our findings. However senior managers confirmed similar concerns identified from other performance findings.

The trust had included a section in divisional and care group meeting called the patients voice which included a summary of all patient feedback in the previous month which included mystery patient and friends and family response. This enabled the service to see patients' feedback in a timely way. Feedback was shared with the ward who also had access to the monthly information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were quarterly meetings to review friends and family results and "mystery patient information". The "mystery patient" was a newly introduced scheme which enabled patients and visitors with smart phone to provide an immediate reaction to the care they had received and when needed ensure a timely response.

Patient voice reports were included within the MLTC division and had been available since February 2022. The patient voice included all patient feedback, including compliments and complaints, friends and family survey results and mystery patient feedback. Feedback posters with a quick response (QR) bar code were available within ward areas.

The service had collaborated with partner organisations to help improve services for patients. There had been workshops with patient groups prior to moving into the new AMU building. Healthwatch had supported the trust to design some patient information leaflets to understand the role of AMU. The leaflet described the remit of AMU as an assessment unit and it was likely they would be moved again onto another ward for further treatment.

The trust had a "Macmillan hub" which was available to support patients who had cancer or a life limiting condition to promote their health and wellbeing.

Information was shared with staff via newsletters, email and face to face meetings. The trust had a meeting with executives on a Friday which staff could drop into during their break for tea and coffee and cake provided by the executives. The meeting was based on a Swedish idea and were called FIKA Friday. Managers said they had a good response from staff who appreciated the informality of the meetings and the cakes provided whilst giving executives an opportunity to hear direct from staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Medical care (including older people's care)

We saw many examples of improvements made to the service to enhance and improve patient care. Leaders encouraged innovation and spoke about quality improvement initiatives which had improved service delivery for example the changes to improve patient discharge arrangements. Improved services and service developments had been achieved by increased staff investment.

Clinicians spoke with enthusiasm and passion about their services and changes made to improve patient care. One example was the lung cancer service. A clinician told us with support from the medical director the service had enrolled onto a lung cancer improvement programme. Prior to the improvement programme there had been several reported incidents of patients who had pleural nodes who had developed lung cancer but was diagnosed at a late stage. There had been no incidents in the last 18 months of patients as patients are regularly screened and any cancer is detected earlier meaning treatment is more effective.

Since January 2021 the trust had a multi-disciplinary diabetes and renal clinic which had improved patient care, one of the first trusts (apart from large regionally and national centres) to provide this service. The trust had submitted their findings to national and international meetings and professional journals.

The diabetes service had received several awards for improvements identified as a result of the Digital Evaluation of Ketosis and Other Diabetic Emergencies (DEKODE) project. Diabetes staff were proud of these innovations and improvements made to patient care.

Surgery

Good  

Is the service safe?

Requires Improvement  

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff and most staff completed it.

Most nursing and medical staff received and kept up to date with their mandatory training. Across all subjects and staffing groups training completion figures were at 89% overall which was slightly below the trust's target of 90%. The trust monitored key areas which required improvement and they included for example; fire safety, information governance, infection prevention and control, resuscitation and safeguarding children and adult level 3. Senior staff told us most staff who were not up to date had been booked to attend mandatory training. Staff reported that some face to face sessions had been cancelled due to staff shortages. Where this had occurred, staff were booked to attend the next available training session.

Not all staff were always given enough protected time to complete their mandatory training. We spoke to a foundation year one doctor who said they were up to date with their mandatory training. However, they had to complete it in their own time because wards were so busy, and they could not always be released to do the training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were required to complete mandatory training in a range of topics including safeguarding adults and children, information governance and data security, equality and diversity, conflict resolution, fire safety, health and safety, moving and handling, dementia awareness and infection prevention and control.

Staff could access mandatory training in a variety of ways and included online e-learning and face-to-face sessions as appropriate. Staff were allocated dedicated time to complete 'face to face' mandatory training. Training was completed and entered onto the trust's electronic system where competences achieved following training could then be awarded.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed. Staff feedback about all aspects of this training was positive. Data provided by the trust following our inspection showed 93% of staff within the surgical division had attended dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Both nursing and medical staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The trust had three safeguarding levels of training for nursing, medical and non-medical staff which were mandatory. Data provided by the trust following our inspection showed that staff either completed safeguarding adult or children level 1, 2 or level 3. Overall compliance for safeguarding children level 1-3 was at 91.1% and 90.2% for safeguarding adults levels 1-3 which was in line with the trust's target of 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff on ward 12 demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a safeguarding adult lead nurse and the safeguarding children lead nurse within the trust who could be contacted for additional help and support. There was a trust quarterly safeguarding steering group which was chaired by the director of nursing. Those at the meeting reviewed training compliance rates, any safeguarding process concerns, action plans from serious adult reviews and serious child reviews and incidents reported relating to safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about safeguarding and some could give examples of when they had needed to act to safeguard patients.

The service had a safeguarding adult at risk policy and a safeguarding children and young people policy. The policies were version controlled, in date and reflected national guidance. Ward managers, senior managers and the safeguarding leads supported staff to raise, report safeguarding concerns and make safeguarding referrals to the local authority.

Nursing staff had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Nursing staff confirmed FGM was included in their safeguarding training.

Recognised recruitment procedures were followed, which helped to ensure staff were safe and suitable to work with people or children who received care from the service. Discussions with staff showed required employment checks were made before staff provided patient care. For example, checks of staff previous employment, work history and checks with the disclosure and barring service. This helped the trust to make safe recruitment decisions about an applicant's suitability.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. However, staff did not always use control measures to protect patients, themselves and others from infection.

Not all staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gel and PPE. Masks were worn in line with trust policy. However, we observed some examples of poor infection prevention and control practices in ward 11 where not all staff wore appropriate PPE while taking blood and serving meals. This was raised at the time of our inspection.

Surgery

Staff received training about infection prevention and control (IPC) and hand hygiene during their trust induction and annual mandatory training. Following our inspection, data provided by the trust showed as of October 2022, 77.1% of all staff groups within surgery had completed Infection Control Level 1 and 2 training which was lower than the trust's target of 90%.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were recently refurbished areas such as theatres which had been designed to the latest national standards and included laminar air flow required for patients undergoing hip or knee operations.

The service generally performed well for cleanliness. Ward infection prevention and control performance was monitored. We reviewed infection prevention and control audits for July 2022 for wards 10, 11,12, 20a and 20b and overall compliance was at 92.3%. Auditors sent audit results to ward managers, matrons and the divisional director of nursing at time of completion. Any non-compliance was fed back to the area at the time of audit and action plans are owned by the areas.
Staff provided assurance and feedback at the infection control committee.

Staff used records to identify how well the service prevented infections. The service carried out quarterly hand hygiene audits and measured compliance against observed hand hygiene opportunities. The overall compliance for audits done in July 2022 was 97.2%. Staff reported quarterly hand hygiene audits to the IPC committee and these were escalated to quality committees.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment between patients. There was no evidence of high-level dust. Staff told us they would always clean equipment before and after use. We reviewed a selection of items including commodes, clinical observation and resuscitation equipment and found them to be clean as stated on the 'I am clean' label.

During our inspection, we found the general cleaning of the environment and furnishings in all ward areas was consistently of a high standard.

Staff worked effectively to prevent, identify and treat surgical site infections. Clinical staff adhered to the trust's being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three.

Hand hygiene gels were available for use at each entrance and throughout the ward, and there was hand hygiene advice displayed on the walls, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. Appropriate PPE, such as masks, gloves and aprons were readily available for staff to use.

Equipment within theatres was cleaned in accordance with the NHS healthcare cleaning manual. We reviewed the theatre cleaning frequency and responsibilities document which listed the areas and equipment to be cleaned and who was responsible for ensuring the tasks were complete. We saw equipment being cleaned in theatres.

Infection rates within the surgical division were monitored. The surgery division monitored surgical site infections using a nationally recognised infection prevention and control pathology system. Staff presented themes and actions to the patient safety group ultimately the quality, patient experience and safety committee, which was a sub-committee of the board.

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients on ward 11 said staff responded quickly although there were occasional delays when everyone rang at once.

Bays situated close to the nurses' station were allocated to patients who were more dependent on nursing care and meant staff had better visibility of patients within them. For example, patients with mobility difficulties, at higher risk of falls, requiring closer monitoring or living with dementia. This was to reduce the risk of higher risk patients coming to harm and staff could respond more promptly.

The design of the environment followed national guidance. Surgical and anaesthetic equipment was available and fit for purpose and checked in line with professional guidance. For example, digital blood pressure monitors were all within electrical and biomedical engineering (EBME) service dates and visible stickers were seen to evidence it. Single use sterile instruments were stored appropriately and kept within their expiry dates. Surgical procedure packs, implants and consumable items were stored in a tidy and organised manner.

Staff carried out daily safety checks of specialist equipment. Daily and weekly checks of the trolleys were consistently completed, according to the recorded entries in their resuscitation books. During our inspection, we checked the resuscitation trolleys and saw all appropriate equipment was present and accounted for.

Equipment required in an emergency was available within theatres, in recovery and on most surgical wards. Resuscitation trolleys and equipment were standardised and the contents were checked daily. Resuscitation trolleys had a tamper proof tag, which assured staff that the trolley had not been used and the required equipment was available for emergency use. On ward 20b the resuscitation trolley was shared with ward 20c and was placed between both wards. The wards were next to each other and the resuscitation trolley was accessible to all.

The service had suitable facilities to meet the needs of patients' families. Patients with learning disabilities were often given side rooms so relatives could stay with them to offer support.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to mobility aids such as Zimmer frames and walking sticks which were adjustable and tailored for use by specific patients.

Staff disposed of clinical waste safely. Clinical waste was segregated and disposed of in separate clinical waste bins or sharp-instrument containers. We saw staff following waste management practices during our inspection and none of the waste bins or containers on the wards were unacceptably full.

We found equipment stored in corridors within theatres which was not in line with safety standards. We raised this with senior staff at the time of our inspection who said the department was currently undergoing a refurbishment and provision would be made for storage of equipment to mitigate risks.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. However, they identified and quickly acted upon patients at risk of deterioration.

Surgery

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The National Institute for Health and Care Excellence Guidelines (NICE) NG89 Venous thromboembolism (VTE) in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism), states the risk of VTE or bleeding needs to be identified as soon as possible after admission to hospital or by the time of the first consultant review. During our inspection, we found initial VTE assessment and reassessment was not carried out on nine out of 18 patients. Following our inspection, the trust provided figures around VTE performance which showed 42.3% compliance in July and 42% compliance in August across five surgical wards.

We looked at the quality report 2021/2022 and the trust generally had not achieved their target of 95% of all patients receiving a VTE assessment within 24 hours of admission. From May 2021 to April 2022 the overall compliance for surgery was at 92.4% which was slightly below the target. The service recognised VTE had been a focus of improvement and a quality improvement project was planned within the division of surgery. Consultants received a daily report of compliance and divisions received a monthly report to enable a focus on improving timely patient assessments.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used nationally recognised tools to assess patients' risk of developing for example, pressure ulcers and nutritional risks and escalated them appropriately. They also used a multi-factorial falls risk assessment to identify each patients' risk of falls and any associated risks with moving and handling. We saw these risk assessments were reviewed regularly and when patients moved wards or had a change in condition, they were reassessed.

The surgical division had at any given time, at least one member of recovery staff who was trained and certified to an appropriate level in life support. Following our inspection, data provided by the trust showed 88.6% of consultants and 100% at non-consultant level had received advanced life support training including 19.2% trained as trainers.

During our inspection, we reviewed seven patient records and found falls risk assessment had been completed for all patients, and care plans were in place for those patients that were deemed at risk of falls.

Staff undertook daily assessments for bed rail suitability where it was considered that bed rails may be useful. During the inspection, we saw that bed rails were used following an appropriate assessment that indicated bedrails would support a patient to safely remain in bed rather than rolling out.

We looked, in detail at sets of records across six wards and theatres which were a combination of paper and digital records on the trust's handheld Electronic Patient Record (EPR) system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Staff knew about and dealt with any specific risk issues. All patient observations were entered into the trust's handheld EPR system. The system automatically screened for patients at risk of sepsis and an alert was sent to the nurse or doctor's mobile device. They then had the authority to deescalate through their clinical judgement or continue on the sepsis pathway.

The service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist which was an improvement from our last inspection in July 2019. Staff carried out WHO briefs between 8.30 and 9am either in the anaesthetic room or in operating theatres. We observed the WHO checklist for safe surgery being used and

noted good practice in that patients were checked in by the surgeon, anaesthetist and anaesthetic assistant. Staff said any breaches of completing these safety checks resulted in an incident forms being raised. We looked at six records for patients who had just had surgery during our inspection and the WHO checklist was correctly followed and recorded in all cases.

There was a hospital wide standardised approach to deteriorating patients and a clear documented escalation process. The trust used the national early warning score (NEWS) to determine whether a patient's health was deteriorating and utilised an electronic system for recording patient scores. NEWS is a combination of observations that indicate whether a patient is deteriorating and what associated actions should be taken.

The trust could demonstrate it followed sepsis guidelines (NICE and the UK Sepsis Trust), to identify the sepsis triggers and commence treatment within the 'golden hour'. This was monitored monthly and was fed back to the surgical teams on a regular basis. A sepsis and outreach response team (SORT) was created in January 2022 within the trust amalgamating the critical care current outreach team alongside a newly formed sepsis team. Since the development of the SORT, the overall divisional performance for surgery in percentage of antibiotics completed within one hour had increased from 43.5% in October 2021 to 80.6% in August 2022.

The trust used an electronic system whereby patients' observations were entered and a score, relating to their level of deterioration, was displayed. If a patient's score was five or higher the ward doctor, on-call doctor or outreach service were contacted to carry out a review. Observation frequency was increased to review if the patient was deteriorating. If scores were rated five or above a sepsis screening tool was completed. Staff followed the Situation, Background, Assessment and Recommendation (SBAR) tool. This tool outlines the deteriorating patients' clinical details and symptoms when escalating to a senior medical member of staff. This ensured staff had all the information needed to respond appropriately. There were also designated quality champions on the wards which enabled training and feedback to take place at ward level.

The service put in a business case to the board in July 2021 for the introduction of a Sepsis Response Team led by a band 7 independent advanced care practitioner to support early identification of sepsis and the timely implementation of the sepsis Six within 60 minutes. The initial recommendation was around the initial introduction of rapid response team for 12 hours per day, 7 days per week to demonstrate the benefits of improved implementation of the sepsis six within one hour. The team will expand to 24/7 provided those benefits are delivered within 12 months and are expected to deliver a reduction in mortality associated with sepsis, a reduction in admission to ICU and a reduced length of stay for patients with sepsis.

All elective patients had a pre-operative assessment before admission to assess fitness for surgery and assist in the reduction of cancelled operations. All patients were seen on the day prior to surgery by the anaesthetist and surgical medical staff. All patients had consent for their operation taken before they came to theatre in line with trust policy.

Patients who were electively booked for theatres had a Methicillin Resistance Staphyloccocus Aureus (MRSA) negative swab result available prior to the operation taking place. No patients were admitted to the elective wards without a negative status. If no swab was available and the procedure was clinically essential then it was up to the consultant surgeon to make the decision to operate or not. The surgical division did not monitor compliance for MRSA. The trustwide overall compliance for MRSA screening on admission was at 76% and there was no action plan in place to improve performance.

The infection control team completed MRSA screening compliance and presented figures to the infection control committee on a monthly basis.

Surgery

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Three nursing staff we spoke with knew how to get support from the mental health liaison support team.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information. Nursing staff had daily handovers and ward rounds to discuss each patients' needs. Staff highlighted staffing and workload issues, patients due for discharge and patients who were cohorted or required supervision. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. Staff told us they knew which patients were at risk of falls in each area and used an eye icon on the patient whiteboard to indicate they were under supervision.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, actual nursing rotas did not always match planned numbers.

The service had enough nursing and support staff to keep patients safe. Data provided by the trust following our inspection showed staffing levels were appropriate to deliver safe care and treatment to patients.

The trust had taken steps to increase staffing within the surgical directorate. The division had recruited 108 overseas nurses since the program began in March 2021, with a further 24 nursing staff in the pipeline to join the surgical division from September to November 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers completed and signed off allocated rosters eight weeks prior to the roster commencement date via a two-tier system. They put bank requests onto the system especially where gaps within the roster were identified to enable staff pick up shifts via the nurse bank. If any shifts remained unfilled 72 hours prior to the commencement of the shift, this was reviewed by the senior ward team and sent out to agency.

The divisional director of nursing, matrons and ward managers used a daily risk assessment for staffing on the wards. This was used to identify issues and escalate any gaps/shortfalls in staffing. The assessment also recorded daily acuity on each ward and aided in the decision making to ensure all areas were safely staffed.

The number of nurses and healthcare assistants did not always match the planned numbers. During our inspection we noted that on ward 20b the actual staffing did not meet the planned levels. Early shifts on the 29 September, 1,2 and 3 October 2022 remained unfilled despite being escalated to an agency. Similarly, on the day of our inspection, we reviewed staffing rotas on ward 12 and also noted gaps in the nursing rota. They required five nurses and had four nurses, and there was a nurse less than the planned number on the day prior to our inspection. Two nurses told us they could often only provide basic care to patients due to staff shortages. A theatre list had to be cancelled on the day of our inspection due to staffing issues.

Surgery

Managers discussed the varying needs of the different wards at a bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. Staff confirmed they were occasionally moved to other areas to provide cover as a result of staff shortages. They clearly knew the staffing needs of each ward and any shortfalls or extra capacity in ward staffing. This meant they were able to work together to deal with immediate staffing issues such as sickness, emergency admissions and patients who were more acutely unwell than expected.

The surgical admissions unit, ward 12 was a 27 bedded unit which received patients from the emergency department and surgical ambulatory care unit. The ward was substantively staffed for 27 patients, although the budget reflected a 12 bedded unit.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us that if additional staff were required, for example to support one-to-one supervision of a patient, it was escalated to the ward sisters for authorisation. In other instances where the ward was short staffed and additional staff could not be redeployed to the ward, staff told us the ward sisters worked clinically to support staff. Staff also told us the team were flexible and changed their shifts to cover staff shortages.

In theatres staff used a staffing tool to help plan the number of staff required on each shift. There was a staffing board in reception showing who was on duty. A theatre staffing business case expanded the band 6 ratio within theatres giving further opportunity to staff within the department and providing an opportunity to recruit externally to enhance the skills and experience within the theatre complex.

The service had low vacancy rates of 1.4%. The service was oversubscribed in some areas and so flexed staff to cover staff shortages in areas as required.

The service had reducing rates of bank and agency nurses. Staff forward planning bank recruitment monthly and all bank staff attend a full induction programme to ensure they had the appropriate skills.

Sickness rates were mostly aligned to the waves of covid infection in the local community with staff sickness deceasing and increasing alongside community covid infection rates. The service reported an overall nursing sickness rate of 5.4% in October 2022. We reviewed the divisional action plan for July 2022 which highlighted anaesthetics staffing issues (consultant and junior workforces) around sickness and ability to cover the required demand. The rota co-ordinator and anaesthetic rota lead reviewed sickness data and shared an escalation plan for the reduction of elective lists in line with sickness.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers held workforce and agency review meetings monthly and on an ad hoc basis to monitor and review bank and agency use.

Managers made sure all bank and agency staff had a full induction and understood the service. We were shown how all agency staff were given an induction. All staff new to the surgical wards told us they had a supernumerary induction period and bank staff told us they had received an induction. Managers had no problems accessing the trust and clinical induction for new starters.

Arrangements for handovers and shift changes ensured people's needs were communicated. There were standardised handover procedures for nursing staff, both for shift handovers and discharge of patients. Each morning and night, during shift changes, the nursing staff carried out a handover from night to day and day to night shift.

Surgery

The service had a surgical ambulatory care unit which provided 24-hour service although financially budgeted for a daytime only service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Foundation year doctors were always available and there were good consultant numbers and consultants conducted pre- and post-operative ward rounds each day.

The service always had a consultant on call during evenings and weekends. Orthopaedic or general consultant surgical cover was available 24 hours a day, seven days a week. Junior medical staff were supported by more senior staff if needed.

The service had enough medical staff to keep patients safe. The trust board had approved a £1.64M per year investment in 34 whole time equivalent (WTE) theatre staff and 4.6 WTE consultant anaesthetists, delivering a workforce that was both the right size and met association for perioperative practice guidelines. All theatre staff had been recruited since approval.

Funding had also been approved to expand recruitment of consultants in general surgery, therapists, breast advanced care practitioners, urology, trauma and orthopaedic consultants and additional independent practitioners.

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift.

The service had low vacancy rates of 3.84 for medical staff.

The service had low turnover rates for medical staff.

The service reported an overall medical and dental staffing sickness rate of 2.1% in October 2022.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Physiotherapists and occupational therapists attended and contributed to board rounds from Mondays to Saturdays and provided input on patient progress and care plans.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.

Patient notes were comprehensive and all staff could access them easily. The majority of records were paper based. However, the trust recorded a range of information on its electronic patient record (EPR) system. Patient demographic details (such as name, date of birth and address), referrals and blood and diagnostic tests were stored electronically.

Surgery

We reviewed 18 patient records and found they were clearly written and legible. Most records were up-to-date and available to all staff providing care with all entries, dated, timed, signed and the designation of the person making the entry identified. Admission records and nursing assessments were legibly documented in keeping with national Record Keeping Guidelines. However, weight was not recorded on three out of 18 of them. There was a potential risk of patients not being prescribed the right medication dose.

Matrons completed monthly documentation audits and found no evidence of any recurring themes or trends requiring an action plan following a review. We requested monthly documentation audits but did not receive them from the trust. There are plans to review and amend the audit tool and the trust are currently in a training phase of a new integrated nursing documentation/risk assessment admission document.

Bed rail assessments, falls risk assessment, Malnutrition Universal Screening Tool assessments and all relevant risk assessments were completed in records we reviewed, with patient wishes documented in the assessments. Patients at risk of falls had a falls care plan in place.

When patients transferred to a new team, there were no delays in staff accessing their records. All the required information was available when patients moved between teams, services and organisations. Patient records were available upon discharge.

Recommended Summary Plan for Emergency Care and Treatment (RESPECT) and Do not Attempt Cardiopulmonary Resuscitation DNACPR records were properly recorded for patients who needed them.

Records were stored securely. Patients' medical and nursing records were centrally stored on site. On admission, patients' records were requested and stored securely in lockable trolleys either in corridors or store cupboards on the ward. During our inspection, we saw no notes trolleys left unattended when unlocked. We also saw that no patient identifiable data was left unattended or in public view and computers were locked when not in use. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual account log-in details. Staff received training on information governance as part of their mandatory training programme.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff monitored and reviewed the effects of medicines administered.

Pharmacy technicians carried out random checks and audits on trolleys, fridge temperatures and controlled drugs. Pharmacists completed safety checklists which included antibiotics audits and there was good online resource on antibiotic stewardship. Pharmacists were visible on ward areas we visited.

Surgical wards had produced an antimicrobial audit report from April to June 2022 with the quarter two report scheduled for submission at the next medicines management meeting at the end of October 2022. The Commissioning

for Quality and Innovation (CQUIN) target for first quarter of submission was surpassed by 10%, with 89% compliance noted in appropriate prescribing. To further improve compliance, the service had sought support from medical and nursing teams to ensure urine sample taken at time of diagnosis were in line with guidance. Reports and action plans were reviewed during medicines management group meetings.

Staff completed medicines records accurately and kept them up to date. The management of controlled drugs was in line with legislation and NHS regulations. There was a controlled drug register which recorded drugs being booked into stock, administered to a patient and any destruction or return to pharmacy. Staff we spoke with were aware of the policies on the administration of controlled drugs. We reviewed the register and saw it had been completed in full.

Staff stored and managed all medicines and prescribing documents safely. Fridge temperatures were monitored by ward staff. Any discrepancies were acted upon immediately and staff were aware of what action to take if the temperatures were not safe for medicine storage. We reviewed data confirming medicines were stored within the recommended temperature range for safe medicine storage, all of which were correctly recorded. If temperatures were outside of required ranges, the pharmacy department were contacted.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacists regularly reviewed medicines charts to ensure patients were on the right medicines and the right dosage.

Staff learned from safety alerts and incidents to improve practice. The service had a robust system in place for reporting incidents and for receiving and dealing with medicines safety alerts. A medicines safety officer was involved in all medicine related incidents.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff throughout the wards we visited described the process for reporting incidents and were confident in using the system.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. In theatres there was a good awareness of incidents with senior and junior staff able to describe learning following recent events.

The service reported four incidents classified as never events from October 2021 to October 2022. Of the four reported never events, three were related to wrong site surgery and one to a retained foreign object. The trust carried out thorough investigations following the never events and now had additional systems in place including a system oversight for all medical staff following a never event which involved a locum doctor.

There was evidence that changes had been made as a result of feedback. For example, following a recent incident which involved a block, the service introduced a block trolley which contained laminated cards that stated “stop before you

block" which could be put on the trolley or on the plastic tray containing equipment for giving a block. We visited the trauma theatre anaesthetic room and were shown the block trolley. The ultrasound machine had stickers on it saying, 'stop before you block'. The theatre care plan had been redesigned with two sections that required confirmation of site before giving a block. These improvements were made to prevent never events from happening.

Theatre staff stored implants on a separate trolley, checking them at the beginning of a list and ensuring checks were done at the time of implant to prevent human error.

The service had introduced a new initiative in general surgery called "10000 feet and falling" which was taken from the air industry. Staff could shout out at any stage during a procedure if they felt a patient was deteriorating or was becoming unstable.

Managers shared learning about never events with their staff and across the trust. The trust held divisional governance monthly meetings, during meeting incidents were discussed, with learning across all clinicians.

Managers shared learning with their staff about never events that happened elsewhere. Nursing and medical staff were aware of a recent never event outside of the inspected activities and told us how it had been discussed and learning disseminated.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 50 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from September 2021 to September 2022. We reviewed five final investigation reports and found the serious incidents had been thoroughly investigated and included lessons learnt and recommendations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation.

Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives. The trust had identified concerns around culture within theatres and carried out an independent review in May 2022. During our inspection, senior clinicians spoke openly and positively about a shift in culture following a recent investigation into upper limb surgery.

Staff met to discuss the feedback and look at improvements to patient care. Leaders shared feedback following any improvements during safety huddles.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Senior staff across theatres reviewed incidents for trends and to action when necessary to ensure patient safety.

Is the service effective?

Good ↑

Surgery

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Policies we reviewed were up to date and included a next review date.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not encounter patients who were subject to the Mental Health Act, but staff were aware of the code of practice and the policies that were in place.

Patients' physical, mental health and social needs were mostly fully assessed. Staff within the surgical division screened patients for pressure ulcers, falls, venous thromboembolism (VTE) and mental capacity throughout their admission. Practice was in line with the National Institute for Health and Care Excellence Guidelines CG92 (Reducing the risks for patients developing venous thromboembolism in hospital), QS86 (Falls in older people) and CG179 (Prevention and management of pressure ulcers). Within all 18 patient records we reviewed, although there were gaps in appropriately assessing for VTE, there was evidence most patients were fully assessed and/or screened on admission and daily using validated and reliable scales. This was an improvement from our last inspection.

The service followed NICE NG51 Sepsis: recognition, diagnosis and early management guidance and carried out ongoing local audits to monitor trust progress. The World Health Organisation safer surgery checklist was used within the theatre department to ensure all safety aspects were achieved and adhered to. Compliance was monitored by monthly audits, which showed that practice in theatres was good.

The service had processes in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff told us they followed the trust's Equality, Diversity and Inclusion policy when making decisions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patient records reviews showed that patients' psychological and emotional needs were recorded.

Staff used technology and equipment to enhance the delivery of effective care and treatment and to support people's independence. Physio therapists carried out assessments to ensure patients had the right equipment prior to discharge.

Senior clinical leads told us that they are involved in contributing data for the national bariatric surgery register and this was completed by a specialist bariatric nurse.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Surgery

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients could choose from a wide range of foods that accommodated clinical needs, religious needs and personal preferences to promote eating. Every patient to whom we spoke was complementary about the quality and choice of the food that they were served.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patients' notes showed that patients who needed their fluid intake and nutrition monitored had this done by staff.

When patients had surgery, staff effectively managed nausea and vomiting. For example, we saw evidence of anti-sickness medicines prescribed in drug charts of patients who had recently had surgery.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. This included their weight.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff had good access to specialist input including from specialists in swallowing as well as dietitians.

Patients waiting to have surgery were not left nil by mouth for long periods.

Staff met the nutritional needs of patients. We saw patients who were unable to intake food orally during our inspection. The patients who required nasogastric and percutaneous endoscopic gastrostomy (PEG) feeding were supported appropriately by staff.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Wards had access to a specialist pain team during the day seven days a week including bank holidays.

Patients received pain relief soon after requesting it. A patient on ward 11 told us staff were responsive to their pain relief needs.

The surgical division and pain management lead consultant were currently auditing and reviewing the backpain pathway for acute spinal admissions and the pathway for management of chest injury and rib fracture pain. Staff planned to introduce a new policy which aimed to improve the accuracy of pain scoring and appropriate referral to the acute pain and critical care outreach teams. There were plans to carry out a 3-month audit assessing the efficacy of a new proforma for clerking patients presenting with back pain to the trauma team.

The service had a management of chest injuries and rib fractures pathway stated that a stepwise approach to pain relief medicines and regular reviews from a team of specialists, including medical, nursing, pain management and physiotherapy may reduce complications and mortality.

Staff prescribed, administered and recorded pain relief accurately. Patient records showed pain relief needs and medicines was recorded correctly.

Surgery

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. They participated in audits such as the National Lung Cancer, National Bowel Cancer, National Oesogastric and Fracture Neck of Femur audits. Outcomes for patients were largely positive, consistent and met expectations, such as national standards.

During our last inspection, the surgical division did not have oversight of all their clinical outcomes because they did not always have the required staffing to ensure consistent and accurate input of data. This had improved during this inspection as they had recruited consultants who monitored patient outcomes.

Managers used information from the audits to improve care and treatment. Where there were shortfalls in performance managers took action to improve the standard of treatment.

Managers and staff used the results to improve patients' outcomes. The service recently received a fracture neck of femur (NOF) award which was an improvement from them being an outlier in NOF mortality a few years ago. They had carried out a lot of quality improvement projects with significant improvement made in the NOF pathway supported by therapy resources.

The perioperative medical assessment rate was 94.7% in December 2019, which was similar to the national standard of 92.8%.

The risk adjusted 30-day mortality rate for the National Emergency Laparotomy Audit was 7.7% which was similar to the national average of 9.3% in November 2019. Although the risk adjusted 30-day mortality rate for National Hip Fracture was at 10.6% and worse than the national average of 6.1% in March 2019, there had been an improvement as previous performance figure was at 11.3% in December 2018.

The risk adjusted 90-day post-operative mortality rate for National Bowel Cancer Audit performance was at 3.4% which was similar to the national average of 2.9% in March 2019.

Cancelled operations not treated within 28 days of non-clinical cancellation performance was at 15.5% which was similar to the national average of 23.7%.

The service had presented a business case for genomic testing to determine if chemotherapy would benefit node positive patients living with breast cancer. The test performs a deeper look into the genetic changes of individual cancer cells to determine the best cancer therapy. The purpose of this test is to better identify people who will or will not benefit from chemotherapy and reduce the chances of patients having chemotherapy by 70%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and made sure staff understood information from the audits. The service conducted several audits including the theatre audit bundle, five moments of hand hygiene and surgical site infections. We reviewed surgical wound assessment audits carried out across various surgical ward areas and compliance figures ranged between 90% to 100% in July and August. We reviewed minutes of a surgical site improvement group meeting which was held in June and found a recent incident which was surgical site infection was discussed and included learning and recommendations.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. There were three surgical outliers on day one of our inspection. From October 2021 to September 2022, the service reported 78 bed days of surgical outliers. These were almost entirely as a result of transfers of care to a surgical consultant. Staff said the trust adopted a no tolerance approach to both medical and surgical outliers.

Managers shared and made sure staff understood information from the audits. Theatre staff audited each step of the five steps of safer surgery. Results of the World Health Organisation observational audit was displayed on a board in theatres. We reviewed team brief, sign in, sign out, time out and team debrief audits for June, July and August 2022. Compliance ranged between 93% to 100%. Team leaders had an action plan in place and had a safety huddle at 8am daily.

Competent staff

The service made sure staff were competent for their roles. They held supervision meetings with them to provide support and development. However, managers had not appraised most staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had sufficient training and support to care for patients.

Managers gave all new staff a full induction tailored to their role before they started work. The professional development team within theatres developed a robust induction and competency package to support new starters. This included a 12-week supernumerary training period to support the development of recovery and scrub competencies for new starters with either no or limited theatre experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified poor staff performance promptly and supported staff to improve. Following our inspection, the trust provided appraisal rates within the surgical division. This data showed that appraisal rates for all staff across the surgical division was 72.7% which was lower than the trust's target of 90%.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The Trust had appointed an associate deputy chief medical officer to develop a programme to expand the role of physician associates advanced care practitioners to the trust.

The clinical educators supported the learning and development needs of staff. All newly recruited overseas nurses had pastoral care delivered by the clinical fellowship programme (CFP) and team force with allocated senior nurse support. The service provided accommodation to everyone during the pastoral care.

All Clinical Fellow Nurses (CFN's) had a nursing buddy assigned to support them with everyday queries or transition into the UK. The trust had a dedicated team to support the recruitment and support of CFNs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The professional development team within theatres had commenced operating department practitioner apprenticeship course to support the development of the key skills band two staff required within the department.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were positive about this experience.

Managers made sure staff received any specialist training for their role. There were programmes in place across theatres to develop existing nursing and other staff at all levels through development opportunities including apprenticeships and registered associate programmes.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed working effective relationships between doctors, nurses, allied health professions, administration and housekeeping staff. Communication between them was clear, concise and respectful. This was observed on the surgical wards and within theatres.

We saw examples of MDT meetings convened to address the specific needs of patients. Meetings sometimes needed to be held “virtually” due to the COVID-19 pandemic, but we understood they always took place when needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were positive about the contribution made by all members of staff and staff who were members of professions allied to medicine told us they felt valued.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. Staff had access to mental health specialists and that there was good consideration of patient’s individual mental health needs and anxieties of patients receiving specialist surgery such as bariatric surgery.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We saw that consultants carried out ward rounds seven days a week for most surgical specialties and where this was not the case patients were reviewed by suitably senior and experienced doctors.

Pharmacy and microbiology services were available throughout the week during the hours 9am to 5pm. At night and at weekends, on-call pharmacy support was provided.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Access to clinical investigations was available across the whole week. Services included, x-rays, magnetic resonance imaging (MRI) scans and computerised tomography (CT or CAT) scans.

Theatres were open five days a week, with an on-call service for out of hours. There was a 24-hour outreach on-call service. Trauma theatres provided seven day working.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Surgery

The service had relevant information promoting healthy lifestyles and support on wards. The nature of much of the surgery provided by the unit meant patients needed to change aspects of their lifestyle either to prepare for or to take best advantage of the planned treatment. Patients told us that this was discussed in depth pre-operatively and they were given good support and guidance.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Printed material relevant to healthier living generally as well as specific to surgery was available on ward areas.

The pre-assessment clinic provided patients with information on how they could promote their fitness before their procedure. Staff reminded patients of the importance of eating a balanced diet, limiting alcohol intake and quitting smoking.

The trust was an NHS designated centre for weight loss surgery and offered a range of keyhole bariatric procedures. There was a team of specialist dietitians available for bariatric patients for weight management who worked Monday to Friday. Dietitians are a team of health professionals that assess, diagnose and treat dietary problems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe the process for completing a mental capacity assessment. Training in relation to consent was made mandatory for all clinicians who consented patients.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients consistently told us that the risks and benefits of surgery were explained well and that they gave their explicit consent for surgery and any emergency procedure that might be needed. We were also told how relatives were invited into the discussions if desired.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were able to explain the best interests' decision-making process. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they involved the patient's relatives and carers to provide further information about the patient's wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. Patient's notes showed all patients had a record of their capacity and psychological welfare on admission and where an assessment was needed this had been completed.

Staff clearly recorded consent in the patients' records. We noted that consent forms were completed correctly and that these represented good conversations with patients where the risks and benefits of their surgery had been discussed.

Surgery

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Theatre staff demonstrated good knowledge of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Where patient's lacked relevant mental capacity during completion of 'ReSPECT' forms, we saw capacity assessments were completed and discussions with family were detailed. Staff told us that medical staff were responsible for completing mental capacity assessments. Senior nurses completed DOLS application forms electronically if required.

The safeguarding team carried out monthly ReSPECT form audits and presented the ReSPECT data to safeguarding committee each month. Overall compliance for July 2022 was at 96%. Due to retirement and awaiting new starter to commence in post, no ReSPECT audits were completed in August and September 2022.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a ward round on ward 11 and patients were made aware of who staff were and why they were visiting them. The staff on the surgical wards were compliant with National Institute for Health and Care Excellence QS15 (Patient experience in adult NHS services), as patients were introduced to all healthcare professionals involved in their care and were made aware of their roles and responsibilities. We observed staff introduce themselves to patients in various ward areas we visited. This was an improvement from our last inspection where staff did not always introduce themselves to patients.

Patients said staff treated them well and with kindness. We spoke to six patients and they all said staff treated them with kindness and were enthusiastic about the care they had received.

Surgery

Staff followed policy to keep patient care and treatment confidential. We spent time on wards watching the interactions between staff and patients. Staff ensured that treatment, personal care and private conversation took place behind curtains and moderated their voices to ensure privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. There was an increased awareness of the mental health needs of patients because patients were more isolated as a result of COVID-19 which was evident in patients' notes. Some patients told us that staff asked about how they were managing with restricted visiting and helped them to express their frustrations and anxieties.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff had access to a chaplaincy service and told us they would respond to the varying needs of patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient feedback demonstrated high levels of satisfaction for the emotional support received from staff and almost all responses were good or very good.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good. There were high scores in the Friends and Family Test survey for staff attitude, implementation of care and clinical treatment.

From April 2021 to March 2022 the surgical division received a total of 19685 friends and family test responses. Senior staff had included the Friends and Family Test QR code on every mystery patient poster in order to increase the responses across the entire division.

Staff supported patients to make informed decisions about their care. When reviewing patient notes we saw an example of where a patient had made an advanced decision about the care they wished to receive including not to receive cardiopulmonary resuscitation.

Surgery

Patients gave positive feedback about the service. The trust had introduced a mystery patient scheme and from March 2021 to April 2022 surgical division received a total of 28 mystery patient responses. A patient who attended cancer services said, 'staff are very friendly and look after you well, well informed, treatment has been spot on and waiting times for appointments are good'.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. At the time of our inspection, due to the COVID-19 pandemic, services had been, and continued to be reconfigured to deal with both the threat of the disease and also to ensure that patients who needed urgent surgery got it in as safe a way as possible.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The surgical wards knew which patients would be admitted to the wards or coming through from critical care or surgery they were able to plan bed spaces and manage those patients that arrived as emergencies. From October 2021 to September 2022, there had been one mixed sex breach which occurred as a result of placing a COVID-19 contact bedbound female in a side room where the side room was located within a male bay. The service had undertaken a risk assessment which considered the patient's complex nursing needs with regular involvement from the critical care outreach team, tendency to deteriorate and the risk of transferring them to an outlying ward.

Facilities and premises were appropriate for the services being delivered. Surgical services consisted of a pre-assessment centre, arrivals lounge, 11 theatres, two recovery areas and six surgical wards. The operating theatres were split into two suites. The west wing suite consisted of five operating theatres, which were used for emergencies, general surgery, elective orthopaedics procedures and trauma and orthopaedic procedures. Some theatres were being refurbished at the time of our inspection.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention. There were specialised outreach services to help manage deteriorating patients as well as a specialist team to support cardiac patients with learning disabilities.

The service had systems to help care for patients in need of additional support or specialist intervention. Before the start of a session the theatre team leader ensured that the theatre team brief took place and all relevant equipment was available for that sessions procedures. If equipment was not available or deemed clinically unsafe for use the surgeon was informed before surgery started. The equipment manager was notified at the earliest opportunity and a clinical incident completed.

The service provided a bariatric anaesthetic clinic in line with their bariatric enhanced recovery pathway. This was put in place to decrease intensive care unit bed usage by planning and delivering tailored care. The clinic implemented a bariatric drug chart and pre ordered medication for patients on their arrival to the ward.

Patients' needs and choices were identified and used to inform how services were improved and developed. There had been significant patient engagement in the re-design of the Urology Service Collaboration, working with the Royal Wolverhampton NHS Trust to deliver the Urology Area Network (UAN), in line with the national strategy set by the Getting It Right First Time (GIRFT) programme. This process included consultation with patient forums and appropriate challenge working alongside HealthWatch and both Walsall and Wolverhampton Health Oversight and Scrutiny Committees.

The GIRFT programme's National Specialty Report for Urology, was published in July 2018. A key recommendation of the report was that UANs should be established in order "to provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency". The national review of urology services led to the conclusion that organising urological care on a trust by trust basis was unsatisfactory, as only a few trusts could offer comprehensive urology services in isolation. This led to the recommendation that UANs be developed.

Managers monitored and took action to minimise missed appointments. We spoke to staff who were proactive in ensuring that patients attended for both physical and virtual appointments by calling them prior to attendance to ensure they attended.

Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day.

Staff had access to communication aids to help patients become partners in their care and treatment. Although we did not see them being used, leaflets and other information could be provided in different languages.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our inspection, we observed nursing and medical staff interacting with patients and undertaking ward rounds. While they discussed their physical health needs and conditions, they also reviewed their mental health needs and made adjustments where necessary.

Wards were designed to meet the needs of patients living with dementia. There were named dementia link nurses on the surgical wards who provided additional advice on caring for patients living with the condition.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Examples of these were used in the surgical assessment unit. Staff were complimentary of the team that supported patients with a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust wide enhanced care team provided staff for one-to-one observation also included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls.

The service had information leaflets available in languages spoken by the patients and local community. Posters used displayed the information relating to interpreter services in different languages. For example, in Punjabi, Urdu, Romanian and Polish. Leaflets were not printed in different languages or braille, but staff were on hand to explain information when required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were very varied with a wide choice of meals. They met a variety of cultural and personal dietary preferences and were well aligned to meet the needs of local communities.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to appropriate translation services, and sign language interpreters when required. Staff had access to a telephone interpreter if they could not attend the ward at short notice. Staff told us they had not experienced any difficulties with accessing interpreters when they were needed.

Cancer services had introduced a dedicated code to classify cancer imaging requests from August 2022, alongside the introduction of faster diagnosis standard pathways and one-stop clinics for patients presenting with haematuria (blood in urine).

The trust recruited a family and carer co-ordinator and the role will involve advocacy and support for the unpaid carer, strengthening access to open visiting, mealtime support and will link in with Forward Carers Walsall.

Access and flow

Although people could not always access the service when they needed it, the trust was working hard to ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. Once admitted to hospital, patients' received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. We understood that the COVID-19 pandemic had had significant effects on the service's ability to carry out surgery. Sixty one percent of patients were treated within 18 weeks which was among the lowest in the region with regional average of 68% and national average of 70%. Failure to achieve 18 weeks referral to treatment constitutional standards in the division of surgery was identified as a risk within the trust's risk register. Control measures had been put in place, staff held restoration and recovery meetings with oversight at executive level.

From June to July 2022 there was a 15% increase in the number of patients waiting over 52 weeks compared to 5% regional and 6% national trends. The proportion of the total waiting list that had waited 52+ weeks (3%) was lower than regional (9%) and national averages (6%). At the time of our inspection, the trust was ranked 9 out of 20 acute trusts in the Midlands for patients waiting in excess of 52 weeks for treatment.

The longest waiting lists were for surgery and trauma and orthopaedics. General surgery also had the most waits over 52 weeks with 11.5% of the waiting list waiting over a year.

The service carried out monthly clinical harm reviews on patients who waited longer than 104 days and worked in close collaboration with system partners.

The trust met the national requirement to have 0 patients waiting in excess of 104 weeks by April 2022. In the process, the trust provided mutual aid for 14 patients across two neighbouring NHS trusts. The trust remained on track with the national requirement to have 0 patients waiting in excess of 78 weeks by March 2023.

Surgery

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The surgical division received 7,195 elective admissions and 9,752 emergency admissions from October 2021 to September 2022. Emergency admissions included those to the surgical ambulatory care unit where patients were seen for assessment.

The trust had performed well in ensuring surgery for those patients classified as needing treatment within a month (P2), with the trust consistently ensuring in excess of 70% of patients were waiting fewer than 30 days for this most urgent classification of elective surgery.

Patients' with the most urgent needs had their care and treatment prioritised. As of October 2022, 68.3% of patients were receiving treatment for their cancer within 62 days of referral, placing the trust at a national ranking of 40th and significantly ahead of the regional average (49.2%) and national average (60.5%).

The trust had made several investments to support the delivery of timely elective care:

- £1.64M/year investment to expand by 35 WTE theatre staff and 4.6 WTE consultant anaesthetists, approved by trust board in 2021/22.
- £761k/year investment in a joint urology collaboration between Walsall and Wolverhampton, that would in turn provide 600 new appointments, 600 follow up appointments, 1,512 diagnostic procedures and 406-day cases/year. An additional £76k had supported the introduction of a one-stop prostate biopsy clinic, based in outpatients.
- Refurbishment of 2 theatres in West Wing, delivered in 2021/22, without disruption to elective surgery. A further £9.1M refurbishment of 4 further theatres, anticipated for commencement in 2022/23.
- A £744k/year investment in the general surgery service, expanding the consultant workforce, providing additional elective clinics and diagnostic sessions.
- A £264k/year investment, introducing three additional trauma and orthopaedic consultants.

In addition, the trust provided a ring-fenced elective wing to the Hospital, providing dedicated elective beds, inclusive of an Enhanced Recovery Unit for seven elective operating theatres.

The trust had submitted an overarching plan for both 18-week RTT recovery and 78-week recovery to the Black Country and West Birmingham integrated care system (ICS). The plan and elective recovery pack were monitored both within the trust governance processes (accountable to the chief operating officer and to the performance and finance committee) and to the ICS elective care board. The trust was performing well with the provision of elective activity, with >100% of value weighted activity (when compared with 2019/20) being delivered consistently since August 2022.

During our inspection, staff and managers told us that they were seeing a rise in patients admitted both for and with COVID-19. The trust was starting to put in place arrangements to cope with this increase.

Managers and staff worked to make sure patients did not stay longer than they needed to. Across all surgical specialities length of stay was comparable to the national average.

Managers worked to minimise the number of surgical patients on non-surgical wards. Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. During our inspection, there were

three surgical patients on non-surgical wards. We reviewed their notes and the had been seen by the surgical team daily. Staff did not move patients between wards at night. The service moved patients only when there was a clear medical reason or in their best interest. Under the heightened infection control precautions due to the COVID-19 pandemic, ward moves were even more restricted.

Trauma and orthopaedic surgery activity was also very low during the pandemic and this had resulted in a large backlog of patients needing surgery. Again, theatre sessions in the independent health sector were being used to address the waiting lists.

Managers worked to keep the number of cancelled operations to a minimum. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. The trust had not cancelled an operation due to the lack of access to an elective inpatient bed since March 2020.

Cancellations were monitored through weekly meetings and a root cause analysis conducted to understand the reason behind each cancellation. A total of 51 planned procedures were cancelled in August 2022 and 43 in September. The service monitored reasons for cancelled procedure and procedures were cancelled due to patients being unfit for surgery on the day, cancellation due to cases becoming more complex and lack of theatre time.

Managers monitored that patient moves between wards were kept to a minimum. There were regular meetings throughout the day where capacity and flow were discussed and issues escalated. The frequency of these and the seniority of the managers present was dependent on the level of pressure the trust was under. The surgical division recorded an average of 170 out of hours admissions from 10pm to 6am.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge planning usually started as part of the pre-operative assessment. Where required there was a multi-disciplinary approach and we saw good examples of this in the records.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The surgical division monitored patients declared medically stable for discharge daily and worked in conjunction with the intermediate care service within the community. Delays were managed via daily escalation meetings. There had been an average of three delays over the past 12 months. The division expanded therapist provision across surgical wards to expedite assessment and determine the appropriate discharge pathway for patients.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were advice leaflets and posters on how to complain displayed prominently throughout the wards.

Surgery

From 2021 to 2022, the surgical division received 116 formal complaints which was an increase when compared to 84 complaints received from 2020 to 2021. Examples of complaints received included poor communication regarding visiting, very basic updates on condition and miscommunication in relation to ward transfers.

During the same reporting period from 2021 to 2022, the service received 48 compliments for the division which were equally spread between the departments.

Staff understood the policy on complaints and knew how to handle them. There was information available to help them do so including signposting them to the patient advice and liaison service. Staff told us that they would always want patients to approach them directly so issues could be resolved quickly for the patient's benefit.

Managers investigated complaints and identified themes. Managers were able to give examples of recent complaints and were knowledgeable about themes and trends in their area.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw example complaints where patients had been kept informed and involved in their complaint and also an example where the duty of candour had been followed.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service was led by a director of operations, divisional director and a divisional director of nursing. Clinical directors, matrons and care group managers within the surgical division were clearly knowledgeable about the services for which they were responsible and had the required qualifications and experience. They demonstrated integrity in their dealing with us by the honesty in talking about any problems with the service.

Most clinical directors/leads were consultants within surgical disciplines or anaesthetics and matrons had extensive experience in the areas they were leading. Care managers had experience in operations across hospitals. All staff told us they were confident in the leadership of the care groups.

Staff were positive about their leaders and co-workers and leaders spoke highly of their staff. Senior managers told us they were proud of how staff were working to recover surgical services.

Local nursing leaders were visible, supportive and approachable. Staff within the ward areas and theatres said they were familiar with the senior management team as they visited the surgical areas often and were approachable and provided support.

Surgery

Staff said leaders at all levels were present on the wards, they were usually able to name them and talked positively of the support they gave.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them.

The trust values were; respect, compassion, professionalism and teamwork. The values were displayed on notice boards.

The surgical division developed a "Vision for Outstanding" early in 2021. At the time of production, the document formed a series of objectives each care group within the division would complete. The division delivered monthly team briefs and the core of this brief adopted a "You Said. We Did" approach, with frequent updates against the original objectives.

All staff we spoke with knew what they were and felt they represented their own personal values. Staff demonstrated the values during our inspection, as they all showed compassion to patients, relatives/carers and each other; were professional; demonstrated high levels of teamwork and respect to others.

Staff had been involved in shaping the values of the trust. Staff had been consulted and were given the opportunity to put forward suggestions on what the trust values should be. The staff then voted on the values they felt were most applicable to the trust.

Staff understood and demonstrated the trust's vision and values and they felt the service adhered to the trust's aims. The trust's vision was 'caring for Walsall together' and was underpinned by five strategic objectives.

A nursing strategy 2019-2024 had been developed by involving patients and volunteers. This strategy was applicable to all registered nurses, care support workers and ward support staff. Staff gave very positive feedback about the strategy, for example, one nurse told us that "this is a good voice for all nurses".

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

A recent review highlighted cultural issues relating to the reporting of incidents by surgeons within the surgical division. Surgeons did not always report incidents and provided limited information to the division which resulted in a paucity of data available to the governance team and a lack of assurance around the quality of service. Staff we spoke with during our inspection said there has been a shift from this culture. All surgeons now openly report incidents.

Staff were overwhelmingly positive about how they felt supported, respected and valued by both their line managers and more senior staff. They gave examples of how they had been cared for and how they in turn had cared for one another while they gave support to other areas in the hospital and in some cases across the trust and in other hospitals.

Senior staff in theatres told us that they ran an open-door policy and that the most recent staff survey demonstrated an improvement in staff engagement. Junior staff said that the culture was good and that they were able to approach management and escalate concerns.

There was an openness in talking about where things had gone wrong and staff were comfortable discussing incidents and complaints, identifying what had gone wrong and how it was to be fixed. When things did wrong to the extent that a patient suffered harm, we saw that there was a supportive approach to finding out what went wrong, addressing the complaint and the "duty of candour" as required by the regulations was followed.

There was a real sense that staff were positive and proud to work in the division and for the trust and morale was high Staff told us that because staff were frequently moved from their usual ward to cover on other wards some of them found this stressful.

Governance

Governance processes were not always robust throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance process around monitoring of venous thromboembolism (VTE) assessments was not robust. The service reported 30 hospital acquired thrombosis (blood clots) from May 2021 to August 2022, three occurred in June, one in July and zero in August 2022. Hospital acquired thrombosis was reviewed by the divisional director and presented at monthly trust wide VTE meeting. There had been a recent change in process which now allowed VTE assessment to be done in the emergency department as part of the initial assessment. However, data reviewed did not always reflect the change in practice which demonstrated this change in practice had not been well embedded.

A monthly meeting was held for each care group which was attended by the clinical director/lead, matron and care group manager. There was monthly consultant, matron, band seven nurse, medical advisory committee, clinical governance, care group meetings and board divisional quality meetings. We were told all the meetings were minuted and circulated to attendees. There were also weekly and daily safety huddles on wards and within theatres. Daily trauma meetings took place which were attended by consultants and middle grade doctors.

The surgical division held monthly quality board meetings. Attendees included the divisional director, performance manager, decontamination manager, matrons, care group managers, clinical directors, patient safety manager and deputy director of operations. We reviewed minutes from the July 2022 divisional board meeting which showed the organisation took concerns very seriously and were working to understand the root causes and respond. They also clearly recognised the impact on staffing and ultimately performance and the quality of patient care.

Clinical governance meetings were held for the theatres, anaesthetics and critical care (TACC) care group. We were told they took place monthly. Items on the agenda included but were not limited to risk, staffing, falls, audits and finance. Top divisional risks and risks requiring escalating to the corporate risk register were discussed at divisional performance review and taken to risk management executive.

Safety huddles were held twice a day. During the safety huddle the nurses in charge of the ward provided updates to staff on new or changes to risks within the surgical division and on the ward.

All ward areas had WhatsApp team meeting groups which had been introduced due to Covid 19 restrictions. Documents were added to the group for all members to read and no patient or staff identifiable material was shared.

The service invited two members of the Association for Perioperative Practice (AfPP) to undertake a peer review of theatres in February 2022 to identify where practices were in line or deviating from the AfPP standards and

recommendations for safe perioperative practice (2016). They found staffing establishment within the operating theatres did not meet the minimum standard of AfPP staffing for patients in the perioperative setting. Following this review, a business case was submitted and approved to increase the establishment of operating theatre staff and anaesthetists.

The service had service level agreements (SLA) with third party providers. There were SLAs with local acute trusts to provide certain services including head and neck, ophthalmology, maxillofacial and rheumatology. The consultants from the local acute trusts attended Walsall Healthcare NHS trust to provide the services.

Surgical services at Walsall Healthcare NHS Trust led on the 'waiting list prioritisation' workstream. The trust is currently evaluating the effectiveness of the Copeland Clinical Artificial Intelligence Tool which utilises nonclinical factors such as sex, ethnicity and deprivation as part of a peer-review predictive model for mortality and morbidity following elective surgery.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, robust processes to monitor post-operative complications were not in place.

There was no robust process in place to monitor return to theatres. Return to theatres was captured through incident forms. Staff reported unplanned return to theatre as incidents. They included the level of harm which informed the extent to which it was investigated in line with the trust's incident management policy. Where an incident required a systematic review of revisions, post-operative complications and returns to theatre, staff requested data as part of the incident investigation. The trust carried out 6813 elective and 3942 emergency procedures from October 2021 to September 2022. They had a total of 25 (0.37) elective and 17 (0.43) emergency procedures with required a revision.

The trust acknowledged there was work to do to build on the current tool to improve the systematic monitoring of post-operative complications and was looking to purchase a surveillance tool which offered statistical process charts to monitor any concerning trends, acting as an early identifier of training needs or management intervention.

The surgical division underwent a trauma and orthopaedic cluster review as there appeared to be a significant number of cases where the technique of a surgeon had been questioned by Royal College of Surgeons review experts. There was previously a poor incident reporting culture and lack of engagement of the governance team with the division decreased the possibility of this cluster of cases being identified at an earlier point.

The surgical division had three core approaches to managing the escalation of concerns or issues. The elective care access policy covered approaches to the management of elective care pathways. Each care group provided a monthly escalation report to the divisional quality board. Mortality and morbidity reviews were discussed during care group quality meetings.

The service held risk registers at a divisional level which were aligned with the issues staff and managers raised with us on the inspection. Failure to adequately assess and record venous thromboembolism assessments was included in the risk register. They were in a suitable format and clearly described the issue, risk, mitigations, remedies and the current status of action plans. Leaders had an oversight of risk register and clinical audits to monitor performance. This included sickness, numbers of vacancies, monitoring audits and themes. Risks due staffing was monitored by senior leaders to manage wards with safety.

Surgery

Each service line within the surgical division kept their own risk register which fed into the surgical division risk register. The surgical division risk register held 146 risks assigned risks which included; departmental, care group, divisional and corporate risks.

Following the identification of the Westwing theatres as joint highest risk on the divisional risk register, plans for its refurbishment had been made to mitigate risk and ensure a safe operating environment for outpatients to ensure air handling units were compliant with Hospital Building Note (HBN) standards. At the time of our inspection, the service had refurbished two Westwing theatres and had plans in place to commence the refurbishment of four further theatres by March 2023.

A neighbouring trust managed pathology service under the banner of Black Country Pathology Service. Leaders reported significant delays in histology and diagnostics reporting impacts on the planning of patients' treatment plan and performance. There was a risk of patients deteriorating due to excessive waiting times. Staff escalated pathology delays weekly and as a result of oversight and scrutiny from the trust's cancer board, a recovery plan had been proposed and was to be considered at the trust's October board meeting. This was included in the trust's risk register.

We discussed systems that the service had in place for assuring safety during operations. We were told that the service had recognised that these needed improving as a result of never events that had taken place. Senior managers were familiar with these incidents and spoke confidently about their causes and the measures taken to prevent a repeat. For example, there had been a recent change in practice in theatres as a result of a recent never event.

The trust had an emergency preparedness and business continuity plan for business interruptions and special arrangements to allow the service to continue, in the event of major or critical incidents, including IT system failure. In addition, the trust had an emergency planning, resilience and response lead.

During our inspection, the trust was becoming increasingly pressured from an emerging COVID-19 wave as well as other respiratory viruses and flu. There was a coordinated response across the site as managers worked to reintroduce measures such as the enhanced wearing of masks.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Information technology systems were used to monitor and improve patient care. The service had suitable clinical and managerial information systems to provide information for patient care, and both day to day and strategic management.

The arrangements for ensuring the confidentiality of identifiable data was in line with data security standards. Nursing and medical staff received training on information governance as part of their mandatory training and compliance rate was at 90.2%.

Staff had their own trust email account and received regular updates on training courses they could attend and could view whether their mandatory training was due or had expired. Staff had access to a personal electronic personal development page on the trust's intranet, where they could access training and review their personal performance records. They could also access policies, practices and guidance using the intranet.

Surgery

Service performance measures were reported and monitored. Managers and senior staff had access to these reports and relevant and appropriate service performance information.

The surgical division used dashboards to monitor performance information for all services. Performance data included referral to treatment time performance, cancer target performance and "did not attend" rates. Information relating to incidents, falls, admissions/discharges, medicines errors, infection prevention and control, staffing, complaints and surgery cancellations were being reviewed monthly by the service leads.

The service provided a trust website for general surgery. This included the range of general and sub speciality surgical procedures offered including bariatric surgery, breast care, colorectal surgery and their pelvic floor services. The website included the services hours of operation, contact information and how to access the service.

Information systems were integrated and secure. The trust had implemented the policy for General Data Protection Regulation 2016 (GDPR) and the policy was available on their website.

Staff had been trained in the accessible information standards (AIS) as part of the Equality Diversity and Inclusion (EDI) training delivered by the senior EDI lead. Staff promoted the use of the accessibility standard through the use of the communication card.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The trust encouraged patients and families on ward areas and theatres to complete the friends and family test. The trust web page displayed feedback from the Friends and Family Test.

A Macmillan hub was available to support patients who had cancer or a life limiting condition to promote their health and wellbeing.

The trust implemented initiatives to ensure staff were actively engaged. On all surgical wards there were notice boards communicating information in an accessible way. The boards were used to communicate positive information, audit results and other key messages. For example, we saw audit results displayed in theatres. Staff were sent a weekly and monthly newsletter by email.

The trust effectively engaged with its staff and the public, kept people informed and listened to people's views. Surgical wards and operating theatres held team meetings and provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff spoke positively of being involved in decisions and new ways of working.

The trust had a health inequality steering group which focused on several projects including surgical pre-optimisation to provide greater equity in both access and ultimately outcomes for patients within the Borough.

The trust implemented initiatives to ensure staff were actively engaged. On all surgical wards there were notice boards communicating information in an accessible way. The boards were used to communicate positive information, audit results and other key messages. Staff were sent a weekly and monthly newsletter by email.

Staff engaged in drop-in sessions with the Chief Executive Officer and told us the visibility of the executive leadership team on ward areas had been positive for staff morale.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service had put many innovative projects in place to improve the service for patients. The intensive care and anaesthetics department had also been central to developments, including:

- The introduction of a ring-fenced elective theatre suite supported by a ring-fenced post-operative surgical ward, supported by an enhanced recovery unit.
- Improvements in outcomes for patients as reported by the Intensive Care National Audit & Research Centre (ICNARC), National Emergency Laparotomy Audit (NELA) and National Hip Fracture Database (NHFD)
- A dedicated Sepsis Response Team, working 7 days per week

The trust maintained a ring-fenced elective wing to the hospital, protecting the provision of elective surgery without disruption since the emergence of the covid-19 pandemic. The elective wing included an enhanced recovery unit which enabled the trust to deliver nationally upper quartile utilisation.

Staff participated in local and national research. The division had published a host of papers in the British Medical Journal, Journal of Anaesthesia and the British Journal of Surgery on the impact of COVID-19 on surgical outcomes. In addition, a novel study was published in the Annals of Surgery taking a collaborative perspective on whether surgical training was prepared for another wave of COVID-19.

The trauma and orthopaedic department did a presentation at the American Academy of Orthopaedic Surgeons identifying pre-op predictors of successful arthroplasty.

All nursing staff spoke positively about the trust's ongoing nursing strategy 2019-2024 and how the nurses and patients were involved in shaping the strategy through a variety of open discussions.

The trust were expected to be announced as receiving the MAKO Robot in October 2022 which will make them the first District General Hospitals to introduce robotic-assisted arthroplasty. The trust had also been accepted by National Institute for Health and Care to Robotic arthroplasty which is a clinical and cost effectiveness randomised controlled trial.

The service received a clinical audit award from the healthcare quality improvement partnership for work on the trust's neck of femur (NOF) pathway. This was an improvement as the trust had recently been a (NOF) outlier.

The trust had taken an innovative approach to undertake varicose vein sclerotherapy under local anaesthetic in an outpatient setting. The surgical division contributed 78 projects to the latest quality improvement annual awards. The winning project came from within surgery, based on improving prompt mobilisation post femur fracture.

The division introduced the Copeland Clinical Artificial Intelligence tool providing elective surgical morbidity and mortality both now as a result of delayed treatment. The tool also provides clinicians with decision support with the prioritisation of surgery, as per Royal College of Surgeons guidance.

Services for children and young people

Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

Nursing staff received and kept up to date with their mandatory training. Staff were knowledgeable about the training they received. For example, staff members told us they had completed training face to face and online on how to move and handle patients safely. The trusts overall compliance for mandatory training was 87%. Children's services were working towards meeting the trust's target of 90% by end of October 2022. Neonatal compliance with mandatory training was 90%.

Mandatory training included, fire safety, health and safety, equality and diversity and human rights, safeguarding level 3, paediatric intermediate life support, European Paediatric Advanced Life Support, information and governance, infection, and prevention control. The care groups had set a target to achieve 90% compliance by the end of October 2022 across all children services. Training statistic had improved, although some data had not pulled through the trust system.

All staff, including clinical support staff, were required to complete mandatory level 3 safeguarding children training, which exceeded the minimum requirements of the Intercollegiate document - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019). The trust had low compliance during COVID-19 however, this had consistently improved and had almost reached the trust's target of 90%. The trust encouraged training and development and monitored compliance rates during governance meetings.

Medical staff received and kept up to date with their mandatory training. Medical staff achieved mandatory training compliance of 100% for consultants and 96% for non-consultants. The trust planned to achieve 100% by the end of November 2022. Compliance targets were set by the care group to improve training.

Fifty per cent of doctors had completed level 2 children's safeguarding training. We saw planned inductions and improvement to achieve the trust target.

The mandatory training was comprehensive. Staff on wards completed safeguarding training, dementia awareness and mental capacity training and gave examples for some of the learning that had taken place.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. We saw staff had completed suicide preventiontraining which included completing risk assessments within patient records during admission to the ward. Staff understood the importance of completing records. However, this was not always consistently completed. Service leads reminded staff, through communication, to improve.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were sent a reminder to complete training when it was due by email and via supervision.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The nursing staff received safeguarding children's level 3 training as minimum. Compliance for September 2022 for level 1 and 2 Childrens safeguarding was 100% and level 3 was 82%. This did not meet the trust target but had improved since June 2022. Staff were working to improve this by end of October 2022.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were trained and knew how to recognise abuse and escalate any concerns or signs in line with the trust safeguarding policies and processes. Consultants completed safeguarding children level 3. As of September 2022, overall compliance was 96%.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff on ward 21 told us, if they had witnessed any bruises or any intimidating behaviour from a parent towards a child, they would raise this immediately for the safety of the child.

Children admitted to the paediatric assessment unit (PAU) and ward 21 were cared for by staff. However, staff did not engage in safeguarding supervision. Supervision was provided by the trust safeguarding team and was accessible to all staff. Staff availability to engage in safeguarding supervision was impacted by staffing difficulties due post COVID-19. The safeguarding lead was keen to improve services and supervision.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood how to report abuse and were aware of the escalation processes of referral.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The staff told us if they had a concern, they would make a referral to the local authority in line with trusts processes. Staff members were able to ask for advice from seniors' leaders and colleagues if they had a concern with a child's welfare.

Staff followed safe procedures for children visiting the ward. All staff on all wards monitored when parents and families were visiting. Staff could visually see on an intercom screen when a visitor buzzed to enter the wards, and the staff member verified which patient they were visiting. Staff were familiar with parents and families who were visiting. The staff used swipe cards to enter wards. The security was managed safely on all wards. The staff knew how to escalate concerns if cameras were not working.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained

Services for children and young people

We inspected ward 21, 28, PAU and outpatients the areas were visibly clean this included patient bays, bathrooms, and playrooms. We spoke to the housekeeping team who consistently worked on the ward and was aware of their responsibilities. The staff told us it was important to keep areas for patients clean for a safe and infectious free environment.

The service performed well for cleanliness. All wards were monitored by an infection control lead and scored 87% overall. This included areas of the environment, sharps, personal protective equipment, linen, waste, hand hygiene and isolation. The ward managers shared environmental audits with staff for improvements during meetings.

Children services reported no infections, C difficile or any blood stream infections between June and August 2022.

We looked at cleaning records during inspection, cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. We saw staff wearing personal protected equipment (PPE) during care and intervention. Staff wore PPE when entering high risk areas where there may be a patient with a transmissible infection. We saw signs for infection control and prevention on doors where patients with infection were cared for.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaned equipment after use and labelled equipment to show when it was last cleaned.

We saw clean toilets and hand washing facilities across all bays and wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Children, young people, and their families could reach call bells and staff responded quickly when called. Parents told us nurses always responded when a child required attention from a member staff. For example, one parent told us, their child's sugar levels became low, and nurses brought some snacks quickly to maintain their sugar levels. We observed staff visible on the wards and talking to parents and children when attention or assistance was required.

The design of the environment followed national guidance. Wards were designed specifically to meet the needs of children and young people. The wards were spacious and with facilities for children like a sensory room, playroom, and outdoor play area. The areas were well maintained and encouraged to be used by the staff. Staff told us, there was a further plan to improve areas for children.

However, the children's outpatients required some improvements to the environment to meet the needs for children and young people. Nurses told us this area had changed during the pandemic to comply with infection control guidance and staff had removed toys and magazine for infection prevention and control purposes. The department had not yet returned to how it was pre-pandemic.

The hospital was building a new paediatric assessment unit adjacent to the emergency department. This was due to open in early 2023. Senior leaders told us this would be a better facility for children, young people and parents to support children when they came to hospital and provide an appropriate environment for children to be assessed.

Staff carried out daily safety checks of specialist equipment. Equipment was checked regularly. A monthly environmental audit for equipment and infection prevention and control scored 95% overall in June 2022. We checked equipment such as blood pressure machines and computers for portal appliance testing. All were compliant except one blood pressure machine that had expired in June 2022. We raised this with staff on the ward. Ward staff were aware of checking equipment before use and escalating any concerns for repair or safety.

The service had enough suitable equipment to help them to safely care for children and young people. The staff informed us they had enough equipment for use, they had slide sheets, hoists, bed pan washers and bathing facilities for children who needed them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. However not all staff were trained to act quickly with children and young people at risk of deterioration.

Theatre staff in West Wing had a dedicated bay for children in the theatre recovery area. This was in line with the Royal College of Anaesthesia (2022) guidelines which states that; 'Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a strong solution'. Control measures such as the use of screens and curtains, separate paediatric airway trolleys and paediatric immediate life support competencies were incorporated into the departmental training plan. Refurbishment of the theatre complex was to commence in 2023 and the new layout was to include a separate paediatric recovery area.

Not all staff in theatre had received paediatric immediate life support (PILS) or European paediatric advanced life support (EPALS) training. We reviewed PILS and EPALS training figures provided by the trust following our inspection that showed, eight members of staff were either PILS or EPALS trained, of these, seven were competent to work in the recovery area. The trust told us, one member of staff trained in either PILS or EPALS would be on duty in the recovery area should a paediatric patient be present. A further 24 staff had been booked to attend PILS or EPALS training on one of three dates between 21 November 2022 and 23 February 2023.

Anaesthetists scheduled for paediatric theatre lists were trained in paediatric emergency training and remained with the patient until the patient had been extubated (removal of the endotracheal tube from the lungs) and the patient was stable. In addition, the anaesthetist remained in the theatre complex until all paediatric patients had returned to the ward.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. All staff knew how to escalate a deteriorating child and used the Paediatric Early Warning Score (PEWS) to identify patients whose condition was deteriorating. Records demonstrated evidence of appropriate escalations and the documentation made specific reference for a consultant review.

Junior doctors and nursing staff were knowledgeable and understood patient risk. All staff undertook observations using PEWS. However, within the seven records we reviewed some observations were not always recorded. If the electronic system identified that staff did not complete a full set of observations a communication was sent to the senior nursing team. Further communication was sent out to remind staff all observations should be completed and if unable to do so, this should be documented in the patient documentation and escalated to the nurse in charge. The staff followed the escalation pathway if a child was unwell and contacted a consultant.

Services for children and young people

A review was carried out locally by nurses to ensure that any escalation made because of a change in PEWS, or an escalation of concern from staff, appropriate actions were taken. Nurses told us they were able to contact a consultant quickly to respond to a child deterioration.

Following our inspection, we reviewed PEWS audits for the reporting period August to November 2022. The trust target was maintained throughout this period (90% or above). Action(s) taken as a result of audit results being below trust target included:

- Senior nurse led campaign for patient observation timeliness.
- Focussed discussions with teams in safety huddles and staff meetings.
- Focus on PEWS and audit quality in senior nurse meetings with a planned paediatric audit tool review in January 2023 when introducing the new senior nursing leadership team to all elements of audit / quality / patient safety.
- Ensure the continued use of both local PEWS audit tool and the trust wide audit tool available on the quality inspection app and platform for health and care settings.

An escalation policy and procedure was in place to support staff in recognising and caring for a seriously unwell child. Clinical Staff were aware of the escalation policy and procedure.

All staff received training in identifying a deteriorating patient with sepsis. Training was delivered with a focus on ensuring time critical interventions were implemented.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Assessments were completed on arrival at PAU and ward 21. These included vital signs of temperature, heart and pulse rate, neurological status, urine, bowel and pain assessment. Medical staff and nurses adapted the frequency of clinical observations depending on the child's condition.

Staff knew about and dealt with any specific risk issues. Staff were aware of how to deal with specific risks, such as sepsis. Paediatrics had implemented the Paediatric Sepsis Six trigger tools.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). The children's services had seven-day access to Child and Adolescent Mental Health Services (CAMHS). CAMHS would attend the hospital to assess any patient that had presented in crisis. Referral was made directly to CAMHS via email and telephone call. A referral was accepted between the times of 8am and 6pm. The children's teams could access support out of working hours for any advice. The trust had appointed a Mental Health lead for Children and Young People to support services to develop and improve.

The trust was registered with three external nursing agencies, specialising in mental health, to provide emergency cover when required. The ward staff and on call managers had utilised this out of hours and continued to access support when required. A designated clinical mental health lead oversaw children services.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Staff used a STORM (skills training on risk management) a self–harm risk assessment and mitigation tool that included safety and care planning for front line staff in line with trusts policy. We saw 10 risk assessments completed, however, some lacked detailed information. The trust leadership had ongoing plans to improve record keeping overall. The trust recognised gaps and communication reminders were cascaded to staff.

Services for children and young people

For the reporting period December 2021 to November 2022, there had been seven patients admitted to the service who required transfer to a mental health (MH) setting. During this period, the average length of time the patient was in the acute setting before being transferred to MH services was 17 days.

Actions taken to mitigate risk and to ensure a safe and appropriate outcome for the patient included:

- Individualised risk Assessment and care planning
- Ligature low risk estate
- One to one supervision by a clinical support worker (CSW) (internal team of mental health CSW's) or agency registered mental health nurse (RMN) via agreed pathway with CAMHS and Commissioning leads.
- Use of SBAR (Situation-Background-Assessment-Recommendation) tool that focused on mental health and well bring assessment and handover of information and risk.

In addition, processes were in place to ensure a safe and appropriate outcome for the patient and included:

- Early discussions with the trust's mental health team and the designated CYP mental health lead nurse within that team to ensure early and clear communication and assessment of risk.
- Clinical nurse specialist for CYP in place for support, training and escalation of concern.
- Early discussions with the mental health trust to discuss assessment, reviews, care planning and risk assessment sharing.
- Escalation to executive team and safeguarding team via the divisional director of nursing and/or matron(s) to ensure external communication and escalation of risk to partner agencies (including the Integrated Care Board (ICB) and NHS England).

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. The team communicated with leads within the community and communicated collaboratively and effectively within multi-disciplinary teams.

Shift changes and handovers included all necessary key information to keep children and young people safe. Key information was shared with the team during handover, this included concerns of the child's health. For example, a child was admitted to ward 21 from emergency department with hypoglycaemia.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. The paediatric assessment unit (PAU) was staffed with two registered nurses and one clinical support worker and additional staff worked on wards, such as housekeeping, play leads and assistants. On some wards there had been periods where agency staff had been used and staff were deployed from other wards due to sickness and absences, these included nursing staff. The service had an action plan in place to address staffing issues this included, a robust recruitment plan. Staff told us that staffing levels had improved, and consistency was getting better. Senior nurses stepped in to cover clinical shifts when there was a need.

Services for children and young people

Ward 21 (acute paediatric ward) daily staffing levels consisted of four registered nurses and two clinical support workers, one of which was the designated mental health nurse.

The neonatal ward had six staff per shift. This consisted of a nurse in charge, two qualified in the speciality, registered nurses and auxiliary nurses. This was in accordance with British Association of Perinatal Medicine (BAPM) recommendations. This was monitored by assessing patient acuity and capacity daily. If additional skilled staff were required, matrons stepped in to cover clinical shifts.

Neonatal nursing staff reported no direct concerns. Recruitment in neonates had been positive. The neonatal ward had a number of nursing staff on maternity leave and absences. Backfill was provided by agency staff, bank support and matrons. Managers made sure all bank and agency staff had a full induction and understood the service.

No negative impact or patient harm had occurred due to low staffing levels. The backfill provided ensured that nurses could continue developing the service and attend projects, such as the family Integrated Care Nurse and Baby Friendly Initiative.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The wards displayed a safety performance board. We looked at other months and the wards maintained safe staffing across all areas. Leaders were continuously reviewing staffing levels to ensure safety.

Ward managers could adjust staffing levels daily according to the needs of children and young people. Managers assessed staffing levels across all areas of children services and deployed staff from other wards if required.

The service was reducing their vacancy rates. Childrens services continued with ongoing recruitment. New starters were due to start in October and November 2022 with a full induction planned. The trust developed a programme for new inductions. The children services were awaiting business cases to be approved for further staffing. The trust looked at ways of implementing development for the staff in children's services due to recruitment challenges.

The turnover rates for paediatric children's unit and ward 21 was 11%, and the trust target was 10%.

Neonatal services had a reducing turnover rate amongst nursing staff at 6%. This was better than the trust target.

The service had reduced sickness rates over the last 6 months. The trust sickness rates reported a 7% average across all children services.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep children and young people safe. Staff told us there were enough medical staff available on the wards, though some days felt busier than others. Handovers took place and were led by medical staff.

Nurses and junior doctors were able to access a paediatric consultant 24 hours a day, seven days a week. Parent of a child told us, following admission to a ward they were seen by a doctor as soon as they were admitted.

Services for children and young people

Staff within outpatients told us there was a high increase in children's clinics following the pandemic. Doctors had been increased to the number of increased clinics; however, the nursing staff had not been increased. The trust had plans for ongoing recruitment across children services.

The medical staffing matched the planned number. We saw planned numbers of staffing displayed. The service had one consultant leave within the last 12 months. Two new consultants had started in September 2022. One consultant was recruited as part of the approved business case to support the new PAU.

Records

Staff kept records of children and young people's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, records were not consistently fully completed.

Patient notes were not always comprehensive. However, all staff could access them easily.

We viewed 10 patient records across PAU, ward 21 and ward 28. Records were not always fully completed. Tools and templates were available for staff to use, to aid their assessments of children, however, there were some elements in records that were not completed in full. For example, some records failed to specify whether the child protection information system (CPIS) had been checked, others did not record ethnicity and importantly, some records we examined did not have all the safeguarding questions completed. There was a lack of flags and alerts on records to easily identify whether a child or young person had any protected characteristics, or whether they were looked after or subject to a child protection or child in need plan. In addition, the voice of the child was not effectively or consistently captured in some records.

Following our inspection, we reviewed documentation audits for the reporting period August to November 2022. The trust target was mostly maintained throughout this period (90% or above). Action(s) taken as a result of audit results being below trust target included:

- Discussion with teams in safety huddles and Staff meetings.
- Increase frequency to weekly audits to ensure focus on documentation standards
- Utilising education leads and cross covering of audit completion to ensure leads did not always complete their own areas audits.
- New matron to ensure feedback to staff on a monthly basis; bringing new ideas in terms of how to share not only audit results, but also give the narrative around their importance and why things are measured. (Aligning to professionalism, accountability, care quality and assurance).

When children and young people transferred to a new team, there were no delays in staff accessing their records. The staff on the wards were able to access records to ensure safety of children.

Records were stored securely. Records were always stored securely in a lockable cupboard on all wards. The staff on all wards were aware of keeping documents safe and secure.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, we did identify some storage issues on ward 21.

Staff followed systems and processes to prescribe and administer medicines safely.

Services for children and young people

We looked at 13 patient medicine records and saw that medicines had been prescribed, administered and recorded in line with trust policies and national guidance. Weights were recorded on all the charts seen which was important for calculating weight-based medicines prescribing in children and neonates. Allergies were highlighted and recorded on all medicine charts. The route of administration was recorded, including the reason for prescribing medicines.

A dedicated prescription chart specifically for the antibiotic gentamicin was available and brightly coloured in orange to ensure it stood out and was easily identifiable from all other medicine charts. This had been developed and designed by the clinical pharmacy team. Gentamicin requires careful monitoring and prescribing to ensure a safe and effective dose is administered.

Ward staff knew who to contact in pharmacy for advice on medicines. There was a dedicated clinical pharmacist led to support and advise staff.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines.

Staff monitored and reviewed the effects of medicines administered, which included regular reviews for antibiotic prescribing. Pharmacists reviewed, monitored and provided clinical advice on the best way to administer medicines. Advice was written onto the medicine charts as reminders.

Staff did not always store and managed all medicines and prescribing documents safely.

Medicines on the Neonatal Unit (NNU) and the PAU had neat and tidy medicine storage. Up-to-date audits were available to ensure safe and secure storage.

Ward 21 had one unlocked medicine cupboard due to a broken lock and were waiting for maintenance to repair. This was resolved during our inspection.

We found one liquid medicine in the medicine trolley on ward 21, which had passed its expiry date. This increased the risk of a medicine being administered with reduced effectiveness. Additionally, medicines were not always stored in their original containers. We found two loose ampoules of two different medicines stored next to each other in a medicine cupboard. This increased the risk of the incorrect medicine being picked and administered in error. A daily medicine checklist was undertaken, however, the storage issues found on ward 21 had not been identified by these.

Emergency medicines were available and stored in tamper proof trolleys or boxes, for example anaphylaxis boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely.

The service ensured that medicines were stored at the recommended room or fridge temperatures.

There were appropriate systems in place for the safe disposal of medicines and destruction of controlled drugs.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

A full medicine history and medicines reconciliation was undertaken on admission to the hospital.

Staff learned from safety alerts and incidents to improve practice. There were robust systems in place for reporting incidents and for receiving and dealing with medicines safety alerts. The Medicine Safety Officer was involved in all medicine related incidents. For example, following a recent medicine incident a patient was sent home from a children's ward with insufficient supplies of medicines. This resulted in a change to practice on issuing and supplying medicines direct from the ward. The introduction of a TTO (to take out) register for pre-packed medicines was proving successful and was well liked by staff. It recorded a running stock balance of packs available and ensured low stocks were identified and replaced. It also ensured it was easy to track and trace medicines when they were handed out to patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff had told us how they reported an incident. They used an electronic system to report. Staff reported a good culture of reporting and incidents were shared through ward safety huddles and across divisional safety huddles. The trust actively investigated and followed them through in line with trust policy. Ward managers and leaders had an oversight of incidents within the children and young person's services.

Staff raised concerns and reported incidents and near misses in line with trust provider policy. Staff reported incidents and were flagged during meetings for staff to learn from. Leaders monitored incidents for themes and learning. This was shared amongst all staff.

There had been no never events within the children's and young people service over the last 12 months.

Managers shared learning from incidents with their staff and across the trust. We saw governance meeting minutes for July and August 2022. They noted how incidents and learning were shared with staff. The staff immediately picked up on incidents and actions were taken to improve.

Managers shared learning with their staff about never events that happened elsewhere. The trust worked in partnership with a local NHS trust to share learning. Leaders and staff told us this helped with learning from never events and networking and sharing practices with other colleagues at the same level. This benefited children's services at Manor Hospital. Staff were able to get advice from other colleagues who worked within the same role.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong. Staff understood and learned when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Senior leaders shared feedback with staff. Learning was part of regularly discussions in safety huddles and divisional governance meetings. Staff were encouraged to improve through training.

There was evidence that changes had been made as a result of feedback and patient voice was listened to through patient surveys, the 15-step challenge and engagement.

Services for children and young people

Managers debriefed and supported staff after any serious incident. Incidents were discussed by ward managers and cascaded to the senior team. Staff took on board when areas required improvement. Staff told us they work hard to always improve when they got it wrong. The trust supported staff and staff were able to reach out to freedom to speak up guardians.

Managers acted in response to patient safety alerts within the deadline and monitored changes. Patient safety alerts were shared with all staff through safety huddles and monitored through clinical audits.

Is the service well-led?

Good 

Our rating of well-led stayed the same We rated it as good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

A divisional director for women's, children and clinical support was appointed in February 2022 to strengthen the leadership. Children services was supported by a divisional director of nursing and clinical director, clinical mental health lead and supporting clinical leaders. New leaders were developed within the service from ward manager to a divisional level. The trust encouraged staff and leaders to grow and be promoted within the trust. The staff informed us senior leaders were approachable and they were able to leaders if they had a concern or required any advice.

Leaders shared information and encouraged staff through meetings and newsletters to develop additional skills. Staff told there was a good structure of leadership across children services.

Leaders were aware of the divisional risks and were implementing mitigating actions. Staffing levels and recruitment were a challenge. A programme of recruitment of adult nurses was planned to commence for children services. The trust was encouraging new recruits to develop. A comprehensive induction pathway specific for children's services was planned, this included process, protocols, and detailed clinical pathways for children.

Staff working in the paediatric assessment unit (PAU) and ward 21 benefited from the support of a committed and proactive safeguarding children's team. The safeguarding children's team developed and delivered ongoing training and supervision.

The safeguarding children's team had implemented 'floor walks;' fulfilled multi-agency obligations at both operational and strategic levels through the multi-agency safeguarding hub (MASH) and the local safeguarding children partnership (LSCP) and had plans in place to strengthen the engagement of acute staff in safeguarding supervision. The 'floor walks' were valued by staff and provided an opportunity to access advice and guidance through face-to-face conversations, as and when required. Staffing challenges within the safeguarding team, however, had led to a temporary reduction from daily 'floor walks' to twice weekly.

Services for children and young people

Vision and Strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a set of values developed with its staff, the values underpinned everything staff did and included Respect, Compassion, Professionalism and Teamwork. Staff knew and understood what the vision, values and strategy were and their role in achieving them.

Leaders had plans for their service which were aligned to the trust strategy. The children's services were continually improving and looked for ways to be different and stand out in the local population and among other trusts. The service was preparing for the opening of a new paediatric assessment unit (PAU) in early 2023. Leaders were looking forward to the new PAU and were motivating staff to embrace new ways of working. They told us it was going be an achievement and improvement for the local community. This would initiate a front door service to the local population within the area, an access point for children's services in Walsall where families, parents and children can be assessed and triaged at first point when entering the hospital.

Children services were working towards and preparing virtual wards which would be supported by a dedicated team of nurses led by a consultant. This was an extension of the hospital at home service and would assist in freeing up in-patient beds in preparation for winter. This would offer observational care following an assessment. Leaders prepared for the challenges ahead to meet the needs of children and young people.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported a good culture and felt valued by the leadership on all wards and across the trust. Staff members felt they were listened to and able to put views and suggestions forward during meetings to improve. Staff led with great passion and worked through challenges to meet the needs of patients and the local population. Wards planned activities for children which included for example, themes such as Chinese New Year, arts, crafts and mental health awareness days. Play leads and assistants encouraged celebrations of different cultures.

Staff working on wards felt they were listened to by the leadership team and the culture had improved. We observed a calm atmosphere and staff were seen working together to meet the needs of children. Staff told us if they had a concern, they would not hesitate to raise it. A recent engagement meeting had shared information across all children services and team building events had been held post pandemic.

Play leads and assistants told us they enjoyed working within the wards. Play leads and assistants had been involved in the development of areas to benefit children using the wards.

The outpatients' department had recently appointed a new matron. A nurse told us, areas were improving, however, the team were not always informed of clinics being listed. The team were previously involved in clinic discussions, but gradually this was getting better following the pandemic.

The divisional nurse director for children and young people shared learning across the team. The wards worked well together and looked for areas to improve.

Services for children and young people

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

All staff and senior leaders were clear about their responsibilities and took accountability of their areas.

The head of nursing for quality monitored quality indicators to identify themes and trends. These were discussed at divisional governance meetings and enabled the service to improve. Outcomes from divisional governance meetings were shared with staff at ward and department level.

Quality indicators were monitored monthly through a performance dashboard and included, deteriorating patient and sepsis, environment, infection prevention and control, medicines management, nutrition and hydration, oral care, pain management and patient experience. For the reporting period, August to November 2022, the trust target was maintained throughout (90% or above).

To maintain focus on performance and sustaining good results, the service had taken the following actions:

- Discussion with teams in safety huddles and staff meetings.
- Utilising education leads and cross covering of audit completion to ensure leads did not always complete their own area audits.
- Matrons to ensure feedback was provided to staff on a monthly basis; bringing new ideas from previous practice in terms of how to share not only audit results, but also give the narrative around their importance and why things are measured. (Aligning to professionalism, accountability, care quality and assurance).

Ward and divisional safety huddles were in place to ensure there were regular discussions around for example, incidents, learning, patient safety alerts and risks.

Clinical audits were completed and managers identified themes and trends to make improvements. This was widely shared amongst children services. The service held a risk register to monitor any risks, this included for example, staffing and recruitment.

Challenges, improvements and proposals for change from the women and children division was shared at board level.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders used systems to manage performance effectively. They had oversight of the divisional risk register and clinical audits to monitor performance. The services main risks were sickness and staff vacancies.

Risks due to staffing was monitored regularly by senior leaders to ensure there were enough nursing staff to keep children, young people, and their families safe from avoidable harm.

A paediatric early warning score audit was completed weekly and monitored by the matron. Actions were taken to improve with electronic paediatric nursing quality indicators.

Children's services had safe processes and procedures in place for escalating paediatric social care and safeguarding concerns.

Performance was discussed during governance meetings. Staff were notified of any changes or new risks through meetings and newsletters. This included specific incidents, improving patient records or implementation of new risk assessment tools.

Leaders told us patient safety came first. Risks within children services were managed widely. Discussions openly took place during local safety huddles, and divisional governance meetings.

Leaders prepared for challenges and adverse events, for example the recent pandemic and winter pressures planning.

Children services had policies and systems in place. We saw a detailed escalation supervision policy and mental health act policy. Medical staff and nurses had clear guidance, when a child deteriorated and worked with multi agency teams

Leaders told us the quality of care was not compromised due to financial pressures and did not stop the service looking for ways to improve.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had improved information management systems. managers told us they were more assured of the accuracy of the information and data they received.

Divisional and care group meetings reviewed all information about the service including staffing, incidents, trends in incidents such as falls and medicine errors, complaints and patient experience, audit findings and overall service performance.

Managers reviewed all information to give them an overall picture of the quality of care provided. For example, they reviewed incidents and complaints against staffing to identify if staffing shortages had been a causative factor. They were able to identify when staff required additional training for example in medicines management.

The trust had included a section in the divisional and care group meeting called the patients voice which included a summary of all patient feedback in the previous month including mystery patient and friends and family response. This enabled the service to see patients' feedback in a timely way, feedback was immediately shared with the wards and departments who also had access to the monthly information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

Services for children and young people

Staff engaged with parents and children, this included using local schools to review their service in order to identify any areas for improvement. The trust encouraged children surveys to be completed. We saw this displayed on boards with a QR code. The service used volunteers with specific skills to support children staying on wards and feedback was used to improve areas within children's services.

Patient experience leads told us feedback was shared actively with wards to improve and recognise and acknowledge good practice.

At ward level, visual departmental feedback results from June, July and August 2022 were collated by play specialists and reported into the patient experience group and the divisional director of nursing report. All areas of good practice were reported at ward level to drive improvements, for example areas included, food, drink and staffing.

The trust used a tool called the 15 Steps Challenge for patient feedback; this was initiated by listening to a specific child who was then involved in improving patient feedback. The 15 Steps Challenge explores different healthcare settings through the eyes of patients and relatives and supports staff to listen to patients and carers and understand the improvements that can be made.

Patient surveys scored in the top 20% of all trusts this had improved from 2018. In the children and young people's service, PAU received 91%, neonatal received 100% and ward 21 received 86% following feedback from patient surveys. The care group and departmental teams reviewed actions following in-patient surveys to further improve.

Patient feedback reports from March to August 2022, included mystery patient feedback,

Friends and Family Test, National Children and Young People's Survey, staff engagement and patient and carer engagement. The trust actively listened to little voices and young listeners and neonatal community outreach. The patient experience group reviewed feedback, such as visiting for families and siblings and prevention of infection control. Areas reflected on improvement and positive feedback such as patient voice to drive change.

Leaders cascaded information to staff across children services through a monthly newsletter to enable shared learning and areas for improvement this included, planning for winter pressures, new risk assessment tools and setting up a virtual ward.

The trust had appointed a specialist advisor for children's services in April 2022, to support improvement and embed positive change. The service had recognised additional support was required for specific improvements such as, recruitment, clinical training, and practice. The wards worked in collaboration across children services.

The special advisor reported that due to the challenge in nurses for children, the trust had appointed four new adult nurses to complete an external learning pathway as development. This initiative was going to be piloted in early February 2023 and was an opportunity for adult nurses to develop their skills in children's services.

Leaders recognised staff at all levels. The wards displayed an excellence board that recognised individual staff for their contribution within children's services.

Learning, and continuous, improvement and innovation.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement. Leaders encouraged innovation.

Services for children and young people

There were systems in place, across the service, to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. Local schools and cadets were involved in reviewing children's services. Leaders told us it was important for children and the local population to be a part of positive change and being involved as individuals who use the service. Patient experience was actively encouraged in development of the 15-step challenge and "little listeners." Children were involved in improving the experience of patients.

Leaders encouraged innovation. Innovative working that the service was proud of included for example:

- Registered nurse (RN) adult recruitment in paediatrics which demonstrated a 'thinking outside the box' approach to the national nurse staffing crisis.
- Child and Adolescent Mental Health Services (CAMHS) collaborative working where the service had taken a multi-stream approach to ensure patient safety and staff confidence looking at; policy, environment, staffing, support, training, and multi-agency in-reach.
- Working closely with colleagues across the system in both mental health trusts, children's services, safeguarding, commissioners and the internal mental health team. This proactive approach had supported the development of a children and young person (CYP) plan to ensure the care that they received was supervised adequately by people who were trained to support and plan to meet their needs.
- The 'We Can Talk' project ensured paediatric staff were confident and competent to communicate with CYP in crisis. The project was designed to improve the knowledge, skills and confidence of any member of staff working with CYP.

The service was preparing for the opening of a new paediatric assessment unit (PAU) in early 2023.

Divisional leaders told us that children and adolescents were involved in speaking at different NHS platforms.

Leaders and staff told us "Every patient admitted brings a different challenge, and we learn from this and improve."

Staff had a good understanding of quality improvement. A paediatric virtual ward had been developed and planned over several months with a trained and designated team to oversee. This supported better collaborative working, particularly supporting the hospital at home service and complex patients to meet the needs of all children.

The trust had embraced quality improvement (QI) and had a well-established QI academy and training programme. Training was to be rolled out across the trust including, for staff in children's services.