This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Walsall Healthcare NHS Trust has one acute hospital, Manor Hospital, Moat Rd, Walsall WS2 9PS. The hospital serves a population of around 270,000 across Walsall and surrounding areas.

(Source: https://www.walsallhealthcare.nhs.uk/patients-and-visitors/planning-your-visit/hospital/)

A list of the acute hospital and main community services is outlined below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manor Hospital</td>
<td>Walsall Manor Hospital, Moat Road, Walsall WS2 9PS</td>
<td>Full range of medical services including acute and urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care.</td>
<td>Currently the trust serves a population of around 270,000 people across Walsall and surrounding areas.</td>
</tr>
<tr>
<td>Midwifery Led Unit</td>
<td>MLU, Charles Street, Walsall WS2 9LZ</td>
<td>Midwifery community hub</td>
<td></td>
</tr>
</tbody>
</table>
Background to the trust

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust consists of one acute hospital site and a number of community sites. The trust’s palliative care centre in Goscote is the trust’s base for a wide range of palliative care and end of life services.

Walsall Manor Hospital has 408 acute inpatient beds. There is a separate three bedded midwifery-led birthing unit (MLU) situated a mile away from the main hospital site. This has remained closed for women to give birth there since September 2017 following safety concerns CQC identified in maternity services at our inspection of the service in June 2017.

The trust previously had a cap on the number of births at the trust set at 4,200. This was imposed by the local clinical commissioning group in 2016 following safety concerns CQC identified in the maternity department at our 2016 CQC inspection of the service. This birth cap was lifted in April 2019 as improvements had been in the maternity department.

The trust’s sexual health service is part of the Walsall Integrated Sexual Health Services (WiSH). The service is ran from the main hospital site and from a number of sexual health clinics in the Walsall area. This service includes sexual health, HIV, long-term contraception and family planning. The trust provides an outreach service following acquisition from the local authority and a contraception and sexual health (CASH) outreach service for young people.

The trust was placed into quality special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection in September 2015. The trust remains in quality special measures.

Facts and data about the trust:

- Total number of inpatient beds – 408 as at September 2018
- Total number of outpatient clinics per week - 1247
- 4158 staff as at September 2018
- A and E attendances from August 2017 to July 2018: 77,306 attendances
- Number of deliveries from April 2017 to March 2018: 3,379

Is this organisation well-led?

Leadership

Not all leaders had the necessary experience, knowledge or capability to lead effectively. Leaders were visible Where executives demonstrated the capacity and capability to deliver, required support structures were not always in place around them to ensure sustainable success. Board development plans were in place for 2019/20.

To write this well-led report, and rate the organisation, we interviewed the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital.
This included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

The Trust Board comprises six Non-Executive Directors (NED) and eight Executive Directors, including the Chief Executive Officer, five of whom were voting directors.

Since our last inspection there had been significant changes to the trust board.

The trust board consisted of:

- The Chair appointed April 2016.
- Chief Executive Officer (CEO), appointed February 2018.
- Chief Operating Officer (interim), appointed October 2018.
- Medical Director appointed in October 2018.
- Director of Nursing appointed July 2018.
- Director of Finance and Performance appointed in 2015.
- Director of People & Culture appointed September 2018.
- Director of Governance appointed June 2018.
- Director of Strategy & Improvement appointed January 2016
- Eight non-executive directors and three associate non-executive directors.

The majority of board members had been appointed to post in the past year.

The maturity of the board working together was at the early stages and it was acknowledged that there was development required at executive and non-executive level to improve board challenge and functionality.

The chief executive and chair demonstrated grounded insight to the progress of improvements, live position and future focus for the organisation, including its leaders, their skill sets and maturity, and infrastructures.

We were informed board development plans for 2019/20 would focus on strengthening cohesion, challenge and chair committee scrutiny.

The board met monthly in both public and private. The public session covered as much detail as possible. The private session was limited to issues which were commercially sensitive only. Various committees and groups operated within the governance structure with their reports presented to the board where appropriate.

Non-executives received inductions and regular board development days were held.

We heard consistently positive messages about the visibility and approachability of the executive team. This appeared to have been highly successful, though we recognised this may be a challenge to sustain longer term.

Walk-arounds of clinical areas were conducted each month by board members. However non-executive directors were not cited on the actions taken following the walkarounds to address the concerns they heard from staff. Some themes were identified – car parking, a lack of buddying arrangements for wards and portering challenges. For executives Fridays were kept ‘meeting light’ to allow walkabouts of clinical areas.

The executives had placed significant emphasis on engaging with staff and improving the culture
within the organisation. Executives had been appointed with purpose to secure a values driven board. Staff acknowledged there was improved openness and transparency within the trust so this approach had been successful.

The pace of change to address other challenges at trust level had not always progressed so well. The Executive understood the risks but did not always have effective plans in place to instigate required changes.

**Board Members**

Of the executive board members at the trust, 0.0% were British Minority Ethnic (BME) and 37.5% were female.

Of the non-executive board members 33.3% were BME and 44.4% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>33.3%</td>
<td>44.4%</td>
</tr>
<tr>
<td>All board members</td>
<td>17.6%</td>
<td>47.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

The pharmacy team had effective leadership. A development programme for staff was in place to ensure clear lines of accountability.

The Director of Pharmacy and Deputy Director of Pharmacy both operated an ‘open-door’ policy to remain visible and approachable to staff. This ensured that staff have access to the senior management team so that risks and issues can be raised and escalated where necessary. A weekly Team Brief also helps generate discussion and an opportunity to share ideas amongst staff.

The sustainability of the pharmacy service was stable, with no problems in recruitment. However, retention was a challenge due to staff leaving to work at other trusts.

Pharmacy staff workforce and succession planning was evident. There had been an increase in the numbers of pharmacy technicians and the team were looking at ways of further developing and using the clinical skills of the pharmacists such as the use of pharmacist independent prescribers.

**Structures below director level were not always sufficient to ensure accountability and the flow of information from leaders.**

The medical director (MD) did not directly manage the medical divisional leads, they were managed by the chief operating officer (COO). Whilst there was partnership working with respect to objective setting, this did not ensure clear lines of accountability for the oversight of medical concerns through the organisation. There were no objectives in place for divisional medical leads. Therefore, there was a risk that the medical director may not be cited on key issues. Plans were in place to appoint a deputy medical director, this would be a new post.

Systems for divisions to effectively escalate risks were not effective and did not provide required assurance. Therefore, the director of governance routinely attended 26 divisional meetings each month to gain trust oversight and assurance. This resulted in executive team members reaching down through governance tiers to trust services to directly seek assurance. The trust advised us this was a short term strategy to support the strengthening of governance systems.
The organisational structure at the trust consisted of four divisions:

- Division of surgery
- Medicine and long-term conditions division
- Women’s, children’s and clinical support services division
- Adult community division

Each division was managed by a triumvirate leadership team.

**Fit and Proper Persons**

**Fit and Proper Person checks were not in place.** We were not assured of the standards and checks were in place to fulfil the requirements of the Fit and Proper Person regulation.

Providers must ensure their executive and non-executive directors, or equivalent, who have director level responsibility for the quality and safety of patient care and for meeting the fundamental standards, are fit and proper to carry out this important role. This in accordance with the Fit and Proper Person regulation 5 of the Health and Social Care Act. This regulation requires directors to have a good character and have the right qualifications and experiences to carry out their role.

The trust had a Fit and Proper Persons Requirement Policy in place. This outlined the process involved to ensure a number of checks on appointment of directors and subsequent on-going checks and declarations.

During the well led inspection we reviewed the employment files of four executive directors and four non-executive directors to determine if the trust had completed the necessary fit and proper person checks. Information was missing where references had been obtained by recruitment companies. We were therefore not assured that the suitability of candidates had been checked prior to appointment.

We raised the omissions in the director files during the inspection to provide the trust with an opportunity to provide this information but did not receive evidence of all records being available.

There was insufficient information in files to demonstrate the recruitment process was robust enough to ensure individuals were suitable to be appointed as directors at the trust.

After our inspection the trust advised us that gaps in information were being sought.

**Vision and strategy**

The trust had a vision and strategy, however it had not kept pace with the trust focus on external systems strategy. Staff were engaged with and lived the trust vision and values every day.

The trusts’ vision and strategy was aligned with partners in the ‘Walsall Together’ initiative the trust was leading on. However, we found this was to the detriment of a clear vision and strategy for the trust locally.

The trust’s strategy was aligned to local ‘Walsall Together’ plans for the wider health and social care economy. The trust’s services had been planned to meet the needs of the local population. Walsall Together was in its planning stage for the Walsall region aimed at aligning all local health and social care organisations with the aim of improving care for the local population.
The trust’s vision, values and strategy had been recently re-developed in collaboration with staff, people who use the services and external partners. Whilst a range of enabling plans were in place to support delivery of the strategy and to ensure progress could be monitored, the enabling plans had not all been refreshed to keep pace with the overarching strategy.

The enabling plans included:

- People strategy
- Information management and technology strategy
- Estates strategy
- Clinical services strategy
- Improvement strategy
- Commercial strategy
- Quality strategy
- Patient experience strategy
- Stakeholder engagement strategy
- Equality and diversity
- Social value strategy

As a result of culture and engagement efforts at the trust, staff were engaged with and lived the trust vision and values on a daily basis. All levels of staff told us how the sense of pride to represent the organisation had significantly improved.

The vision of the trust was ‘Caring for Walsall together’ this was underpinned by five strategic objectives:

- Providing Safe High Quality Care
- Delivering Care at Home
- Working in Partnership
- Valuing our Colleagues
- Making Good use of our Resources.

Staff at the trust were aware of the trust’s vision and values. However, staff did not always understand how their own service linked to the trust’s overall vision and strategy.

A revised nursing strategy had recently been released for 2019-2024 with the aim of improving patient care and outcomes at the trust.
The trust had an up-to-date dementia strategy dated 2019/2021 to promote the care and experiences of those with dementia and their carers.

The trust’s nursing strategy was up-to-date and outlined plans for the next five years to improve patient care and outcomes at the trust.

The trust had a suitable strategy to meet the needs of patients with complex needs such as learning disabilities. The strategy for adult patients with a learning disability was up-to-date and outlined plans for to ensure that patients with a learning disability are provided with timely access to specialist services and reasonable adjustments are made.

The pharmacy team led by the Director of Pharmacy had developed a new Pharmacy Strategy for 2019 – 24 which was currently out for consultation at the Quality, Patient Experience and Safety Committee (QPES). It covered six key areas which included the safety of medicines, clinical services, cost effectiveness, assurance and audit, innovation and development. It was aligned to the new Patient Safety Strategy and the World Health Organisation (WHO) Medication Without Harm challenge.

There was a Hospital Pharmacy Transformation Plan (HPTP) in place which staff were aware of. One of the main priorities is to further improve the clinical pharmacy service to become more ward based and ultimately for patients to have a better experience.

The trust had a Freedom to Speak Up strategy to support the trust’s freedom to speak up function. However, as this document was undated, or document version controlled it was unclear if the strategy was regularly reviewed and updated. The strategy outlined it would be reviewed each year however, though this had not taken place.

The Trust stated that ‘Our ambition is that by 2021 we will be an organisation that is focused on delivering safe care closer to the homes of the communities we serve; have a workforce that is engaged and empowered and is working with partners to ensure our financial sustainability.’

The Trust has recently refreshed its vision in relation to finance, aiming to take definitive steps to tackle our financial challenges by delivering considerable reductions on our deficits.’

The Trust did not have a financial strategy which showed how it will reach financial balance. A report which set out the three-year position was presented to Board in April 2019. The delivery of financial sustainability was linked to review of fragile services and working across the STP.

The trust was a member of the Black Country Sustainability and Transformation Partnership (STP), which is a collaboration of 18 organisations delivering primary care, community services, social care, mental health as well as acute and specialised services. There have been a number of STP wide initiatives that the Trust has been part of, this includes Pathology services and procurement.

**Culture**

**Leaders ensured the promotion of a positive culture across the trust. Staff felt supported and valued.** We heard from all levels how the sense of pride to represent the organisation had significantly improved.

There had been a significant transformation of culture since our previous inspections. The trust culture was felt at all levels to be positive, supportive, inclusive and respectful. Staff satisfaction was positive about the culture at the trust. Staff morale and engagement with the leadership team...
had improved since our previous 2017 inspection. At our inspection of the trust in June 2017, we had identified some significant problems with staff culture at the trust. Since this inspection, we saw the trust had improving the culture at the trust as a priority and was working hard to improve the culture.

Staff felt able to raise concerns. The trust had collated feedback regarding the culture at the trust from various channels such as the Freedom to Speak Up Guardians, Staff side union representatives, exit interviews and pulse surveys. Feedback showed cultural improvements had been made, however the trust recognised further improvements in the culture across the organisation were required.

Reporting medicine incidents was encouraged with a no blame culture. A Medicine Safety Officer looked at all medicine related incidents. Action and learning from any reported medicine errors was undertaken and shared across the trust with a monthly report sent to the Medicine Safety Group. However, it was acknowledged that overall reporting rates could be improved particularly with medical staff.

Appraisals for pharmacy staff were over 90% and rated as ‘green’ with monthly one to ones undertaken for all staff in order to measure individual objectives.

The executive team evidenced they held individuals to account if their behaviour fell below the standards expected in line with the trust’s vision and values. The trust had commissioned a number of reviews to assess the culture and behaviours of staff at the trust.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing staff (%)</th>
<th>Midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British/Irish/Any other white background</td>
<td>2.2%</td>
<td>19.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>BME - British</td>
<td>1.2%</td>
<td>2.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>BME - Non-British</td>
<td>5.1%</td>
<td>3.8%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not stated</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

**Staff Survey 2018 – summary scores**

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to ten – a higher score indicates a better result.
The trust maintained an action plan in response to the staff survey results with the aim to improve staff satisfaction at the trust.

(Source: NHS Staff Survey 2018)

Workforce race equality standard (WRES)

The trust had monitoring arrangements in place to collect and analyse data relating to staff with protected characteristics. This included collating data for this staff group to ensure promotion, disciplinary action and reasons for staff leaving were collated and analysed. This information was regularly monitored in an equality and diversity action plan.

The trust has an active network of equality, diversity and inclusion (EDI) champions. The champions promoted the trust-wide equality and diversity pledge in line with the People and Culture Strategy, 2019-2022. This was with the aim is to create a higher profile for EDI champions and to drive positive cultural change to further support the trust's equality commitments. The network helped the trust to understand any EDI concerns and seek feedback on how to apply the trust's disciplinary policy more consistently and fairly.

The trust had an on-going focus on promoting staff equality of opportunity and valuing diversity. An Equality Analysis Policy for staff had been produced and published on the trust's intranet site. Equality and Diversity was included in staff inductions and as part of staff mandatory training.

We reviewed the latest report dated January 2019 for the 2018 reporting period. As at January 2019, the proportion of BME staff employed at the trust was 26.5%.

The percentage of staff in each of the AfC bands 1-9 and VSM (including executive board
members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and clinical staff:

Data for reporting year

March 2018

<table>
<thead>
<tr>
<th>Band</th>
<th>White</th>
<th>BME</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>72%</td>
<td>28%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 4</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 5</td>
<td>71%</td>
<td>29%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 6</td>
<td>77%</td>
<td>23%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 7</td>
<td>82%</td>
<td>18%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 8A</td>
<td>85%</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>Band 8B</td>
<td>82%</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>Band 8C</td>
<td>93%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 8D</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 9</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>VSM</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>73%</td>
<td>0%</td>
</tr>
<tr>
<td>Non-Consultant/Career grade</td>
<td>13%</td>
<td>83%</td>
<td>4%</td>
</tr>
<tr>
<td>Trainee grade</td>
<td>30%</td>
<td>68%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Data for previous year

March 2017

<table>
<thead>
<tr>
<th>Band</th>
<th>White</th>
<th>BME</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>70%</td>
<td>29%</td>
<td>1%</td>
</tr>
<tr>
<td>Band 2</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>79%</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 4</td>
<td>85%</td>
<td>15%</td>
<td>1%</td>
</tr>
<tr>
<td>Band 5</td>
<td>71%</td>
<td>28%</td>
<td>1%</td>
</tr>
<tr>
<td>Band 6</td>
<td>79%</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 7</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Band 8A</td>
<td>84%</td>
<td>15%</td>
<td>1%</td>
</tr>
<tr>
<td>Band 8B</td>
<td>82%</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>Band 8C</td>
<td>93%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Band 8D</td>
<td>87%</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Band 9</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>VSM</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Consultant</td>
<td>28%</td>
<td>72%</td>
<td>1%</td>
</tr>
<tr>
<td>Non-Consultant/Career grade</td>
<td>14%</td>
<td>83%</td>
<td>3%</td>
</tr>
<tr>
<td>Trainee grade</td>
<td>33%</td>
<td>62%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Data for reporting year**

**March 2018**

<table>
<thead>
<tr>
<th>Overall workforce appointed vs. shortlisted</th>
<th>White</th>
<th>BME</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46%</td>
<td>23%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Relative likelihood of White staff being appointed from shortlisting compared to BME staff: 1.19


**Workforce Race Equality Standard (WRES) Report**

**Staff networks were not in place to promote the diversity of staff.**

Since 1 April 2015, all NHS organisations are required to demonstrate through the nine-point Workforce Race Equality Standard (WRES) metric how they are addressing race equality issues in their organisations. The Workforce Race Equality Standard (WRES) measures race equality in the workforce at the trust. The standard allows trusts to identify trends and themes and recognise potential inequalities and to monitor what improvements are required to develop Black and Minority Ethnic (BME) staff at the trust.

WRES was a standing agenda for the people and organisational development committee. The equality, diversity and inclusion committee developed an action plan to address any disproportion identified in the WRES following the submission of their annual report. This included to increase the number of BME staff at the trust as the current levels were not representative of the local community it serves and involve people who use services at the trust in the design and delivery of those services by reviewing the systems, processes and procedures to positively promote equality, diversity and inclusion in delivery, and co-create a framework for this by March 2022.

The trust had a draft equality diversity and inclusion strategy 2019/21 that was awaiting ratification by the board. An Equality, Diversity and Inclusion Group which included membership of multi-disciplinary staff group including EDI champions, patient experience lead, staff side representatives, Executive lead and was chaired by a Non-Executive Director of the Trust Board did meet.

Currently the trust did not have specific networks to support staff from diverse backgrounds such as BME or LGBT. There were however equality, diversity and inclusion champions. There was the option for staff to contact the Freedom to Speak Up Guardians if they had concerns.
However, this did not allow staff the supportive forums provided by specific network groups and did not ensure that a collective voice from such groups could influence policy in the organisation. The equality Analysis policy was overdue for review as of August 2017.

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care in October 2017 and from February 2018 to September 2018.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from September 2017 to August 2018 were slightly higher the England average.
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators.

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td></td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td></td>
</tr>
<tr>
<td>Clinical Supervision out of hours</td>
<td></td>
</tr>
<tr>
<td>Handover</td>
<td></td>
</tr>
<tr>
<td>Induction</td>
<td></td>
</tr>
<tr>
<td>Adequate Experience</td>
<td></td>
</tr>
<tr>
<td>Supportive environment</td>
<td></td>
</tr>
<tr>
<td>Work Load</td>
<td></td>
</tr>
<tr>
<td>Educational Supervision</td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>Local Teaching</td>
<td></td>
</tr>
<tr>
<td>Regional Teaching</td>
<td></td>
</tr>
<tr>
<td>Study Leave</td>
<td></td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)
The trust had a guardian of safe working (GOSW) in post. This role had been introduced together with the new junior doctor’s contract in 2016/17. All organisations employing or hosting 10 or more trainee doctors are required to appoint a guardian to protect patients and doctors by making sure doctors are not working unsafe hours. The Guardian was required to present a quarterly and annual report to the trust board. This was to provide reassurance to the board that trainees at the trust are working safely under the new contract and if required, highlighting any safety issues.

In the latest Guardian of Safe Working Hours report there were a total of 79 exception reports from May 2018 to December 2019. During this time, the majority of reports were from junior surgical staff. In response to address these concerns, the Guardian had arranged to meet with the surgical team and juniors. The Guardian was assured junior doctor support had improved significantly in the surgical and medical divisions. However, the minimum staffing and rota gaps remained a concern in these divisions.

Some initiatives to address the concerns of junior doctors had been taken, particularly in the surgical division where additional payments were agreed to support junior doctors on an ongoing basis. The number of fines from exception reports had reduced which had allowed reinvestment of the monies into training.

**Freedom to Speak Up Guardian**

The trust had appointed three Freedom to Speak Up Guardians and provided them with sufficient resources and support to help staff to raise concerns.

The Sir Robert Francis report, Freedom to Speak Up; an Independent review into creating an open and honest reporting culture in the NHS (2015), helped to ensure staff felt able to raise concerns.

The trust had three Freedom To Speak Up Guardians (FTSUG) who were all frontline clinicians. They represented different grades of staff from different departments and directorates. The guardians were highly motivated to support staff to raise concerns at the trust.

The freedom to speak up function was well embedded, well accessed and had executive support to ensure appropriate board oversight. The guardians could see the impact of their intervention as a result of trust support to ensure time and capacity of the speak up function.

Staff were aware they could access the guardians to raise concerns. The guardians attended leadership sessions and inductions for new starters at the trust to promote the role of the guardians. The guardians also led a campaign of awareness during October 2018.

There had been no concerns raised by staff between 2017 and 2018. However, an increased number of staff were speaking up and raising concerns during 2018 and 2019. The Staff Survey results for 2018 also demonstrated improved metrics on staff confidence to speak up.

However, a number of staff, including guardians reported they faced challenges as a result of speaking up. The trust acknowledged further commitment was required from senior leaders to further develop and fully support a speaking up culture within the organisation.

Previously there had been insufficient support at board level to support the guardians in their role. The guardians outlined the support from the trust executive team had improved and they had clear lines of escalation. However, the feedback loop with the executive team needed further improvement. They had quarterly meetings with senior members of the trust’s executive team. The trust’s Director of People and Culture was aligned to support their function and the guardians were also supported by a non-executive director. The guardians told us further improvement of the engagement and commitment of the trust board was still required to support their role.

The FTSUGs had some protected time to undertake the role. However, it could be a challenge for
the guardians to fulfil their guardian duties fully as they had to fit their role around their day jobs. The Freedom to Speak Up Guardian’s reported their reports directly to the chief executive and to the trust board. The last report presented to the board was in February 2019 and was written by the guardians. The report included details of how many staff had contacted the FTSU guardians and showed reporting themes and trends. This ensured the board were fully informed regarding the themes and concerns staff were raising and gave the trust an opportunity to learn from concerns raised.

The trust was supporting the guardian role to improve the numbers of concerns reported to them. The trust had adapted the trust’s incident reporting system to include a dedicated part of the system for use by the Freedom to Speak up Guardians for recording concerns raised. This was with the aim of ensuring the guardians collation of concerns information was robust, confidential and would allow timely feedback to individuals raising concerns. This system would also support the guardians to collate and analyse trends and themes.

We reviewed the main themes of concerns raised by staff to the guardians reported in the latest annual guardian report. A large proportion of the concerns raised had an element of quality and safety (43%) which in turn affected patient experience (24%). Following further investigation by the guardians of the patient safety concerns, it was found that the majority of these concerns also had an element of bullying and harassment which affected the quality of care that was delivered by staff. We reviewed the actions taken in response to these concerns. We found that changes had been implemented to address the key themes.

Duty of Candour

The trust did not always apply Duty of Candour robustly and appropriately.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

The trust had an up-to-date Duty of Candour policy to provide guidance to staff to meet the requirements of the duty. The director of nursing was responsible for ensuring the Duty was followed at the trust. The trust had a Duty of Candour guidance pack for staff, this detailed the approach and timescales for Duty of Candour to be undertaken. There was also an information leaflet for patients, friends and families. This provided details of the process and where to access support.

The majority of pharmacy staff understood their responsibility to be open, transparent and honest. Staff could provide examples of apologising to patients and those close to them. Duty of Candour was fully understood by pharmacy staff.

During this inspection, the trust did not have any records available of meetings with families where the Duty of Candour processes had been followed. We were therefore unable to assess the quality of these and determine if they met the legal requirements of the duty.

We reviewed an investigation report of a never event incident where events had gone wrong however there was no assessed harm to the patient. Under the duty of candour policy it is described that no or low harm events should follow a process of openness and candour. The trust on this occasion had decided not to be open to prevent potentially upsetting relatives further. Therefore there was not transparency with the family and those close to the patient to ensure they were fully updated regarding the circumstances of the incident.
The board were cited on the trust’s performance regarding duty of candour processes. There had been a lack of clarity as to why the duty of candour functions were not being fulfilled. Initial rationale had been a lack of training. However, having established the cause not to be a lack of training, board had requested a more detailed review.

**Governance**

The trust did not have effective structures, systems and processes in place to support the delivery of its strategy. We were not assured that the flow of information was always effective or subject to appropriate review.

The trust board held monthly board meetings. These provided an opportunity for scrutiny from members of the executive team and members of the public. The first part of the board meeting was the public meeting. The board then held a private meeting to discuss confidential matters such as business including personal information and/or commercially sensitive information.

The trust board was supported in its role by the following subcommittees, each chaired by a non-executive director:

- Charitable Funds Committee
- Audit Committee
- Finance Performance and Investment Committee
- People and Organisational Development Committee
- Quality, Patient Experience and Safety Committee

The organisational structure at the trust consisted of five divisions:

- Division of surgery
- Medicine and long-term conditions division
- Women’s, children’s and clinical support services division
- Adult community division
- Estates and facilities

Systems of governance at the trust were ineffective. We found the governance system at the trust difficult to navigate. We were not assured the mechanisms to ensure the dual flow of critical information from board to ward were effective. The board could not be assured of being sighted on the key issues and risks at the trust. It was difficult to track ownership, accountability and clarity of key updates and actions. Some decisions were taken at executive level within un-minuted meetings. This did not allow an audit and transparency of how decisions were reached.

An external review of the governance structure had taken place in 2018 and reported to board in October 2018. This had highlighted risks in the governance arrangements of the trust. Despite the findings and clear recommendations, changes had not been implemented.

It was acknowledged that the understanding of governance at divisional and care groups had scope for improvement to ensure information flowed through the organisation.
Board Assurance Framework

The Board Assurance Framework (BAF) detailed 10 strategic objectives within each and accompanying risks. A summary of these is below and their corresponding risk statement is shown below.

- Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm. Five Year Strategic Objective: Care for Patients at home whenever we can. Provide the right care in the right place, by the right person at the right time.
- Failure to achieve financial plans as agreed by the Board and communicated to NHSI. Five Year Strategic Objective: Use resources well to ensure we are sustainable. Use our resources at their optimum.
- If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model. Five Year Strategic Objective: Work closely with partners in Walsall and surrounding areas. Delivering a first-class service working seamlessly with partners.
- Failure to progress the delivery of the Walsall Integrated model for health and social care. Five Year Strategic Objective: Care for Patients at home whenever we can. Clinical and Social needs will be at the Forefront.
- There is a lack of leadership capability and capacity to leader performance improvement and build a high performing organisation. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.
- Effective resourcing. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.
- Staff engagement. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.
- Healthy organisation. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.
- Equality Diversity and Inclusion. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.
- Freedom to Speak Up. Five Year Strategic Objective: Value our colleagues so the recommend us as a place to work. Ensure all colleagues are valued and feel integral to the wider teams.

(Source: Trust Board Assurance Framework – 6 November 2018)

The BAF had been refreshed and updated at the time of our inspection. Each strategic risk was supported by an overview where positive assurances were sought. The detail of the assurances was not documented, and ticks only were recorded to say assurance had been received.

The BAF had 11 strategic risks identified and although the BAF template had an area to link the strategic risk to impact on corporate objectives, this has not been completed for any of the strategic risks. Therefore, there was no correlation evidenced between the strategic risk and...
potential impact on corporate objectives.

There was a lack of control measures included so the board was not receiving assurance that there was sufficient mitigations in place.

Oversight of the BAF took place at a range of committees, however only the section which related to the specific committee was presented. This meant oversight of the BAF was fragmented and any aspects which may link across committees may be missed.

**Appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance.**

At the time of our core service inspections, the trust was not registered for the regulated activity of providing care for the ‘Assessment or medical treatment for persons detained under the Mental Health Act 1983’.

Despite this the trust provided information that five patients had been detained under section 5(2) of the Mental Health Act 1983, therefore the trust was in breach of its registration. We discussed this with the trust and an application to register has been submitted.

The director of nursing was the named lead for mental health in the trust. There was not a named non-executive director for mental health. The trust did not have suitable policies and procedures in place to guide staff regarding detentions. There was also no training to provided to staff on the Mental Health Act 1983. The trust advised us that they would be assessing requirements as the application to be a detaining authority had been submitted.

The trust had an up-to-date dementia strategy for 2019/21. This had aims described and sufficient detail as to what steps were to be taken to achieve the aims.

The trust had engaged with the ‘What matters to me’ campaign and sessions had been held with staff. For patients this meant that boards were placed above beds with the key things highlighted that mattered to them. This meant all staff were aware of these and patients’ individuality was promoted.

The ‘what matters to me’ ethos had also been extended to staff and notice boards on wards recorded what mattered to staff during their work time.

The pharmacy team had a robust governance structure in place for the safe use of medicines with a clear line of reporting through the organisation to the Quality, Patient Experience and Safety Committee. The director of pharmacy was professionally accountable to the medical director.

**Management of risk, issues and performance**

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the detail of controls and assurance of mitigations at board level were not always evident.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
</table>
The Director of Finance had been in post for four years and was previously the Deputy Director of Finance.

The Chair of the Audit Committee was an accountant and had experience of being a non-executive in other NHS organisations.

There was a Finance Committee in place as a formal sub-committee of the Board. It was chaired by a non-executive. NHSI had attended a Finance Committee and had some concerns over the robustness of the challenge and debate.

The finance team required strengthening and it was recognised by the Director of Finance that changes needed to happen.

Boards focus around finance had increased towards the end of the financial year as the position deteriorated. Financial management was being closely scrutinised at board although challenge had not been effective to promote actions. Fortnightly reports to board were provided and weekly meetings were held in attempt to manage the trust finances.

The trust had an increasing projected deficit. Plans to reduce this had failed to be effective. Updated data indicated that the trust was going to incur a significantly higher deficit than was projected. Cost improvement plans (CIPs) and the monitoring of run rate plans had not been effective and the deficit had continued to grow.

The trust risk register recorded that the trust had insufficient resources to maintain the estate. We also found that in some core services there was difficulty obtaining some essential equipment.

**Trust corporate risk register**

The trust provided a document detailing their highest profile risks. There was one risk with a current risk score of 20 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2018</td>
<td>196</td>
<td>Failure to deliver the year Financial Plan and NHS Financial control total.</td>
<td>20</td>
<td>Not provided</td>
<td>10/11/2018</td>
</tr>
</tbody>
</table>

(Source: Risk Register)

**Trust organisation risk register**

The corporate risk register lacked necessary detail to give effective risk oversight at trust level.

The trust risk register served to ensure board oversight of the higher-level risks of the clinical groups. The full corporate risk register was not fully presented to the board. Executives were presented with an overview of the risk register but not the full detail. Therefore, there was a lack
of assurance that there were effective control measures.

Overall the organisation risk register had 20 risks recorded at the time of inspection. Many risks had been on the risk register for some time.

The risk register had dates of entry of risks and risk owners but did not document the direction of travel. Some mitigating actions were identified however review dates had passed with no updates on the actions to be taken. Some mitigating actions did not include a review date. Some mitigating actions were insufficient to ensure there was management of the risk.

The risk register contained some but not all aspects we raised at inspection however the pace of mitigation did not ensure risks were managed. For example, the legality of patients being detained under the Mental Health Act 1983 as this was not part of the trust’s registration was added to the register in June 2017. While actions were due in May 2018 the trust remained in the same position and were not registered to accept detained patients, however this occurred on five occasions in the previous 12 months. The pace of change to this identified risk was not adequate to ensure patients were legally detained.

A risk management strategy policy was provided but was out of date as it referred to the 2016/17 trust objectives. The new strategic risk management policy was currently out for consultation.

The pharmacy department had an active risk register with action plans in place to record and manage the identified risks. The pharmacy department also led in improving medicines optimisation processes through clinical and internal audit.

**Information management**

The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The trust recognised where further improvement was needed to ensure accurate and reliable data sources.

One of the key priorities for the trust in 2019/20 was to implement an electronic patient record (EPR) system. A tender for the system had been agreed. Currently patient records were largely paper. There were some electronic systems used in some areas but electronic records were not established throughout.

Staff accessed policies and procedures on the trust internet, this appeared to be reliable. Data quality had been a priority for the trust and data quality reports were produced. Between April 2018 and July 2018, the score for data quality had improved and was at level 3 (the highest level).

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation’s information governance practices through the provision of evidence of around 45 individual requirements.

The summary Information Governance (IG) report for 2017 – 18 showed a score of 72% which was graded as satisfactory compliance.

The data security and protection toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems, this replaces the previous Information Governance toolkit and has been in place since April 2018. At the time of inspection the trust audit was not available.

The date of implementation of an Electronic Prescribing and Medication Administration (EPMA) system was 2020. This would provide digital support for prescribing and medicine administration.
A project was being undertaken with the electronic incident reporting system ‘Safeguard’ to enable it to interface directly with the Pharmacy Clinical Desktop. This would record any near miss/no harm medicine related incidents as well as any interventions made by the pharmacy team.

The Quality, and Patient Experience and safety committee minutes from 28 February 2019 identified a reduction in the number of out of date policies. A review of all human resources policies had taken place with some yet to be ratified. We did however find some policies and procedures which were overdue for review.

Cyber security was considered a high priority and was included in the trust risk register.

The trust medical director was the named Caldicott Guardian. Information governance was also included in yearly mandatory training requirements for all staff.

**Engagement**

The trust engaged with patients, staff, the public and local organisations to plan and manage services. There had been a focus on increasing engagement with staff over the past 12 months however, engagement with patients required strengthening.

**Staff engagement**

The trust used the Listening into Action Pulse Check Survey as an interim staff engagement census as a way of assessing engagement ahead of the Autumn National NHS Staff Survey. The survey, completed in June 2018, was the 4th time the Pulse Check survey has been undertaken. 51.7% of the organisation responded representing 2080 individuals.

The poorest scoring areas of the Pulse Check survey were listed as:

- Q4. Day-to-day frustrations are quickly identified and resolved. 32% positive responses.
- Q10. Communication between senior management and staff is effective. 38% positive responses.
- Q14. Our work environment, facilities and systems enable me to do my job well. 36% positive responses.

The trust recently refreshed and relaunched its values. This had been done in collaboration with staff. The trust values were:

![Trust Values](image)

Training in the values was being delivered and when staff had completed the attended they wore yellow name badges to indicate this. Staff we spoke with were passionate about the values that...
had been introduced.

The trust held annual award ceremonies to celebrate the achievements of teams and individual staff. Some examples were the emergency department had been recognised for a ‘Back to Basics’ initiative promoting good care. The paediatric team had also developed an App. This provided a range of information to parents, children and staff on the care being delivered. From a who’s who in the team to the type of procedures that took place.

The Chief Pharmacist attends the West Midlands Chief Pharmacist’s network to ensure consistency to share and learn medicine optimisation issues across the Midlands region. Local engagement with Clinical Commissioning Groups also ensured that health economy wide issues were discussed to help improve patient care.

The pharmacy department had recently involved the trust Engagement Lead to help identify areas to improve staff engagement. This resulted in the pharmacy department being the most improved department for the staff survey with an 80% response rate.

Union representatives reported effective communication with the trust’s leadership team. The following up on actions by the trust’s executive team had significantly improved. Staff had access to support for their physical and emotional health requirements through occupational health.

The trust had an annual award programme. All shortlisted nominees were invited to the annual award ceremony held.

The trust had introduced schemes to recognise apprentice and students during their placements at the trust.

The trust had introduced ‘Tuesdays Topics’ weekly for regular messages and the opportunity for staff to hold discussions with the trust’s executive team.

Trust executives had introduced personal blog messages to promote trust values, expected behaviours and to promote staff achievements.

The trust engaged in the ‘Listening into Action’ project. This aims to engage with staff to unlock their potential so that they can contribute to the success of the organisation. Over 60 teams had engaged in taking forward project ideas in the past year.

There were a range of staff health and well-being initiatives in place. This included self-referral for physiotherapy, counselling (including bereavement).

The trust had a team of around 300 volunteers who covered over 30 roles within the trust. Some volunteers were extremely longstanding. They were a visible valued part of the organisation around the hospital and in palliative care settings.

Patient engagement

Patients/service users told the trust about their care in a variety of ways for example, Whose Shoes, What matters to You, Voices Bereavement questionnaire, surveys and audits, forums & focus groups.

The trust was part of the Black Country and West Birmingham sustainability and transformation partnership (STP). The trust was committed to the STP, presented itself as an out-facing organisation and was keen to secure systems delivery and partnerships. However, executive level focus on driving and supporting external systems work had contributed to a reduced focus on internal risks internally for the organisation.

The trust took part in the ‘What matters to me’ campaign. This initiative involved making staff aware of the important aspects to patients. We saw boards behind beds that included aspects of what mattered to patients.
It was acknowledged that the response rate for the friends and family test could be improved. The trust did not have a target response rate but a range of 30 – 40% was being achieved. The trust was working on this and looking at a variety of approaches that could be used to promote feedback. Each week emails were sent to areas which had low response rates to encourage staff to get patients to respond.

There was a patient experience group that included senior level managers. There was work underway to recruit patient representatives to this group.

The patient experience group worked with the complaints team to assess themes and trends from complaints. Any actions were pulled together, work had been completed to improve the quality of these to include aspects such as what the issue was, what mitigation had been put in place, and who, what and when would actions be completed by.

Examples were given where changes had been made as a result of the inpatient survey, these included trying to improve patients sleep by providing earplugs and eye masks and having a ‘quiet time’ protocol.

The visiting policy had been updated recently. As part of this patients, volunteers, and a number of events had been arranged to engage all parties before finalisation.

**External engagement**

The trust was represented at senior level, with the chief executive directly supporting ‘Walsall together’ partnerships and agendas. ‘Walsall together’ was focused on ensuring best health and care experiences for patients and those accessing services across the system.

**Learning, continuous improvement and innovation**

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>97%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>89%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>45</td>
<td>89%</td>
</tr>
</tbody>
</table>

There were 2,627 complaints resolved without formal process in the last 12 months.

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 290 complaints from October 2017 to September 2018. Medical care core service received the most complaints with 110.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>110</td>
<td>37.9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>77</td>
<td>26.6%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>44</td>
<td>15.2%</td>
</tr>
</tbody>
</table>
From October 2017 to September 2018, the trust received a total of 662 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>122</td>
<td>18.4%</td>
</tr>
<tr>
<td>Adults Community</td>
<td>117</td>
<td>17.7%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94</td>
<td>14.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>91</td>
<td>13.7%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>60</td>
<td>9.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>48</td>
<td>7.3%</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>5.6%</td>
</tr>
<tr>
<td>Maternity</td>
<td>35</td>
<td>5.3%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>17</td>
<td>2.6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>14</td>
<td>2.1%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>11</td>
<td>1.7%</td>
</tr>
<tr>
<td>Children, Young People and Families</td>
<td>9</td>
<td>1.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>7</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

We reviewed three complaints responses. Some of these were long and did not always address the points raised.

The timeliness of responding to complaints was not always within target timescales. Sometimes patients and their representatives were contacted, and negotiations offered on the timescales to be achieved. These were often longer than the trust targets but were offered on the basis of ensuring a robust investigation.

An annual report was submitted to board annually. This detailed the number of informal and formal complaints and identified themes and trends. The themes identified were communication, discharge arrangements and clinical care and treatment.

Reviews of online feedback was also completed, the trust responded to the feedback left and invited people to contact them directly to look into concerns further. A range of compliments have also been left online for the trust’s services.

The complaints had been updated and now included the full range of options that patients and their representatives could raise concerns. In the patients survey however many patients reported they didn’t know how to raise concerns.

Complaints responses were overseen and signed off by board members when they had been
completed at divisional level.

**Learning from deaths**

**Systems to identify and learn from unanticipated deaths were ineffective.**

A mortality surveillance group met monthly chaired by the medical director. The mortality report was presented through the Quality and Patient Experience and Safety committee (QPES).

The trust had a plan to appoint medical examiners, but these were not yet in post, it is a statutory requirement for trusts from April 2020 that medical examiners are in post. Some medical examiners were in the process of being appointed. The executive lead for mortality acknowledged that improvements were required to the systems and efficiencies for ensuring investigations and learning from deaths.

Whilst the learning from deaths policy implemented in February 2017 was suitable it was not being followed robustly. This policy was slightly overdue for review as it was due for review in February 2019.

The trust provided us with access to seven records of patients that had died at the trust within the last six months. Each death had been reviewed using the trust review process. The records showed a lack of involvement with families.

We reviewed seven patient records to establish if lessons were learned from deaths. We found four deaths within a 10-day time frame with potential themes, this had not been identified or escalated. We escalated our concerns to the medical director.

There was a lack of learning from deaths and processes to ensure deaths were reviewed was not established. This was included as a risk on the organisational risk register. The number of deaths being reviewed had fallen and there was no assurance that there was learning from deaths.

The HSMR is the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths, for specific conditions accounting for about 80% of inpatient mortality.

The current Hospital Standardised Mortality Ratio (HSMR) was as expected at 102.1 when compared with other trusts. This overall figure included the Hospital Standardised Mortality Ratio weekend statistic. There was a slight difference in the weekday HSMR at 100.6 and the weekend HSMR at 105.6, this indicates the occurrence of death at a weekend was higher than weekdays.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

The summary hospital-level mortality indicator SHMI methodology includes an adjustment for admission method. This is because crude mortality rates for elective admissions tend to be lower than crude mortality rates for non-elective admissions.

For the 12-month period from October 2017 - September 2018, SHMI was as expected with a value of 1.12 (compared to 1.0 for England), this was stable with little variance since October 2016.
Systems were in place to support and encourage pharmacy staff in improvement and innovation. Two pilot projects had been very successful which showed benefits to patient care. The first project showed the benefits of a clinical pharmacy service based within the Emergency Department. The second project involved Pharmacy Technicians undertaking drug administration on wards working with the Practice Development Nurse. This pilot showed evidence of reducing and eliminating missed doses on the wards. However ongoing discussions about funding was preventing further advancement in taking both projects forwards.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>ISO 15189</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>End of life care</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Accreditations tab).*
Acute services

Walsall Healthcare NHS Trust
Moat Road
Walsall
West Midlands
WS2 9PS

Tel: (01922) 721172
www.walsallhospitals.nhs.uk

Urgent and emergency care
Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Walsall Healthcare NHS Trust has a purpose built emergency department (ED) that is situated as part of the Manor Hospital. There is a four-bay resuscitation area, 23 cubicles, a separate waiting area for children that has three treatment rooms and two triage rooms, and new areas for other services that include the frailty team. There is an urgent care centre that is located on the same site and that shares an entrance and reception area with the ED, this was not inspected. The urgent care centre was not inspected as part of this inspection.

From August 2017 to July 2018, there were 77,306 attendances at the trust’s urgent and emergency care services. This included both adults and children attendances for both majors and minors treatment.

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in most recent year compared to previous year. In both years, the proportions were higher than the England averages.
(Source: NHS England)

Urgent and emergency care attendances by disposal method, from August 2017 to July
The Emergency Department (ED) is part of the West Midlands Trauma Network of 33 hospitals in the area. The nearest major trauma centres for adults are the Royal Stoke University Hospital and the Queen Elizabeth Hospital in Birmingham. The nearest trauma centre for children is the Birmingham Children’s Hospital.

We visited the ED as part of our unannounced comprehensive inspection of core services in February 2019. We spoke with seven patients and their relatives, friends or carers, and 29 staff across a range of roles. We tracked patient experience through their time at the ED, checked the quality of records, and observed staff practice.

During the last inspection in June 2017, we rated the ED as requires improvement for safe and responsive, good for effective, caring and well-led, and therefore requires improvement overall. This was because:

- There was unsatisfactory infection prevention and control practice.
- Medicines management was not satisfactory in all areas.
- Some patients were accommodated in a potentially unsafe environment.
- ED was not achieving target times for assessment, treatment and discharge of patients.
- ED was not achieving trust targets for mandatory training or appraisals.
- Improvements had been seen since the previous inspection in 2015 when the ED had been inadequate overall, with increased staff numbers, a dedicated paediatric area, and more equipment storage facilities and availability.
- Patient care had improved.
- Care and treatment was delivered in line with national guidance.
- Multi-disciplinary working was embedded and effective.
- Feedback was positive around staff care.
- The dementia nurse had contributed to significant awareness in staff.
- The departmental managers were supportive and approachable.

At this inspection there had been improvements in all the areas of concern, particularly with regard to infection control, staffing and staff leadership, and risk management. However, there were still some issues, particularly surrounding the safe key question that required improvement, despite the clear upwards improvements and the processes that had been put in place.
By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

The service provided mandatory training in key skills to all staff. The compliance for staff completion was still below targets provided by the trust. However, there had been a large improvement in new staff and refresher training.

While the trust target of 90% completion rate was not met for all training courses, most courses had completion rates of 70% or more. This was a marked improvement on the previous inspection findings. Staff understood the importance of completing mandatory training and applied what they learnt to their practice.

**Mandatory training completion rates**

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory training courses as of September 2018 at Manor Hospital for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>83</td>
<td>83</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>80</td>
<td>83</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>78</td>
<td>83</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>72</td>
<td>83</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>71</td>
<td>83</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>63</td>
<td>83</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>63</td>
<td>83</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>60</td>
<td>83</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>45</td>
<td>83</td>
<td>54%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>27</td>
<td>83</td>
<td>33%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 90% target was met for three of the 10 mandatory training modules for which qualified nursing staff were eligible. Figures from the ED department showed that the overall mandatory training compliance for all courses had increased from 70% in September 2018 to 81% at the end of January 2019.

Overall, mandatory training levels had increased since the previous CQC inspection in 2017 when the compliance had been lower in all areas, except for fire safety. We saw that staff were being booked onto courses in 2019 with the aim of reaching the trust targets in 2019. The issues with compliance in fire safety was compounded by the lack in availability of instructor led courses, which had been escalated as a priority and was acknowledged as an ongoing risk by the clinical and governance management.

Adult basic life support training evidence at the inspection showed that staff were booked onto courses that, when fulfilled, would lead towards 90% compliance in 2019 for staff. We saw internal data that showed compliance was generally improving over the months November 2018
A breakdown of compliance for mandatory training courses as of September 2018 at Manor Hospital for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>4</td>
<td>8</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>4</td>
<td>8</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>3</td>
<td>8</td>
<td>38%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the 90% target was not met for any of the 10 mandatory training modules for which medical staff were eligible.

Sepsis training was not part of the mandatory training programme for nursing or medical staff, but there was awareness with all staff asked at the time of the inspection regarding sepsis. There was a dedicated sepsis information board and huddle information briefings.

A cascade team system had been introduced in the previous eight months to encourage smaller team working with each team having a mix of nurse grades and a band 7 nurse team leader. This structure had been introduced to increase mandatory training compliance by giving each team leader responsibility for compliance. Internal data indicated that this was starting to show improvements and the matron for ED believed that it was a good solution for the future. There was also an increase in staffing levels which was leading to more available training time. The new matron management had demonstrable timetabling plans to increase practice development and training time, and the clinical lead had a priority focus on improving compliance of all 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.** However, not all staff had received up-to-date training in all safeguarding courses, and some course completion was below 75%. We were informed that trust target of 85-90% was due to be achieved in 2019 for all courses.

**Safeguarding training completion rates**

A breakdown of compliance for safeguarding training courses from as of September 2018 for qualified nursing staff in the urgent and emergency care department at Manor Hospital is shown below:
At Manor Hospital urgent and emergency care department the 85% or 95% target (depending on the module) was met for two of the six safeguarding training modules for which qualified nursing staff were eligible.

At the previous inspection in 2017, safeguarding training levels were considerably lower than they were at this inspection where there was an improvement with compliance for all nursing levels. A risk assessment was in place for staff who had not been signed off with all the competencies, including safeguarding. This risk assessment was clear that no staff could work alone who were not compliant with all appropriate safeguarding competencies required of their grade. Through the cascade system and team skill scheduling, there were always staff on duty that did have all the safeguarding compliance to work alongside those that may not. There would always be a senior nursing/medical staff member on duty with all the required safeguarding training compliance.

A breakdown of compliance for safeguarding training courses from as of September 2018 for medical staff in the urgent and emergency care department at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital urgent and emergency care department the 85% or 95% target (depending on the module) was met for two of the six safeguarding training modules for which medical staff were eligible. However, this was an improvement from the previous inspection in June 2017 when only 33% of consultants, and 14% of all other grades, had completed any adult safeguarding training. In June 2017, only 65% of medical staff had undertaken Safeguarding Children Level 2 training and this had improved to 100% compliance. Safeguarding Adults (Level 3) training had not yet been introduced at the department.

Staff, when asked at the inspection, had a good understanding of the principles of safeguarding. There was a clear trust policy on safeguarding, supported by a robust reporting system. The ED improvement plan was clear that standards needed to be improved to provide consistently high expectations, and all the patient care improvement plans for the ED were located and managed through the Safeguarding Risk Register. There was a member of senior staff responsible for safeguarding and trust documents in place for adult safeguarding concerns such as female
genital mutilation management, and children safeguarding. The ED had access to the Walsall NHS Healthcare Trust safeguarding service that also incorporated the Looked After Children (LAC) team. The ED were therefore incorporated into the multi-agency safeguarding hub, the on-call duty service and the access to the child protection list in Walsall.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well, and there had been improvements since the last inspection. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection, such as handwashing and use of personal protective equipment. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

In 2018 the department initiated Infection Control Standards to improve cleanliness and infection control. In practice this meant that there was an increase in the number of staff huddles centred around infection control, awareness weeks for all staff and a joint audit working with the Infection Control Team. A designated infection control nurse was appointed for the ED who had oversight of the department and reported regularly to the matron.

We saw that monthly infection control audits were undertaken in the department. The most recent audits showed improvements from September 2018 to December 2018, with increased compliance in hand hygiene and clinical practices. For example, the overall score in September was 55% for infection control; by December 2018 this had improved to 80% for overall infection control in the department. This coincided with a focus led by the matron to improve standards and to get basic hygiene and infection control measures to a good level.

Hand hygiene practices were audited and good practice was observed throughout the inspection. During 2018 the ‘bare below the elbows’ audit results had been poor. However, the ‘bare below the elbow’ policy was adhered to more consistently now. There was an increase of spot checks and staff challenging poor compliance.

There was good availability of personal protective equipment, with clear associated policies for staff to follow.

Curtains were cleaned when visibly dirty, and routinely every six months. ‘I am Clean’ stickers were used to indicate when equipment was ready for re-use. Each bed in the ED was to be cleaned thoroughly at least twice daily, but this was not always monitored. However, nurses were allocated to cubicles to give them the responsibility for cleanliness in a specific area. At the inspection there was one bed found with dried blood staining. This was highlighted to staff and immediately cleaned and then appropriately indicated as clean.

The trust did not collect data regarding patients who required isolation due to infectious disease. There was a room to isolate patients should it be needed. In addition, all patients were primarily nursed in individual cubicles with standard precautions. Should a patient require admission then a side room would be allocated on a ward.

All paediatric infections requiring isolation (for example chicken pox) could be allocated to the one paediatric bay with a door entry. This was then deep cleaned after vacated, with oversight by senior staff. Any areas where patients with diarrhoea or vomiting had been examined were cleaned with bleach where practicable, as per local policy.

**Environment and equipment**

The adult emergency department was generally fit for purpose, although there were issues
with space and privacy for patients and staff - the service generally had suitable premises and equipment and looked after them well. There were some instances of equipment not in place or starting to wear. Equipment required for resuscitation was available for all age ranges and processes were in place to ensure emergency equipment was checked daily.

Generally, the department was clean, although there was noticeable wear with the building and the age of some of the equipment. Staff acknowledged that some equipment needed replacement – items such as the trolley beds and commodes. There was some new investment in defibrillators and at the time of the inspection the investment of a £36 million purpose built premises had been signed off and was due to be completed in 2021.

We spoke to cleaning staff at the inspection, who were employed directly by the trust and worked solely in the ED. One member of staff stated that it was always a busy area and that sometimes they did feel understaffed. We saw that cleaners undertook both routine and ad hoc cleaning and used all the correct equipment and safety precautions, such as signage and protective clothing. At the time of the inspection it was brought up at a safety huddle that there seemed to be a shortage of cleaning staff compared to historical levels, and that this may be having an impact on the general cleanliness of an aging building.

The ED had commenced a '15 steps' through ED programme of checks to highlight areas that could be improved regarding the basic standards of care, mostly regarding the environment and equipment. The first feedback of this was presented to the ED in January 2019 and highlighted clutter in staff rooms, uniform infringements and storage issues. These 15 step checks were due to continue daily with feedback collated by the management.

There were two review rooms in the ED department. The larger room was for the Rapid Assessment and Treatment (RATs) and was in use from 8am to 10pm. The smaller room was near the nurse station and was in use 24/7 for patients. The ED policy for these two rooms explicitly stated that there should be adequate supervision for both these rooms at all times, and there were strict capacity limits. We saw that the RATs use was effectively used by the ambulance crews and the hospital staff. There was an ambulance staff member on duty most days who liaised with the crews and staff to facilitate a good flow of patients to RATs. However, there were some equipment shortages – for example there was no suction pump present in the room when the inspection team first arrived, and one member of staff was unable to locate an ECG (electrocardiograph) machine.

The smaller review room was strictly for two trolley beds for same sex patients only, as per the policy. We saw one example where there were more than two beds in the room for a long period of time, with patients being assisted by relatives, who were also in the room. This was contrary to the policy and led to difficulties for patients in maintaining dignity and space.

The main nurse station was in the middle of the department and was a busy hub part of ED. There were few spaces for staff to work at, and therefore filling in paperwork and notes was often observed to take place in cramped conditions. There were adequate numbers of IT terminals for staff to be able to record and look up information electronically, although, again, there was a clear lack of space for staff to work in. Some staff commented that they felt they needed more personal space, and less noise, to be able to work more effectively.

The resuscitation trolleys throughout the department contained all the equipment and medicines required for emergency use, and all were in date, sterile and ready for use.

The paediatric waiting room was small for the numbers of patients that could be attending. For example, there were only 14 main seats in the whole area. It also lacked good ventilation, with no outside windows, and as a result the rooms could feel airless and warm. Staff were seen to be
using the space that they had as effectively as possible, but all the staff we spoke to were looking forward to new facilities in the next two years. The paediatric waiting room had information boards, toys, refreshments, secure swipe card entry, a TV screen and hand sanitisers. There was also a board that introduced the staff to the patients.

There was a dedicated mental health assessment room that met national requirement guidelines, with the exception of the glass in some of the windows that was not the stipulated safety glass. The room was located near the nurse station and main staff corridor, which meant that it was good for observations by staff, but also meant that patient privacy was compromised. It was located beyond the other cubicles so that potentially distressed patients had to walk past many of the other cubicles. This was due to be remedied when the ED department was scheduled to be updated.

Future building plans had been signed off and work was due to commence on a large new building to house the existing ED. The plans showed a large increase in floor space, an improved layout for all the areas, together with larger and wider corridors, more storage and dedicated rooms for those with additional needs.

All staff and visitors were challenged for identification to ensure that only ED staff and patients/relatives were in the department. There was swipe card access to the main and paediatric EDs from the waiting room, and we noticed porters and nursing staff continually checking that there were no unauthorised people in the ED. Staff told us they had good relationships with the neighbourhood policing team and the security team based on site. Response times from both were reported to be good. Response times from the police had improved over the previous twelve months. There was also a police liaison to help when patients of no fixed abode left the department before discharge to ensure patients could be tracked and ensure their continuing safety.

Assessing and responding to patient risk

For most patients, we found risks were managed and patients generally received assessments, treatment, and observations in a timely way. The service planned for emergencies and staff understood their roles if one should happen. The trust performed in line with other trusts for performance and risk. There was a clear and robust risk register and governance in place.

There was a clear and easily accessible risk register that staff could access and which gave headline risk plans and reviews for the department. The risk register was now on-line through the intranet system, having been a paper-based system until the end of 2017. Therefore, it was now possible to assess a live picture of the register at any point of the day. Senior staff stated that the view taken regarding risk was now a ‘bottom up’ approach rather than ‘top down’ as it had been previously. This meant that risk at department level was more accurately assessed and monitored by staff in the ED. We saw that procedures and protocols regarding assessing and responding to potential and actual patient risk were in date and recently reviewed. These included the adult triage procedure and the ED reception protocols that promoted appropriate flow of patients through the department.

Emergency Department Survey 2016

The trust scored no better than other trusts for the five Emergency Department Survey questions relevant to safety. The trust scored worse than other trusts for one question and “about the same” as other trusts for the remaining four questions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>7.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median in from October 2017 to September 2018. In December 2017 the median time to initial assessment was highest at 18 minutes compared to the England average of nine minutes.

**Ambulance – Time to initial assessment from October 2017 to September 2018 at Walsall Healthcare NHS Trust**

(Source: NHS Digital - A&E quality indicators)

The latest official data was not available, but the introduction and embedding of the Rapid Assessment Triage system was improving the median times.

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Manor Hospital**

From November 2017 to October 2018, there was generally a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Walsall Manor. The trusts performance worsened slightly in December 2017 and January 2018, where 56.6% and 55.5% of ambulance journeys had turnaround times over 30 minutes respectively.

**Ambulance: Number of journeys with turnaround times over 30 minutes – Manor Hospital**
Ambulance: Percentage of journeys with turnaround times over 30 minutes – Manor Hospital

(Source: National Ambulance Information Group)

The introduction of the RATs system and collaborative working approach with the ambulance service was improving these times since October 2018.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. In our previous inspection in 2017, there had been a reported 249 black breaches from April 2016 to March 2017.

From October 2017 to October 2018 the level of breaches improved. The trust reported 178 “black breaches” although 136 (76.4%) were from October 2017 to February 2018. Please note the last week of data in February encompasses the first few days in March.

The reason for black breaches during the same period were:
  - Level 02 EMS Capacity: one (0.6%)
  - Level 03 EMS Minimal Site Capacity for demand: 121 (68.0%)
  - Level 04 EMS Internal Major Incident: 56 (31.5%)
An embedded triage system was in used throughout the ED to indicate the urgency of the presentation. This was colour coded and recognised by all staff. Additionally, there were clear criteria in place for patients presenting with certain conditions requiring specialist trauma or medical care to be taken by the local ambulance service to a dedicated unit in the locality. For example, those with acute stroke symptoms to be immediately transferred to the stroke unit in a different location if appropriate. Staff competencies and skill mix within the unit did ensure that all emergencies could be dealt with in the department until transfer could take place.

There were processes in place for managing the deteriorating patient. The standard operating policy included visibly checking on any patient causing concern every ten minutes. In the cases of severe deterioration there were processes to consider transfer to specialist departments or other trust locations for optimal treatment.

There were accessible emergency trolleys for life threatening deterioration, and the ability to move the deteriorating patient to the resus area for constant one to one monitoring. There had been a recent issue raised by staff with checking the resus trolleys to ensure always stocked, and this was now part of a priority check list for staff. Compliance of the management of the deteriorating patient was part of the continuing improvement plan for the ED.

National Early Warning Scores (NEWS) and Paediatric Early Warning Scores (PEWS) were used throughout the ED to assess the deteriorating patient, particularly with regard to sepsis. We saw evidence of this system being used for patients and recorded in patient records. There was a dedicated staff noticeboard for the updating of all staff on the sepsis policy, procedures and pathways. All staff spoken to at the inspection were confident in the management of sepsis in the department. There were regular audits to assess management and documentation of patients presenting with sepsis symptoms and to monitor times from presentation to treatment. The ED followed the Sepsis Commissioning for Quality and Innovation (CQUIN) national guidelines.

There was a policy for the evacuation of the department in case of an emergency, with signage to indicate emergency exits. There were fire extinguishers and a fire drill action plan in place. The corridors were generally kept clear for emergency access, although the layout did mean that there was a lack of space when there was full capacity and there could be trolley beds in the corridors awaiting triage. The risk was acknowledged by the ED, and it had also been raised as
a risk in the 15 steps through ED audits where store cages had been left in the corridor posing an evacuation risk. This was highlighted as a priority to be addressed by all staff.

In March 2018 it was identified through staff feedback that there were issues in the ED with the large number of ambulance patients entering the department. Staff considered that this needed urgently addressing to mitigate risk to patients. An action plan was put in place with realistic timelines to assess, investigate and manage these risks. The focus was on the length of the queues, space for patients, lack of rapid assessment facilities and ambulance crews and ED staff not working in a cohesive fashion. It was identified that there needed to be an implementation of a ‘sit to fit’ policy, a rapid ambulance triage (RAT) facility and more staff allocated to ambulance crews on each shift. The actions to put policies, staff and facilities was given a deadline to November 2018. Actions were now in place and embedded with staff and the ambulance service crews. There had been improvements in the ambulance handover times and the ED had been in the four best performing trusts in the locality (out of 14 trusts) since April 2018. The targets of 55% of patients to be seen within one hour was met in July 2018.

There was a clear standard operating procedure in place for the dedicated paediatric area. This policy determined the criteria for those attending and gave details of how to maintain competent staff attendance. It was acknowledged that this area was immediately noticeably understaffed if one staff member was not available. ED staff we spoke to on the inspection stated that the paediatric area installed at the time of the previous inspection was a necessary improvement. However, not all staff were confident that the paediatric staffing levels mitigated potential risk always. This was of particular concern at certain times of the day and the week when there were no doctors on duty and when, for example, one paediatric nurse may have left the paediatric area in order to be in attendance in the resus area.

It had been raised and remained as a risk, that there was a need to have qualified paediatric nursing staff on duty at all times in the paediatric ED waiting area. There was a risk that if there was only one nurse on duty that they could not leave the area, even momentarily. There had been a risk raised that non-paediatric trained staff may cover the area. A risk policy was not in place that prevented that form occurring, stating that all nurse cover had to include only those with the relevant paediatric competency sign off or training. At the time of the inspection, this was a medium risk on the risk register. The action in place for this was for the nurse in charge to support the paediatric area during peak pressures.

An internal audit undertaken in May 2018 measured 252 randomly selected patient notes from the previous month. This audit showed that in that one month 55% of paediatric were not seen for triage in the first 15 minutes. This was contrary to trust policy. Of these patients 4% were not triaged for over two hours. Clearly this posed a risk, which the trust was evidenced to be acknowledging with proposed actions. New procedures were in place to give a swift first assessment to see if the patients were safe to wait for triage. If they were deemed safe to wait longer then a health care assessment was employed to check on the patient in the waiting room until a full triage took place. Staff said to inspectors that some shifts still had staff shortages, but that the system was improving generally. A new policy had been introduced in July 2018 that gave clinicians clear guidance on escalation of paediatric care. This was used when there was a perceived risk regarding the patient remaining in the paediatric unit unsupervised, or in the case of deterioration or concern. The escalation procedure could involve moving the patient to the main ED area for example. It also advocated that the target time for a 15-minute triage of all paediatric patients should be 85%, although there was no recent audit data to show that this was currently occurring at the time of the inspection.

**Nurse staffing**

**The service had nursing staff levels that were improving since the previous inspection.**
Generally, most staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. Nurse staffing levels and skill mix were planned in line with guidance on safe staffing in emergency settings. There were still improvements to be made, but there was a risk assessment in place for competencies and relevant skill mix of all staff.

The trust reported the following qualified nursing staff numbers as of March 2018 and September 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
</tr>
<tr>
<td>Manor Hospital emergency department</td>
<td>88.1</td>
<td>100.3</td>
</tr>
</tbody>
</table>

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 14.1% for qualified nursing staff in urgent and emergency care. By the time of December 2018 this vacancy rate had fallen slightly to around 11%.

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 19.4% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 10%.

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 5.5% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.39%.

Bank and agency staff usage

From October 2017 to September 2018, the trust reported there were no qualified nursing shifts in urgent and emergency care were filled by bank staff or agency staff. However, from November 2018 to January 2019 there were occasional agency nursing shifts to cover for staff absence. The total number of agency shifts were in the region of 65 in total for this three-month period, according to the evidence seen at the inspection.

At the inspection we looked at the paediatric rota for the month of November, which showed that the staffing levels were almost always filled according to the department current requirement targets. However, it could not show if staff were pulled away from the main ED to the paediatric area, which anecdotally we were informed could occur. The rota for December did show less cover than the month previously, with seven shifts not covered to requirements. The rota for January showed that there were 17 shift requirements that were not filled. The week previous to the inspection showed a rota where there had been ten shifts in total over seven days that had required either bank or agency staff. All the shift vacancies had been covered by either of these routes.

Paediatric standards had been adopted in the department. These stipulated that there should be two registered children nurses on each shift and that these staff had to possess trauma and emergency training. Staff said that there had been an occasion in 2018 when a member of staff who was not suitably trained had attended the paediatric ED. Staff had raised this as a concern.
and staff now had to possess the required paediatric competencies.

At the time of the inspection there was a business case pending approval by the trust, based on the paediatric standards expected in the department, to increase further the levels of dedicated paediatric staff. This business case had been compiled to demonstrate that the standards of care expected would require further staff investment going forwards. At the time of the inspection this increase in staff recruitment had not been signed off, although we did witness potential new staff being interviewed. However, these staff did not necessarily have an actual job role to be offered at that time. The deadline for recruitment to ensure two dedicated registered children nurses for each shift was end of March 2019, with the end of April 2019 for completion of the trauma and emergency training. A sister in the department did think that the staffing levels had improved in the last two years, particularly for paediatrics. For example, in 2017 there was only one matron and one nurse per paediatric shift; in January 2019 there was a matron, one band 7 nurse, and one other nurse for many of the shifts.

Generally, nursing shifts in the ED were covered by the hospital own staff. From November 2018 to January 2019 there were between 11-14% of shifts that were not completely covered by the ED staff, with, in most cases one member of staff down on the target levels. Records showed that agency staff were sometimes used to fill the numbers.

The senior staff all generally thought that the staffing levels were at the minimum levels, but that they were safe. They all, when asked, wanted more staff to ensure internal cover for absences and to accommodate better co-operation with the new initiatives in the department, such as the Rapid Assessment Triage (RATs) working pattern and to provide cover when staff undertook transfers out of the ED.

There were four Emergency Nurse Practitioners (ENPs) which was 100% fill on the target.

**Medical staffing**

The service still had some concerns with the level of medical staff employed at the trust. However, there had been an innovative approach at the trust to employ a new band of medical staff (Advance Clinical Practitioners) that were had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment and to increase the staffing levels at the department.

The trust reported the following medical staffing numbers as of March 2018 and September 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Manor Hospital emergency department</td>
<td>41.3</td>
<td>51.0</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From October 2017 to September 2018, the trust reported a vacancy rate of 32.9% for medical staff in urgent and emergency care.

**Turnover rates**

From October 2017 to September 2018, the trust reported a turnover rate of 0% for medical staff in urgent and emergency care. This was lower than the trust target of 10%.
Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 2.3% for medical staff in urgent and emergency care. This was lower than the trust target of 3.39%.

Locum and agency staff usage

From September 2017 to August 2018, the trust reported that 42.9% of medical shifts in urgent and emergency care were filled by locum staff, and 26.7% of shifts were filled by agency staff. In addition, 15.6% of shifts were not filled by bank and locum staff to cover staff absence.

Staffing skill mix

From July 2017 to July 2018, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the average.

Staffing skill mix for the 22 whole time equivalent staff working in urgent and emergency care at Walsall Healthcare NHS Trust.

At the time of the inspection we were told that of the target of ten permanently employed consultants in the department, there was still only a 50% fill (five staff). There were a further four consultants on a yearly contract and only one unfilled vacancy. There was 100% fill for middle grades and junior doctor roles (18 staff in total). In addition, there were plans to recruit a total of seven Advanced Clinical Practitioners (ACPs), of which there were five already in post and were supernumerary to the stipulated medical staffing levels.

We spoke to four junior doctors and medical students. They felt that they were well supported, supervised and were given enough time to assess patients.

Records

There were appropriate records of patients’ care and treatment. Generally, records were completed and included early warning score charts where appropriate. Audits were in place and led to increased compliance action plans.
We reviewed 17 records and found that they had all been completed for pain scores and relevant observational checklists where required. Where pain scores had been indicated there was analgesia offered and documented. In four of the 17 records there had been delays in triage for up to 40 minutes. There was one record where an unintentional paediatric overdose of medicines had not triggered a telephone call to social services when the patient was known to them. There was also no recorded risk assessment. This was contrary to policy and national guidance.

There were paediatric early warning score charts (PEWS) in place for paediatric records and an associated escalation chart for medical staff to work to. The records for observations and escalation indicators were completed. We saw clear and comprehensive standard operating procedures (SOPs) for the record keeping of all paediatric attending the department.

The documentation audit of 2018 in the trust showed that there were still improvements to be made with some completion of records – particularly with regard to filling in the pain scores and ensuring sepsis bundles were easily accessed.

There had been a recent incident with the accuracy of a mortuary passport, which had resulted in the mortuary department visiting the department to educate staff on the specific documentation requirements for the mortuary.

A general issue noticed was that some pro forma paperwork was printed or copied onto low quality paper that was sometimes difficult to read clearly or mark with pens/pencils.

**Medicines**

The service generally prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. There were incidents reported that had been dealt with in a timely manner with learning and action plans going forwards.

Medicine Management standards were reviewed in 2018. This had also meant that a member of the ED staff became a Medicine Champion for the department and there were now formalised joint audit working.

A recent pilot trial of a pharmacist working in the department demonstrated the benefits and support the presence of a pharmacist contributed to collaborative team working. Examples included undertaking medicine reconciliation for frail elderly patients, medicine advice and knowledge. This pilot came to an end and the pharmacy service was removed, however a business case was being put forward for a permanent pharmacist to be based in the department. We saw at a safety huddle that some staff had concerns regarding current delays in prescription and medicine dispensing.

Medicines including intravenous fluids were stored safely behind locked doors in restricted areas which was only accessible to authorised staff. The temperatures of the medicine storage area including medicine refrigerators were monitored and recorded. Staff were aware of what action to take if the temperatures were not safe for medicine storage. Records documented that medicines were stored within the recommended temperature range for safe medicine storage. Controlled Drugs which require special storage and recording were stored following good guidance procedures including twice daily checks by two nurses.

Staff knew how to report a medicine incident following trust policy. Any learning from medicine incidents were shared across the team. Two examples of learning from medicine incidents were
discussed including what action was taken and the shared learning across the team. The learning was open and transparent with patients fully informed under the Duty of Candour policy. There had been pertinent reflections and learning undertaken, including a new focus on the human factors in healthcare and how this could be managed.

Resuscitation drugs were stored on the designated trolleys and all were checked weekly as per policy.

The paediatric medicines had undergone some changes since the previous inspection, and there were prescribing staff on duty. All plaster casting was now performed, where possible, in the paediatric area rather than the plaster room in the adult area.

Incidents

The service managed patient safety incidents well and there was a robust and comprehensive electronic incident reporting system in place. Staff recognised incidents and reported them appropriately. 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.

Incidents and safety learning were discussed at regular weekly safety huddles. These huddles were well attended by all grades of staff, and a register was taken so that management could ascertain who had attended. There were, additionally, weekly divisional safety huddles meetings in which the trust board and other departments were represented. We attended one of these meetings where it was confirmed that new incidents were discussed, and actions were chased on previously discussed incidents. There were examples where clear learning processes had been influenced and implemented following these meetings. One example was the improved body mapping following an incident where a pressure ulcer had not been adequately noted in the patient record.

Incident reporting was now managed using the newly introduced computer software and was accessible to all staff. There was also a new incident form that had been introduced the week before the inspection that was more concise and easier to complete than the previous form.

We saw one incident where medication had been given in error. All safety procedures were seen to have been rapidly put into place and all staff had immediately been informed. There was a safety huddle where this was flagged so that learning could be given to all staff. In addition, all staff were informed where appropriate through direct contact with senior staff. Pharmacy was informed and an investigation was underway with named senior staff in charge. There was observed to be full transparency and Duty of Candour. We were informed that the Trust Director of the Department of Pharmacy always investigated these incidents and was part of the closing of the loop in terms of learning and relevant actions.

Incidents were observed to be generally well managed in a timely manner with clear timelines. However, at the inspection there was one concern were the buzzer in the paediatric bay did not alarm in the waiting room for staff to hear it. This had been raised as an incident but had not been actioned by estates. Staff felt it was a priority and needed prompter action.

Two members of staff did feel that the incident reporting system was not always confidential, and
therefore there could be difficulty with duty of candour. When we raised this with senior staff we were assured that there were confidentiality processes within the system but acknowledged that not all staff may know about them and that this needed to be communicated to all staff.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no incidents classified as a never events for urgent and emergency care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incidents meeting SI criteria reported were:

- Treatment delay: three incidents
- Diagnostic: two incidents

*(Source: Strategic Executive Information System (STEIS))*

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure
ulcers, one fall with harm and one new urinary tract infection in a patient with a catheter from October 2017 to October 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Walsall Healthcare NHS Trust**

The ED was not quite achieving 90% compliance with correct sepsis management. Instead for the year to end 2018 the departments were generally at or below 90%, ending in December with 85% compliance.

Duty of candour leaflets had been circulated in the ED since the beginning of 2018 to all staff. The leaflets had a sticker system to follow up reported incidents and the trust was acknowledged as having best practice for Duty of Candour by NHS Resolution. There were risk roadshows that were held quarterly where incidents and Duty of Candour could be discussed. There were also ‘kitchen table’ events once a year to further increase learning gained from incident reporting.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Information was clearly accessible to staff and there was a clear audit programme.

ED treatment guidelines were based on published evidence based care from the National Institute for Health Care and Excellence (NICE) and the Royal College of Emergency Medicine.

There were printed leaflets and noticeboard displays throughout the department for the benefit of all staff to read. These clearly outlined recent news regarding national guidance in management, treatment and contacts for a range of areas including disease, trauma and safeguarding. There was a clear calendar of events to discuss best practice or learning based on national and local data collection or guidance.

There was a clear audit programme within the department to measure patient outcomes.
Nutrition and hydration

Staff generally gave patients enough food and drink to meet their needs while in the ED.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

However, we did see that the paediatric department had a trolley with several flavoured squashes and jugs of water for children and adults to freely help themselves to while they waited. The main hospital area had several retail and food outlets.

Pain relief

Pain was assessed and managed and was generally monitored by staff.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 7.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A paediatric pain management audit had been undertaken at the end of 2018 that documented the timeliness of pain relief administered in the department over the three months. It showed that the levels of analgesia administered had increased by both doctor administration and through the uptake of patient general direction (PGD) administered analgesia.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. While they did not generally meet national standards, performance was mostly comparable with national averages or just below. Where risk was perceived, this was added to the risk register.

There was an audit schedule in place at the ED which included, for example, completed audits in pain in children, management of the acute wheeze, correct dementia documentation in notes, and return admissions to the ED. Audits in progress at the time of the inspection included oxygen prescriptions, pulmonary embolism in the ED, triage waiting times, communications with the GP, urgent care referrals and a documentation audit. There was a mortality audit that was currently being analysed and was leading to new planning around end of life planning. A recent GP audit was currently looking at GP communication and transfer of patient information.
There were two dedicated audit leads who were responsible for the audit programme.

The ED participated in national audit for RCEM (Royal College of Emergency Medicine) and was currently participating in the audits for feverish children, vital signs in adults and a major trauma audit. The internal results suggested that they would be around the average compared to national levels of performance.

In 2018 the ED had participated in the RCEM audit for fractured neck of femur audit and achieved average results compared to national levels. Below are results of audit in the year 2016-2017:

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Manor Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- **Standard 1a:** O2 should be given on arrival to maintain sats 94-98%: This department 84.3%; UK: 19%.
- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
  
  This department: 95.5%; UK: 52%

The department was in the lower UK quartile for three standards all of which the trust scored 0%:

- **Standard 2a:** Vital signs should be measured and recorded on arrival at the ED: This department: 0%; UK: 26%
- **Standard 5:** If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - 5a: Within one hour of arrival (acute severe): This department: 0%; UK: 19%
  - 5b: Within four hours (moderate): This department: 0%; UK: 28%

The department’s results for the remaining two standards were within the middle 50% of results:

- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 35.3%; UK: 25%.
- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 72%; UK: 77%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, Manor Hospital emergency department failed to meet any of the national standards.

The department’s results for three standards were all within the middle 50% of results:

- **Standard 1 (developmental):** Consultant reviewed: atraumatic chest pain in patients aged
30 years and over. This department: 14.3%; UK: 11%.

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 20.0%; UK: 8%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 11.5%; UK: 10%.

The department did not report standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Manor Hospital emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for six standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 41.7%; UK: 69.1%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 7.0%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 8.5%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 4.2%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 6.3%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 25.0%; UK: 44.4%.

The department’s results for the remaining two standards were all within the middle 50% of results.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 72.9%; UK: 64.6%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 6.3%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

It was noted at the inspection that the sepsis results were investigated in the ED and the issues centred around documentation rather than the care given.

Unplanned re-attendance rate within seven days

From October 2017 and September 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average. In the latest month, September 2018, the trust performance was 7.0% compared to an England average of 8.5%.

Unplanned re-attendance rate within seven days - Walsall Healthcare NHS Trust
Competent staff

The service made sure staff were competent for their roles. Staff were encouraged and supported to develop their knowledge, skills and practice. Competency frameworks were in place to ensure staff gained the skills and experience relevant to their grade and to help formulate and manage risks for those who had not achieved all their competencies. However, not all medical staff were up to date with appraisal.

There was a range of training available to staff with an average of 12.5 hours of training per staff member for the year 2017-2018. In areas we looked at there was a good uptake of some training-for example, in ED medical devices training there was compliance of up to 100% for some devices, although there were areas where compliance was only around 10%. Figures from the department showed that the level of training offered was increasing month on month for nursing staff. Independent Personal Development Records (IPDRs) and electronic staff records (ESRs) were at 60% completion in September 2017 and by January 2019 were at 87% completion for all staff.

Staff told us they had received mental health awareness training. The local mental health trust provided free ad hoc training to Walsall Manor hospital staff. Staff also received dementia awareness training. External staff told us that staff in the Emergency Department had significantly improved their awareness of dementia over the last few years and were very skilled in supporting patients who had dementia or a cognitive impairment. There was a dementia lead nurse that was driving increasing staff and patient understanding. Staff did not receive any specific awareness training for substance misuse, learning disability or autism.

There was widespread use of the Care Support Workers (CSWs) and these had been upskilled to NVQ level 3. This was documented internally to be saving around £40,000 per annum on phlebotomy agency costs. They also had valuable extra skills for the department to utilise such as male catheterisation and plastering. We spoke to two CSW staff who both stated that they enjoyed the role and felt supported with good training and supervision. Both felt that there was scope to progress their careers.

There had been a general upskilling of staff in the department in 2018, with some staff moved up bands and a new paediatric band 7 lead nurse appointment where before the department had a band 6 lead.

Other improvements in the training and education of staff in 2018 had included an increase to
more than 70% of 5th year medical students opting to undertake their Year 1 training at the Walsall ED and a staff overall compliance in Paediatric 2018 Training Requirements.

There was a robust and comprehensive schedule of emergency department simulation drills. These had been introduced at the end of 2018. Each month one particular topic was chosen, for example pelvic fracture or complete heart block, and was subject to a clinical simulation headed by the staff education officer. All staff were welcome to attend and all learning was then shared and communicated to all staff afterwards.

The education officer spent three days in the ED department to supply training to junior doctors and to run skills and drills.

**Appraisal rates**

From April 2018 to September 2018, 88.4% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>70</td>
<td>83</td>
<td>84.3%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>62</td>
<td>63</td>
<td>98.4%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>145</strong></td>
<td><strong>164</strong></td>
<td><strong>88.4%</strong></td>
</tr>
</tbody>
</table>

In 2018 there had been the innovative introduction of Advanced Clinical Practitioners (ACPs) to the department, and there were plans to continue to build on the use of these clinicians. These were staff from a paramedic or nursing background that had additional skills to enable them to perform a wide range of tasks in addition to basic training. These included major trauma management of the patients, sepsis management, neurology, abdominal pain management and limb reductions.

This ACP workforce was a permanent addition to the team in ED and managed themselves with oversight provided by the clinical director and matron of the ED. They were responsible for maintaining their own competencies and capabilities, working to a comprehensive framework, and were regulated through registration with a professional body. The ACP training programme had seen that there had been an opportunity to reduce 14 middle grades to eight, which had generated a salary cost reduction of £200,000 per annum.

The introduction of a Band 8B ACP lead to provide specific leadership and oversight had brought further ACP involvement in the department. This had been particularly positive in the flow in the rapid assessment and triage (RATs) area; in the continuing reduction in waiting times; the increased service cover provided for other ED staff to attend training; and an increase in positive working and collaboration with the ambulance service. Oversight was continually maintained, and all patients discussed with consultants when required. However, with the registration to the Royal College of Emergency Medicine (RCEM) there were scope for ACP competencies to mean that they could provide their own oversight and therefore there was scope to increase flow of patients from triage through to referral or discharge.

All ACPs had 20% non-clinical time for teaching, competency sign off, clinical development and skills. They would also visit other departments, such as intensive care, to could broaden experience and knowledge. There were dedicated social media groups, plus formal bi-monthly meetings, for all ACPs to maintain communication within the team, and the ACP team were
commencing their own audit data on performance. Additionally, data was being collected on collaborative working with the ambulance service. Appraisals were conducted by the lead ACP.

There was a dedicated Practice Development Nurse, who had training oversight to ensure that nursing staff met the national competencies framework. This competencies framework was affiliated to the Royal College of Nursing and covered levels 1 and 2.

There was a clear induction process and a growing skills and devices training programme. The main challenge to this training was identified as releasing staff from shift duties and finding appropriate times for the part time employees. Therefore, this training was now undertaken at different times during the week to be able to offer flexible options for staff. This was anecdotally shown to be improving attendance. All staff confirmed that in addition to the competencies framework training allocation that they had a good allocation of hours for revalidation. To continue the improvements, there were plans to employ a second practice development nurse to provide more training provision. There was a risk assessment in place that ensured there was a mix of staff in attendance at all times that ensured that there were staff on duty that had completed their competency framework.

**Multidisciplinary working**

The multidisciplinary team worked together to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff told us they routinely involved other professionals to support patients with complex needs. We saw evidence of staff considering referrals to the falls service, dietetics, therapy teams and local authority adult social care. The Frailty team were on site to support patients with complex needs. The dementia support workers supported patients while the waited for specialist assessments and referred on to the specialist Older People Mental Health Team if they felt the patient required more specialised assessment and intervention. There was a good working relationship with the other hospital departments.

The urgent care centre (UCC) was currently being taken back under the control of the trust. There was a co-operative working with the ED and patients were referred to the UCC at triage if appropriate.

**Seven-day services**

Both the adult and children’s ED were operational 24 hours a day, seven days a week.

Some staff felt that the pressure in ED was increasing with a lack of local GP coverage and a local difficulty with of out of hours GP services. The urgent care centre was not manned overnight and therefore the ED was seeing a yearly increase in patients for these times during the week. The department had recently been given more finance to provide weekend cover. The consensus with ED management was that this was more economically spent in non-substantive workforce, as the limited finance did not stretch to substantive roles. Substantive roles were, however, the aim going forwards when more finance would be made available.

**Health Promotion**

Patients who used urgent and emergency care services were supported to live healthier lives and manage their own health, care and wellbeing.

There were dedicated noticeboards in the main ED and the paediatric waiting room that gave information on health promotion, such as vaccination and eating well. There were leaflets available and staff stated that they did try and encourage better lifestyle options where
Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The trust had introduced a training programme to support staff with their understanding and use of the Mental Capacity Act 2005. We asked four staff at the inspection to explain the principles of capacity, all were easily able to demonstrate their knowledge. Staff told us that nurses did not complete capacity assessments, only doctors completed them. Staff in the paediatric team understood Gillick Competence. Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

When we carried out this inspection, there were no patients subject to a Deprivation of Liberty Safeguards under the Mental Capacity Act 2005. Staff said they would get advice from their medical staff or the safeguarding lead if they needed information about the Mental Capacity Act 2005.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that as of September 2018 Mental Capacity Act (MCA) training was completed by 95.4% of staff in urgent and emergency care compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 90.8% of staff in within urgent and emergency care compared to the trust target of 90%.

Is the service caring?

Compassionate care

Staff cared for patients with compassion, kindness and respect. Feedback from patients and those close to them was positive about the way staff treated them. Patients felt supported and cared for by staff.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from October 2017 to September 2018. In September-2018 the trust performance was 74.4% compared to England’s performance, which was 86.5%.

A&E Friends and Family Test performance - Walsall Healthcare NHS Trust
All the staff we observed displayed compassion and understanding when discussing patients who had a cognitive impairment. They were respectful and empathic in their attitudes and actions.

We spoke to six patients at the inspection. All patients stated that the staff were kind and caring. One said that ‘nothing was too much trouble’ for the nursing staff, and another felt that it was a very polite and helpful service. All the patients would recommend the unit based on their most recent experience.

At the inspection it was noted that porterage staff went out of their way to help patients with mobility or emotional needs, and generally would spend a proportion of their time talking to patients waiting. Their presence was appreciated by the patients and gave encouragement to people to have conversations while they waited to be seen.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patient’s emotional and social needs were seen as being as important as their physical needs.

The ED department made considerable use of volunteers during Monday to Friday (with at least one volunteer rostered per day). These volunteers provided voluntary care to patients, for example ensuring that they had refreshments and had a dedicated someone to talk to for emotional support.

Staff generally felt that they were emotionally supported by the ED team. For example, there had recently been a traumatic cardiac arrest which some staff had found difficult. There had been formal and informal debriefs in the department and staff affected by the events felt that they were able to discuss the circumstances and any learning. They had also been able to work constructively with simulations and honest discussion of what could be done better if the event happened again.

(Source: NHS England Friends and Family Test)
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Emergency Department Survey 2016

There were 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for nine questions and about the same as other trusts for the remaining 15 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>7.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your</td>
<td>4.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
---|---|---
usual activities, such as when to go back to work or drive a car? | | 
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department? | 4.6 | About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 5.4 | About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 6.4 | Worse than other trusts
Q45. Overall. (please circle a number) | 7.5 | About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient experience and feedback was an area of continued and now embedded behaviour within the unit. Dedicated patient experience staff gave feedback sessions during shifts which were open to all staff. Previous patients were recorded talking about their experience of being in the department and their thoughts on the good and the bad that they found. It was also a usefully employed tool for staff to see how the practice of the ED is felt by the service users, which new members of staff found particularly helpful.

Patient Charter Posters had been used throughout the department to manage patient expectations ad to give more information regarding the ED.

Patient feedback and carer feedback was very good about the ED. The only issue at the time of the inspection was a wait for a mental health bed which was beyond the control of the ED staff. It was due to a regional pressure on beds.

Latest internal figures provided by the department showed that there was now a greater than 80% rating of positive feedback for End of Life Patient experience. There had been a recent introduction of the role of end of life champions which was a role shared by two nurses. They both reported to the palliative care lead. There was a dedicated cubicle for these patients, a clear standard operating policy and a system in place to collaborate with ambulance and community to improve patient experience. The bereavement feedback improvements had encouraged staff to feel positive that this area was now managed better than previously. The ED matron was seen by inspectors discussing the introduction of ‘blossom boxes’ (that could capture personal mementos such as locks of hair) and introducing new volunteers to the department to give further support at the time of bereavement.

There was an active drive, led by the Advanced Clinical Practitioners (ACPs) and some staff from the local NHS ambulance service, to provide feedback to ambulance crews regarding patient outcomes. This was in response to the desire from some ambulance crews to know the outcomes for certain patients that they had brought in.

Is the service responsive?

Service delivery to meet the needs of local people

The trust was undertaking work to develop the local services. They planned and provided services in a way that generally met the needs of local people.
Staff told us they could easily access interpreters if needed, included British Sign Language. They also had access to Makaton and pictorial style communication aids.

Patients with complex physical and mental health needs could be referred to the frailty team. This team liaised with multiple agencies to ensure suitable discharge arrangements were in place. The chaplaincy service was also available to support patients. Some staff told us that response times from the local authority community teams could be improved. However, local authority social care teams and staff to complete Continuing Health Care assessments were based within the hospital which staff said improved multi-agency communication and aided patient discharge.

Staff told us they had access to a drug and alcohol team, based off site. They used these specialist staff to help plan for the additional needs of patients with substance misuse issues. However, staff told us these specialist workers had previously been based within the hospital and having to refer to an outside agency meant they lost valuable time and potential targeted intervention for patients.

Staff told us they would speak with the dementia support service or the psychiatric liaison service if they needed support or guidance to meet a patient's mental health needs. There was a dementia champion nurse based within the emergency department and staff had access to dementia soothing tools such as “twiddle muffs” for patients who might benefit from them. Staff could get speedy access to the Dementia Support Workers when they needed to. These specialist dementia workers could bring tools such as the electronic “My Life” programme and reminiscence aids to engage and occupy patients while they were in the department.

If a patient needed more intensive support and observation to manage individual risks, staff could access one to one mental health nursing support if required. The trust could access the bank staff of the local mental health trust if they chose to. Staff had a ready supply of basic reminiscence aids and soothing objects such as “twiddle muffs” for patients living with dementia to use. Patients were given their twiddle muff to take home with them after their stay in the Emergency Department.

Meeting people's individual needs

The service generally took account of patients’ individual needs. There was ongoing work with the local mental health and psychiatry teams.

Staff had access to a liaison psychiatry team 24/7. The team was known locally as the psychiatric liaison team and employed mental health nurses to carry out assessments of patients using Walsall Manor Hospital inpatient and emergency services. The service was commissioned by the local Clinical Commissioning Group (CCG) and was provided by the local mental health trust. The CCG also commissioned an Older People Mental Health Team directly from Walsall Manor Hospital. This team employed mental health nurses and a psychiatrist. The CCG and local authority also funded and commissioned a Dementia Support Service. This team had four dementia support workers who worked with patients using hospital services who had dementia or a cognitive impairment.

Staff could also access a Child and Adolescent Mental Health Service (CAMHS). This service was available daily, between the hours of 8am and 8pm. In line with guidance form the National Institute for Health and Care Excellence (NICE) CAMHS assessments were carried out when children and young people had been admitted to a ward and not in the Emergency Department. Staff knew how to contact all of these specialist mental health teams. They said the referral process was straightforward and the response time to referrals was very good.

Staff told us the patient record system did not contain a “flag” system to alert staff that a patient
may have additional needs, for example in mental health, substance misuse or learning disability. Staff told us the detailed patient medical records would contain information pertaining to individual patient needs, which would alert them to any additional patient needs they might need to plan for. We looked at two patient records and saw that the initial medical assessment document contained information on past medical history. In each of the records this referenced if the patient had a mental health diagnosis or a learning disability.

There was a clear escalation policy for mental health management and a detailed management flow for all patients under these criteria.

If a patient had been seen by an external specialist mental health team, their mental health assessment and care plan was not held on the trust patient record. It was held on the local mental health trust patient record system. These patient record systems were not linked. However, the patient record system noted if the team were involved with the patient and the team could write in the patient paper notes to inform Walsall Manor clinicians of the outcome of their assessment and advise them of any planned intervention. Internal specialist mental health teams shared one patient record system, which was accessible to all clinicians who needed to see it. There was then joint patient case review system in place to further assess and manage the patient needs.

Patient cubicles did have an informative journey map in them to illustrate the flow for patients through the ED and beyond. However, this had apparently had mixed feedback from patients and staff as the knowledge did not mitigate the delays that were experienced. There were plans to speak to the ambulance service to encourage better management of patient expectations en-route to the hospital.

**Emergency Department Survey 2016**

There were three questions asked in the Emergency Department Survey questions relevant to the responsive domain. The trust scored worse than other trusts for one questions and about the same as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.6</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

Not all patients could access the service promptly when they needed it. Waiting times to be seen for treatment were generally higher (worse) than the England average. More patients waited longer than four hours for a decision to admit, treat or discharge than the England average.
Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for the 12-month period from October 2017 to September 2018.

From October 2017 to September 2018 the trust’s performance was worse against this standard showed and the England average. The trust has shown a general trend of improvement, except for June 2018 when performance worsened. In September 2018 the trust’s median time to treatment was 77 minutes compared to the England average of 61 minutes.

Median time from arrival to treatment from October 2017 to September 2018 at Walsall Healthcare NHS Trust

(\textit{Source: NHS Digital - A&E quality indicators})

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments was that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From November 2017 to October 2018 the trust failed to meet the standard and performed consistently worse than the England average.

From November 2017 to March 2018 the trust’s performance dropped to 77% or below. Performance increased in April and May 2018, and then showed a decline in performance from May to September 2018. For October 2018 the trust performance improved to 87% compared to the England average of 89%. Between December 2018 and March 2019 the trusts’ performance remained steady at between 81% - 84% so targets were not being met.

Four hour target performance - Walsall Healthcare NHS Trust
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From November 2017 to September 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From November 2017 to October 2018 performance against this metric showed trend of improvement except for February, July and September 2018, when performance declined. The latest month of October 2018 the trust performance was better than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Walsall Healthcare NHS Trust

(Source: NHS England - A&E SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

(Source: NHS England - A&E Waiting times)
Over the 12 months from November 2017 to October 2018, no patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in January 2017 (811), December 2017 (730), and March 2018 (708).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>391</td>
<td>0</td>
</tr>
<tr>
<td>December 2017</td>
<td>730</td>
<td>0</td>
</tr>
<tr>
<td>January 2018</td>
<td>811</td>
<td>0</td>
</tr>
<tr>
<td>February 2018</td>
<td>522</td>
<td>0</td>
</tr>
<tr>
<td>March 2018</td>
<td>708</td>
<td>0</td>
</tr>
<tr>
<td>April 2018</td>
<td>334</td>
<td>0</td>
</tr>
<tr>
<td>May 2018</td>
<td>202</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>318</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>488</td>
<td>0</td>
</tr>
<tr>
<td>August 2018</td>
<td>343</td>
<td>0</td>
</tr>
<tr>
<td>September 2018</td>
<td>477</td>
<td>0</td>
</tr>
<tr>
<td>October 2018</td>
<td>217</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From October 2017 to September 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently worse than to the England average.

From October 2017 to September 2018 performance against this metric showed trend of improvement from November 2017 to May 2018. Performance then began to decline until the latest month in September 2018 when the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 5%, compared to the England average which was 1.9%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Walsall Healthcare NHS Trust

(Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From November 2017 to October 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average.

The latest month in September 2018, the trust’s monthly median total time in A&E for all patients was 172 minutes compared to the England average of 154 minutes.

Median total time in A&E per patient - Walsall Healthcare NHS Trust

(Source: NHS Digital - A&E quality indicators)

Patients with urgent mental health needs were seen within one hour of being referred to the liaison psychiatry team and the older adult people mental health team if they were in the Emergency Department and within four hours if they were a patient on one of the wards. Patients referred to the dementia support workers were seen within 10-20 minutes of being referred by staff in the Emergency Department.

The paediatric department was recording year on year increases with attendances. In the year 2018 there was a 1% increase to 15,296 attendances in total. At the time of the inspection it was noted that the paediatric waiting room was full of people waiting to be seen each afternoon by 4pm.

Flow had been improved with the addition of a paediatric doctor shift every week day afternoon from 3pm to midnight. A booklet was being designed by the ED to aid junior doctors in the department to orientate themselves and to give clear guidance on protocols, such as process for a foreign body, or leaving before treatment. There was also clinical oversight and increased autonomy in this department with the availability of a paediatric consultant every day for a few hours. This improved examination, treatment and discharge times.

An internal audit had been undertaken that showed encouraging improvements in adult triage times in the department. In July 2018 patients in ED waited around 30 minutes on average to be seen for the initial triage. By December this had dropped to around 20 minutes as the average time. In this same period improvements were also seen in the number of patients triaged within 15 minutes. In July 2018 around 45% of patients were seen within 15 minutes; in December 2018 around 60% were seen within 15 minutes of attending the ED and being registered. The audit
findings demonstrated the positive effect of adding an extra triage nurse to the evening shift and increasing the training available for triage competencies that the Professional Development Nurse was providing.

In 2018 there had been an introduction of changes to aid flow and access to the ED and other departments. For patients arriving by ambulance there had been the introduction of the Rapid Assessment and Treatment (RATs) area. This also introduced the new dedicated alternative pathways for patients with the aim to provide more appropriate care and improve flow. Other pathways included ambulatory care, frailty assessment and treatment, speciality admission and discharge to a place of safety.

These pathways were constantly monitored and we saw regular audit information on the difference they were making to the flow in the department. For example, the latest audit showed that around 14% were seen and immediately discharged from the department by being able to use this rapid assessment area and 14% were transferred to frailty assessment. The results from an internal report into the use of RATS in September 2018 showed that on average less than 47% of patient arriving by ambulance were streamed into the main Emergency Department to be seen and treated by ED Clinicians and that streaming pathways were effectively used for remaining 53% of patients from point of arrival away from the main ED.

Flow was demonstrably improved by close working with the ambulance service. There was a dedicated hospital ambulance liaison officer - ‘halo’ (part funded by the Walsall trust) who was solely in charge of accommodating swift and appropriate flow of patients brought in by ambulance through the ED department, to triage more effectively and to release ambulance more expediently. A member of ED staff was the designated ambulance triage and this role was made clear with the wearing of an armband over the staff uniform.

The halo officer worked four days at the ED unit and stated that there was considerable pressure to maintain effective triage and to free ambulances from waiting too long to be seen. An example given was on one day the previous week there had been 79 patients listed on the board as being in ED, and there were 12 ambulance crews waiting to handover patients. There were shifts where up to 22 crews had been waiting to handover. There had been an improvement in relationships and understanding between ambulance crews and ED staff, resulting in better flow according to the halo officer. The issues that were highlighted to inspectors during the inspection were of the difficulty of GP involvement generally, and discharge at ward level. Staff, when asked, thought there was a perceived lack of investment in community infrastructure.

For those patients not arriving via ambulance, there was a streaming service in the waiting room to assess if the patient could go straight to the urgent care centre, if it was open. There were clear criteria for suitability for urgent care to reduce risk of patients being undertreated. The urgent care had been up until recently operated by an outside provider. This was due to come back under the trust management at the time of the inspection.

On some days there was the difficulty in maintaining discharge at ward level. Full capacity on wards, with little bed movement, would inevitably lead to a backlog at ED on busy days. Staff acknowledged this as a main issue with improvement to flow, and therefore was part of a longer term managerial focus to work holistically with the entire hospital to fully manage patient journeys though the hospital from ED to ward to discharge. There were also discussions at senior level with the need to work more with social services and focus on community discharge. On one day of the inspection, for example, there were 80 beds forecast for the ED to move patients to at the beginning of the day. By after lunch this was forecast to be only one bed, which was causing issues with movement. The Chief Operating Officer liaised as silver control in the hospital to see if
beds could be freed in the other wards of the hospital. Therefore, there was evidence that the trust was involved and pro-active in aiding the ED to accommodate incoming patients.

Ambulance handover times had improved in 2018, and the trust had been first in the local region of 14 trusts for handover compliance in April and May 2018. Since this time compliance had been in the top four of the 14 local trusts. A target of 55% to be seen within 60 minutes was met, or was almost met, since the introduction of the RATs in July 2018. Before this time the percentage seen in 60 minutes had been around 30-40%. As the RATs progressed and became more embedded, the ED department noticed that there was also an improvement in the average time to be seen from 104 minutes in October 2017 to 80 minutes in October 2018.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, some complaints were not always dealt with in a timely manner.

Summary of complaints

From October 2017 to September 2018 there were 44 complaints about urgent and emergency care services. The trust took an average of 36 working days to investigate and close complaints. The trusts complaints policy states 70% or more completed within 30 working days.

A breakdown of the three highest number of complaints is given below:

- Treatment, care, supervision: 15
- Treatment advice: nine
- Treatment suitability: six

The number of high and moderate severity complaints had reduced since 2016, from 11 in 2016 to none in 2018. However, the low severity complaints had risen from 13 in 2016 to 29 in 2018. The number of successful claims against the ED had reduced from four in 2016 to zero in 2018.

Complaints were dealt with in the department as far as possible. There was also a complaints co-ordinator which was a centralised role. Each complaint was assigned an investigating officer, which was often the ED matron. Verbal complaints were reported as incidents and there were around two per week. Sometimes these complaints involved PALS contact and all received a telephone from the matron to the complainant where possible.

At a divisional safety committee meeting the inspection team saw that staff were discussing the need to further improve the complaints process. There was a detailed discussion as to future improvements in communications with the patient and better investigation processes.

Number of compliments made to the trust

From October 2017 to September 2018 there were 60 compliments in urgent and emergency care.

We saw a patient feedback wall in the department that displayed 11 recent compliments for staff, including one from a relative of a patient who stated that the ED should be proud of itself and the team. Other compliments seen included that the staff were excellent and that they gave the patient dignity and respect throughout.
Is the service well-led?

Leadership

The urgent and emergency care service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care, and there had been some recent appointments. Staff spoke positively about the senior management team and department managers, and felt well supported and there were noticeable recent improvements in staffing, management and morale.

There was a clear hierarchy structure for medical and nursing staff in the department. There was support for each banding in the nurse structure and clear responsibility channels. With the change in senior nurse leadership in the ED, this oversight provided through the nursing structure was now becoming embedded.

Leadership was privy to continued feedback, though initiatives such as the Listening into Action workshops. These were focus groups for all staff and were a forum for management to formulate actions based on concerns, and for all staff to have the opportunity to take ownership of areas of concern.

The trust enforced limits to recruitment and this was a barrier when staff in ED were due to have maternity leave. For example, in 2018 there were ten staff on maternity leave in a relatively small department. There was a leadership led block on booking agency staff for any length of time, or pay an enhanced rate to existing staff to cover vacancies. Staff felt that leadership needed to understand the effect that this would have on staff morale if it was not addressed in a timely fashion.

The new Director of Nursing and the newly appointed Chief Executive were viewed positively by staff. There was the ‘Daily Dose’ newsletter and coffee morning opportunities to discuss any concerns with the Chief Executive. Staff felt that the trust was pro-active in developing ED and were open to change and improvement. There was also a trust initiative led from the top to drive attendance for staff on quality improvement courses and develop new strategies, such as the new nursing strategy.

The vision for Walsall Together was to look to forge community relationships and was encouraged by the leadership as the future for the locality.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action. The vision and strategy were developed with involvement from staff and included a new development place for a new building and facilities.

There was a strategy to use innovation to employ different pathways for care and to reduce the pressure on the ED department. In 2018 a decision had been made to use Advanced Clinical Practitioners (ACPs) to try and mitigate the issues around the expense of recruiting, training and retaining medical staff. ACPs are highly skilled and they were able to reduce the reliance on locum medical staff, enhance patient care and safety (through familiarity of the department and the local policies and procedures), improve key performance indicators and improve referral times and review. This was coupled with an increase in social care response through joint working with the intermediate care services and the rapid response team.
There had been a recent approval for the business case to develop a new ED with a new building and a large financial investment in improvement. The vision was for the ED to be completed in the next two years with a larger floor area for all areas. It was not clear on the final staffing targets, but there was a clear and confident optimism that this would significantly improve the working environment and management of the ED.

There was a plan in place to develop the ED patient records as a single document and a longer-term plan to become technologically enabled with an infrastructure to support a paperless ED.

Clinical streaming was under constant review and discussion, and there was a vision to embed the Urgent Care Centre as a front-line service. This would look to build on the joint working partnerships too across Walsall with the Walsall Together programme that brought multi-disciplinary services such as mental health, social care and GP services together with the ED.

**Culture**

Managers across the service promoted an improving and positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience and worked together to do so. This was led by the clinical management team.

There was a noticeable encouragement to foster a culture of team communication, learning and shared governance responsibility. According to staff, this positive outlook was led by the management in the department, in particular from the clinical director and the matron, with support from the non-clinical manager based permanently in the department and the patient safety manager. New staff grades were being introduced with the introduction of ACPs and Training Nurse Associates that had the aim to relieve pressure on other staff and provide new ways to work.

There was a move to embed and continuously improve professional standards and pathways across specialities to treat the emergency care patients.

The senior nursing staff and clinical leads were encouraging learning and transparency. To this end there were noticeboards throughout the ED displaying, for example, friends and family feedback, end of life feedback and learning points, sepsis management, audits, mental health management and safeguarding incidents and education. Staff appointed as champions were seen to be engaged with the continuous improvement of pathways and audit.

**Governance**

The service now used a systematic approach to continually improve the quality of its services and safeguard high standards of care. This was driven by both the senior management and the governance staff. Staff understood their roles and accountabilities.

There were regular governance meetings in both the trust and the ED department. For example, each day there were departmental huddles daily which covered different topics. Every week there were weekly drop ins, matron and senior sister meetings and operations meetings. Each month there was a care group meeting and a risk register review, and then, quarterly, there were larger care group meetings, risk road shows, and champions meetings. Champions in each department were leads for their speciality – for example infection control or dementia. These champion roles also took ownership of relevant incidents to ensure a closed loop on actions and learning.

There were monthly meetings for Paediatric Working Group Committee with a formal agenda, detailed minutes and realistic action points that a member of staff would take ownership of and manage going forwards. Further specialist monthly meetings covered safety, audits, staffing, triage standards, incidents, safeguarding and the flow/access to the department for that area. All
meetings had a sign in sheet to assess attendance. There were intradepartmental meetings (weekly huddles) to increase communications trust wide. There were also monthly meetings for mortality surveillance, where the whole trust was represented, including the ED. These formal meetings reflected on performance, data presentations, learning and recommendations.

Staff were not able to identify who within the trust leadership held the lead for mental health. However, they had strong links with senior nurses within the department and the wider trust who led on mental health, dementia and safeguarding. There was also an accessible and recently reviewed policy on emergency care and escalation for mental health referral delays. This had clear protocol conditions and a comprehensive list of contacts for all times of day.

There was a monthly newsletter for the ED that gave a comprehensive picture of governance, management, areas of risk, good news, training and events for staff.

Management of risk, issues and performance

The service had effective systems for identifying risks, and managing them appropriately.

There was a centralised risk register that could be accessed by all staff and enabled risks to be tracked, managed and reviewed with clear timelines.

The risk register was segregated into four tiers – departmental, care group, divisional and then corporate levels. All staff stated that departmental risk was significantly improved with the new IT based system and the four-tier approach. There was oversight at each level and a clear escalation process of movement of risk upwards until the corporate risk level was reached.

The risk register was set up so that ED department risks could be easily identified and actioned. Staff could state how to access the risk register. Generally, staff stated that the risk register was becoming embedded and was working well. Staff further stated that it was improving management of risk, identifying areas of improvement, and enabling more effective decision making. The patient safety manager had a continuous oversight of the risk register and would work with the ED management to ensure that risks were being managed appropriately. Furthermore, there was a team of staff that incorporated a trust wide risk team, and which had oversight of all the risks always. The Health and Safety teams, facilities team and the Corporate Risk Team all produced reports that were collated and overseen by the Patient Safety Committee. Patient Care Improvement Plans (PCIPs) were generated from risk and followed the four-tier risk system of department, care group, division and corporate level. Examples of where the PCIPs had resulted in actions included the establishment of the Listening into Actions forums for all staff and the introduction of the champions system within the department.

There had been improvements in clinical management flow charts, such as a process in place to manage the paediatric patients. There was a demonstrable focus on the identification of risk areas and where these could be improved in the short term, and the longer term (with the scheduled building of a new ED department). In tandem with this, the ED had improved standards in the department since the last inspection, with new escalation standard operating procedures in place and improvements in triage management for paediatrics, resulting in more paediatrics triaged within 15 minutes than two years previously (90% in October 2018 compared to 80% in October 2016).

The department realised that it was a challenge to achieve target times for triage, times to be seen and discharge within four-hour targets. The ED was often at, or near, capacity and sometimes there was overcrowding. The management of this was clear at the inspection as there had been a noticeable improvement in staff feedback and suggestions and a focus on small changes to make
larger differences. For example, the work with the ambulance service to improve handovers and patient pathways. The issues of continuing to recruit and retain staff and maintain improvements in patient flow were mentioned by most staff, as was the immediate issues with space. Innovative solutions by continued discussions with management, clinical management and trust engagement were clearly encouraged within ED.

When staff were asked what they considered the biggest threats to the department going forwards, the main threat that staff felt was finances. A new development programme incorporating a new building had been signed off. However, the staff all stated that investment needed to continue into staffing, equipment and training to reduce the risk to patients and maintain improvements in performance. Other threats raised to inspectors included the levels of staffing (particularly at night and in the paediatric department, although there were acknowledged improvements and plans to continue to recruit when finances were finalised); the problems in the level of the infection control and cleanliness being maintained with an aging infrastructure; a need for more collection of feedback; and a drive to continue to improve incident reporting and management. The large amount of breaches and the difficulties in improving flow through the department were a risk to performance, but the recent introduction of the Advanced Care Practitioners, together with a focus on improving pathways from the ED, and with the community, were starting to embed. Staff were generally optimistic that breach levels would start to improve.

**Information management**

The service had recently invested in this area with regard to incident reporting. There had been the introduction of an intranet based incident reporting system in the last 18 months. This had improved the system that had been paper based only before, and enabled a current picture to be seen at all times. The department was to commence a trial during February 2019 for paperless patient records using hand held mobile devices.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.

The department was engaged with other stakeholders, and sought out feedback from patients, other hospital departments, and staff. There had been specific engagement workshops with the staff teams and dedicated staff champion roles had been given for various specialities within the department to educate the rest of the team and to be a focal point for learning and oversight. There had been a large effort from the patient safety team to engage with service users and other stakeholders to improve communications and engagement.

The main thrust to improving flow and capacity was to engage more with GP services, community services, social services and the other hospital departments. There were acknowledged challenges for all these. For example, end of life care required closer working with GPs, but there was a local challenge to primary care staffing for services which stretched resources for both hospital and GPs. The initiative ‘Walsall Together’ went some way to address communication across primary healthcare through to tertiary care and was an initiative that the trust ED were enthusiastic to participate in for the future.

**Learning, continuous improvement and innovation**
The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There had been a recent award for innovation.

The ED had established Patient Care Improvement Plans (PCIPs) – improvements recognised from reports, incidents, audits and patient feedback for example. There had been 27 improvement plans documented since 2017, which were discussed by clinical teams in order to develop action plans. These were discussed at safety huddles and at the monthly Care Group Quality Team meetings. At the time of the inspection, six of the improvement plans were ‘green’, denoting that they were consistently compliant. The others were amber to show that they were now partially compliant. There was one plan that was red – that of sickness levels of staff. Therefore, the approach to dealing with this was a high priority. All the improvement plans were available on the risk register for all staff to access as part of the learning and continuous improvement strategy.

Senior ED departmental management flagged to inspectors the need to continuously improve the pathways. They highlighted the requirements to revise the GP and referral pathways so that the ED had more ownership of patient flow. The inference was that the ambulatory and MAU departments were pro-active with their patient intake from ED, but that other routes needed improvement and further staff innovation to achieve similar progressive results. The aim was to continue the trust wide holistic view of capacity and focus on discharge from other wards to improve total flow through the hospital. At the time of the inspection there was a particularly busy shift where discharge levels from wards were very low, causing a backlog to occur at the ED level. Eventually a full capacity protocol was initiated which mobilised trust level managerial staff to work with ward staff to increase discharge and improve flow. Senior staff talked about increasing the ‘push’ of patients to other pathways and departments, and not to rely solely on the ‘pull’ that some departments were undertaking. The effective pull teams that were noticed to aid flow were the frailty unit, the ambulatory care and the urgent care facility.

Innovations were being constantly sought by senior management and leadership to solve the issue of timely discharge in the ED. One recent innovation was the radiographer led discharge programme where radiographers had been upskilled to give them the ability to discharge patients without having to return to the ED for discharge. There was no actual data on this, but there was an assumption that this would reduce the length of stay for patients in the ED and would improve the patient experience.

The Patient Safety team had worked hard to reduce admissions for frequent attenders. This had resulted in the innovative scheme – The High Flyers Initiative. This programme worked intensely with select service users to understand their actual needs, and work with other agencies to find a solution and to prevent them from attending ED with more social needs. This resulted in solutions such as provision of therapy courses, help with housing, bereavement counselling and family support. It had also contributed to cost savings for the trust in 2017 of around £74,000 in A&E attendances and £174,000 in inpatient bed days. This scheme had received awards and the team were being asked to present to other trusts to see if it could be rolled out to other areas.

**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care service at Manor Hospital provides care and treatment for:

- General Medicine
- Acute older adult
• Cardiology
• Frail Elderly Service (Medicine)
• Diabetes, renal and haematology
• Gastroenterology
• Respiratory Medicine

Short stay acute care adults. There are 190 medical inpatient beds located across ten wards:

• Ward 1
• Ward 2
• Ward 3
• Ward 7
• Ward 10
• Ward 14
• Ward 15
• Ward 16
• Ward 17
• Ward 29

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 31,532 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 19,392 (61.5%), 142 (0.5%) were elective, and the remaining 11,998 (38.1%) were day case.

Admissions for the top three medical specialties were:

• General medicine: 19,305
• Gastroenterology: 4,585
• Cardiology: 1,800

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training
Mandatory training completion rates

The service provided mandatory training in key skills to all staff but not everyone eligible completed it.

Manor Hospital

Not all nursing staff received and were up to date with their mandatory training for clinical updated, conflict resolution, patient handling, information governance, adult basic life support or fire safety.

The 90% target was met for four of the ten mandatory training modules for which qualified nursing staff were eligible on the medical wards. The three lowest modular completion rates were for fire safety, adult basic life support and information governance.

A breakdown of compliance for mandatory training courses as of September 2018 for qualified nursing staff in medicine at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>210</td>
<td>211</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>208</td>
<td>211</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>202</td>
<td>211</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>190</td>
<td>211</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>181</td>
<td>211</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>178</td>
<td>211</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>174</td>
<td>211</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>162</td>
<td>211</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>160</td>
<td>211</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>153</td>
<td>211</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital the 90% target was met for only one of the ten mandatory training modules for which medical staff were eligible.

Not all medical staff received and were up to date with their mandatory training for falls awareness, conflict resolution, load handling, adult basic life support, fire safety, clinical update, equality and diversity, patient handling, and information governance.
A breakdown of compliance for mandatory training courses as of September 2018 for medical staff in medicine at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>14</td>
<td>17</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>13</td>
<td>17</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Load Handling</td>
<td>13</td>
<td>17</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>11</td>
<td>17</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>11</td>
<td>17</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>6</td>
<td>17</td>
<td>35%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Training was available as online or face to face modules. Medical and nursing staff within the medical wards had access a personal electronic training record which served to identify their statutory and mandatory training required for their role and which triggered expiry dates for specific training. This system provided sufficient time for training to be completed within the normal working day. Some staff found it difficult to undertake mandatory training within their working day and some completed the training in their own time and on most occasions, were given the time back. A number of staff were reluctant to using the electronic staff record but staff who were non-compliant in completing their mandatory training within the allocated time period were followed up by their managers who monitored mandatory training to ensure completion. Managers met regularly with staff to make sure they booked time for training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**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.

**Safeguarding training completion rates**

The trust set a target of 85-95% for completion of safeguarding training and this was achieved or nearly achieved for all safeguarding modules.

**Manor Hospital**

A breakdown of compliance for safeguarding training courses from as of September 2018 for qualified nursing staff in medicine at Manor Hospital is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>164</td>
<td>168</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>15</td>
<td>16</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>39</td>
<td>43</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>37</td>
<td>43</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>141</td>
<td>168</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>163</td>
<td>195</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital the 85% and 90% targets were fully met in January 2019 for four of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from as of September 2018 for medical staff in medicine at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>8</td>
<td>14</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>4</td>
<td>11</td>
<td>36%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital the 85% and 90% targets were met in September 2018 for four of the six safeguarding training modules for which medical staff were eligible. Data given during the inspection for January 2019 showed that safeguarding adult training at level 3 had fallen to 84.1%, level 2 to 81.03% and level 1 to 97.40%

(Source: Routine Provider Information Request (RPIR) – Training tab)

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 suspected abuse and they knew how to apply it.

Staff were aware of the different types of abuse, how to identify them and knew how to escalate concerns. Staff could give examples of situations whereby they had raised safeguarding concerns and reported them through the trust’s procedures. Staff told us that they had access to the safeguarding site on the trust intranet. Staff were able to recognise the signs of abuse and were aware of the different forms of abuse including female genital mutilation and the abuse of older adults. Staff were confident in being able to access support from the safeguarding team. The safeguarding team used a range of systems to ensure that staff but especially nurses were updated with safeguarding mandatory training including printing off e-learning material and undertaking one to one face to face tuition. The team assisted with safeguarding referrals by helping with the paperwork for the local authority and by speaking to patients about the concerns where appropriate. Staff were aware of who the safeguarding nurses were and how to refer
concerns to them. Staff told us that they were responsive to referrals and could often be seen on wards following up on patients where safeguarding concerns had been raised.

Staff told us that they had received PREVENT awareness training during corporate induction sessions. PREVENT is one of the components of the government’s anti-terrorism strategy. It addresses the need for staff to raise concerns about individuals being drawn towards radicalisation. PREVENT training formed part of the wider safeguarding agenda and encouraged staff to view a patient’s vulnerability as they would any other safeguarding issue.

**Cleanliness, infection control and hygiene**

*The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.*

The hospital wards we visited were visibly clean, generally tidy and free of clutter. We visited all 12 inpatient medical wards and we undertook an inspection of the key areas of the individual wards including the dirty utility rooms and treatment rooms. Patients told us doctors and nurses frequently washed their hands and that the ward domestic staff were diligent in their approach to overall ward cleanliness. All patients thought the wards to be visibly clean and tidy. Two of the ward domestic staff showed us the comprehensive cleaning checklists they followed daily.

Ward bed curtains were changed if required as necessary and in line with the trusts policy, although this was not dated so it could not be assured that the frequency of change was monitored.

There was a plentiful supply of hand sanitiser gel dispensers at the entrances to each clinical area and within the wards at the entrances to bays and cubicles and there was sufficient hand washing sinks in each of the wards. There were prominent posters in each clinical area encouraging patients and visitors to wash or gel their hands before entering or leaving the wards. Doctors conducting their ward rounds maintained good hand hygiene practice when they attended to patients.

The medical wards undertook a range of cleaning audits including hand hygiene audits where results showed consistently near 100% compliance.

The service had systems for the management and disposal of waste and all staff followed the processes for segregating infected materials using national colour-coded bags.

All medical wards had side rooms which staff could use for isolating patients with infectious conditions or where patients needed protection from potential infections. Patients who had or were at risk from infections were segregated in single cubicles or cohorted in discrete closed bays. Staff had placed barrier nursing warning signs on isolation cubicles to alert staff of a patient infection or infection risk. Signage was in place to alert staff and visitors of the risk of infection.

The wards ensured when they attended to patients that equipment was visibly clean. Staff used dated green ‘I am clean’ stickers to indicate that effective hygiene procedures for commodes, infusion stands and other equipment had been undertaken and to show when equipment had been cleaned and disinfected.

The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded
waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow. On site waste management was handled appropriately with separate colour coded bins for general, clinical and sharp waste. Staff in all medical areas were seen to dispose of clinical and domestic waste correctly. Sharps boxes in all wards were checked and were dated and used correctly.

The trust’s infection prevention and control team conducted regular quality walks on the medical wards for infection control. Ward staff told us regular visits by the infection control team had made them more aware of all aspects of infection control and any issues were discussed at the safety huddles.

The medical wards had appointed individual members of staff to act as IPC link nurses who participated in the trust wide IPC team activities. These nurses attended quarterly IPC meetings and fed back updates to ward staff where any actions were discussed within the patient safety huddles. In date infection control policies including a policy for the management of infection outbreaks were freely available via the trust intranet.

Trust wide sepsis bundles had been introduced and all staff had been trained in their use.

**Environment and Equipment**

The service maintained equipment in a timely way in order to keep it was safe to use. The service had suitable premises and equipment and looked after them well.

The medical wards were able to access medical equipment which had been appropriately tested and maintained.

Resuscitation equipment, including emergency medicines, was available on all wards. Resuscitation trolleys in each ward area were regularly checked and items within them were in date and ready for use. The trolleys were tagged and tamperproof and staff completed and recorded daily checks on all the medical wards which were fully completed.

Staff on the wards staff could obtain equipment such as intravenous (IV) infusion pumps from the equipment store. Equipment had been tested for electrical safety and that stickers were applied to show this.

There were deficiencies in the provision of suction equipment on ward 1 to one bed space which posed a risk of delay in treating patients in an emergency, this was escalated to the matron. This risk featured on the service’s risk register and plans were in place to address this issue with ongoing work streams and a review date of September 2019. However, portable suction apparatus had been made available.

The wards throughout the medical division were secure against intruders. The ward doors had buzzer access which were rigorously monitored. All fire doors on all wards were appropriately closed for fire risk and also to minimise abscondment by individual patients.

**Assessing and responding to patient risk**

We were assured that risks to patients were always managed positively within the service. Staff used systems to identify deteriorating patients, and there was consistency in sepsis
management, good awareness around dietary risks and the use of red tray systems for vulnerable patients.

Staff completed and updated risk assessments for each patient and they kept clear records and asked for support when necessary.

In late 2018 the division had undertaken a thematic review of the management of deteriorating patients and as a result had implemented a range of improvement strategies. This had included additional ward based training and the introduction of NEWS 2 in January 2019. Staff within the service had undertaken additional training and had utilised new skin care bundles to reduce the incident of pressure area ulcers across all medical wards. Staff were aware of how equipment could be utilised to safeguard patients from falls and pressure ulcers and had timely access to pressure relieving mattresses and high-low beds to assist patients at risk.

Sepsis management in the service was effective and the sepsis policy included the introduction of an electronic sepsis screening and sepsis six bundle based around the National Institute for Health and Care Excellence guidelines (NICE), and sepsis trust guidance. Electronic screening for patient deterioration was facilitated through the use of an electronic monitoring device, a hand held devices for assessing vital signs of patients. This captured patient physiological data and allowed staff to rapidly identify and subsequently respond to the signs of patient deterioration. The data from the devices was streamed to tablets kept within the medical offices and ward desk areas to allow prompt responses by doctors. Additionally, the medical wards such as ward 15 (endocrine) had introduced a deteriorating patient note stamp to put in notes to ensure that changes in vital signs were escalated. We saw that the deteriorating patient pathway stamp had enhanced the more rapid medical response to the monitoring device and tablet recordings of deteriorating patients’ observations.

NEWS2, the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, was being rolled out across the medical wards throughout January 2019. NEWS2 is a system to standardise the assessment and response to acute illness. An electronic monitoring device was used across the division to record the six physiological parameters which form the basis of the NEWS2 scoring system. Staff on the wards which had rolled out the new process for detecting patient deterioration were fully aware of how to use both the electronic monitoring device and NEWS2 and the sepsis six bundle to monitor patients for signs of deterioration. We saw that the doctors were fully confident in using the tablets to review the electronic monitoring data on patients’ physiological status. Staff who had completed the NEW2 training told us that were more confident in managing patient deterioration.

The service used the Situation, Background, Assessment, Recommendation (SBAR) communication tool in order to handover patients from other wards or departments.

Clinical staff carried out comprehensive risk assessments for outlier patients that were cared for on other wards which were not part of the division of medicine. Improvement in spotting the deteriorating patient were a result a divisional thematic review of the management of deteriorating patients, conducted in recognition that some staff members had been failing to adequately recognise the signs of deterioration in certain patients with a failure to escalate.
The Doctor Foster Unit based at Imperial College London works with a wide variety of centres, departments and organisations both internal and external to the College on patient safety and improving the quality of care within the NHS through the use of routinely collected medical data. Since a Doctor Foster outlier alert to the trust for deaths attributed to fluid and electrolyte imbalance in 2018 the trust had undertaken a review of mortality outliers for this group of deceased patients. A mortality outlier is where more than an expected numbers of deaths occur for a particular condition. Patients who died in the trust between December 2017 and January 2018 with a primary diagnosis of fluid and electrolyte imbalance were reviewed and a number of lessons had been learned and cascaded including the need to improve clinical documentation.

The corporate nursing department and the patient safety group incorporated learning from assessments of incidents reported via the electronic incident reporting system into the monthly “Lessons Learned” Bulletin. This had resulted in an increased awareness among ward staff of the importance of recognising deteriorating patients.

The service had previously reported a high instance of patient falls and we saw that a major initiative to resolve this had been taken with ward-based fall training being implemented to address poor documentation and the completion of falls assessments across the division. Additional action had been taken by the division to ensure that care plans included steps to ensure that neurological observations and the recording of lying and standing blood pressure recordings were recorded. Dashboard data within each ward demonstrated that patient falls had declined since the introduction of the additional training over the latter part of 2018.

The service had measures in place to reduce the risk of patient falls including completing falls assessments for patients at risk, and in providing non-slip socks to identified at risk patients.

Clinical staff working with patients who were susceptible to falls had implemented a “bay safe” initiative where multiple patients at risk of falls were cared for together in a bay. Such bays were allocated additional member of staff to supervise patients to prevent them from falling.

The ward-based falls training was comprehensive and had been delivered by the practice development nurse and through the corporate nursing department. A widely based divisional falls campaign initiative had been undertaken throughout November 2018 with the focus being delivered through the introduction of daily safety huddles. The safety huddles were conducted around recently introduced patient safety magnetic boards which gave clear indications of the current state of patient safety including those patients at risk from falls and we saw that patient falls had declined. The application of falls assessment and the introduction of the safety huddles was responsible for the reduction in patient falls.

Senior nurses and matrons had undertaken daily reviews of falls documentation and timely assessments and the number of falls reported.

The staff on the medical wards were supported by the critical care outreach team who attended promptly by bleep when concerns about individual patients were escalated. For example, the outreach team would support nurses in care delivery for patients receiving non-invasive ventilation (NIV, or mask ventilation) or tracheostomy care. We saw on wards where patients were receiving NIV that appropriate skill mix of nurses with appropriate training were allocated on a daily basis.
Nurse staffing

The service did not have sufficient numbers of suitably qualified permanent nursing staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse at all times.

Although most medical wards but not all the acute medical unit used an acuity tool and safe staffing risk assessment templates to assess safe staffing, staff numbers were lower than recommended in national guidance. the trust told us after our inspection: Nurse to patient ratio and all staff to patient ratio is detailed daily on the nursing staff risk assessment. The nursing establishment review had included acuity and safer nursing care tool (SNCT) methodology.

The majority of staff we spoke with felt there were not enough staff to fully meet patient needs.

To address the issue of staff shortages the trust had undertaken a nursing staffing review in the Autumn of 2018 and the Trust Board had signed off the fill rate of 95%. This had led to some positive staff changes. For example, on the acute medical unit prior to the review, shifts consisted of seven registered nurses and seven care support workers and after the review this was amended to eight registered nurses and six care support workers.

However, the review had stipulated that clinical areas could only fill to 95% of the new staffing numbers. This had resulted in the loss of 21 registered nurse shifts and 14 care support worker shifts per week. This led to the senior nurses on the acute medical unit reporting 74 incident reports within three months pertinent to staff shortages. This was exacerbated when fulltime experienced acute medical unit staff were sent to other wards to provide cover leaving the skill mix predominantly made up of bank or agency nurses, and where in turn the acute medical unit was allocated a substitute bank nurse.

The Acute medical unit nursing staff rosters for the third of December 2018 through to the third of February 2019 showed that staff sickness was impacting on safe staffing ratios. For example, on the 31 January 2019 there was a shortfall of two registered nurses for the day shift and two health care support workers for the late shift. The roster also showed for example a shortfall of three registered nurses and one health care support worker on the first of February 2019. One of the matrons had implemented a safe staffing risk assessment template to monitor daily staffing across the medical wards. This template recorded actual staffing levels versus planned staffing levels. The safe staffing risk assessment template recordings for the fourth of February 2019 showed discrepancies in actual staffing on six of the medical wards including the acute medical unit. Information forwarded to us by the trust after our inspection identified that all staffing shortfalls were risk assessed and an operational plan was put in place to mitigate the risk.

On ward 4 the stroke unit, the off-duty rota showed that the staffing plan versus the actual staffing level was short by one registered nurse and one care support worker on the day shift of sixth of February 2019. The stroke unit ward 4 had regular staffing discrepancies with a 25% discrepancy for registered nurses and health care assistants on the sixth of February 2019. On the fifth of February 2019 there was a shortfall of two health care support workers for the early shift and three for the late shift. On the fourth of February the ward was short of two health care support workers for the early shift. The medical division was not always able to meet the Royal College of Nursing’s Guidance on Safe Nurse Staffing Levels in the UK which sets out the range of different factors that influence the total demand for staff and highlights the variety of methods for planning
or reviewing staffing levels’.

Senior medical staff expressed concerns and worries about nurse staffing with one stating that “nurses were stretched to the limit”. Most patients we spoke apart from one told us that staff were busy but that there were enough staff on duty to care for them. Measures taken to use staff on a short term basis to deliver care also meant that staff were not familiar with patients care needs or preferences.

The trust reported the following qualified nursing staff numbers as of March 2018 and September 2018 for medicine.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th></th>
<th>September 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual WTE</td>
</tr>
<tr>
<td>Manor Hospital</td>
<td>211.9</td>
<td>240.9</td>
<td>87.9%</td>
<td>210.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a nursing vacancy rate of 47.4 (13%) within the medical division although 26.76 were in the recruitment process.

We attended the weekly divisional safety huddle meeting, which was the name given to the mortality and morbidity meeting between the consultants and matrons of the division. This was the forum for discussing mortality and morbidity related to reported serious incidents throughout the division. Two serious incidents were related to staffing concerns pertinent to ward 29. The nurses who had filed the incident reports were not only concerned about patient safety but also about staff morale which was being adversely affected by staff shortages.

Despite this the implementation of the winter pressure plan by the divisional director of operations had taken into account the staffing requirements to ensure safe delivery of care throughout the season.

The matrons were using a safe staffing risk assessment tool to make cross divisional assessments of staffing which allowed them to move staff from areas of low acuity to areas of high acuity. We were shown an example of this dated the 4 February 2019. However, staff told us that they were often moved to other wards to ensure safe staffing levels were met across the medical wards of the division.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018, the trust reported a nursing staff turnover rate of 12.9% in medicine. This was higher than the trust target of 10%.

Ward managers were especially concerned about skill mix and staffing levels at night and the matrons were planning to introduce a twilight shift system to alleviate some of the night shift pressures.
The divisional director of nursing told us that the trust was placing an emphasis on nursing associate training, apprenticeships and pharmacy technicians to alleviate some of the skill mix concerns. We spoke with one of the apprentices who was planning to undertake further training to complete the nursing associate course.

We saw that the trust had developed an online video for prospective applicants to the nursing associate course which was being jointly run by the trust and the University of Wolverhampton.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From October 2017 to September 2018, the trust reported a sickness rate of 5.5% in medicine. This was higher than the trust target of 3.39%.

Staff told us that the staffing problem was being exacerbated by an increase in seasonal illness among staff, although the flu immunization rate was high. The matrons had implemented systems where they personally managed and monitored individual staff members who were off sick. However, staff we spoke with throughout the wards of the division told us that that low staffing levels was the cause of lowered overall morale and an increase in stress related sickness.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From October 2017 to September 2018, the trust reported a bank usage of 16.0%, an agency usage rate of 10.5%, and an unfilled rate of 4.1% in medicine for all nursing staff.

There was a reliance on bank and agency use within the medical wards and to help alleviate some of the nurse staffing issues the matrons attended meetings with the nurse banks managers twice daily to provide a weekly forward look at staffing requirements for the medical wards.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Shifts</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td>Qualified Nurse</td>
<td>30,149</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-qualified Nurse</td>
<td>61,732</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service had shortages in the acute medical workforce, but locum arrangements ensured that the service remained safe.

The emergency assessment unit had eight consultant posts, 50% of these were filled with NHS locum consultants. The gastroenterology unit had a shortfall of two consultant posts both filled by
agency locums. One of the four consultant posts on the respiratory unit was filled with an agency locum and one of the five consultant posts on the elderly care ward was filled with an NHS vacancy. Additionally, one of the five consultant post within the cariology ward was filled by a locum and one of the two consultant post on the neurology ward was filled by an agency locum.

Consultant cover was available every day seven days per week from 8am through till 5pm. Thereafter a consultant was available from 5pm until 9.30pm when a consultant grade resident medical officer (RMO) provided medical cover throughout the night with access to an on-call consultant. Other doctors we spoke with told us that all patients were reviewed by a consultant twice in every 24 hours.

Medical outliers that were cared for on the surgical unit were seen daily by the medical consultants responsible for their care delivery.

Arrangements for locum doctors to keep patients safe were in place and one locum consultant we spoke with told us that they had been given access to all systems necessary on the day that they started and were supported by the other consultants to ensure that they were competent to perform their role.

The Manor Hospital has reported their staffing numbers below as of March 2018 and September 2018 for medicine.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th></th>
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</tr>
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<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Manor Hospital</td>
<td>82.5</td>
<td>95.0</td>
<td>86.8%</td>
<td>86.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From October 2017 to September 2018, the trust reported a vacancy rate of 9.7% in medicine.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From October 2017 to September 2018, the trust reported a turnover rate of 10.7% in medicine. This was similar to the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From October 2017 to September 2018, the trust reported a sickness rate of 2.2% in medicine. This was lower than the trust target of 3.39%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Locum and agency staff usage

From September 2017 to August 2018, the trust reported a locum usage rate of 45.4%, agency usage rate of 14.3% in medicine and an unfilled rate of 26.3%.

The service relied on locum consultants to provide medical cover on the wards of the service. Medical staff told us there were sometimes gaps in the registrar on call rota but that consultants within the service would often step-down and fill the gaps to ensure that cover was provided. The service had eight dedicated consultants for acute medicine and the lead consultant told us that the 14-hour standard set by the Royal College of Medicine for seeing patients after admission was met.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

All grades of doctors we spoke with told us skill mix within the medical wards was satisfactory and met college standards. However, we were told by the Acute Surgical Unit (wards 11&12) ward manager (band 7) that there were no ward rounds for medical patients (outliers) during the weekends. There were 11 medical patients on the ward at the time of our inspection. Similarly, senior nurses on ward 4 (the stroke unit) told us that it was difficult to get doctors to review the medical outliers on their ward and that their own stroke doctors undertook this activity.

Staffing skill mix for the 116 whole time equivalent staff working in medicine at Walsall Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>19%</td>
<td>27%</td>
</tr>
<tr>
<td>Junior*</td>
<td>36%</td>
<td>25%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (July 2018)
Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care and managed in a way that kept patients safe.

Records were stored in locked trolleys and patient confidentiality was paramount in all clinical areas.

We reviewed six sets of patient records, some were fully completed but some were only partially Completed. All were dated and signed with the name and grade of the doctor or nurse clearly legible.

We saw that the Nursing assessments had been completed on all but one of the records and all patients had a falls risk assessment undertaken. All but one patient had been subject to a nutritional assessment and mental health needs had been assessed where appropriate.

We saw there was one discrepancy with an oxygen prescription which had been prescribed on the patient care plan page but had not been subsequently prescribed on the drug chart. All patients had a care plan and all consent forms or DNACPR (do not attempt cardiac pulmonary resuscitation) forms had been appropriately completed where applicable.

The records included details of a patient’s admission, risk assessments and treatment plans. Nurses and allied health professionals contributed to information in patients’ medical records and medical staff completed a review of the patient at least daily. There was a record of discussions held with the patient and/or their close relatives. The records also identified the input from the multi-disciplinary team such as therapists and dietitians. Individual risk assessment documentation for example, for falls, bed rails, malnutrition scoring and pressure ulcer assessments were completed appropriately. The records showed that care was individualised for each patient’s needs. We saw that patients had skin viability assessments completed on admission and that patients with a pressure ulcer had pressure care plans in place which included positioning regimes and additional equipment support. The notes inspection showed that antibiotic reviews for all applicable patients had been implemented and that all early warning scores had been recorded and escalated as required.

We saw that all computer screens throughout the wards were locked and password protected to maintain patient confidentiality.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Controlled drugs (CDs) were stored and accessed appropriately and checked daily in line with trust policy. Controlled drugs are medicines controlled under the Misuse of Drugs Act 1971 (and subsequent amendments). Examples include: morphine, and methadone. Regulations state that controlled drugs should be secured in a lockable wall mounted cupboard with only authorised staff having access to keys.
Medicines were stored securely with access restricted to authorised staff. The management of controlled drugs on the wards met required standards and daily checks were always completed. There had been significant improvements in overall medicine storage. The previous CQC inspection had found deficiencies in both medicine storage and medicine organisation within the drug trolleys. Each ward had drug trolleys with laminated posters attached to the front of the trolleys reminding staff of their obligations to maintain safe drug storage. Senior nurses on the wards we visited told us that compliance to this directive had been high and was reinforced at the daily safety huddles. We checked the trolleys on the wards we visited and saw that the drugs were tidily stored and that the drugs were clearly labelled and in date. Medicine trolleys were secured to the wall when not in use and the medicine rooms were locked and had keypad entry.

External and internal medicines were stored separately, and intravenous fluids were stored in locked cupboards although ward 1 and the acute medical unit had left these doors unlocked on the day of the inspection despite having clear notices on the doors stating that they were to be locked at all times. When staff were alerted to this the cupboards were immediately locked.

However, all staff we spoke with had a good understanding about security and the trust medicines policy. Medical gasses were stored securely in line with national guidance.

The clinical pharmacist we spoke with on ward 1 and 2 had no concerns about medicine administration, storage or omissions on the ward. The remit of the clinical pharmacist included on call duties where for example, urgently needed supplies of medication at night were provided or in responding to calls when the pharmacy was closed. The pharmacy team also provided an out of hours service and shared an on-call rota. The pharmacists undertook daily ward rounds and checked all new patient prescriptions and evaluating the medication of patients prior to their admission to hospital. The pharmacists undertook regular audits to check that medicines were securely locked.

The process for monitoring medicines requiring refrigeration was adhered to and drug fridge temperatures were monitored daily.

A review of four sets of notes showed that the medicine charts were correctly completed and up to date. For example, any known allergies to medicines were recorded to prevent the potential of a medicine being given in error and causing harm.

Staff were aware of the process for identifying and reporting medicine errors via the online reporting system.

Antibiotics were prescribed with stop dates supporting good antimicrobial stewardship, patient allergies were identified, and wristbands were in place. Patient’s weight and any allergies were recorded. We saw that the discharge coordinator on ward 1 considered the antibiotic status of those patients who were medically fit for discharge and these were highlighted on the ward dashboard.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event. From October 2017 to September 2018, the trust reported no incidents classified as never events for medicine.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 67 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2017 to September 2018.

![Diagram showing breakdown of serious incidents](chart.png)

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with 39 (58.2% of total incidents).
- Slips/trips/falls meeting SI criteria with 12 (17.9% of total incidents).
- HCAI/Infection control incident meeting SI criteria with nine (24.3% of total incidents).
- Treatment delay meeting SI criteria with three (4.5% of total incidents).
- All other categories with four (6.0% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*

The trust used an electronic incident reporting system and staff we spoke with knew how to report incidents and were encouraged to do so whenever they had concerns, including staffing issues.

Incidents were investigated by senior nurses and staff we spoke with told us that they received prompt feedback from incidents they reported via the online electronic incident reporting system.
Learning from clinical incidents was shared in a variety of ways but for nursing staff usually through the safety huddles which were held twice daily, and at team briefs that occurred in the morning of every shift. We attended two safety huddle meetings where all incidents including falls and pressure sores were fully discussed.

The acute medical unit held lunchtime meetings every Tuesday where incidents and learning from incidents were discussed.

The trust held full trust mortality meetings each week which were recorded in minutes and the medical division held weekly safety huddles attended by consultants and the matrons where minutes from the meetings were cascaded to the monthly held divisional quality team meetings. Additionally, the division held monthly care group meetings and as part of the division’s governance structure monthly risk register meetings were held.

Matrons led quality audits of the ward safety huddle dashboards, these were conducted monthly where 10 patient cases were reviewed per audit.

We attended the weekly divisional safety huddle meeting (mortality and morbidity meeting) on the 5 February 2019 where substantive discussion took place about all of the serious incidents on the meeting agenda for that week including safe staffing incident notifications.

One case on the agenda concerned a preventable death linked to the fluid balance of a patient, the 72-hour review had been completed. The incident had been reported via the incident reporting system and escalated to be investigated through the serious incident framework and discussion at the weekly mortality meeting. Case record reviews are undertaken prior to record/note review to determine whether there were any lessons to be learned in the care provided to the patient. We were informed after the meeting that a root cause analysis and the collection of data for the Strategic Executive Information System (STEIS) which captures all serious incidents would be completed within 60 working days.

In context following the Dr Foster review of patient deaths within the division the practice development nurse was leading on nursing updates related to the teaching of fluid balance management.

**Duty of candour**

We saw discussions were held on the application of the duty of candour in the case of a potential preventable death staff had tried to contact the relatives of the patient but had been unable to do so. Other methods of contact was being attempted.

The nursing and medical staff fully understood their responsibilities about the duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

The service had a duty of candour policy available to staff on the trust intranet and laminated notices pertinent to the duty of candour were evident in staff areas of the medical wards.

For example, we examined the medical record of a patient who had suffered a complication following surgery and saw that there was a dated duty of candour record made by the surgeon concerned, who had apologised to the patient after the incident in the application of the duty of candour.
Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The service monitored the instance of falls and pressure sores for example and took appropriate action as the result of findings.

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. We saw that wards entered data into the safety thermometer dashboard daily.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 13 new pressure ulcers, 16 falls with harm and 16 new urinary tract infections in patients with a catheter from October 2017 to October 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Walsall Healthcare NHS Trust**

1. **Total Pressure ulcers** (13)
   - Data from Oct-17 to Oct-18

2. **Total Falls** (16)
   - Data from Oct-17 to Oct-18

3. **Total CUTIs** (16)
   - Data from Oct-17 to Oct-18

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only
Is the service effective?

Evidence-based care and treatment

We saw that treatment and assessment was delivered in line with legislation, standards and evidence-based guidance including guidance from the National Institute of Clinical Excellence (NICE).

Staff members told us that they were able to access the trust intranet to locate policies and procedures and we checked a sample of seven of these polices related to infection control and saw that all were up to date. This included infection prevention strategies, the blood borne virus policy and the management of blood and body spillages. We also saw that national policies and procedures were fully available such as NICE guidance.

The hospital used a sepsis screening tool and an evidence-based sepsis care pathway based on the ‘sepsis six’, this is a national screening tool for sepsis. In addition to the introduction of the NEWS2 early warning sign system the division had undertaken a thematic review of the deteriorating patient which showed that timely patient observations had improved over a three-day period in September 2018 and that late observations for patients with early warning scores of five or above had also improved.

Nutrition and hydration

We saw that staff gave patients enough food and drink to meet their needs and improve their nutrition and that they used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patient’s nutrition and hydration needs were assessed via the MUST screening tool and evidence of its use and completion were in the notes we looked at. ‘MUST’ is the malnutrition universal screening tool five-step to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

The service offered different menus for differing diets including culturally appropriate menus and menus for patients whose diet was restricted by a medical condition. We saw that the ward menus offered good patient choice including vegetarian options. We saw the ward hostesses plating up patient meals which were hot and delivered to the patient in a timely manner with a choice of drinks.

All seven patients, apart from one we spoke with were complimentary about the food provided to them in hospital.

Patients who had difficulty in eating their meals or who needed assistance were served their meals on red trays. To reduce nutritional risk red trays are used on wards in hospitals to help staff
identify which patients need extra attention when eating or need foods that have a modified texture (such as mashed or pureed foods).

Care support workers and apprentices had been trained and were very familiar with the use and application of red tray interventions and fully understood the need to help these vulnerable patients. Food charts and fluid balance charts were used extensively throughout the division.

The service had access to dieticians and staff were aware of how to refer to the services. Some staff found it was sometimes difficult to access a speech and language therapist to undertake assessments for patients who had difficulty swallowing.

On ward 2 the introduction of the tea party club which had been devised by the ward manager had been helpful in achieving optimum food and drink intake in patients living with dementia.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools such as the Abbey Pain scale which is used for patients living with dementia and non-verbal patients who may potentially be in pain. The staff were very familiar with using the Abbey pain scale for patients struggling with verbalisation.

Patient’s told us that they felt their pain was well managed and that staff were responsive with pain relief when it was requested. Patients were routinely asked about their pain when staff conducted their observations.

The trust had a pain management team provided by the pain management department to whom staff could refer to for complex pain concerns. Staff were aware of how to refer to the team and told us that they were responsive to referrals especially where patients suffered chronic pain.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment given to patients and used the findings to improve care delivery. However, outcomes for people who use services were sometimes below expectations compared with similar services.

**Risk of readmission**

**Trust level**

From July 2017 to June 2018, patients at the trust had a slightly higher than expected risk of readmission for both elective and non-elective admissions when compared to their respective England averages.

- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for elective admissions

**Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine had a slightly higher than expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

The data below relates to this trust however all stroke services were transferred to another NHS provider on 1 April 2018 and the trust no longer delivers stroke services or contributes to the SSNAP programme.

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in the latest audit for which we have data for them, December 2017 to March 2018.

Note: for other trusts, data is available for April 2018 to June 2018, and for July 2018 to September 2018. However, there was no data in these dates ranges for Manor Hospital.
Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 73.6%, which did not meet the audit minimum standard of 90%. The 2016 figure was 79.7% so this was improving.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 14.1%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 65.6%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 53.8%. This is within the expected range. The 2016 figure was not significantly different to the national level.
The one-year relative survival rate for the trust in 2017 is 36.4%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 30%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 13%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 63%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 89%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

A range of internal audits were regularly completed. These included peer audits where for example on the acute medical unit staff from ward 17 (the designated buddy ward is where staff from individual wards acted as internal peer reviewers for other wards) would conduct a weekly audit of deteriorating patients.

Advanced nurse practitioners provided an effective hospital at night cover for patient interventions and they handed over to the outreach team every morning. The outreach team provided expert advice to staff caring for sick or deteriorating patients within the wards. This team consisted of five nurses, two at band 7 and three at band 6 and they provided an outreach service from 8am through till 8.30pm, seven days per week. The outreach team members carried bleeps to allow ward staff to contact them for rapid advice or intervention. The outreach time typically supported patients with tracheostomies, including decannulation and provided training for staff in the care of these patients. However, the outreach team nurses had some concerns about medically fit for discharge patients on ward 14 because these patients were not regularly reviewed by medical staff. This had resulted in an increase level of calls to the outreach team. However, the ward had become primarily a nurse led unit where twice weekly assessments of frail elderly patients were conducted by a clinical nurse practitioner who had close links to the discharge co-ordinator. Information provided by the trust after our inspection identified there were processes in place for review by an advanced nurse practitioner five days each week.

Competent staff

The service made sure staff were competent for their roles. Managers told us that they appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
Nursing staff had the skills, knowledge and experience to identify and manage issues arising from patients living with dementia through training provided by the hospital. Dementia awareness training was part of the services induction programme.

The trust gave staff a five day trust induction plus local induction within areas where new staff would be working.

New clinical staff received a comprehensive induction and there was a system in place to ensure agency staff had the information they needed to work within the service. The service employed practice development nurses to oversee induction programmes for new nursing staff.

Competency training for example, in basic life support was provided to all health professionals and was provided by the Walsall Healthcare Education Academy (WHEA) which is within the grounds of the Manor Hospital. This aimed to improve the quality of healthcare for patients in the hospital, and people of Walsall.

**Staff were encouraged and given opportunities to develop. Staff at all levels told us they were encouraged to undertake additional training.**

A band 6 nurse we spoke with on ward 15 told us that the division had funded them to complete a top up degree at Wolverhampton University and that the trust was good at funding course for nurses. Similarly, one of the clinical outreach nursing team had been funded to undertake the masters level non-medical prescribing course to enhance patient care and safety. To help with staff development the wards had created link nurse roles for activities including such as infection prevention and control.

Junior doctors we spoke with reported that they access to good teaching and support from consultants and we saw that the consultants used the ward huddles to teach juniors.

**Appraisal rates**

From March 2018 to September 2018, 91.7% of staff within medicine at the trust received an appraisal compared to a trust target of 90%.

Staff throughout the service were supported to deliver effective care and treatment with a yearly appraisal. Staff told us their appraisals were meaningful and that training needs were identified using the process. Ward managers had a performance improvement programme to manage and support staff with poor or variable performance.

Staff we spoke with during the inspection all confirmed that they had completed an annual appraisal and the data showed a 91.7% appraisal completion rate. Registered professionals were supported by the senior managers in the division through the revalidation process by checking their reflective pieces and offering experienced mentors for the process.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
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<tr>
<td>NHS infrastructure support</td>
<td>6</td>
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<td>100.0%</td>
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Support to doctors and nursing staff | 214 | 228 | 93.9%
Medical & Dental staff - Hospital | 32 | 35 | 91.4%
Qualified nursing & health visiting staff (Qualified nurses) | 188 | 211 | 89.1%
Grand Total | 440 | 480 | 91.7%

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff consistently told us there was good multidisciplinary team working across the medical wards. There was good communication between therapy teams, nurses and doctors and they regularly held effective multi-disciplinary team (MDT) huddle meetings around the safety magnetic wall mounted boards to discuss patient issues. The huddle round we attended on ward 1 was attended by nurses, doctors, a discharge co-ordinator, a physiotherapist, an occupational therapist, a consultant, a registrar and a junior doctor and we saw this was a nurse led meeting. During this meeting the voices of each member of the multi-disciplinary teams were heard, listened to and their contribution valued.

A clinical pharmacist told us pharmacists were assigned to individual medical wards and they felt there was strong MDT working across the whole division and they felt confident that they could challenge doctors and nurses in the interests of patients.

Seven-day services

The service was continuing to work towards seven-day services although had not yet achieved it.

The clinical outreach team provided a 7-day service to the medical division.

There were eight consultants available for acute medicine and consultant cover within the medical division was available 7 days per week from 8.00am until 5.00pm and then from 5.00pm to 9.30pm by one consultant. Thereafter responsible medical officers (RMOs) provided cover. Although dependent on locum doctors the wards were compliant to NICE and Royal College of Physician standards for safe medical staffing.

Pharmacy cover out of hours was provided via an on-call roster.

Physiotherapy was available 5 days per week with an on call respiratory service, covered by weekend and overtime rosters. Speech and language therapists were available five days per week, this meant there was no service for patients with swallowing difficulties over the weekend periods.

Health promotion
Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.

Patients were signposted to various services to promote their health and wellbeing. For example, staff told us that patients who smoked were offered information about the NHS stop smoking service and we saw posters advertising this.

The service provided a wide range of information leaflets for patients and their families. We examined a range of these including among others, patient guide to falls, Welcome to the acute medical unit: A patient guide, Walsall stop smoking service, thinking about end of life care, staying active in hospital, Good night, sleep tight (quiet protocol), flexible sigmoidoscopy, think skins and a guide to hepatic encephalopathy. We were told these were available on demand in other languages.

The service had participated in the end PJ (pyjama) paralysis initiative. The initiative aimed to promote patients dressing in their day clothes while in hospital rather than pyjamas or gowns. This aimed to enhance normalisation, dignity, autonomy and in many instances shortening their stay. Getting patients up and moving has been shown to reduce falls, improve patient experience and reduce length of stay by 1.5 days. We saw evidence of this on all the wards we visited, and, in the patients, we spoke with. On ward 2 we saw patients dressed in their own clothes participating in a range of dementia friendly recreational activities such as playing card games.

The occupational health department had pursued a rigorous flu immunization scheme for staff and staff we spoke with told us that uptake of the vaccine among care staff was high. The occupational health department offered all trust employees appropriate vaccines for their occupation or work activities.

Mental Capacity Act and Deprivation of Liberty

The rights of patient’s subject to the Mental Capacity Act 2005 were not fully protected in all clinical areas as processes were not being robustly followed.

We saw that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, processes were not always followed to ensure the legality of restrictions.

Staff generally had knowledge of DoLs procedures and could give appropriate examples of where DoLs applications had been made for patients. The DoLS protect people who are not able to make specific decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Patients who did not have capacity to consent had mental capacity assessments and were consented by a doctor if the procedure was deemed to be in their best interests.

Deprivation of Liberty Safeguards (DoLS) applications were made by staff when required. However, review processes for application of DoLS extensions following the two week initial period were not robust. This meant that a re-application was made just after the two week period as the review had not been made.

There lacked ward level oversight of the DoLS timescales and processes. We inspected several Deprivation of Liberty Safeguards applications. The DoLS under the MCA allows restraint and
restrictions that amount to a deprivation of liberty but only if they are in a person’s best interests. On three of the wards we inspected DoLs applications had expired without review. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. However, some doctors had not completed Mental Capacity Act 2005 (MCA) documentation when Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) procedures were implemented.

The leads for adult safeguarding informed us that some doctors were failing to fully complete some mental capacity assessments following a decision to apply do not attempt cardiac pulmonary resuscitation (DNACPR) for certain patients. A review of seven records on wards 2 and 3 for DoLS and DNACPR compliance and found there were discrepancies in the application of DoLS processes but especially in the management of those which had expired after the 2-week period allowed in law. Additionally, we saw that some of the mental capacity assessments had not been formally undertaken and this posed threats to the legality of any DNACPR directive.

Medical and nursing staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking procedures who had capacity. This was in line with the consent for examination and treatment policy which gave clear guidance for staff.

The trust reported that from as of September 2018 Mental Capacity Act 2005 (MCA) training was completed by 99% of staff in medicine compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards (DoLs) training was completed by 92% of staff in within medicine compared to the trust target of 90%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We saw staff took the time to speak with patients and their relatives in a respectful and considerate way. We saw members of the multidisciplinary team talking to patients in a compassionate way using language they could understand. Patients told us they were very pleased with the care they received, and we saw examples of therapeutic touching being administered by staff to distraught patients.

Ward 2 was very dementia friendly and had a homely atmosphere created by well thought out colour schemes and furniture. Staff engaged with patients and through sharing stories prompted by family photographs.

There were many compliments on notice boards of the medical wards consisting of thank you cards from patients and their relatives, which offered praise to the staff for their care delivery.
Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 47% which was better than the England average of 25% from October 2017 to September 2018.

Patients told us there was strong positive feelings about Manor Hospital in the Walsall community and the results of the friends and family test throughout 2017 and 2018 showed high levels of recommendations.

Friends and family Test – Response rate from October 2017 to September 2018 by site

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Key

Highest score to lowest score

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff provided patients with appropriate and timely support and provided information to assist them to cope emotionally and socially with their admission.

Ward 15 had recently launched a communication clinic operating from 3.00pm - 5.00pm during visiting hours with a mandate to offer emotional support to visiting relatives. We saw a poster advertising the service and a family relative of one of the patients we spoke with told us that the staff always endeavoured to explain all aspects of her family members care delivery.

The chaplaincy service provided a team of chaplains and various faith representatives who were available to support patients in their time of need. We saw members of the chaplaincy conducting their ward rounds.
The chaplaincy service was available throughout the hospital for patients, carers, visitors and members of staff. The service was supported by volunteers and represented Christian faiths, Muslim, Sikh and Hindu faiths.

However, staff told us that care for patients suffering stroke on ward 4 was being compromised by the high number of medical outliers who were being boarded on the ward.

We saw that out of 28 beds that 10 were occupied by medical outliers this is patients who are on a ward with care needs which is not part of the speciality of the ward. Staff told us it was the stroke doctors who usually looked after the outliers in addition to their primary stroke rehabilitation patients. The acuity of the medical outliers was compromising optimum care delivery to the stroke rehabilitation patients. The very sick outliers many of whom had associated dementia were often noisy at night causing lack of sleep in the stroke rehabilitation patients some of whom were subsequently too tired in the morning to attend their physiotherapy sessions.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

To help improve care staff understanding of the individual needs of their patients, the ward manager of ward 2 had developed “this is me” white boards which were placed at the bedhead of every patient’s bed space. These white boards provided details of the specific interests of the patient’s and helped nurses to better engage with them for example by citing the patients favourite aspects such as music or a movie star.

Ward 2 used My Life’s “Digital Reminiscence Therapy Software” (DRTS), to help facilitate better conversation between patients, staff and loved ones. This nostalgic range of media allowed nurses or relatives to make selections from different time periods of the 20th century allowing access to differing aspects of a patient’s former life before dementia affected them. A satisfaction survey conducted on ward 2 confirmed that patients on the ward were very happy with their care delivery.

Staff communicated with patients and their relatives in a way in which they could understand their care, treatment and condition. We observed nursing staff greeting patients in a friendly manner and explaining the treatment they would like to give before seeking consent for treatment. We observed nursing staff speaking with patients and asking if they had any questions about their treatment plans and telling patients that they could ask them questions at any time.

Patients we spoke with told us staff always kept them informed of their treatment and discharge plans. One patient who had been admitted to the ward on many occasions throughout the years told us that the staff were always at pains to ensure that they always understood what was happening.

Patient’s told us that they felt fully involved within the process of their care planning. We observed doctors explaining conditions to patients using simple terms and asking patients whether they understood or had any questions.

**Is the service responsive?**
Service planning and delivery to meet the needs of the local people

The trust planned and provided services in a way that met the needs of local people.

The service reflected on the needs of the ageing population served by introducing a frail elderly service. It is known that fragility can cause a clinically recognisable state of increased vulnerability is certain patients usually linked to age associated decline in health. Staff within the division had been provided with five key indicators of potential patient frailty which were designed to help them escalate the patient for a more comprehensive geriatric assessment. The National Institute for Health and Care Excellence (NICE) recommend this as older people make up a significant proportion of hospital admissions and many have complex medical, functional, psychological and social needs. Carrying out a comprehensive assessment supported care staff to develop a long-term plan to manage those needs.

The division had provided frailty screening across the wards to ensure rapid intervention to promote maximum patient independence. The frailty service had been operational since January 2016 and triggered the rapid assessment of patients who had been identified as frail in the emergency department or the acute medical unit. The frail elderly pathway team operated across the division 7 days a week between 8.30am – 6.30pm.

The medical wards considered patients living with dementia when planning the ward layouts and some of the elderly care wards had bays painted in different colours to help orientate patients living with dementia. Although the acute medical unit was old and cramped, plans had been approved for an initiative to build a new emergency department and acute medical unit. With a start date at the end of 2019, with a view to opening it fully by October 2021.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The service demonstrated they were proactive in putting in place measures to meet patient’s individual needs, especially for patients living with dementia. An initiative to improve call bell access by patients had been successfully implemented and patients told us that call bells were promptly answered by members of the care team.

The trust had taken into consideration that people living with dementia needed additional facilities to live fuller lives within the confines of the hospital situation. The care environment had been adapted to include enhanced signage for washing and toilet facilities. On ward 2 for example the environment of care was very dementia friendly under the positive and innovatory leadership of the ward manager who had introduced “what matters to me” white boards at the head of each bed to facilitate individual care preferences. Additionally, the recreational rest areas of the ward had been adapted to create a homelier environment.

The manager of ward 2 manager had developed a tea party area with associated cake stands to allow social gatherings of patients on the ward. This also facilitated various recreational activities such as card games and jigsaws.

The division employed discharge coordinators who worked directly with staff and patients. The discharge coordinator we spoke with on ward 17 told us they had to cover three wards which led
to a very heavy workload for them. Three new staff members were imminently due to join the discharge team.

An older people’s mental health liaison team consisting of a specialist group of skilled and experienced mental health practitioners were available to monitor, support and improve the experience of older adults with mental health issues, such as dementia, who were admitted to wards in the division. This service was available seven days a week between 8.30am – 4.30pm.

Staff had introduced a new project on ward 2 to help build better communication with patients living with dementia. The 'What Matters to Me' boards allowed patients to inform staff of important aspects to them such as their favourite meals, while others choose to display who were the important people in their lives. Patients could also detail their past occupations, favourite films, music or how they like to take their medication.

Some of the ward bays which cared for people living with dementia had utilised the butterfly scheme. The scheme allowed people with memory impairment to make their needs clear to staff and receive a form of personalized care during their stay in hospital. It also reminded staff of how to interact and communicate with people living with dementia and to include their families and carers in the process, to reduce stress and anxiety. We observed the butterfly symbol in place to identify patients living with dementia on many of the wards.

The medical wards had access to two learning disability liaison support nurses who were able to work with patients over 18 years of age with learning disabilities and the staff who cared for them. This service was available Monday to Friday 9am - 5pm with some weekend availability by arrangement.

There was a range of service specific leaflets on the wards that we visited to provide patients and their relatives information about the trust and medical conditions.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The medical wards capacity necessitated a number of medical outliers. A medical outlier is a patient with a medical speciality in a bed on a ward which is of a different speciality to their needs. In addition to using ward 4 for outliers the division also placed outliers on surgical wards. We were informed by staff on ward 4 that caring for outliers was compromising the delivery of optimum care to stroke patients.

However, the service had a number of initiatives in place to improve flow and discharges within the division. Across the wards there were twice daily huddle board rounds which were attended by the multi-disciplinary team. At the board round the team would discuss individual patients to expedite their appropriate discharge and to ensure that patients were discharged safely. The service had a discharge liaison team who assisted the wards with complex discharges including patients requiring rehabilitation, community beds and care packages. Discharge coordinators attended the board meetings where fit for discharge patients were reviewed. The discharge liaison team had
nurses allocated to individual wards for consistency. We saw one of the team liaising with staff on ward 17 where they gave advice. Staff were aware of how to refer to the discharge liaison team and told us they came swiftly when bleeped. However, the discharge coordinator we spoke with told us that because of staff shortages within the team they was having to provide cover for three of the medical wards. All medically fit for discharge patients were highlighted on the ward dashboards by the discharge coordinators and at the huddle board meetings we attended we saw that the discharge coordinators discussed the discharge status, home environment and situation of potential discharges. They also contributed to discussions on discharge medication such as antibiotics.

To help improve patient flow and as part of the winter plan the division had create a capacity ward which cared for 12-19 patients who had been deemed as medically fit for discharge. The ward was formerly a frail elderly ward and it was planned that after the winter that it would return to that designation. In the interim the frail elderly patients were accommodated on other wards across the division.

**Average length of stay**

**Trust Level**

From August 2017 to July 2018 the average length of stay for medical elective patients at the trust was 3.9 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.2 days, which is slightly lower than the England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology was lower than the England average.
- Average length of stay for elective patients in gastroenterology was higher than the England average.
- Average length of stay for elective patients in general medicine was lower than the England average.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for elective specialties]

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was higher than the England average.
- Average length of stay for non-elective patients in cardiology was lower than the England average.
Average length of stay for non-elective patients in geriatric medicine was higher than the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Manor Hospital

From August 2017 to July 2018 the average length of stay for medical elective patients at Manor Hospital was 3.9 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.9 days, which is lower than England average of 6.3 days.

Average length of stay for elective specialties:
- Average length of stay for elective patients in cardiology was lower than the England average.
- Average length of stay for elective patients in gastroenterology was higher than the England average.
- Average length of stay for elective patients in general medicine was lower than the England average.

Elective Average Length of Stay - Manor Hospital

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in general medicine was lower than the England average.
- Average length of stay for non-elective patients in cardiology was lower than the England average.
• Average length of stay for non-elective patients in geriatric medicine was higher than the England average.

Non-Elective Average Length of Stay - Manor Hospital

![Graph showing average length of stay](image)

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2017 to November 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average. Trust performance dropped below the England average from December 2017 to March 2018. From April 2018 to September 2018 the trust has shown a trend of improvement and has remained better than the England average. In the latest month, September 2018 the trust scored 96.5% compared to the England average of 88.1%.

![Graph showing referral to treatment](image)

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Six specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>General medicine</td>
<td>94.7%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.2%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moving wards per admission**

The trust electronic systems currently did not allow monitoring of the number of bed moves per admission. Therefore, the trust was not aware of the impact that this may have on patient care.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

From October 2017 to September 2018, there were 5,028 patient moving wards at night within medicine. The majority of ward moves at night were on the below wards:

- Ward 5 (AMU) with 1,766 (35.1%)
- Ward 6 (AMU) with 1,422 (28.3%)
- AMU with 638 (12.7%)

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff.

Patients and relatives were encouraged to make complaints where they felt it necessary. We observed that there were leaflets with details of how to complain on display across the wards that we visited and information on how to complain featured in the trust’s welcome booklet for patients.

Complaints were monitored as part of the quality dashboards displayed on wards. The quality dashboard showed how many complaints the ward had received in a month.

We saw that the trust had a complaints policy that could be viewed by staff on the trust’s intranet.

The trust had developed a public website which offered advice and support for both patients and visitors. This website provided information on these services and how to access them. The trust also had developed a Patient Relations Service.

**Summary of complaints**
From October 2017 to September 2018, there were 110 complaints about medical care. The trust took an average of 37 days to investigate and close complaints. The trust’s overall target is for 70% or more complaints to be completed within 30 working days, and they have a target of 45 working days for complex complaints or complaints with a higher level of harm.

A breakdown of complaint subject with seven or more complaints are below:

- Treatment/ care/ supervision: 34
- Treatment - advice/ issues: eight
- Discharge Query: seven

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From October 2017 to September 2018 there were 122 compliments within medicine.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Managers at all levels in the division were developing the right skills and abilities to run a service providing quality sustainable care.

The medical division structure encompassed seven care groups including an emergency care group and an adult community care group who were not part of this inspection. The division was led by a director of operations, divisional director of operations. a divisional medical director of operations, and two directors of nursing, one for acute medicine and one for community nursing. They linked to the executive team for the trust and had oversight of medical services across the trust. The individual care groups comprising the various medical ward were led by matrons.

Throughout the division we saw the overarching trust philosophy of caring for Walsall, together and respect, compassion, professionalism and team work were fully embedded. We saw evidence of this in all areas we inspected, including large posters, and painted murals promoting the philosophy. All staff we spoke with were aware of and proud of this philosophy.

Staff told us the executive and medical team were highly visible around the hospital and nursing staff were aware of who the new director of nursing for the division was. They told us they often saw the director of nursing on the wards and that she would visit individual wards if there were site pressures. Although the director of nursing had only been in post for a short period, staff were reassured that she was bringing stability to the management structure.

Staff consistently told us across the service that they felt supported by their immediate managers and matrons. Staff were enabled and encouraged to go to their ward managers with any concerns and were reassured that they would be escalated appropriately. One member of staff told us their ward manager who had developed the “shout out board” initiative which had promoted enthusiasm and pride across the ward.
Senior medical and nursing staff told us they felt supported in their roles by the executive team consisting of a recently appointed chief executive and a recently appointed trust director of nursing. Leaders within the service had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. Leaders were focused on risks within the service and motivated to deliver continued improvements on quality and performance.

**Vision and strategy**

The division had a corporate vision for what it wanted to achieve for improving patient services and had developed workable plans to turn this vision into action with involvement from staff, patients, and key groups representing the local community.

In late 2018 the division had held a planned engagement meeting with members of the CQC in which the senior managers of the division had shared their plans and aspirations for the future direction of travel to ensure that there was a consistent delivery of the fundamentals of care across the whole division. This had included the identification of the challenges that the division faced including staffing shortages and the formulation of plans to overcome any obstacles to resolving these issues. Much of the strategy involved the matrons leading improvements at ward level and in undertaking regular quality assurance exercises on the wards. The division had developed a patient care improvement plan (PCIP) to address previously identified patient care problems such as access to call bells and patient falls incidences which had been resolved satisfactorily. The division had participated in the learning from excellence initiatives and had embraced innovations by staff pertinent to patient safety. We saw the division has been a winner of a national award for excellence in clinical governance and risk management patient safety category.

**Culture**

*Managers across the division promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.*

Staff within the division were aware of the trust values and all members of staff that we spoke with could name them. All nursing, allied health professionals and medical staff we spoke to told us they enjoyed working at the trust and that the teams communicated well with each other. Staff told us they were supported by their leaders and were part of the team. The division was undergoing many culture changes but in particular the introduction of greater multidisciplinary team (MDT) ownership of the safety huddles. The divisional matrons were ensuring nursing leadership visibility across the various care groups. Greater emphasis had been placed on managing patients with long term conditions and practice development nurses were working in partnership with the patient safety team to roll out learning from incidents, complaints and audits.

Staff told us the implementation of the new trust values were improving the ownership of the overall care culture within the division. At the ward board huddle meetings and other safety huddles we attended we saw prominence was given to patients' mental health and emotional needs. We also saw the wards within the division used “shout out boards” to allow staff to complement each other on work achievements as a form of morale boosting and peer emotional support.

Staff were encouraged to demonstrate candour, openness and honesty at all levels. All staff we spoke with, including senior leaders, had a clear understanding of the need to be open and honest with patients and apologise when things went wrong.

We saw staff successes were celebrated using notice boards on the wards and the “shout out” initiative had proved popular as a way of celebrating staff contributions to care delivery.
Governance.

The division used a systematic approach to continually improve the quality of its services and safe guarding high standards of care by creating an environment in which excellence in clinical care would flourish. The divisional structure was led by four managers made up of a director of nursing, a divisional operating officer, a medical director and a head of nursing for the community. The medical service comprised five care groups covering the various medical wards. Each care group was led by a matron.

The Deputy Director of Nursing and Senior Nurse for Quality had instigated a series of medical ward reviews with for example Ward 2 the 34-bedded acute care of the elderly ward being conducted on the 20th December 2018. The ward review processes took a multi-disciplinary approach using a proforma developed in line with the CQC Key Lines of Enquiry. These ward review reports presented their findings under the five CQC domains of: Safe, responsive, caring, effective and well-led. These reports for each ward highlighted areas of care which required immediate actions to improve service delivery.

The governance structure comprised of an overarching risk management committee which received minutes from a monthly divisional quality board which in turn received information from a variety of other governance structures. These included the weekly divisional safety huddle and the quarterly care group reviews. The divisional safety huddles had detailed agendas for each meeting which subsequently generated action logs for the meetings with designated individuals being identified for delivering any specific actions pertinent to specific incidents with completion dates. Case reviews pertinent to patient incidents were fully completed and recorded.

Weekly matron’s meetings facilitated sharing of information to senior ward managers meetings. Senior leaders within the division told us the services performance was reported on a monthly basis to the divisional quality meetings and the care group quality meetings. Weekly divisional safety huddles with transcribed minutes facilitated in depth discussion of all serious incidents. Weekly matron meetings and senior sister meetings were held to cement governance arrangements within the medical wards.

The division participated in preparing monthly reports to the Trust Board in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016) and the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014.

Management of risk, issues and performance

The medical division had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The divisional meetings identified any challenges facing clinical areas and sought to deliver solutions to overcome these. The division had implemented band 6/7 professional development for nurses to help change the culture and accountability within the wards. The division had identified the top risks to their quest to deliver the trust philosophy within the medical wards namely patient falls, and staff shortages among the nursing teams.

Falls had been addressed through a medical ward initiative which had seen successful in reducing the number of falls reported. Nursing shortages had been identified at 47.5 WTE positions but 26.8 WTE were in the recruitment process. The division had implemented a patient centred improvement plan (PCIP) across the division with PCIPs lined to each divisional care group and
ward based risks and to focus on staffing, mandatory training, appraisal compliance, call bell availability, the care of neutropenia patients and the ability of staff to safely administer medication via peripherally inserted central catheters. The success in achieving the PCIPs was being monitored at the divisional and ward based safety huddles. PCIP performance as added as a monthly item on the divisional quality board and care group quality team meetings.

There had been 31 serious clinical incidents within the division excluding pressure ulcers between the September 2016 and September 2017 and 23 serious clinical incidents between September 2017 and September 2018 equivalent to a 26% decrease in serious incidents for the medical core service.

The risk register showed that the division was experiencing difficulties in maintaining adequate staffing levels with a shortfall of 20 registered nurses compromising the ability of the service to provide assurances for welfare and safety of patients and staff.

A review of nurse staffing had been undertaken in the Autumn of 2018 and risk was being managed through authorised use of bank and agency staff. The risk register had also identified some wards where additional capacity spaces had been created but without medical gas supplies being available at the bed heads. Additionally, we saw that on ward 1 that some beds did not have access to suction and when we escalated our concerns to the matron action to acquire portable apparatus was undertaken. The risk across the division was being managed by ensuring that staff risk assessed patients that were using extra capacity spaces in each bay of wards concerned.

**Information management.**

The division collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The division used dashboards to monitor performance and we saw that wards entered data into the safety thermometer dashboard daily. The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Complaints were monitored as part of the quality dashboards displayed on wards. The quality dashboard showed how many complaints the ward had received in a month.

**Engagement**

**The division worked well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

The medical division had implemented a learning from excellence initiative where the first step had involved a stakeholder engagement with the among others the members of the clinical commissioning group. At ward level the safety huddles offered good opportunities for staff and patient engagement. The creation of a communication clinic on ward 15 facilitated good interaction with the relatives of service users and the nurse in charge. The clinic was available between three and five pm each day. The matrons and the patient discharge nurses were actively engaging with ward staff and ensuring nursing leadership visibility on all wards.

Between August 2017 and September 2018, the medical wards had been given 61 learning from excellence nominations including aspects pertinent to patient safety such as the introduction of pressure ulcer improvement work across all of the wards and for example a steady decrease in falls on ward 2 and reduced necessity of using sedation.
In 2018 the division and the trust participated in a public consultation to review the sustainability of providing a hyper-acute stroke unit (HASU), in line with the recommendations given in the National Stroke Strategy. As part of the trust’s vision “Caring for Walsall together” the trust had committed to working with partners throughout the black country.

Learning, continuous improvement and innovation

The medical division was committed to improving services by learning when things went well and when they went wrong, promoting training, research and innovation. The prevention of fall initiative, the introduction of the sepsis and skin care bundles had all come about following concerns about optimum patient care.

Walsall Healthcare NHS Trust was guided by five strategic objectives which combine to form the overall ‘vision’ for the organisation. The strategy sought to provide safe, high-quality care, partnership working, valuing colleagues and using resources wisely. The patient centred improvement plans had been fully incorporated within the division.

A number of innovations such as appointing a ward manager with a mental health background on ward 2 had led to significant improvements in dementia care.

The division had implemented a range of learning from both service delivery problems and from excellence. The implementation of strategies to prevent falls and pressure area ulcers had been successfully put into action. As part of an innovation’s strategy on ward 2 the division had appointed a mental health nurse manager. Under the leadership of the manager there had been a reduction in the use of and use of sedation medications.
Surgery

**Facts and data about this service**

Manor Hospital is the main site providing acute services for Walsall Healthcare NHS Trust. The surgical division provides adult elective and emergency services for a range of the following specialisms: trauma and orthopaedics (T&O), general surgery (including urology), bariatrics, breast care, colorectal surgery, outpatient vascular, upper gastrointestinal, ear, nose and throat service and day case cataract surgery (under local anaesthetic).

The surgical department is comprised of six surgical wards, arrivals and a discharge lounge. The service has 11 operating theatres; three of which have laminar flow and associated areas for anaesthetics and recovery. The hospital had 106 surgical inpatient beds and eight day-case beds.

There are usually 26 beds on the emergency trauma and orthopaedics ward (ward nine) but at the time of our inspection capacity had increased to 33 beds to accommodate seven additional patients due to escalation measures.

The acute surgical unit usually has 41 beds (wards 11 and 12) but at the time of our inspection capacity had increased to 53 beds to accommodate 12 medical patients due to escalation measures during the winter period. A breakdown of additional surgical wards visited are listed below:

- There are 16 beds on the elective trauma and orthopaedic surgery ward (ward 20a).
- There are 24 beds on the elective general surgery ward (ward 20b).
- The surgical assessment unit has 12 assessment chairs and a bay of three trolleys.
- The day-case unit has eight patient trolley spaces and one side room.

The trust had 16,975 surgical admissions from July 2017 to June 2018. Emergency admissions accounted for 5,997 (35.3%), 8,745 (51.5%) were day case, and the remaining 2,233 (13.2%) were elective.

During the inspection visit, the inspection team:
- Spoke with 18 patients and 12 relatives.
- Reviewed 13 patient records.
- Observed staff caring for patients within scheduled care wards and theatres.
- Reviewed performance information and data from and about the trust.
- Spoke with 45 members of staff at different grades from band two to band eight including matrons, ward managers, nurses, physiotherapists, pharmacists, doctors, consultants, discharge coordinators, administration and housekeeping.
- Met with a director of operations, divisional director of nursing, clinical director for theatres, anaesthetics and critical care and care group managers for the surgical division.

The service was last inspected June 2017. At the last inspection of the surgery division we rated this as requires improvement overall including safe and effective. It was rated good in the caring, responsive and well led key questions. The surgery service was issued with one requirement notice and two recommendations for service improvement in the safe, effective and responsive domains. During our inspection, we looked at the changes the surgical directorate had made to address these concerns.

Trust wide data is included within the surgery core service report for comparison with the core service data. Please refer to the provider level report for further information.
Is the service safe?

Mandatory Training

The service provided mandatory training in key skills. There was a programme of mandatory training and updates for staff, which included but was not limited to adult basic life support, falls awareness, equality and diversity, conflict resolution, clinical update and information governance. The full list can be seen in the table below.

Nursing staffing mandatory training compliance rates were below the trust target. The trust set a target of 90% for completion of mandatory training. The 90% target was met for four of the 10 mandatory training modules for which qualified nursing staff were eligible. Levels of compliance differed from ward to ward. For example, on the surgical assessment unit, compliance was at 95% but on ward nine, compliance with mandatory training was at 65%. Compliance with some training modules also fluctuated; for example, on ward nine, eight out of 27 staff were overdue for information governance training.

A breakdown of compliance for mandatory training courses as of September 2018 for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>160</td>
<td>161</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>160</td>
<td>161</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>158</td>
<td>161</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>149</td>
<td>161</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>142</td>
<td>161</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>139</td>
<td>161</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>130</td>
<td>161</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>129</td>
<td>161</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>125</td>
<td>161</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>121</td>
<td>161</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff at all levels had not completed all aspects of mandatory training deemed essential to provide safe care and treatment. The trust provided the up to date mandatory training compliance rates for the surgical division for September 2018 to February 2019. We found the surgical division remained below the trust target. The trust did not provide a breakdown of separate modules and if these applied to nursing or medical staff.

Mandatory training compliance for nursing staff was monitored. Ward managers and service leads within the surgical division were aware of their nursing staff compliance rates and told us staff were being chased to complete training. Ward managers were sent monthly reports on staff training compliance and would display notices relating to compliance rates. We saw this on ward nine and the surgical assessment unit.

Staff did not always have time to complete training. Most staff told us they did not have
protected time to complete training and this was undertaken when on shift. Nursing staff received a yearly clinical update which was face-to-face training but some mandatory training modules were e-learning. As part of the clinical update, training included but not limited to safeguarding level two, adult basic life support, fire safety, manual handling and tissue viability.

A breakdown of compliance for mandatory training courses as of September 2018 for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>48</td>
<td>51</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>46</td>
<td>51</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>41</td>
<td>51</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>40</td>
<td>51</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>38</td>
<td>51</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>37</td>
<td>51</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>37</td>
<td>51</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>31</td>
<td>51</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>29</td>
<td>51</td>
<td>57%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>26</td>
<td>51</td>
<td>51%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust 90% target was met for two of the 10 mandatory training modules for which medical staff were eligible. Medical staff compliance for adult basic life support, including sepsis, was at 57%, which meant 22 medical staff were currently non-compliant. The trust provided current mandatory training compliance for all nursing and medical staff and this was below trust target but was not broken down into individual modules.

**Sepsis**

**Staff understood how to identify sepsis.** Staff we spoke with were aware of the NICE clinical guidelines on sepsis: recognition, diagnosis and early management (NG51) recommendations. The trust used a recognised Royal College of Emergency Medicines sepsis tool to identify and manage sepsis. We saw this being used on the acute surgical unit.

Information, support and advice on sepsis identification and management was easily accessible to staff within the surgical division. For example, we saw a sepsis information board located within theatres which provided guidance and advice which staff could access at any time. Theatres had a sepsis link worker who offered support and advice on sepsis protocols and management. There was an up to date sepsis policy on the trust intranet which staff knew how to access.

There were trust wide initiatives to raise awareness of sepsis management. The FEVERED campaign was launched in March 2018 which was a campaign around safer practice which included the deteriorating patient, VTE (venous thromboembolism) and sepsis.

All nursing and medical staff were not compliant with sepsis training. As part of the
mandatory training programme, sepsis training was included in adult basic life support training. This included ward based education for all levels of staff. However, nursing and medical staffing did not achieve sepsis training compliance and were below trust target at 78% and 57% respectively. This did not assure us that all nursing and medical staff had the most up to date training.

**Performance in relation to sepsis management within the division was not being monitored.** Sepsis audit data was requested but was not reported at divisional level. It was only reported at trust level. The service held sepsis review meetings which included the audit team, antimicrobial pharmacist and the clinical leads within surgery. We were told that lessons learnt from the monthly deteriorating patient audit was an agenda item at the monthly care group quality meetings, however, upon review of these minutes it was not always an agenda item.

**Safeguarding**

**Staff understood how to protect patients from abuse.** All staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures. Staff could describe when a safeguarding referral should be made and the process for doing so. They had knowledge of the safeguarding adult policy and could provide examples when a referral had been made and for what reasons, even if they were not directly involved.

Patient safeguarding was promoted and staff had access to support and advice. Within the trust, there was the safeguarding adult lead nurse and the safeguarding children lead nurse who could be contacted for additional help and support. There was a trust quarterly safeguarding steering group and 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 received effective training in safeguarding systems, processes and practices. Clinical staff undertook level-two training as part of their clinical update. The trust set a target of 85-95% for the completion of safeguarding training. The trust 85-95% target was met for five out of six relevant safeguarding training modules for all nursing staff. The full list can be seen in the table below.

A breakdown of compliance for safeguarding training courses as of September 2018 for qualified nursing staff in the surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 3</td>
<td>29</td>
<td>29</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>129</td>
<td>132</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>125</td>
<td>133</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>26</td>
<td>28</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>113</td>
<td>135</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital the 85% and 90% targets were met for five of the six safeguarding training modules for which qualified nursing staff were eligible.
Both Safeguarding Adult and Children training data was included within the trust performance dashboard and through each division’s quarterly review.

A breakdown of compliance for safeguarding training courses as of September 2018 for medical staff in surgery at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>30</td>
<td>33</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>15</td>
<td>18</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>24</td>
<td>33</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>25</td>
<td>41</td>
<td>61%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Manor Hospital the 85% and 90% targets were met for two of the six safeguarding training modules for which medical staff were eligible.

There was a chaperoning policy in operation within the surgical division. Although we saw notices advertising the availability of chaperones, we did not observe any patient interactions where one was required.

The trust provided safeguarding training compliance for February 2019 for the surgical division and this was above the trusts 90% target for all modules apart from safeguarding children level 2 which was 81%. This assured us that the trust was monitoring these modules and staff were compliant. The table below shows the compliance rates for all surgical staff for February 2019.

<table>
<thead>
<tr>
<th></th>
<th>Adults Level 1</th>
<th>Adults Level 2</th>
<th>Adults Level 3</th>
<th>Children Level 1</th>
<th>Children Level 2</th>
<th>Children Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Division</td>
<td>98%</td>
<td>92%</td>
<td>89%</td>
<td>96%</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cleanliness, infection control and hygiene**

_The surgery division did not always control infection risk well._ Bed spaces on every ward were visibly clean in both the easy and hard to reach areas and ‘I am clean’ stickers were used to identify when something had been cleaned.

Ward infection prevention and control performance was monitored but compliance was variable. Ward managers received monthly reports on infection prevention and control performance of their areas with a view to implementing any action plans for areas that have not achieved the trust target.

Audit results were shared with heads of service and were reported to and discussed at infection prevention and control committee meetings. Infection control was a standardised agenda item at the...
divisional quality board meetings and represented by the infection control nurse for the trust.

Any non-compliance was fed back to the area at the time of audit. These annual audits were in addition to monthly observational audits for all ward areas which were undertaken monthly by the infection prevention and control team during the year with matrons. We reviewed infection prevention and control audits for October, November and December 2018. Wards 20a, 20b and 20c scored 100%, 95% and 91% respectively in October 2018 and the surgical assessment unit scored 95% in December 2018. However, in October, November and December 2018 the acute surgical unit only achieved compliance rates of 73%, 71% and 73% respectively. In November 2018, ward nine only achieved 73% compliance.

There were systems, processes and practices to prevent and protect people from healthcare-associated infections but they were not always followed. We observed staff adhering to some infection prevention and control practices, which were in accordance with National Institute for Health and Care Excellence QS61 (Infection prevention and control), as they washed their hands before and after each patient direct contact or episode of care. We saw hand hygiene audit results for October, November and December 2018 for all surgical wards and theatres, which demonstrated practice on the ward was not always 100% compliant. For example, compliance on ward nine in November 2018 was 67% compliant with hand hygiene standards. In December 2018, compliance on ward 20a and ward nine were at 83% and 86% respectively. The full list can be seen in the table below.

Ward hand hygiene audit results:

<table>
<thead>
<tr>
<th>DATE/WARD</th>
<th>9</th>
<th>11</th>
<th>12/SAU</th>
<th>20a</th>
<th>20b</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>November</td>
<td>67%</td>
<td>100%</td>
<td>*</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>December</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>84.3%</td>
<td>100%</td>
<td>66.6%</td>
<td>94.3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Indicates no audit took place for this calendar month

Most infection prevention and control practices were consistently followed. All staff on surgical wards were bare below the elbow to enable effective hand-washing. Adequate personal protective equipment (PPE) was available around the wards, which included disposable gloves and aprons. We observed staff using equipment appropriately during each patient interaction. We saw staff and visitors using the hand sanitising gels that were available on entry and exit to the wards and sinks in all bays and side rooms.

There were systems for cleaning the ward areas with tasks allocated to staff members each day. All clinical areas appeared visibly clean and staff had systems for ensuring standards were maintained. We reviewed an allocation book on ward nine which listed the daily cleaning tasks on the ward, along with the member of staff who was responsible for carrying them out. Upon review we saw each task had been allocated to a staff member and signed off once completed over the month of February 2019.

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 surveillance methodology which provided feedback to surgeons and surgical teams either through a root cause analysis process or through divisional quality meetings.

The surgical division completed an assessment toolkit for infection prevention practice across the surgical pathway. However, compliance was not always high, as in February 2018, a score of 64% was achieved for overall compliance with the framework. It was identified there were issues in relation to preoperative warming management across all areas of surgery and the prevention of skin recolonization. The trust also had an electronic system which alerted them to any patient re-admitted within 30 days of surgery and up to one year if prosthetic surgery, or if a positive swab result was received during that time.

The surgery division participation in the mandatory surveillance for total hip replacement and total knee replacement surgical site infections (SSI) between April and June 2018, which showed there had been low numbers of surgical site infections. The results can be seen in the table below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Total no of records submitted</th>
<th>No of SSI inpatient</th>
<th>No of SSI readmission</th>
<th>Total SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacement</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>59</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The trust also provided data for their performance relating to surgical site infections between October and December 2017. The results can be seen in the table below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Total no of records submitted</th>
<th>No of SSI inpatient</th>
<th>No of SSI readmission</th>
<th>Total SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacement</td>
<td>23</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>49</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Performance relating to infection prevention and control was monitored within theatres but audits carried out differed in level of detail and compliance was not always at required levels. We saw audits from July 2018, October 2018 and January 2019 but they were all different in terms of what was audited. In the July 2018 audit; theatres two, seven, eight and 12 were reviewed and compliance with infection prevention and control for each was 91%, 89%, 96% and 91% respectively. The audit carried out in October 2018 only covered three theatres but covered a wider range of environments, including changing rooms, anaesthetic rooms, scrub rooms and recovery. The overall compliance for the October 2018 audit was 87%. The audit carried out in January 2019 only covered one theatre and did not include any other environments. The overall compliance score was 89%.

There was conflicting data in relation to whether all elective surgery patients were screened for MRSA. We were told all elective patients were swabbed for MRSA at their pre-operative assessment. We were also told patients attended the arrivals lounge prior to theatre and further checks would be carried out by staff 48 hours prior to admission to ensure MRSA swabs were current. The original data submitted by the trust showed the overall compliance rate from January 2018 to December 2018 was 89%. However, we were provided with additional evidence following the inspection which showed the overall compliance score was actually 98%.
There was one hospital acquired E-Coli (bacteria found in the environment) reported in December 2018, on ward 20a. Staff told us there has been improved hand hygiene compliance and all staff were aware they should be bare below the elbow.

The trust had an administration of infection prevention and control policy which was in date. The trust had a infection prevention and control team which included a decontamination lead and senior infection control nurses and consultant microbiologist.

Staff on ward 20b told us they were celebrating 100 days of being infection free and had received a certificate from the trust.

Facilities were utilised to reduce the risk of unit-acquired infections but some staff practices were non-compliant with the infection prevention and control policy. Wards had side rooms available to provide appropriate isolation facilities and individual infection control risks were clearly signposted on entry to the siderooms. There were isolation rooms on surgical wards, which were used for patients who had an infection or were at risk of infection due to low immunity. We observed the rooms being used during our inspection but doors were not always kept closed, despite signs on the doors requiring them to be.

Shared facilities were not always clean and hygienic. For example, during our inspection on the acute surgical unit we observed a piece of faeces soiled clothing in the shower area, this was not removed for a long period of time.

There were facilities to dispose of used blood bags but we saw one left on the nursing station desk on the acute surgical unit. When we raised this, we were told it should not have been left there and was promptly disposed of.

The trust’s surgical sterilisation unit (SSU) was based on site. The amount of cancelled surgeries relating to delays in decontamination of equipment had reduced. The service had three washers with the capability to increase to four. There had been seven non-conformances reported between January 2018 and January 2019.

Environment and equipment

In general, the service had suitable premises and equipment to provide safe care and treatment to patients.

There were six surgical wards within the surgical division and each were of varied sizes. On ward nine there were 27 beds which had increased to 34 as part of the trust’s winter plan. The acute surgical unit had 40 beds which had been increased to 53 beds to accommodate medical patients as part of the trust’s winter plan. Emergency call buttons, suction and piped oxygen was available at every bedside. Each patient bay was used for either male or female patients. 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 surgical wards were not always secure. Access to most surgical wards was restricted by an
intercom system, as the entrances to the wards could only be granted to those who were allowed in by staff. Once access to the wards was granted, visitors could enter the clinical areas of the unit without any further restrictions. However, we observed the doors to the acute surgical unit were left open on multiple occasions and when the intercom was pressed, those granting access rarely asked those requiring access for their name or purpose for entering.

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. Equipment that was checked by EBME was on the anaesthesia risk register to be assessed twelve monthly. 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. We saw equipment was stored within one dormant theatre area.

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 ensured 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. The wards were near each other.

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

**The maintenance and use of equipment kept people safe.** We saw equipment had been serviced and maintained regularly. When an item of equipment either electrical or non-electrical broke down or became faulty within the surgical division, staff reported the equipment to the equipment office in the first instance. We checked a range of equipment within theatres and on surgical wards, and each piece of equipment had been serviced within the last 12 months.

The trust held a database of all its equipment. We saw that equipment issues were discussed in the monthly care group meetings and added to the action log. The trust used manufacturers guidelines to plan and monitor maintenance schedules. All medical devices had a unique identification number and schedules were populated from the database to produce a work order in advance for the engineers to plan the recall. Maintenance and servicing within the department mitigated the risk of unavailability of equipment.

All medical devices at the time of service/planned maintenance underwent electrical safety testing and carried a red and white sticker with a ‘do not use after’ label. Ward clerks had an up to date log book for each area to monitor ongoing and completed maintenance work. The trust had an out of hours on call service.

It was identified there was not a robust scanning system within theatre for surgical implants. The scanner used within theatres did not recognise certain implants/equipment. Therefore, the barcodes had to be inputted manually. It was recognised during an investigation into a never event that this created a risk of human error when inputting manually and was put on the theatres risk register. Work was underway to streamline the implants/equipment processes to mitigate the risk. However, this was not on the surgery division risk register.
Arrangements for managing clinical waste were appropriate. 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.

**Assessing and responding to patient risk**

**Staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and wellbeing.**

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. The clinical lead within the trust regularly audited and reviewed all patients with sepsis. Between October 2017 and September 2018, 1,607 patients were discharged with a diagnosis of sepsis, 20% (327) of whom died. The hospital standardised mortality ratio (HSMR) for sepsis equated to 88, which indicated good outcomes for patients and was the second lowest of the 14 trusts in the region. The review of sepsis mortality helped the trust to understand the common themes/errors in the management of sepsis patients and feedback was given to the team at care group level.

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 trust used comprehensive risk assessments for patients but they were not always fully completed and there was limited evidence of clear risk management plans. Each patient on surgical wards should be assessed for their risk of developing pressure ulcers, suffering a fall and developing a deep vein thrombosis. We saw some evidence of these being carried out upon review of patient notes, but we saw five out of 14 records where they were not fully completed. We did not see, when patients’ risks were scored as high, the care plans on how to reduce their risk.

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 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.

Ward staff documented whether or not the patient had a Venous Thromboembolism (VTE) assessment on the WHO Surgical Safety Checklist. All patients with the exception of emergencies had their MRSA status documented on the WHO Surgical Safety Checklist. However, we reviewed data which showed the surgical division had not achieved a compliance score of over 88%, for MRSA screening, since July 2018. Scores have ranged from 83% to 88% from August to December 2018.

The service did not always ensure compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. The trust’s theatre service operation policy stated, “all patients will have a current version of the WHO Surgical Safety Checklist completed as part of their perioperative care provision”. We saw most staff adhering to guidance during our inspection and practice within theatres was audited monthly. The five steps to safer surgery was a mandatory requirement for all patients undergoing surgical interventions and all monthly audits were submitted to the governance team. Every theatre selected ten random patients’ surgeries per month to answer 28 questions which were pre-supplied on the five steps audit tool. Teams which did not achieve 100% had an action plan. The findings were then sent monthly, as a report to the divisional quality board however, we did not see reference to audit performance in any of the three sets of minutes we reviewed from 23 October, 27 November 2018 and 22 January 2019.

In October 2018 a new audit method had been introduced, which now included the brief and debrief. As described in the incident section, there had been 16 reported never events from October 2018 and February 2019. The investigation into one of these revealed the team briefing before and during the surgery had been inadequate. It was recommended by the investigation team to review the current audit process for the WHO surgical safety checklist and consider peer review and observational audits. According to the data provided from January 2018, compliance with the WHO surgical safety checklist was good. We only saw two procedures where practice had not been fully compliant.

Staff told us that some medical staff “needed a push” when undertaking the WHO checklist. Staff told us that they were not confident that all staff in theatres were “on board” when undertaking the ‘surgical time out’. The surgical time out is a final review immediately prior to surgery. This is used to ensure correct patient identity, correct procedure and correct surgical site. As part of the WHO checklist staff undertake a ‘sign out’ check. This is where instruments and equipment are checked and the operating team must discuss any key concerns for recovery management of the patient. Staff told us that the ‘sign out’ was usually not fully completed and improvements were being made.

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
According to the trust, 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. We requested the safer staffing tool for ward 9 and ward 20b as we were told there were consistent staffing issues on these wards. We were provided with the tool for ward 20b but not ward 9. We were also provided with the tool for the surgical assessment unit. We reviewed the safer staffing tool for ward 20b and saw the patient acuity sections had been completed but it had not ever been recorded for the surgical assessment unit. As we were not provided with the safer staffing tool for ward nine, we cannot determine whether the risk assessments were correctly carried out. This process did not ensure all areas were safely staffed in relation to patient acuity.

The safer staffing requirements on the surgical assessment unit (SAU) were unclear. We reviewed the safer staffing data for the acute surgical unit, from 1 December 2018 and 3 February 2019, and it was unclear whether the data relating to staffing requirements were calculated correctly. According to data provided by the trust the staffing requirements amounted to 26 planned hours per day shift. The data was unclear on whether the 26 planned hours for the unit covered the seven registered nurses required for a day shift or whether it included the additional staffing requirements due to the increase in beds. However, due to the increase in beds, there would be up to nine registered nurses working on the unit during a day shift. Therefore, 26 planned hours would not account for the required additional staffing.

As described above, additional beds had been opened on the acute surgical unit due to the trust’s winter plan. A staffing model was used to work out how many staff were required as additional beds were opened. The additional beds significantly impacted on the workloads of staff and established staffing levels could not meet the required levels. We were told the additional beds on the unit were going to be closed week beginning 18 February 2019, however, during a brief visit on 22 February 2019, we saw the beds remained open and staffing was still not in line with the required levels. Upon visiting the acute surgical unit on 19 March 2019 we saw the 13 additional beds had been closed.

At the time of our inspection, it was determined by the nursing management team that the acute surgical unit required seven registered nurses and five clinical support workers on an early or late shift and five registered nurses and three clinical support workers on a night shift. As there were 13 additional beds on the unit due to escalation, they also required two additional registered nurses and one/two clinical support workers on each early/late/night shift. Out of 12 days in February 2019, nine days had not been fully staffed. On seven of those 12 days staffing had been down by two registered nurses and on two days, the unit had been down by one registered nurse. We were told staffing shortfalls were risk assessed a minimum of twice daily to understand the risk and mitigate with an operational plan. However, staff told us when staffing was not at the required levels, the quality of care delivered was impacted negatively.

It was determined by the nursing management team that there was a need for one additional registered nurse and clinical support worker per early/late/night shift on ward nine due to the escalated seven bed capacity. Staff told us these shifts were usually covered by bank or agency.

Ward managers did not always remain supernumerary and would work shifts on their non-working days. We were told by all levels of staff that ward managers regularly had to fill shifts to make the staffing levels safer. We were told it was recorded on off-duty rotas when a ward manager was not
supernumerary. Following the inspection, we were told it was the expectation ward managers would work one or more clinical shifts to demonstrate clinical leadership. However, we were told during the inspection the intention was to mitigate the risk to patients due to staffing being lower than the required level.

The data systems used by the service did not provide assurance staffing levels were safe. Conflicting data was submitted by the trust, which made it difficult to determine whether there were nurse and clinical support worker staffing issues on wards 20b and 20c. We reviewed the safer staffing data from these wards from 1 December 2018 to 24 February 2019. Staff on ward 20b were also required to look after patients admitted to ward 20c, over-night. According to data the overall fill rate for registered nurses, for day shifts, during December, January and February was 97%, 96% and 76% respectively. The overall fill rate for clinical support workers, for day shifts, during December, January and February was 91%, 92% and 83% respectively. The data showed the nursing fill rates for night shifts during the same period was 97%, 100% and 63%. For clinical support workers it was 100%, 100% and 35%. All the figures included substantive, bank and agency staff. However, data submitted after the inspection, which included off duty rotas, covering 4 February 2019 to 17 March 2019, contradicted the original data.

Staff were moved between areas to fill gaps in staffing on other wards. During our inspection, a registered nurse and clinical support worker had been moved from the surgical assessment unit to ward nine to assist with the personal care of patients.

The surgical division had recognised staffing levels were a risk. This had been included on the risk register for general surgery and the acute surgical unit. According to the risk register, these risks were being mitigated by block booking agency nurses, monitoring and managing sickness, monitoring staff vacancies, actively recruiting for band five nurses, commencing a band four training programme (January 2017), weekend and night only job adverts, twice daily shift huddles and overseas recruitment.

Ward managers confirmed there were nurse staffing meetings each day. Meetings were attended by matrons and ward managers to discuss staffing levels and changes to staffing arrangements. It was at these meetings where staff moves would be discussed. We were not assured patient acuity was discussed as we found this was not recorded on the safer staffing tool we reviewed for the acute surgical unit.

The trust had taken steps to increase staffing within the surgical directorate. An apprenticeship scheme had been implemented to attract more staff to the hospital. On ward nine and ward 20a four apprentices had completed their training to become clinical support workers.

Theatre staff were allocated according to recommended guidance by the Association for Perioperative Practice (AfPP). Staff told us within theatres that they felt the staffing was mostly sufficient. The recovery area within theatres was staffed as per British Anaesthetic and Recovery Nurses Association (BARNA) standards of practice which states there should be staffing ratio of 1:2 (one nurse/two patients) for the reception of the patient, 2:1 (two patients/one nurse) for the stabilisation period and 3:1 (three patients/one nurse) for discharge from recovery.
Staff told us colleagues who were band three or four did not have the necessary competencies to be able to perform regular observations of vital signs. Staff told us further training for staff to reach these competencies was being undertaken in conjunction with the local college. We were told after the inspection theatres do not employ band three substantive staff. Qualified staff were paid at band three level once all recognised competencies were passed and are awaiting their registration pin number. Band four staff had recognised competencies in conjunction with the local college/university. Completed competencies were kept by each staff member.

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. We observed a morning handover on wards nine, 20b and the acute surgical unit and saw that all relevant details were shared and discussed. The nurses used a handover document which was filled in by the nurse in charge and communicated to the nurses coming on duty.

The trust has reported their staffing numbers below as of March 2018 and September 2018 in surgery.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th></th>
<th></th>
<th>September 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Manor Hospital surgery department</td>
<td>133.5</td>
<td>159.8</td>
<td>83.5%</td>
<td>133.7</td>
<td>157.5</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From October 2017 to September 2018, the trust reported a vacancy rate of 17.0% in surgery. On ward nine there were 2.2 whole time equivalent (WTE) vacancies for registered nurses and will shortly have 0.61 WTE for clinical support workers.

There were high numbers of vacancies on the acute surgical unit. For example, there were two whole time equivalent (WTE) vacancies for band six nurses, 10 WTE vacancies for band five nurses, one WTE vacancy for band three staff and four WTE vacancies for band two staff. It was recognised by senior nursing leaders that this was potentially impacting on the ability to safely staff the unit. We were told that work was being carried out to identify if and how patient safety was being impacted.

**Turnover rates**

From October 2017 to September 2018, the trust reported a turnover rate of 11.1% in surgery. This is above their target of 10%.

The trust provided us with updated data for nursing staff turnover (bands five to eight). Staff at band six to eight were within the trusts 10% target however, there was a 14% turnover rate for band 5 from August 2018 – January 2019 which was above the trust target.
Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 6.4% in surgery. The trust provided a breakdown of the current sickness rates within the division of surgery.

| AfC Band 7 | 10.85% | 7.06% | 7.12% | 7.18% | 4.03% | 4.08% |
| AfC Band 8A | 0.00% | 6.95% | 6.92% | 6.89% | 6.86% | 6.83% |
| AfC Band 8C | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |

Bank and agency staff usage

Surgical wards used regular bank and agency staff who were familiar with the ward areas. From October 2017 to September 2018, the trust reported a bank usage of 9.5%, an agency usage rate of 14.6%, and an unfilled rate of 6.6% in surgery for all nursing staff. When agency nurses and clinical support workers started a shift, they were required to sign in and have a uniform check. We observed agency nurses signing in and reviewed one of the sign-in books but the documentation was not always in chronological order. There were two sign-in books on the acute surgical wards which some agency nurses had signed both, but some only signed one.

There were high levels of agency use on the surgical assessment unit (SAU). The required safer staffing levels for the SAU had been calculated at 26 hours. The safer staffing data showed that between 1 December 2018 and 3 February 2019, there had been 20 days when agency nursing staff had been used to cover shifts and on 16 of those days, agency nursing staff were used for 13 hours during a shift. On 22 December 2018 there were no substantive staff working a day shift, as 13 hours were covered by bank and 13 were covered by agency.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Shifts</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
<td>Agency</td>
</tr>
<tr>
<td>Qualified Nurse</td>
<td>16,884</td>
<td>25,997</td>
</tr>
<tr>
<td>Non-qualified Nurse</td>
<td>30,415</td>
<td>5,707</td>
</tr>
</tbody>
</table>

Staff temporarily covering patient care from other wards were not always given appropriate handovers. Nurses and clinical support workers, moved from other wards, were not always given handovers. During our inspection, two staff on ward 9 were unaware of any patient’s DNACPR as they had not been given a handover when transferred from another surgical ward. At the time, there were two patients, in the bay the transferred staff were working, who had DNACPRs.
Medical staffing

Medical staffing arrangements on surgical wards were safe. Doctors were ward based Monday to Friday and covered from 8am to 5pm. On weekends the cover was provided by doctors on call. Consultants on call over the weekend were on site 8am-2pm to do a full ward round of all surgical patients. In the week a hot week model was utilised which meant a different consultant on call every night who took handover at 5.30 pm in theatres and stayed on site if required. This cover was provided by consultant, registrar and year one and two foundation doctor.

Working arrangements for anaesthetists were safe. Middle and consultant grade anaesthetists worked on two separate rotas. Each middle grade doctor worked on call one week in eight. Each consultant worked on call one week in 11. When anaesthetists were on call they covered from 6pm to 8am. There was a 30-minute overlap for anaesthetists to handover. During weekdays, within theatre two, there was a middle grade and consultant anaesthetist on duty. The consultant carried a dedicated bleep to ensure they could have a supervisory role and could attend theatres and step in if there were any issues. We saw this during our inspection when a middle grade anaesthetist, in another theatre, had an issue with a difficult airway. The consultant from theatre two attended to assist with the patient. The middle grade anaesthetist in theatre two could carry on with the case.

The trust has reported their staffing numbers below as of March 2018 and September 2018 in surgery.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Manor Hospital surgery department</td>
<td>122.8</td>
<td>139.7</td>
</tr>
</tbody>
</table>

The surgical directorate did not routinely collect, record or monitor data in relation to unfilled shifts relating to medical staffing. We requested this data from the trust but they confirmed they did not collect it on a routine basis. The trust used a third-party system to tender out shifts but were unable to provide data in relation to those shifts tendered out or left unfilled.

Vacancy rates

As at October 2017 to September 2018, the trust reported a vacancy rate of 12.9% in surgery.

There were some doctor vacancies within anaesthetics. There had been an issue with recruitment but at the time of our inspection, there was one middle grade doctor and one consultant vacancy within the surgical division. There were two middle grade doctors due to start employment within the next few months.

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 6.8% in surgery. This is below their target of 10%.
Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 1.4% in surgery. Medical staffing sickness levels were low.

Bank and locum staff usage

From September 2017 to August 2018, the trust reported a bank usage of 64.7%, an agency usage rate of 9.3%, and an unfilled rate of 13.3% in surgery.

Staffing skill mix

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the whole time equivalent staff working at Walsall Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>12%</td>
<td>27%</td>
</tr>
<tr>
<td>Junior*</td>
<td>20%</td>
<td>13%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Allied Health Professionals

Allied health professional staffing was not sufficient to deliver the services proposed by the division. Allied health professionals supported the surgical division but service was limited due to low staffing levels. For example, there was a band two therapy clinical support worker, band five rotational post, band six occupational therapist and band seven physiotherapist who provided cover for ward nine from Monday to Saturday. However, each only worked five days a week and Saturdays were covered on a rota basis. This meant there would be only a band two or band seven physiotherapist working on a Saturday. There was no rehabilitation service on a Sunday. We were told the physiotherapy and occupational therapy services were fully staffed but if one therapist was off on leave or sick, another therapist would have to come down from their allocated ward to cover, which meant neither ward received a full service.
Physiotherapists and occupational therapists attended and contributed to board rounds. On ward nine and ward 20a board round took place every morning. From Mondays to Saturdays, therapy support staff attended them and provided input on patient progress and care plans.

Therapy cover was limited. Both occupational therapists and physiotherapists worked from 7.45am to 4pm. There was an on-call hospital-wide respiratory service available out of hours and on Sundays. There was no occupational therapy service on a Sunday. We were told by all levels of staff that the limited cover provided by allied health professionals made timely discharges more difficult as they were not always available to see patients fit for discharge due to their limited capacity.

There was limited dietitian and speech and language therapy (SALT) support. There was no dedicated dietetic or SALT services to the surgical division but staff could access on-call services. Both the dietitian and SALT services were only available from Monday to Friday.

Clinical support worker arrangements were not always safe on the surgical assessment unit. Between 1 December 2018 and 3 February 2019 there were 20 days when the total hours covered by clinical support workers was less than the planned hours. On four of those days there were no clinical support workers on shift at all.

There were consistent clinical support worker staffing issues on ward 20b and 20c. We reviewed the safer staffing data on ward 20b and 20c from 1 December 2018 to 24 February 2019. There were 24 occasions, between the period above, when planned clinical support worker staffing level requirements were not met during day shifts. Of those 24, there were 13 occasions when staffing hours had been down by over 11 hours. There were also 16 occasions when clinical support worker staffing level requirements were not met during night shifts. On all 16 of those occasions clinical support worker staffing hours had been down by 21 hours.

Records

Staff did not always keep detailed records of patient care and treatment. Within some surgical wards, patient records were incomplete. Although we saw some records which contained most of the expected information relating to patient care from admission to discharge, this was inconsistent. On some wards it was not clear whether patients had individual care plans which were revised and adapted as treatment progressed. Records were not always comprehensive and were difficult to follow. Patient records did not follow a set format in that they were not ordered in the same way for each patient.

Quality in the information needed to deliver safe care and treatment was varied and information was not always available in a timely and accessible way. We reviewed 13 patient records during our inspection and found that seven did not contain all the required information. For example, Malnutrition Universal Screening Tool (MUST) assessments were not fully completed, nursing notes were missing for whole days, discharge information was not completed before patients left the ward, pain assessments were missing, consultant and GP details were not recorded, falls assessments were incomplete, dementia screening assessments were not completed and care plans for patients assessed as having a high risk of developing a pressure ulcer were missing. When this was raised
with staff they confirmed records were not always completed contemporaneously as they had limited capacity due to low staffing.

Not all the required information was available when patients moved between teams, services and organisations. We were told by staff patient records were not always available upon discharge. For example, patient records did not always travel with them when they were transferred to the discharge lounge. Staff told us patients were often transferred but their notes remained on the ward they had been admitted to. We also saw evidence a patient’s “do not attempt resuscitation” letter did not travel with the patient on discharge and had to be sent to them by taxi after they had arrived home. We reviewed the discharge lounge risk register and this was not added.

Patient records within the surgical division were paper based, apart from some risk assessments which were electronic. The core patient record was paper-based and was supplemented by two electronic patient record systems. One was used to manage the patient from an administrative perspective whilst the other provided clinical information used by the clinician to diagnose and decide treatment for the patient. The trust had recently linked their theatre systems into the portal to bring across the patient notes, but it was recognised there were weaknesses in relation to availability of the paper-based record in multiple locations and gaps where systems were not connected to the patient portal for the passing of clinical data.

Relevant risk assessments were used within the surgical division. Risk assessments included but were not limited to the prevention of venous thromboembolism, pressure ulcers, malnutrition and falls. Within all 13 of the records reviewed, we saw evidence of completed risk assessments but within five records some were partially complete and lacked sufficient levels of detail. Identified actions from the assessments were not always noted or implemented.

The surgical division considered patient records a risk. The divisional risk register held a risk in relation to patient records as it was identified they were not always legible, not all entries were signed, dated or printed with staff names. We observed these issues during our review of patient records. Although the division had acted to address this by carrying out documentation audits, writing a policy highlighting basic standards and discussing compliance at governance meetings, the standard of patient records was poor. Also, the risk did not include all the issues with patient notes, for example, that they were not always complete.

**Medicines**

The service mostly followed best practice when prescribing, giving, recording and storing medicines. Non-emergency medicines were stored appropriately in locked cupboards. However, IV fluids were not always stored in locked cupboards. In a random check of a range of medicines stored within surgical wards, we saw that all were in date. Drugs keys were held by the nurse in charge during a shift.

Although the trust had comprehensive arrangements in place to obtain medicines, including out of hours when pharmacy was closed, medicines were not always available to give and had not been obtained to ensure the continuation of patients’ treatment. Out of twelve patients medicine charts looked at, on ward nine, we found 4 patients did not have some of their medicines available to administer and two patients had not had their prescribed eye drops administered for two days. No
explanation could be given why the medicines had not been made available although delays in obtaining medicines from pharmacy was mentioned as an issue at times.

Medicines which required refrigeration were kept at the correct temperature. The 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.

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.

It was identified on the surgical division risk register that there was a high risk relating to the inability to provide assurance for the safe storage and handling of non-controlled drugs within theatres. This was because multiple people had access to drug cupboards which were not subject to the same monitoring as controlled drugs. There had also been two incidents relating to non-controlled drugs in theatres. Actions were being taken to mitigate against the risk which included but was not limited to; staff had to sign when taking the keys out and returning them at the end of a shift; divisional director of nursing and pharmacist doing regular checks.

Prescription charts used on the unit were complete and included all the relevant information. Of the one prescription chart we reviewed it was clear on who prescribed a medication, when a prescription had been made and patient allergies were identified.

Most medicines were appropriately administered and/or supplied to people in line with relevant legislation, national guidance and best available evidence. We observed nurses preparing medicines in line with best practice. Where appropriate, patients were informed of why, what and how they were going to be administered. However, on the acute surgical unit we found a single tablet left unattended in an area accessible by patients. This was raised with the nursing staff however, there was no attempt to find out what the medicine was, who it should have been administered to or how it got there.

Medicine management practices on surgical wards were audited. There were medicines audits for controlled drugs which was carried out quarterly, a drug storage audit and a ward medicines trolley audit. Following a review of the trust medicines management annual report, it showed controlled drug compliance was generally acceptable, but there were locations which were persistently below an acceptable standard. Drug storage audits showed an average compliance rate of up to 90% for the last 12 months. However, drug trolley audits showed compliance was around 75%. The main concern being that liquid medicines were opened but with no expiry attached from the date of opening. The issue with liquid medicines in the drug trolley was being addressed through weekly self-audits.

The main concern regarding controlled drugs audits was around wards which were persistently below the 90% compliance threshold. The director of pharmacy was in discussions with matrons to implement an escalation of the frequency of audit if compliance was poor. The matrons took direct ownership for follow up of audit action plans which were on a monthly or weekly re-audit.
Actions included making amendments in the controlled drug record book, evidencing controlled drug stock count at shift handover and signing for controlled drugs at the point of receipt in the requisition book.

Audit results were presented at the medicines management committee, which reported to the quality and safety committee. All audits were presented by pharmacy representatives at care group level with accountability for actions to divisional boards.

Incidents relating to medication management errors were low. We reviewed data relating to medication errors and saw evidence that there had been 56 between August 2018 – January 2019, with 18 and 12 on acute surgical unit and ward nine respectively. Below shows this broken down by surgical areas:

<table>
<thead>
<tr>
<th>Surgical Area</th>
<th>Aug-18</th>
<th>Sep-18</th>
<th>Oct-18</th>
<th>Nov-18</th>
<th>Dec-18</th>
<th>Jan-19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Surgical Unit (ASU)</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Discharge Lounge (Temporary)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Pre-Assessment</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Surgical Assessment Unit (SAU)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Theatres</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Ward 20A</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Ward 20B</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Ward 9</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>West Wing Theatres</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>10</td>
<td>5</td>
<td>17</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>56</td>
</tr>
</tbody>
</table>

A medicines management handbook was developed and circulated to nursing staff. A controlled drugs poster was also developed and situated on every ward-located controlled drugs cupboard to assist staff when making amendments to the register.

Incidents
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no incidents classified as never events for surgery.

From October 2018 to February 2019, the trust reported 16 incidents classified as never events for surgery. All 16 relate to a placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. Of the 16 never events, 15 involved the placement of a stainless steel femoral head instead of a chrome cobalt femoral head during hip revision surgery. One of the never events involved a patient undergoing revision of hip and fixation of the peri-prosthetic fracture. Following surgery, the surgeon realised they should have inserted a ceramic head with the ceramic liner rather than stainless steel for compatibility. The investigation report for the 15 other never events was not available at the time of our inspection.
The never event involving the stainless-steel femoral head instead of a ceramic one was investigated and the cause of the incident was determined to be human error. Following identification of the error and subsequent investigation, the patient was informed as soon as the incident was identified and the option of returning to theatre was given to the patient. Processes such as the team brief were reviewed immediately and appropriate changes were made. In addition, the storage of prosthesis was reviewed and streamlined; a femoral head review took place and the stainless-steel heads were removed from the shelves. In addition, a review of any potential risks within theatres was undertaken and we were told it was entered onto the departmental risk register. The risk was not recorded on the surgical division risk register. An immediate inspection of theatres was undertaken and an action plan devised.

Within investigation reports it was recognised that learning from never events needed to be fed through to the organisation highlighting the importance of effective and thorough checklists when carrying out invasive procedures outside the theatre setting. However, most staff on the surgical wards were unaware of the recent never events which took place in the theatre departments. Staff told us they would find out about never events or serious incidents during ward meetings. They did not recall being informed about the recent never events at ward meetings or safety briefs.

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incident reported were

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with four (30.8% of total incidents).
- Pressure ulcer meeting SI criteria with three (23.1% of total incidents).
- HCAI/Infection control incident meeting SI criteria two (15.4% of total incidents).
- Medication incident meeting SI criteria with one (7.7% of total incidents).
- Slips/trips/falls meeting SI criteria with one (7.7% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria one (7.7% of total incidents).
- VTE meeting SI criteria one (7.7% of total incidents).

![Bar chart showing the number of serious incidents by type.](image)

Patients and their families were told when they were affected by something that went wrong. They
were given an apology and informed of any actions as a result. The unit had applied the duty of candour in all applicable situations we were made aware of. Staff were aware of their responsibilities and when the duty applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We saw evidence of the duty of candour being applied when a never event took place. The documentation we reviewed outlined the patient was told what went wrong, why and what was being done to reduce the risk of it occurring again. An apology and the opportunity to discuss the issue with the appropriate persons was offered to the patient.

Most staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally but not all incidents were reported or done so promptly. Staff were encouraged to report incidents and often received feedback on the incidents they had reported. However, staff confirmed they did not always report low staffing as incidents and felt escalation to their line manager or matrons was sufficient. On the acute surgical unit, some of the locks on the patient records trollies were broken. We were told this had not been reported as an incident, escalated to the ward manager or put on the unit’s risk register. We were told after the inspection, the locks had been reported as needing to be repaired and put on the risk register. There was also a failure to report, as an incident, the failed discharge of a patient with their “do not attempt resuscitation” letter. We saw it had taken 10 days to report a never event as an incident. There was also a failure to report, as an incident, the failed discharge of a patient with their “do not attempt resuscitation” letter. We saw it had taken 10 days to report a never event as an incident.

Staff were aware of the incidents that colleagues had reported as they were displayed on boards across the surgical wards. Specifically, the units displayed the top three most frequently occurring incidents on the ward and across their care group.

There were arrangements for reporting, reviewing and investigating safety incidents when things went wrong. The trust had an electronic system for reporting incidents, which all staff had access to and had been trained to use. Each ward manager was responsible for investigating minor and moderate incidents on the unit once reported. Any serious incidents were investigated by a staff member outside of the ward to maintain impartiality. Investigations into any themes or trends were carried out and shared with staff at the Friday general surgery patient safety meeting. If an incident related to specific issues the report would also be received by a specific service so they were aware and could provide support if required. For example, safeguarding or pressure ulcer incidents would also be sent to the safeguarding leads or tissue viability services.

When themes or trends in incidents were identified action was taken to reduce their occurrence. It was identified that there had been an increase in avoidable pressure ulcers within the surgical division and it was included on the division’s risk register. Action had been taken to mitigate this risk. For example, on ward nine, we were told there had been an increase in the number of pressure ulcers reported. As a result, input from the tissue viability team had been sought. The nurses within the tissue viability team had visited the ward to deliver training sessions. The ward was also trialling a new type of air boot to see if it was successful in reducing pressure ulcers on patients’ heels. We were told ward nine had achieved a reduction in pressure ulcers as a result.

Surgical morbidity and mortality reviews were undertaken monthly. We saw evidence of a monthly morbidity and mortality review presentation being delivered at a general surgery care group safety
and quality meeting, in January 2019. There had been a review of the meetings which identified there were no real themes or proper actions being pulled out from the reviews. Mortality issues or discussions were not being escalated at the mortality surveillance group due to lack of attendance by the mortality lead. There was no ability for the mortality lead to quality check the mortality review paperwork to ensure that it was up to standard. As a result, a new process was being piloted to improve the process, although it had only recently been implemented.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported six new pressure ulcers, five falls with harm and one new catheter urinary tract infection from October 2017 to October 2018 for surgery.

Data collected covered incidences of hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four); patient falls causing harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis).

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Walsall Healthcare NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Is the service effective?

Evidence-based care and treatment

The service did not always provide safe care treatment and did not always follow national guidance.

Patients’ physical, mental health and social needs were not always fully assessed. Staff within the surgical division screened patients for pressure ulcers, falls, venous thromboembolism and 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 13 patient records we reviewed, there was evidence some patients were fully assessed and/or screened on admission and daily using validated and reliable scales. There were gaps, as discussed in the records section, which meant not all patients were appropriately assessed.

Staff had access to all existing trust policies, procedures and protocols. A wide range of policies and guidelines were available for staff. They were based on national guidance such as the National Institute for Health and Care Excellence and staff told us these guidelines were referenced on the trust intranet.

We reviewed five polices, all of which had been reviewed recently and referenced the current best practice from national and international guidance, including the National Institute for Health and Care Excellence (NICE). During the inspection process, we reviewed the trust’s policy in relation to infection prevention and control, theatre operations, blood transfusion and step down from critical or high dependency care. We saw the theatre services operations policy was not fully up to date as it referenced the previous matron for theatres, anaesthetics and critical care. We also saw the surgical division was aware the policy was out of date as this was referenced in the investigation into one of the never events. The investigation report highlighted the policy did not cover manufacturers’ representatives being present in theatre along with their roles and responsibilities. Work was being carried out to review the whole policy.

The service did not always provide care and treatment based on national guidance. There was a system for identifying and disseminating national guidance, standards and practice, including information issued by NHS England, the National Institute for Health and Care Excellence (NICE) and Public Health England. The service contributed to national audits, which benchmarks performance and outcomes to evidence based best practice guidance. For example, these included:

- Hip fracture
- Bowel Cancer Audit
- National Vascular Registry
- Oesophago-Gastric Cancer National Audit
- National Emergency Laparotomy Audit
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 but was not always adhered to. Compliance was monitored by monthly audits, which showed that practice in theatres was good. However, there was issues as described in the assessing and responding to risk section above.

We observed staff following the current National Institute for Health and Care Excellence advice care pathway for difficult airway intubation using video laryngoscope. Staff told us that they had training for unanticipated difficult tracheal intubation and followed the protocol. We saw intubation and anaphylaxis guidelines displayed in the anaesthetic room.

Systems ensured there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. All staff underwent equality and diversity training as part of the mandatory training programme. As of September 2018, 93% of nursing staff had completed the training, however, only 78% medical staff within the surgical division had completed the training, against a trust target of 90%. All policies we reviewed had been assessed to ensure there was no impact upon equality and diversity.

The surgical service did not always ensure that surgery was managed in accordance with the principles in national confidential enquiry into patient outcome and death (NCEPOD) recommendations. We were told patients admitted to the surgical assessment unit (SAU), should be clerked by a doctor-in-training within one hour of admission and reviewed by a senior doctor (consultant or registrar) within two. The NCEPOD recommends that standards of clerking/examination and recording thereof should be improved and each hospital should ensure the detail required in clerking and examination is explicit and communicated to doctors-in-training as part of the induction process. They also recommend a regular (six-monthly) audit of performance against these agreed standards should be performed and reported through the governance structure of the organisation. It was confirmed by staff that an audit of practice within the SAU in relation to clerking and senior doctor review was not taking place. It was also confirmed the SAU were not assured the one or two-hour targets were being achieved. There were appropriate supervision processes for doctors-in-training but they were not always followed. We saw in one patient record from the SAU that a patient had been reviewed by a doctor-in-training but not by a senior doctor before being discharged. The SAU had no way of monitoring how often this occurred.

Compliance with required assessments was not always high. We were told venous thromboembolism assessments were not always carried out at the required times. The National Institute for Health and Care Excellence Guidelines (NICE) NG89 (Venous thromboembolism 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. The trust target was for 100% patients to be assessed upon admission. On the surgical assessment unit (SAU), this responsibility fell on the doctors-in-training. However, compliance on the SAU in January 2019 was at 85%, which was lower (worse) than the trust target. The trust provided data for the last six months for the surgical division and this was lower than the trust target. Please see table below.

VTE completion data
National Institute for Health and Care Excellence could not always be followed due to low staffing. As described above in the allied health professional section, the physiotherapy service was not provided seven days a week due to low staffing. As a result, they were not always able to follow guidance from Hip Fracture: Management Clinical Guidance (CG124). The guidance states patients should be offered a physiotherapy assessment and, unless medically or surgically contraindicated, mobilised on the day after surgery. This was not possible if patients had surgery on a Saturday as there were no physiotherapists to mobilise them on a Sunday. It also states patients should be mobilised at least once a day and ensure regular physiotherapy reviews. As above, this was not possible on a Sunday.

Initiatives had been implemented which were based on best practice. An enhanced recovery programme had been implemented within the musculoskeletal service but had ceased in December 2018. The programme was due to be re-instated but the service would not have been able to be delivered as physiotherapists did not work seven days a week. However, the programme included a joint school for elective hip replacement patients. The joint school was attended by patients to educate them on what the expected outcomes for surgery were and how they could help with their own recovery. The joint school had recently been reinstated at the time of our inspection and took place once a week.

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. The surgical division did not always comply with National Institute for Health and Care Excellence QS15 (Patient experience in NHS Services) as there was varied evidence that patients’ physical needs were regularly assessed. However, all patients we spoke with told us they had enough food and drink to meet their needs.

Everyone using healthcare and care services were not always screened to identify those who are malnourished or at risk of becoming malnourished. A malnutrition universal assessment tool (MUST) was being used on surgical wards which evaluated the standard risks, including body mass index, recent weight loss, mobility, age and gender. However, within the two of the 13 patient records we reviewed, one had no MUST assessment and the other was only partially completed. We did see patients’ fluid balance was calculated, recorded and assessed to ensure they were at appropriate levels.

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.
Patients we spoke with told us that they were happy with the food choices and variety. We observed patient’s drinks were in reach on their bedside tables. Menus seen on the inpatient wards catered for dietary needs including soya milk, halal meat, gluten and lactose free food and de-caffeinated hot drinks. Menus also included a recommended daily salt intake information from the Department of Health.

Dietary and nutritional specialist cover was available but the service provided was on-call. There was an on-call dietitian available to the surgical wards five days a week. Staff told us they would access the service if they required additional support or advice. On days when the service was unavailable staff had access to emergency regimes they could implement by following a standard operating procedure.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. Although it was not clear whether pain assessments had been carried out within all the patient records we reviewed, patients told us their pain levels had been assessed and relief given whenever required. We were told by staff pain was assessed daily and a given score. When pain scores were recorded within patient records we saw all assessments were complete and detailed. We observed staff asking patients about their pain levels during our inspection and the patients we spoke with said they were made to feel comfortable.

Staff told us that they had access to the pain management team and this was a part time service. We were told that if the pain management team were not available then staff were advised to ask advice from the consultants.

**Patient outcomes**

The surgical division did not have oversight of all their clinical outcomes. This was because there had been a period when the division did not have the required staffing to ensure consistent and accurate input of data. This had been recognised as a risk on the divisional risk register and it was identified there was no assurance of submission or the quality of data to the national reports. For example, the division described the data submitted to the Hip Fracture database, National Joint Registry and PROMS for hips and knee replacement as inconsistent, piecemeal and missing. However, data was submitted in respect of patient outcomes, which can be seen below.

Patient outcomes were not always monitored due to delayed patients

Long term overviews of patients are necessary to measure patient outcomes. Data provided by the trust showed that patients who were delayed had increased month on month. This meant that patients who were active in the trust pathways had become lost (for various reasons) at the point of their follow up. In January 2018, 683 patients were delayed and the December data showed 1,851 patients for that month. The total amount of delayed patients from January to December 2018 was 13,050 patients.

**Trust level**

From July 2017 to June 2018, general surgery and urology patients at the trust had a higher
expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

The below table shows the expected risks of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a slightly higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions – Trust Level**

**National Hip Fracture Database**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 9.0% which was within the expected range. The 2016 figure was 6.8%.
The proportion of patients having surgery on the day of or day after admission was 61.3%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 59.3%.

The perioperative medical assessment rate was 86.6%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 91.5%.

The proportion of patients not developing pressure ulcers was 96%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 98.4%.

The length of stay was 25.3 days, which falls within the bottom 25% of trusts. The 2016 figure was 25.0.

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, the number of patients undergoing a major resection had a post-operative length of stay greater than five days was not reported. The 2016 figure was 78.9%.

The risk-adjusted 90-day post-operative mortality rate was not reported. The 2016 figure was 5.3%.

The risk-adjusted 2-year post-operative mortality rate was 31.4% which was worse than expected. The 2016 figure was 26.2%.

The risk-adjusted 30-day unplanned readmission rate was not reported. The 2016 figure was 5.4%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 40.5% which was within the expected range. The 2016 figure was 43.8%.

**National Vascular Registry**

This data was requested from the trust. We were told by the trust this data was submitted via Russell’s Hall Hospital who are the vascular hub.

**Oesophago-Gastric Cancer National Audit**

In the 2016 National Oesophago-Gastric Cancer National (NOGCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that less than 15% of records had the referral source missing.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

**National Emergency Laparotomy Audit**
The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the Manor Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 103 cases.

The site achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 79 cases.

The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 55 cases.

The site achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 44 cases.

The risk-adjusted 30-day mortality for the site was within the expected range, based on 103 cases.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. This is broken down below the graph.
• In 2016/17 performance on groin hernias was worse as the England average.
• For varicose veins, performance was better as the England average.
• For hip replacements, performance was about the same as the England average.
• For knee replacements was about the same as the England average.

**Competent staff**

**The service made sure staff were competent for their roles.** Patients had their assessed needs, preferences and choices met by staff with the right skills and knowledge.

Staff were encouraged and given opportunities to develop. For example; appraisals were carried out by band seven ward managers but they gave band six nurses the opportunity to carry out the appraisals of band five nurses to assist with their development.

Specialist equipment was only used by staff who had completed the necessary training to do so. There was a medical device competency monitoring process. There was a training compliance spreadsheet showing which staff had been trained to use equipment and presented the compliance percentage for each piece of equipment. The spreadsheet used a red, amber, green (RAG) rating system to identify when there were low, moderate or high levels of compliance for each specific piece of equipment. Staff told us they would not use equipment unless they had received the appropriate training to do so.

The arrangements for supporting and managing staff to deliver effective care and treatment were not always apparent. There were no formal processes for supervision across the trust but this was being reviewed by the director of nursing. We were told one to one supervision could be provided for staff but only if requested. All staff were part of de-brief sessions following an event such as a serious incident to ensure support was in place for staff. The nursing teams on wards had a weekly 'safety huddle' which gave individual team members the opportunity to express items of concern and receive peer support and supervision, but this was on an ad hoc basis. There was a monthly matrons' forum which was preceded by a matrons' pre-meet where they provided supervision and support to each other. There was also a ward sisters' forum which provided the same opportunities.

Staff spoke positively about education opportunities within theatres and ward nine. For example, the theatre department worked with local education providers to offer education opportunities. The trust
offered theatre support workers opportunities to re take GCSE courses. This would enable them to develop into higher bandings within the theatre team.

**Appraisal rates**

We collected data during and after the inspection regarding the current appraisal rates within some areas of the surgical division. This data showed that appraisal rates for medical staff within the general surgery care group was 88%. On ward nine only one out of 27 staff had an outstanding appraisal, meaning compliance was at 96%, which was higher (better) than the trust target.

From March 2018 to September 2018, 87.8% of staff within surgery at the trust received an appraisal compared to a trust target of 90%. We reviewed updated data relating to nursing staff on the surgical division and saw the current appraisal compliance rates for 231 nursing staff. We saw 133 were completed, 73 have appraisals booked and 32 were overdue.

Induction programmes were in place for new staff. Employees, bank staff, volunteers and consultants attended the trust induction programme, where possible, prior to or on the first day of employment with the trust. New staff also followed local induction requirements, as outlined on a local induction checklist. At the time of inspection, we did not see a completed form to evidence if they were being completed. Agency nurses we spoke with told us they had completed an induction on the first day of their employment on a ward.

**Multidisciplinary working**

**Staff of different professions worked together as a team to benefit patients.** 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.

Patients’ care and treatment was being delivered by appropriate disciplines. We saw patients being treated by physiotherapists during our inspection and physiotherapists told us they worked in conjunction with the wider multi-professional team to ensure patients’ treatment plans were progressed.

Information about patient care was communicated and shared effectively. For example, daily ward rounds took place on ward nine. Attendance was required from consultant orthopaedic consultants, orthopaedic geriatrician, physiotherapists, occupational therapists, nurse representatives and the discharge coordinator. Each patient and the needs were discussed after which the meeting was concluded to start the doctors ward round and they were accompanied by the nurse in charge of the ward. We saw multiple examples of good multi-disciplinary working.

Surgical wards sought advice from external parties when required. For example, ward nine had experienced issues when caring for spinal patients as a lack of expertise relating to positioning had been identified. Patients were left with avoidable pressure ulcers to their heels and sacrum as a result. To address this gap in knowledge work was carried out to obtain external advice. This resulted in extra teaching sessions for staff and had identified that documentation relating to patient non-concordance needed to be improved.
Seven-day services

The service was continuing to work towards seven-day services although were yet to achieve it.

There were some services within the surgical division which were not available seven days a week. The virtual clinic pathway, within the surgical assessment unit, was run seven days a week, in that patients were scanned and the images reviewed seven days a week but telephone calls to the patient to discuss the results were not made from Friday to Sunday. If scan results were urgent it would be escalated to the on-call surgical team for further review and action.

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.

Physiotherapy services, in relation to rehabilitation, were not available across the entire week. There was no dedicated physiotherapy cover on Sundays but an on-call hospital-wide respiratory service was available. A six-day physiotherapy service was delivered to the trauma and orthopaedic wards.

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 provide seven day working and followed the AfPP safe staffing guidelines.

Staff told us that the ortho-geriatrician covered six days a week. An ortho-geriatrician was involved in the care of patients over 65 years of age who required an orthopaedic review.

Health Promotion

Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery.

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 offers a range of keyhole bariatric procedures. There was a team of specialist dietetics 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

Patients were supported to make decisions in line with relevant legislation and guidance but performance was poor.
We saw staff gaining verbal and implied consent during our inspection. The trust had a consent policy which was reviewed in March 2017. To monitor compliance with the policy, the trust carried out an annual audit. The audit was a two-part process, the first involved a review of patient records and the second was a patient questionnaire.

In March 2017, the trust reviewed 130 sets of patient records to check for evidence including but not limited to; documented risks, benefits and alternatives; documented evidence of discussions with patients; application of the two-stage process including date and signature of all parties; copies in patients notes.

The patient questionnaire reflected the questions in the national patient survey 2016. The results from the survey demonstrated low performing elements in respect of information given to the patient before and after a procedure. This was reflective of the outputs from the 2016 National Patient Survey and complaints raised with patient advice and liaison services. The audit was completed in August 2018 and the results compared against the 2017 audit. Results from 2018 revealed only 42% of records had written evidence of a discussion with the patient, 45% had written evidence of the two-stage process (including date and signature of clinician and patient), 14% had evidence of written information given to the patient recorded in the notes and 11% had evidence of patient information given to the patient confirmed by the patient. There had been minimal improvement from the previous years’ audit.

**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.

Poor adherence to the trust consent policy had been identified as a risk. Specifically, patients were being consented on the day of surgery leading to potential poor patient safety and experience. To mitigate against this risk, consent training was made mandatory for all clinicians who consent patients and audits within the theatres, anaesthetics and critical care division were carried out to identify compliance with the consent policy. Incidents were also being raised when non-compliance with the consent policy was identified. The process for booking patients was also revised so they could not be progressed unless they had been consented.

Staff were aware of how to make deprivation of liberty applications. Information relating to deprivation of liberty application process was available to staff and we saw posters on walls as reminders. We also saw resource folders with the relevant guidance. Staff told us the process they would follow which was in line with guidance.

**Mental Capacity Act and Deprivation of Liberty training Safeguards completion**

The trust reported that as of September 2018 Mental Capacity Act (MCA) training was completed by 97.9% of staff in surgery care compared to the trust target of 90%. Over the same period Deprivation of Liberty Safeguards (DoLS) training was completed by 94.0% of staff in within surgery compared to the trust target of 90%.
The deprivation of liberty safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The trust Safeguarding Adults annual report 2017/18 stated there was 208 deprivation of liberty safeguards applications in 2017/18 and this was a decrease of 124 of the 332 applications submitted for 2016/17. One of the key priorities from the annual report was the achievement of safeguarding training trajectories levels 1–3 to ensure staff have the skills and competence to recognise concerns and report as necessary.

Is the service caring?

Compassionate care

Staff did not always care for patients with compassion.

Patients were not always made aware of who staff were and why they were visiting them. The staff on the surgical wards were not always compliant with National Institute for Health and Care Excellence QS15 (Patient experience in adult NHS services), as patients were not always introduced to all healthcare professionals involved in their care and were not made aware of their roles and responsibilities. We observed staff failing to introduce themselves to patients and/or not explaining what their role was. However, staff did wear name badges.

However we also observed many staff communicating with patients, their relatives and carers in a kind and compassionate manner during our inspection. These staff were understanding when advice or an update was sought. Most patients we spoke with told us staff kept them regularly updated and there was always someone available to ask questions or share concerns with.

Staff did not always ensure patients’ privacy and dignity was respected. During physical and intimate care, we did see curtains being drawn but there were two occasions when patient’s dignity and privacy were not protected. For example, we observed a patient asking multiple times to use the bathroom and shouting “I really am desperate”. When replying to the patient the nursing staff did not use the patients name and did not stop their conversation with us prompting us to end the interaction and the staff member attending to the patient.

Staff did not always respect confidentiality when conversations about patient care took place. Generally, voices were kept low to minimise the risk of others overhearing but we observed multiple occasions when staff did not do this. For example, we heard a clinical support worker loudly discussing with the patient regarding their intimate care which did not maintain their privacy. There were rooms on most wards where conversations about patient care could be discussed without other patients/relatives/carers overhearing. For example, there was a communications room on ward nine.
Staff understood and respected patients’ personal, cultural, social and religious needs and took them into account when delivering care. There was a chaplaincy service available to patients 24 hours a day. If patients had different cultural or religious needs, other than Christianity, a representative of their religion would be contacted. Although we did not see patients using the service, we saw evidence of the service availability in the form of a leaflet and posters around the surgical wards and corridors. We also saw at a nursing handover that patients’ religious needs were accommodated. For example; it was identified a female patient was Muslim and staff made arrangements for only female nursing and clinical support worker staff to care and treat her.

Patient satisfaction scores across the surgical division were consistently high. We were provided with data from the friends and family test performance between October 2017 and September 2018 for wards 9, surgical assessment unit and 20A. None of the wards had achieved a satisfaction score of less than 83%.

Friends and Family test performance

From October 2017 to September 2018 the trust’s Friends and Family Test response rate for surgery was 41.0%, which was better than the England average of 27%. The scores and response rates by site can are in the table below. Please note, wards 16 and 10 were medical wards.

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<td>94%</td>
</tr>
<tr>
<td>WARD 18 (HDU)</td>
<td>139</td>
<td>221%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>WARD 10</td>
<td>133</td>
<td>49%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>70%</td>
<td>100%</td>
<td>89%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

4. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
5. Sorted by total response.
6. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Conversations between staff and patients were clear and uncomplicated. We observed conversations between staff and patients and noted that technical language was kept to a minimum and patients were invited to ask questions at every opportunity.

Patients’ relatives and carers were mostly informed of what was happening to their loved ones and involved in their care. We observed telephone conversations taking place where relatives were updated on patients’ conditions and what care they were receiving.

Understanding and involvement of patients and those close to them
Staff did not always involve patients and those close to them in decisions about their care and treatment. Most patients told us they felt involved in their own care and treatment as staff took time to explain what was happening and why. However, we were told by some patients that staff did not have the time to do this and they did not feel involved in their care.

Patient’s carers and representatives including family members and friends were not always identified and treated as important partners in the delivery of their care. We did not observe or hear relatives being included in their loved ones’ care. We did not see any references to conversations with relatives in patient notes.

Not all staff understood the impact a patient’s care, treatment and condition had on their wellbeing. Staff were not always compliant with NICE QS15 (Patient experience in adult NHS services) as patients’ physical and psychological needs were not fully or regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene. Within the patient records we reviewed, we saw uncompleted assessments for the above and reviews were not always carried out when applicable. Some patients we spoke with said their pain and comfort had been inconsistently managed effectively and staff had asked how they were feeling whereas others did not receive the same care.

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.

Is the service responsive?

Service delivery to meet the needs of the local people

The service planned and provided services in a way that mostly met the needs of local people. The surgical assessment unit (SAU) had introduced a virtual clinic which meant patients admitted to the SAU did not have to be admitted into hospital while they awaited a scan. The virtual clinic pathway was utilised by patients who were admitted to the SAU and who were determined to require a scan, but not an admission, following review by a doctor-in-training and senior doctor. They were discharged home where they would await a scan within 72 hours. Following the patients scan, they received a telephone call where they were either called back to the hospital for admission and/or treatment or discharged from the service. If scans were urgent a patient would not be put on the virtual clinic pathway. We reviewed two records from the SAU, one patient had followed the pathway successfully but the other had not received a scan within 72 hours.

The surgical division, specifically the trauma and orthopaedic service, had worked in partnership with the clinical commissioning group to set up a triaging system. As part of the system all referrals, involving pain or rheumatology, were filtered into the triage system where patients would be seen by a physiotherapist initially. The physiotherapist would carry out an assessment where it would be determined whether the patient required further clinical input or physiotherapy. This improved referral to treatment times and resulted in more appropriate management of patients’ conditions.
The surgical division had implemented an abscess pathway. The pathway worked to streamline patients requiring surgical intervention for abscesses. Patients were seen in the surgical assessment unit and were fast tracked for an MRSA swab. If negative they would be booked in for surgery the next day as a day case patient.

Surgical services consisted of a pre-assessment centre, arrivals lounge, nine 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. The out patient and day case suite consisted of four operating theatres, which were used for orthopaedic elective procedures, ear, nose and throat, dental, podiatry and elective pain management, urology and colorectal procedures.

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.

Emergency surgery was available over a 24hour period by theatre two’s emergency team. The surgical and anaesthetic teams managed clinical demand flexibly within the all day session accommodating any national confidential enquiries into perioperative deaths (NCEPOD) cases accordingly.

The nursing team was staffed in accordance with the National Association for Peri-Operative Practice (NAFPP) guidelines at all times and any deviation from this resulted in a clinical incident being raised. Emergency patients were booked by the requesting doctor/surgeon who attended the west wing theatre reception and completed a booking form in the emergency folder. The booking doctor/surgeon informed the anaesthetist and operating surgeon. The patient was assessed by an anaesthetist before the case was brought to theatre.

In the event that a CEPOD patient needed to be operated on when the emergency theatre was already in use, work in an elective theatre was interrupted to accommodate the patient. The first available theatre that was suitable was utilised. This would be coordinated by the consultant anaesthetist covering the emergency theatre along with the team leader for the theatre.

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.

The service ensured there was level two and three postoperative care provided in a critical care unit. The trust had a critical care and high dependency unit on site which had a capacity of 16 beds. The surgical division had an escalation process for acquiring a critical care bed for a theatre patient. If a patient was identified as requiring a critical care bed at their pre-assessment clinic, this was logged on the trust’s electronic theatre booking system and a bed would be arranged accordingly. If the need for a critical care bed was identified on the day of surgery this was communicated to the team leader in charge of the relevant theatre. The lead nurse would then be informed, and subsequently contact the capacity manager. The lead nurse would then feedback the outcome to the theatre team
leader to confirm whether a bed was available. If there were any problems the lead nurse would escalate to the matron for theatres, anaesthetics and critical care.

Meeting people’s individual needs

Services within the surgical directorate coordinated and delivered care to ensure they were accessible and responsive to patients with complex needs. Data was not collected on the number of patients admitted to surgical wards with complex needs. Staff told us the numbers on some surgical wards were high, for example on ward nine and the acute surgical unit. Some reasonable steps were taken to ensure the service took account of the complex needs of patients when they were admitted. For example, surgical wards used the purple butterfly scheme to identify patients living with dementia and also held dementia tea parties. Comfort boxes were also used which contained reminiscent aids and diversion therapies, for example twiddle muffs. There were named dementia link nurses on the surgical wards who provided additional advice on caring for patients living with the condition. However, staff told us in theatres and at pre-assessment that they did not have dementia link workers. The trust provided dementia awareness training for clinical staff and compliance was higher (better) than the trust target. In September 2018, 99% of nursing staff and 94% of medical staff had completed dementia awareness training against a target of 90%.

The trust also provided additional training on learning disabilities and mental health. As of March 2018, 92.8% of staff had completed the training. Staff on surgical wards could also access the trust’s mental health team who could provide support on caring for patients with mental health conditions. Staff told us in theatres that they did not have a link worker for patients living with learning disabilities.

Translation services were available to patients whose first language was not English. Staff were aware of how to access the service and confirmed the service had been used in all applicable circumstances. If interpreters were required, this was identified during pre-operative assessments, for elective patients, and then booked for attendance at the admission lounge. We saw the availability of translation services being advertised using posters. The 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.

Surgical wards could accommodate patients in single sex areas. Patient bays were split into female and male bays on each surgical ward. We did not see any mixed sex breaches during our inspection. Latest data relating to mixed sex breaches for the trust showed there had only been four between October and December 2018 across the whole trust.

Access and flow

People could access the service when they needed it and received the right care promptly.

All patients were booked onto an elective theatre session by the in-patient access team. According to the trust’s theatre operations policy it was the surgeon’s responsibility to ensure patients were listed correctly and in the right order to ensure maximum theatre utilisation. All sessions were populated with patients at least 24 hours before surgery. The theatre team leader accessed the theatre lists using the electronic booking system at 4pm on the day before surgery so that the theatre
was prepared accordingly. Therefore, any late additions were negotiated between the surgeon and the theatre team leader. On the day case unit theatre lists were provided four weeks in advance, however, theatre lists could be changed on the day of surgery. This happened during our inspection and we were told this was not a rare occurrence. It was the decision of the surgeon as to whether surgery went ahead.

People with the most urgent needs had their care and treatment prioritised. When preparing an operating list consideration of individual patient clinical need, safety and efficiency was made. Patients were put first on the list of any operating session if the patient was diabetic, if the patient has previously been cancelled by the hospital or breached the 18-week target or if the patient was clinically urgent. All infected patients should be scheduled last on the list.

Bed meetings took place three times a day to identify potential discharges and anticipated bed capacity.

**Manor Hospital - elective patients**

From August 2017 to July 2018 the average length of stay for all elective patients at Manor Hospital was 3.5 days, which is lower compared to the England average of 3.9 days.

- The average length of stay for trauma and orthopaedics elective patients at Manor Hospital was 3.8 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for general surgery elective patients at Manor Hospital was 4.9 days, which is higher compared to the England average of 4.0 days.
- The average length of stay for urology elective patients at Manor Hospital was 2.1 days, which is lower compared to the England average of 2.5 days.

**Elective Average Length of Stay - Manor Hospital**

![Graph showing Elective Average Length of Stay](image)

*Note: Top three specialties for specific site based on count of activity.*

**Manor Hospital - non-elective patients**

The average length of stay for all non-elective patients at Manor Hospital was 5.1 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at Manor Hospital was 3.4 days, which is lower compared to the England average of 3.8 days.
• The average length of stay for Trauma and orthopaedics non-elective patients at Manor Hospital was 9.2 days, which is higher compared to the England average of 8.7 days.
• The average length of stay for Urology non-elective patients at Manor Hospital was 4.5 days, which is higher compared to the England average of 2.8 days.

Non-Elective Average Length of Stay - Manor Hospital

Note: Top three specialties for specific site based on count of activity.

Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2017 to May 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average, except for in January and February 2018, when trust performance was similar to the England average. From June to September 2018, the trust has shown a trend of improvement and performed better than the England average.

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>ENT</td>
<td>89.5%</td>
<td>63.5%</td>
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<tr>
<td>Ophthalmology</td>
<td>74.8%</td>
<td>67.8%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>66.7%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

Three specialties were lower the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>75.1%</td>
<td>76.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>67.9%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>20.7%</td>
<td>59.1%</td>
</tr>
</tbody>
</table>

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From quarter three 2016/17 to quarter one 2018/19, the trust cancelled 256 operations. Of these 256 cancellations, all of them were treated within 28 days, which was consistently better than the England average. Performance declined in quarter two 2018/19, where the trust cancelled 29 surgeries, of which 21% were not treated within 28 days. This was worse than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**
- **Walsall Healthcare NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions]

**Cancelled Operations as a percentage of elective admissions - Walsall Healthcare NHS Trust**
Over the two years, the percentage of cancelled operations at the trust showed a slight decreasing trend from quarter four 2016/17 to quarter one 2017/18, with the exception of quarter three 2017/18, when the trust percentage increased a small amount. The trust percentage was consistently lower than the England average from quarter three 2016/17 to quarter 2018/19, except in quarter four 2016/17, when the trust performance was slightly higher than the England average.

The decision to cancel a surgery was only taken after formal processes were followed. The theatre operations policy set out the process for cancelling surgeries for non-clinical reasons and staff were aware of the actions needed to be taken. The theatre team leader had to inform the lead nurse when a patient’s procedure needed to be cancelled. However, before action was taken to cancel, the team leader had to identify the reason, whether there was scope for the procedure to be carried out in another theatre by another surgeon or if staff were willing to stay over, if a cancellation request was being made because of time constraints. The lead nurse checked whether the patient had been cancelled previously on the day of surgery and if so, escalated this to the care group matron and/or any member of the care group management team. The management team then obtained approval from the director for the patient to be cancelled. The lead nurse informed the team leader the patient could be cancelled and it was their responsibility to ensure the patient was cancelled on their electronic system. It was the lead nurse’s responsibility to ensure the patient was informed in a timely manner and notified that they will receive a new date for their surgery within the next 28 days. This process was monitored through the theatre user group as part of theatre utilisation performance.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Staff across the service were familiar with the trust complaints policy. Governance safety huddle meetings were held weekly and an overview of complaints and the timeliness of investigating and responding were discussed amongst senior staff. We attended a divisional safety huddle meeting and we saw there were currently seven complaints for the surgery division, with four overdue. For example, one complaint was due 21 January 2019 and the overdue reason given was it was “held up due to inability to locate notes to date.”
Patients we spoke with knew how to raise concerns and make formal complaints. Posters detailing how to make a complaint were displayed on the wards. Patients told us the nursing staff were approachable and if they wished to raise a concern they would do this by speaking with the nurses who were caring for them at that time.

The trust had a patient advice and liaison service (PALS) which patients could access if they wished to raise a concern. There was a detailed section on the trust website of how to make a complaint and how to contact Patient Relations.

Staff told us that complaints were shared for learning.

From October 2017 to September 2018 there were 77 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints. The trust’s overall target is for 70% or more complaints to be completed within 30 working days, and they have a target of 45 working days for complex complaints or complaints with a higher level of harm.

A breakdown of complaint subject with seven or more complaints are below:

- Treatment, care, supervision: 16
- Treatment suitability: 10
- Treatment/procedure: six

From October 2017 to September 2018 there were 91 compliments within surgery. We saw within ward areas and theatres thank you cards from patients and families displayed on walls.

Is the service well-led?

Leadership

Most managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Most leaders had the skills, knowledge and integrity that they required. Clinical directors, matrons and care group managers within the surgical division had the necessary knowledge to lead their respective services. Within each care group there was a clinical director/lead, matron and care group manager who were known as the team of three (ToT). There was a ToT for the musculoskeletal, head and neck, general surgery/urology and theatres, anaesthetics and critical care (TACC). There had been changes to the leadership structure within the surgical division which meant many leaders had only been in post a short time. For example, the divisional director for nursing, the clinical lead for theatres, matron for the musculoskeletal service and ward manager for the surgical assessment unit had only been in post since January 2019. 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.

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. Nursing staff said they often saw the matron on the ward and felt able to approach them with concerns and/or questions and they would be listened to. We did not get the opportunity to speak to many foundation level and middle grade doctors so it was unclear whether the same level of visibility was apparent within the medical leadership. Operational leaders’ visibility was described as variable as staff said they saw less of them on the ward. Staff told us the executive team did visit the ward and had done so recently.

Leaders understood the challenges to quality and sustainability but could not always identify the actions needed to address them. All leaders within the surgical division were aware nursing staffing was a significant risk but it was not always clear whether appropriate steps were being taken to minimise the risk to patients. For example, the acute surgical unit and ward 20b had significant staffing issues but the action taken to ensure staffing was sufficient for the number and acuity of patients was not always clear. As detailed in the staffing section, data was collected on safer staffing but it was not always completed correctly. Therefore, there was no assurance leaders had the correct information when assessing what actions needed to be taken. Following the inspection, we were informed appropriate actions were taken as staff were moved around to ensure all areas were safely staffed but the staff moves were not always recorded.

Vision and strategy

**The service had a clear set of values, with quality and sustainability as the top priorities.** The trust values were; respect, compassion, professionalism and teamwork. The values were displayed on notice boards and staff name badges. All staff we spoke with knew what they were and felt they represented their own personal values. Generally, staff demonstrated the values during our inspection, as most showed compassion to patients, relatives/carers and each other; were professional; demonstrated high levels of teamwork and respect to others. However, as detailed in the caring section, there were some instances where compassion and respect were not shown.

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 which were:

- Provide safe, high quality care
- Deliver care at home
- Work with partners
- Value our colleagues
- Use resources well

The trust introduced a nursing strategy 2019-2024 which was to develop a positive culture and patient experience. It had four main principles:

- Enhance and maintain patient safety
- Positive patient experience
- Enhanced professionalism
- Clinical leadership closest to the patient
The strategy was developed by involving patients and volunteers. This strategy was applicable to all registered nurses, clinical 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”.

Most staff were aware of initiatives being implemented but they did not appear to have been engaged in their delivery of these. For example, the enhanced recovery programme for elective orthopaedic patients was going to be reintroduced within a week of our inspection. This was planned as a seven-day service, however, the physiotherapists within the surgical service only worked six days a week. Input from all those delivering the service had not been engaged. Following our inspection, some members of the therapies team had been engaged and we saw evidence of this but this did not include the staff delivering the service.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Most staff, including nurses, consultants, pharmacists, physiotherapists and support staff, told us they enjoyed working within the surgical division. They expressed pride in working on their ward or area and they were passionate about wanting to provide high quality care. Staff told us their local leaders supported them in delivering the best possible patient care and treatment. All felt respected by colleagues at all levels. For example, most nurses told us they felt listened to by consultants and middle grade doctors. We observed friendly and professional conduct between the multidisciplinary teams on surgical wards and within theatres.

Openness and honesty was encouraged in response to incidents. Staff were honest during our inspection and spoke openly about the challenges to providing safe and high-quality care. Staff told us they could raise concerns with senior colleagues on the unit and members of the multidisciplinary team. Staff had no fear of retribution for raising concerns but felt they were not always addressed. For example, the consistent low staffing levels.

Morale within the surgical division was mixed. Staff on some wards were positive about their roles and the service being delivered to patients. They described feeling valued and respected. Most staff felt they were being supported by local leaders to provide care and treatment which was both safe and of high quality. However, there were staff on some wards who felt the staffing levels were affecting their ability to provide safe and high-quality care to all their patients. They did not feel supported by more senior leaders and lacked confidence they would be able to address the current challenges.

There was not always a strong emphasis on the safety and well-being of staff. There were times when the well-being of staff was not always considered. For example, the surgical assessment unit was open from 7am to 9pm but we were told the unit would stay open until the last patient was either discharged or transferred. This meant the ward could be open for a longer period and there had been occasions when it remained open until 11.30pm. Staff would often have to work extended hours and sometimes up to a 16-hour shift. At the time of the inspection, staff were recording the additional hours they were working but there was no formal decision or communication on when or if this time would be given back as time off in lieu. We saw no evidence this was being monitored,
although we were told and saw evidence this had been raised as a risk but was not included on the surgical division risk register.

**Governance**

**There were extensive governance arrangements within the surgical division, but they were not always effective.** 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.

Care group meetings were not always minuted. We requested three sets of minutes from each care group. We were provided with seven; three general surgery, two head and neck, one urology and one musculoskeletal care group meetings. Agendas differed from month to month. Items included theatre, rotas, vacancies, referral to treatment time performance, ward issues, pathways, service development, equipment, finance, patient feedback and complaints. The minutes varied in their level of detail but the majority were not very comprehensive.

Although performance, quality and safety were discussed at clinical governance meetings, some significant subject matters were absent. 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 three sets of minutes from October 2018, November 2018 and January 2019. The meetings followed a set agenda which included but was not limited to falls, quality dashboards, care group quality improvement plans, equipment, patient safety reports, complaints, infection prevention and control, risks and policy updates. However, world health organisation surgical safety checklist compliance audits were not discussed. We were also told leaders within the theatres, anaesthetics and critical care (TACC) care group had not seen the audit reports.

Clinical governance meetings were held for the theatres, anaesthetics and critical care (TACC) care group. We were told they took place monthly but we were only provided with one set of minutes from May 2018. Items on the agenda included but were not limited to risk, staffing, falls, audits and finance. However, world health organisation surgical safety checklist compliance audits were not discussed.

Monthly anaesthetic consultant meetings took place. We reviewed three sets of minutes from October 2018, November 2018 and January 2019, however, the minutes were not very detailed. The agendas for the meeting included items on staffing, training and rotas but there was no other consistent discussion topics regarding performance or risk.

Ward manager meetings were held within the musculoskeletal service. The meetings were chaired by the matron. We were told they were held each month but we were only provided with one set of minutes from January 2019. It was unclear whether an agenda was followed but the minutes were detailed. Discussion topics included key performance indicators, rostering, vacancies, sickness and friends and family survey results.

Theatre management group meetings took place monthly. Attendees included but were not limited to the clinical lead for theatres, matron for theatres, anaesthetics and critical care and surgical sterilisation services manager. Agenda items included but were not limited to equipment, pharmacy, patient flow, patient experience and risks. We reviewed minutes from October 2018, December 2018
and January 2019. We did not see risk discussed during every meeting and there was no discussion regarding theatre utilisation or performance.

Governance processes within theatres were not always effective. Concerns were raised around new equipment being brought into theatres and the inability and inconsistencies around traceability of implants/equipment due to an inadequate scanning system. This came to light following the investigation into the never events described in the incidents section above. A full review around these processes was going to be undertaken but areas of improvements for governance processes within theatres had been identified. The report stated the issues had been escalated and a risk was entered on the theatre risk register. However, the risk was not on the surgical division risk register.

Meetings to disseminate information to staff on wards were not always consistent. We were told ward nine had ward meetings but they were infrequent and attendance was variable. We saw that a ward meeting had taken place on the surgical assessment unit in January 2019. The meeting followed an agenda and we reviewed one set of minutes although they were brief. Agenda items included staffing, incidents and risks.

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.

Work was being carried out to improve the monitoring of service level agreements (SLA) with third parties. 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. The SLAs were managed by the care group managers, however, we were told the SLAs were vague. To address this, work was being carried out to make the SLAs more comprehensive and detailed.

**Management of risk, issues and performance**

The service had a system for identifying risks, planning to eliminate or reduce them but the risk register was not complete. Each service line within the surgical division kept their own risk register which fed into the surgical division risk register. We reviewed the surgical division risk register and saw it held high level risks, those rated six to 16, across all service lines. However, the divisional risk register did not appear to be complete. Although risks were identified, some of the risk descriptions did not contain all aspects of the potential harm. It was not clear how risks from service lines were escalated to the divisional risk register or what types of risk were escalated. There were high risks discussed with us during the inspection which were not on the divisional risk register.

There was a lack of assurance all risks associated with the surgical division had been recorded and mitigated. There were risks identified before and during our inspection which were not on the register. For example, there was a risk associated with patient records on the register but it did not identify that records were not being fully completed and not always secure across more wards than just the outpatient department. The surgical division had not identified failing to monitor the performance of the surgical assessment and surgical sterilisation units as a risk. However, this was recognised as a risk during the inspection. During the investigation into the never events, as described in the incident section, the never event report identified the risk that the division were not assured of submission or quality onto national reports. The report highlighted whether this could have led to an identification of mixing of metal implants, however, this was not included as an entry on the surgical division risk register.
On the surgical assessment unit (SAU) and ward 20a the top three risks associated with surgery and specific to the wards themselves were displayed. The top three risks related to the SAU were the late closure of the unit, poor compliance with venous thromboembolism assessments and discharge documentation was not completed in a timely manner. The top three risks associated with ward 20a were trauma patients being admitted to the ward, failing to keep patient trollies locked when in use and poor visibility of patients in specific rooms.

Although data was collected on theatre utilisation, it appeared to be inaccurate and was not used to drive improvement. The trust had a computerised operating room management information system which provided information to assist with the strategic and operational management of theatres. The data was captured live as the procedures happened by the theatre staff on ‘touch screen carts’. The care group had a designated information analyst whom produced monthly reports showing overall percentage utilisation and then by speciality. However, we did not see any reference to this data apart from in two sets of divisional quality board meeting minutes. It was unclear if inefficiencies were scrutinised so that problems could be identified and inform decisions made. The trust provided theatre utilisation data from April 2018 – January 2019 which was broken down by speciality. On review of the data we discovered that some of the total figures were inaccurate. This did not assure us that the correct data was recorded for the theatre time used.

Audit data reporting was not always accurate. Concerns around data entry for the National Hip fracture database, National Joint Registry and PROMS Hips and Knee Replacement were detailed on the surgical division risk register. The trust had no assurance that the submission and quality of the data to national reports was accurate. Data was entered inconsistently by various members of staff across different teams. There was a lack of understanding within the trust regarding the impact of incorrectly submitted data and the consequences upon national publications.

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.

The surgical division did not routinely collect, monitor or review data relating to areas of performance which impacted on patient safety. For example, the service did not routinely collect data in relation to the amount of time escalation beds were open. During our inspection we spoke with a number of leaders who told us conflicting information regarding how many times the escalation beds on ward nine had been open. This meant there was a lack of data relating to the impact escalation beds had on ward nine and the acute surgical unit in terms of staffing and patient acuity. The division did not routinely collect data on the number of unfilled shifts for nursing and medical staff which again meant there was limited oversight on the level of risk staffing levels had on the surgical division. Sepsis management data was not split per division and was only reported at trust level which meant there was limited awareness of what issues were specific to surgery.

Information management

The service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards.
A range of performance measures were being collected and monitored at various governance meetings, as described in governance above. The surgical division were using dashboards to monitor performance information for all services but they were not in “real time”. 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. However, information was not being collected, monitored or reviewed in relation to the performance of the surgical assessment unit (SAU) or the surgical sterilisation unit. This was recognised as a gap as both services impacted on the access and flow throughout the surgical division. We were told an electronic monitoring system was in the process of being implemented within the SAU to track patients but this process had been ongoing for over 24 months.

The arrangements for ensuring the confidentiality of identifiable data were not always in line with data security standards. Nursing and medical staff received training on information governance as part of their mandatory training but compliance rates were below the trust target at 86% and 51% respectively. During our inspection, trolleys containing patient records were left open on multiple occasions. Loose patient records were left unattended on top of trolleys, nurses’ station desks and in areas where they could be taken or lost. We found a prescription chart within a folder relating to agency nurse shift sign-in. This was brought to the attention of staff however, trolleys were still left unlocked when checked later in the day.

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.

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.

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

**Engagement**

The service engaged well with patients, staff and the public to plan and manage appropriate services. The trust encouraged patients and families on ward areas and theatres to complete the friends and family test.

The trust gathers information by asking patients one question “How likely are you to recommend our ward/department/service to friends and family if they needed similar care or treatment?” Patients are asked to answer on a scale of extremely likely to extremely unlikely. This test is used to measure patient experience. The trust reported their Friends and Family Test (FFT) results for surgery and we saw these were almost at the trust target of 90%. Below is a breakdown of FFT results from September 2018 to January 2019. The trust did not provide the number of patients these results were based on.
The trust web page displayed feedback from the Friends and Family Test and we saw positive feedback for the surgical assessment unit - “very compassionate nurses. Thank you for looking after me and my wife”.

**There were initiatives to encourage engagement between patients and nursing leads.** There were weekly “tea with matron” sessions on the general surgery and urology wards, which provided patients and families dedicated time to ask questions about the care provided. This was a new initiative and early feedback was positive. Although we did not observe any taking place, we did see displays advertising the sessions.

**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. Most wards had also engaged in an initiative where thoughts and ideas were collated on what mattered most to staff and where improvements to care could be made. We saw evidence of this on ward 20a.

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. Staff told us there is a daily bulletin from the executive team with trust news and updates and there was a monthly chief executive feedback email to all staff.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation. The divisional and ward leaders took decisive action to make improvements in the running of the surgery services. They had regular meetings where learning was discussed in a variety of forums. For example, matrons’ meetings and quality and governance meetings. Staff we spoke with told us there was an improved culture across the service and there was strong leadership at local level.

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.

---

<table>
<thead>
<tr>
<th></th>
<th>Sept 18</th>
<th>Oct 18</th>
<th>Nov 18</th>
<th>Dec 18</th>
<th>Jan 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAU</td>
<td>95.08</td>
<td>92</td>
<td>93</td>
<td>92</td>
<td>93.15</td>
</tr>
<tr>
<td>Ward 9</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>96.88</td>
</tr>
<tr>
<td>ASU</td>
<td>89.55</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td>85.71</td>
</tr>
<tr>
<td>Ward 20a</td>
<td>100</td>
<td>94</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Ward 20b</td>
<td>100</td>
<td>98</td>
<td>99</td>
<td>98</td>
<td>96.77</td>
</tr>
<tr>
<td>Ward 20c</td>
<td>100</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

---

Critical care
Facts and data about this service

The trust has one critical care unit based at Walsall Manor Hospital. We inspected the critical care service as part of the next phase of our inspection methodology. We conducted an unannounced inspection of the service from 4 to 6 of February 2019.

The critical care unit cares for adult patients needing intensive care (ITU), (level three) or high dependency care, (HDU) (level two) as defined by the Intensive Care Society document Levels of Critical Care for Adult Patients (2009). The critical care unit accommodates male and female adult patients and does not have provision to care for children.

Patients are admitted to the critical care unit following medical and surgical emergencies and/or serious operations. Patients receive intensive treatment and monitoring on the unit until their condition has stabilised.

There were 357 admissions to the intensive care unit at Walsall Manor Hospital between April 2018 and September 2018, of which 73% (273) were non-surgical admissions, 15.8% (59) were emergency surgical admissions and 11.2% (42) were elective surgical admissions.

The unit provides support for all inpatient specialities and to the emergency department at Walsall Manor Hospital.

A consultant intensivist (a consultant specialising in intensive care medicine) leads the critical care service. They are supported by consultants, junior doctors, nursing staff and support staff.

The hospital opened a purpose built critical care facility on 1 December 2018. This combined the previously separated HDU and ITU into one unit. The unit had capacity for 16 intensive care beds, had nine side rooms and an isolation suite. Commissioners provided funding for 18 patients.

The new critical care unit has:

- An isolation suite with lobby area, en-suite bathroom facilities and a fixed track patient hoist
- Nine single bedded side rooms
- An open bay with capacity for eight beds
- A central monitoring station
- A clean and dirty utility room
- A kitchen to prepare patient food
- A consumable store room
- An interview room and handover office
- A housekeeping room
- A waste disposal hold
- A relative’s room (Francoise Suite)

During the inspection, the inspection team:

- Spoke with five patients and seven relatives
- Reviewed nine patient records
- Reviewed trust policies for critical care
- Reviewed performance information and data about the trust
- Spoke with 25 members of staff including nurses, pharmacists, consultants, administration staff and domestic staff
• Met with service leads and the matron for the service.

The Care Quality Commission last inspected the critical care service in June 2017. We rated the critical care service as requires improvement overall with safe, effective, responsive and well led rated as requires improvement and caring was rated as good.

We issued the critical care service with three requirement notices and six recommendations for service improvement.

During this inspection, we reviewed changes the critical care service had made to address these previous concerns.

The previously separated HDU and ITU units had 13 critical care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Walsall Healthcare NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 13.3%</td>
<td>Paediatric, 7.8%</td>
</tr>
<tr>
<td>Adult, 86.7%</td>
<td>Neonatal, 23.8%</td>
</tr>
<tr>
<td></td>
<td>Adult, 68.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

**The service provided mandatory training in key skills to all nursing staff.** The compliance rates were above the trust target for seven of the training modules and just below the trust target for the remaining three modules.

Critical care staff completed mandatory training and training updates in accordance with their role requirements. Training modules included but were not limited to dementia awareness, conflict resolution, adult basic life support, fire safety, load handling and information governance.

Staff had received annual training on sepsis management including the use of the sepsis screening tools and use of sepsis care bundles. The management of sepsis training became part of the trust’s mandatory training from April 2018. Staff could access the trust’s sepsis guidance on the trust’s intranet.
All staff updated from April 2018 had completed this training. From August 2018, all staff who had conducted cardiopulmonary resuscitation (CPR) updates had also completed their sepsis training.

**Mandatory training completion rates**

The trust set a target of 90% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from March 2018 to September 2018 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>64</td>
<td>64</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>64</td>
<td>64</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>64</td>
<td>64</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>62</td>
<td>64</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>60</td>
<td>64</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>57</td>
<td>64</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>57</td>
<td>64</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>56</td>
<td>64</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>55</td>
<td>64</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>54</td>
<td>64</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care, the 90% target was met for five of the 10 mandatory training modules for which qualified nursing staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

During our inspection, we received updated mandatory training data for qualified nursing staff in critical care as at January 2019 as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
As of January 2019, in critical care the 90% trust target was met for seven of the 10 mandatory training modules for which qualified nursing staff were eligible. For the remaining three modules, compliance levels were just below the trust target.

Leaders of the service had increasing mandatory training compliance as a priority. At our previous June 2017 inspection, training compliance rates for critical care nursing staff were below the mandatory training compliance rates for the majority of modules. The service had improved nursing staff training compliance. The practice development nurse had achieved this as they had been proactive to ensure staff completed their training to increase mandatory training compliance rates.

The practice development nurse (PDN) monitored staff compliance with mandatory training. They monitored mandatory training and had systems that alerted staff when they needed to update it. They used an electronic system to monitor completion of training modules and staff received regular email communication alerting them to training expiry dates. The practice development nurse had been situated on the unit since December 2018. This had helped them to have full oversight of staff training needs and ensured they were able to address any gaps in staff training. The PDN provided leaders with a monthly update of staff training compliance to ensure the leadership team for the service had full oversight of where training was required.

Staff were notified by email when their training was due. Mandatory training compliance was also discussed in team meetings. Staff could struggle to complete mandatory training as they did not have protected time to complete mandatory training and role specific training and due to the shift patterns worked. The PDN arranged study days to include mandatory training sessions as much as possible to ensure staff could complete some mandatory training modules on the same day.

Staff conducted either face-to-face training or e-learning modules. The PDN had started a messaging group to help staff coordinate training to ensure as much flexibility with training courses as possible. Staff told us the PDN was supportive and approachable to help staff complete their training. Staff could request one-to-one PDN support.

**Medical staff mandatory training**

**Mandatory training compliance levels for medical staff were below the trust’s target for seven of the 10 mandatory training modules.**

We received mandatory training compliance data for medical staff following our inspection.

A breakdown of compliance for mandatory training courses as at January 2019 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc. Privacy &amp; Dignity standards)</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In critical care the 90% target was met for three of the 10 mandatory training modules for which medical staff were eligible.

As at January 2019, the overall mandatory training compliance rate for medical staff in critical care was below the trust target of 90% at 72%.

We had raised mandatory training rates as a concern during our previous inspection. We identified an improvement in nursing staff training rates during this inspection however, mandatory training compliance for medical staff required further improvement.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had received training on how to recognise and report abuse and they knew how to apply it.** Nursing staff met the trust's target for all safeguarding and PREVENT training modules. However, medical staff had met the trust target for three of the five mandatory training modules.

Staff could describe the basic process of when and how to make a safeguarding referral. Staff were aware of the trust’s safeguarding adult and children policies which they could access could on the trust’s intranet. Staff could obtain additional support from their team leaders or the trust’s safeguarding lead if necessary. Staff were aware of who the safeguarding lead for the hospital and told us they were accessible. Staff could contact them to support them with safeguarding concerns and to work in partnership with other agencies to ensure vulnerable patients were supported and protected.

Staff understood the potential needs of patients with mental health conditions. The unit made provisions to keep patients safe when at risk of self-harm. Staff were aware of the Mental Health Act 1983 in line with the trust’s local policies and procedures for keeping patients safe. The trust had policies and procedures detailing information for when rapid tranquilisation was required for patients assessed as at risk of self-harm. These policies were based on best practice guidance and legislation.

During our previous inspection of critical care, we identified staff safeguarding training rates were below the trust target. The service had been proactive to increase safeguarding training compliance. Nursing staff safeguarding and PREVENT training compliance rates had significantly improved as the trust target was met for all five training modules. However, compliance rates for medical staff still required further improvement. PREVENT training aims to safeguard people from becoming terrorists or supporting terrorism.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training and 90% for completion of Prevent training.

<table>
<thead>
<tr>
<th>Conflict Resolution</th>
<th>70%</th>
<th>90%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Update</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>51%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
A breakdown of compliance for safeguarding training courses from March 2018 to September 2018 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>56</td>
<td>57</td>
<td>98.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>52</td>
<td>57</td>
<td>91.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care, the 85% and 90% targets were met for three of the six safeguarding and prevent training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection, we reviewed updated safeguarding training data for qualified nursing staff in critical care as at 23 January 2019 as shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>96.72%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>92.19%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>91.80%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In critical care the 85% and 90% targets were met for all six safeguarding and prevent training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from as at January 2019 for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>93.33%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>75.68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>95.45%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>90.91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In critical care the 85% and 90% targets were met for four out of six safeguarding and prevent training modules for which medical staff in critical care were eligible.

**Cleanliness, infection control and hygiene**

**The service did not always control infection risk well.**

The critical care environment was visibly clean and well-organised. The unit had designated domestic staff that worked on the unit. Equipment was visibly clean and the service held records demonstrating equipment had been cleaned regularly. Staff used ‘I am clean’ stickers to identify when equipment had been cleaned. Relatives who had visited the previous critical care unit described it as “spotless” and “in a different league to the old unit.”

At our previous inspection, we identified the unit had insufficient side rooms to protect patients with lowered immunity from hospital-acquired infections. In the previous ITU and HDU, it had been difficult to segregate patients with infections or at risk of infection due to low immunity levels as there was only one side room. The new critical care unit had 10 side rooms which allowed the service to effectively identify and monitor all infectious patients in the CCU in line with the Core Standards for Intensive Care. This ensured staff could barrier nurse and reverse barrier nurse patients more easily. One of the side rooms was a designated isolation suite with a gowning up lobby for staff to use for patients with highly infectious diseases. The service also used the side rooms wherever possible for patients who had an infection or where patients had an increased risk of infection due to their low levels of immunity. All side rooms had dedicated ventilation. The isolation suite also had an air change facility.

Staff followed the trust’s infection, prevention and control policy to prevent and protect patients from healthcare-associated infections. Staff washed their hands before and after each patient direct contact or episode of care. This was in line with the National Institute for Health and Care Excellence guidance (NICE QS61 (Infection prevention and control). All staff were bare below the elbow to enable effective hand washing. Staff told us personal protective equipment (PPE) such as disposable gloves and aprons was readily available. Staff were using necessary PPE during each patient contact. There was not currently signage and guidance reminding staff and visitors to use the hand sanitising gel on the unit. These were due to be displayed. Hand sanitising gel was readily available; we saw this being used at appropriate times by both staff and visitors.

However, staff were using yellow aprons regardless of the infection status of patients. They were usually used to identify staff were caring for an infected patient. Staff told us they had a surplus of yellow aprons and were continuing to use them for non-infected patients until they had reduced the stock levels. Once this stock had been used, staff would revert back to using white aprons for non-infectious patients and yellow aprons for infectious patients. We were concerned if this practice continued, patients could be exposed to the risk of cross infection as it was unclear which staff were caring for infectious patients and taking appropriate infection control precautions.

Senior staff monitored the effectiveness of infection prevention and control procedures by conducting monthly audits. The audits had numerous metrics to review IPC practices of staff of different roles. These audits included for example, hand hygiene checks and whether sanitary items were clean and in a good state of repair. The trust target for IPC compliance was 90%. Any IPC results that fell below 90% were flagged in red on the audit checklist form to demonstrate non-compliance. Following our inspection, we requested the last three-monthly audits. For the most recent audit conducted in January 2019, the overall IPC score was above the trust target at 91%. The overall score for hand hygiene had not been calculated. We did not receive an audit for December 2018. We received audit results for November 2018 before the unit relocated and it was a separate ITU and HDU. For the audit for HDU in November 2018, overall compliance was below the trust target at 77% with the hand hygiene score above the trust target at 100%. For the
November audit 2018, for ITU overall compliance was below the trust target at 77% and the hand hygiene was 100%. We had requested associated action plans from the trust to demonstrate how the service planned to address non-compliance and share this information with staff. However, the trust did not provide us with action plans to address areas of non-compliance. We were not fully assured robust measures were in place to drive improvement in IPC compliance.

The service provided evidence following our inspection processes were in place to mitigate against the risk of legionella and waterborne viruses as described in the trust policy. We saw evidence of legionella testing was conducted by an external company before the new critical care unit opened and since the unit had been in use.

Staff reviewed central lines on a daily basis. A microbiologist designated to the unit also attended the unit each day from Monday to Friday to meet with the consultant on call and was available on call. The unit had a dedicated link nurse with specialist infection prevention and control expertise. As part of their role, they coordinated with the trusts’ infection prevention and control leads. We requested additional information from the service regarding whether the unit undertook audits into the insertion and ongoing care of cannulas (peripheral lines, central lines, urinary catheters and renal catheters). However, the service did not provide us with this information and we could not determine if these routinely took place.

The unit reported to the Intensive Care National Audit and Research Centre for April 2018 to September 2018 (ICNARC: an organisation reporting performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. The data showed that the critical care unit rate for unit-acquired infections in blood had been slightly higher (worse) at 1% than other similar units at 0.8% but was better (lower) than the national average at 1.6%. The data showed the unit had zero cases of unit-acquired Methicillin-resistant Staphylococcus (MRSA) in this time period, this was lower (better) than other similar units at 0.2% and better than the national average at 0.1%. However, there had been two acute MRSA bacteraemia reported so far on the ITU since 2018-2019.

All patients were screened for Methicillin-resistant Staphylococcus (MRSA) on admission to the critical care unit. This was documented in patient records. Staff did not routinely screen every patient that was an emergency admission for blood borne diseases such as human immunodeficiency virus (HIV), Hepatitis B and syphilis. Consultants would conduct a risk assessment to determine if this screening was required and would conduct a best interest capacity assessment if the tests were deemed necessary.

Environment and equipment

The service had suitable premises and equipment and looked after them well. The purpose built unit met Health Building Notes guidance for critical care units.

During our previous June 2017 inspection we highlighted the critical care unit (CCU) environment was in need of a refurbishment as it was not fit for purpose. The high dependency unit (HDU) and intensive care unit (ICU) were located on separate wards a few minutes walking distance from one another.

During this inspection, we saw the service had addressed these concerns regarding the limitations of the physical CCU environment. The trust opened a purpose built critical care unit in December 2018. This was much improved from the previous unit with the design, maintenance and use of the facilities suitable to keep patients safe. This addressed these previous concerns as the unit combined these two areas into one cohesive area staffed by staff from both the HDU and ITU.

Staff told us they could provide a higher level of patient care to patients as the new equipment
and layout of the unit supported this. However, several staff told us they sometimes felt isolated when caring for patients in the side rooms.

The unit was in the early stages from transitioning from the previous unit. Service leaders monitored any concerns staff raised with the new environment of the new unit. The service had a logbook for staff to document any initial concerns or maintenance problems in the unit. Concerns raised by staff were monitored at the band seven meeting. Senior staff escalated maintenance problems with the building contractor company each week. However, responses to concerns raised were not always acted on in a timely way. We saw this had been discussed at the critical care team meeting on 12 February 2019 as all jobs had been logged but remained outstanding.

Staff had enough room to treat patients in an emergency. We had previously raised there was insufficient space between beds on the HDU to accommodate the use of the resuscitation trolley. The service had addressed this as the current critical care facilities met current national Health Building Notes standards (HBN 04-02) and were fully compliant with the Guidelines for the Provision of Intensive Care Services, 2015. Staff could easily and quickly access emergency equipment. The unit had two resuscitation trolleys and two difficult airway trolleys; one of each was located next to the side room area and one was positioned in the open bay area. An airway champion was allocated to each shift to carry out checks on the airway equipment. Both trolleys contained appropriate emergency equipment and medicines. Staff checked the resuscitation trolleys twice a day; once during each shift. Staff had checked the resuscitation trolleys each day for January 2019, with the exception of 14 January 2019 where staff had not documented in the logbook they had carried out checks. We checked both the resuscitation and difficult airways trolleys and all required equipment was in place.

Due to the previous space restrictions in the HDU and ITU, the ability for physiotherapists to conduct physiotherapy exercises with patients had been restricted. The unit now had moveable beds that could be positioned into a number of positions, which aided exercises and could be fully rotated to enable patients to look out of the window if they wished. The side rooms had adequate room for chairs to be used to aid exercise. The patient beds used in the previous HDU and ITU were not equipped to weigh patients. It is essential for patient’s weight to be accurately calculated to effectively plan a patient’s treatment. All beds in the unit now had a weighing function which mitigated the need weigh patients separately. Staff were competent to use the weighing function on the beds.

The maintenance and use of the equipment kept patients safe. All eight pieces of equipment we checked were up-to-date with electrical testing. Staff raised any concerns with equipment at the morning safety huddle. Staff had been actively involved in the trialling and procurement of equipment for the new unit. Staff records showed all staff had conducted competency training on the new equipment for the unit including the capnographs. The unit’s practice development nurse had overseen this training. A capnograph is an essential piece of equipment which measures how much carbon dioxide is present in a ventilated patient’s breath. However, critical care operational meeting notes for January 2019 referenced new nursing staff on CCU were unable to use the ventilators. To address this, an e-video training manual was being developed for staff and staff needed to pass an e-video test before being signed off as competent.

During our previous inspection, we identified that there was not enough suitable equipment to keep patients safe. We specified there were insufficient capnography machines available for patients as there should be one capnography available for each bed space. The service had only three capnography machines for all patients in both the ICU and HDU. The service had addressed this deficit in capnography provision as each bed space had a dedicated capnograph.

The CCU was secure and ensured patients and visitors were safe. At our previous inspection we identified as HDU was accessible from two separate entrances we had concerns the unit could
be accessed by unauthorised people. Visitor access to the current critical care unit was restricted by an intercom and buzzer system. The unit had a separate entrance for visitors directly next to the waiting room. Staff monitored the visitors entrance using CCTV and would allow visitors to access the unit once their identity had been determined. On arrival to the unit, staff directed visitors to the waiting room. Staff accessed the unit through a dedicated staff entrance. Access through this door was restricted and staff used their swipe passes to gain entry.

There was sufficient provision for patient washing and toilet facilities. The new unit had dedicated bathroom facilities and access to handwashing facilities. This was an improvement from the previous facility, which had insufficient shower and toilet facilities.

Staff appropriately managed clinical and non-clinical waste. Clinical waste was segregated and disposed of in clinical waste bins or sharps containers. We observed, during the inspection, domestic staff ensured bins did not become overfilled.

The unit did not provide treatment for children under the age of 16. The unit transferred children to regional paediatric critical care centres using the Kids Intensive Care and Decision Support (KIDS) transfer and advice service. This service is an acute transport and advice service for the management of critically ill children requiring intensive care in the Midlands region.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.

Staff completed patient risk assessments for patients on the unit. Risk assessments included nutritional, Waterlow (skin integrity), falls, bed rails and venous thromboembolism. Staff had completed risk assessments for patients on admission and as appropriate in the nine records we checked. A critical care consultant reviewed patients at least once a day.

As the unit was now one cohesive unit, the service could manage patients who ‘stepped up’ from requiring level two care to level three care more effectively as appropriate equipment was available throughout the unit to accommodate any additional patient care requirements. Adult patients needing intensive care (ITU) are classified as level three and patients needing high dependency care, (HDU) are classified as level two, as defined by the Intensive Care Society document Levels of Critical Care for Adult Patients (2009).

Staff understood how to manage a patient suspected of having sepsis in line with the Sepsis Six Care Bundle. The recognition and management of severe infection was an integral role of staff on the unit. Staff completed sepsis training on induction, as part of their mandatory training and as part of the intensive care competency training document. Staff could access sepsis guidance through the trust intranet. Staff had appropriately documented observations regarding the sepsis six bundles in patient records we reviewed. The sepsis six care bundle is a screening tool staff completed in the event of a patient’s condition deteriorating. The trust planned to implement the Acute Illness Management (AIM) course. The Aim course trained staff to recognise and manage deteriorating patients. A new multidisciplinary audit with the involvement of the outreach team was being developed for deteriorating patients to be analysed quarterly.

The unit had one nursing station positioned in close proximity to the side rooms to ensure visibility of patients and staff was optimised. The station had a central monitoring screen to help monitor patients being cared for in the side rooms. However, staff told us if they were caring for two level two patients it was difficult to observe both patients sufficiently. When staff were providing care in side rooms they could not hear other patient alarms. Staff also stated it was
difficult to care for two level two patients in the single rooms due to the limited lines of sight in the unit. Some staff told us they had the same number of staff as for the previous HDU and ITU units however, this unit was much bigger.

The cover provided by the critical care outreach team was insufficient to sufficiently mitigate risk.

The CCU included an outreach team which had previously been managed by the medicine division but had recently moved to the surgical division. The team currently consisted of four whole time equivalent staff. The purpose of the outreach team was to assess deteriorating or critically ill patients to help avoid patient admission to CCU or supported a timely patient transfer to the CCU. The outreach team did not currently provide 24-hour cover, seven days a week as they covered from 8am to 9pm. This was recorded as a risk on the critical care risk register. The hospital at night team covered the critical care service from 8pm to 8am. Leaders of the service had completed an outreach business case to increase staffing the staffing establishment of the outreach team, which they had presented to the board. The aim was to use four Advanced Critical Care Practitioners, one in CCU and three in the outreach team. The service was currently recruiting one whole time equivalent for the outreach team. They were due to start their role in April 2019. The service aimed to have 24-hour cover, seven days a week by June 2019. At our previous inspection we identified the critical care outreach team were not up-to-date with critical care competencies. The PDN had developed a competencies document for outreach staff and all staff were up-to-date with this training.

The service used the Modified Early Warning Score (MEWS) reporting system to record patients’ vital signs. This system was used to calculate a patient’s MEWS scores to identify acutely unwell or deteriorating patients. All records we checked showed patients admitted to the critical care unit, had been escalated appropriately. The service was planning to change to using MEWS2 which was an updated version of MEWS.

The service was prepared for a major incident. Staff had held a major incident drill ‘Exercise Caracus’ before moving into the new CCU. This involved a full evacuation of ‘patients’ where staff played the role of patients. This involved other emergencies services including the local fire service. The local authority also attended. The matron and care group manager for CCU observed the exercise to assess what went well and where improvement was needed. Service leaders wrote a report from the drill and learned lessons to improve future drills and emergencies. The report was to be included in the ‘Learning from Excellence’ programme. The new unit had been designed to ensure the environment and infrastructure was suitable in the event of an emergency. Each bay had access to a gas supply. All side rooms and the open bay bed spaces had been designed so two beds could be positioned in each area in the event of a major incident. Senior staff had held discussions with other units who had experienced major incidents to share learning and good practice. A major incident folder was held on the unit however, not all staff knew where it was located. All staff should be knowledgeable about the major incident procedures as it could be required to be implemented at any time. Some staff from the unit had attended a Trauma Care Conference in the management of injuries related to terrorism to ensure staff had up-to-date specialist skills in the event of this type of incident.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, clinical support worker provision for the unit was currently insufficient.

Service leaders planned staffing and skill mix on the unit to ensure patients received safe care and treatment. Senior staff used an acuity tool to ensure staffing levels were safe and the unit had an appropriate skill mix. Senior staff planned and regularly reviewed their nursing
staff levels.

Service leaders complied with the Guidelines for the Provision of Intensive Care Services 2015 for nurse to patient ratios. These guidelines outlined level three patients required a registered nurse to patient ratio of a minimum of one-to-one to deliver direct care. Level two patients required a registered nurse to patient ratio of a minimum one to two to deliver direct care. The unit used a points system which enabled staff to appropriately respond to increased or unexpected demand or acuity of patients in the critical care unit. The points system was based on the acuity of the patient. Level three patients accrued a higher number of points than level two patients that required a registered nurse to patient ratio of a minimum of one to two. Staff were flexible in order to respond to changes in patient acuity and activity on the unit. Senior staff monitored this on each shift to ensure staffing ratios met GPICS standards.

Nursing staff worked 7am to 7.30pm for day shifts and 7pm to 7.30am for night shifts. Ward clerks covered 8am to 6pm, seven days a week. Ward clerk provision had increased to seven ward clerks supporting the nursing staff to include cover for weekends. Nursing staff covered administrative tasks overnight. The department maintained a communications book for staff to let the administrative team know if there were any problems with data overnight they needed to be aware of.

The unit had sufficient supernumerary staff to support the unit in line with GPICS standards. Newly qualified nurses on the unit were not included in the planned staffing levels. However, the CSW provision for the unit was currently insufficient as one CSW covered each shift and cared for nine or 10 patients. On one of our inspection days, a CSW was not at work and the remaining nursing staff including the ward manager had to cover their tasks. We reviewed the numbers of shifts in December 2018 with unfilled CSW shifts. There were 10 shifts where there were unfilled CSW shifts. Service leaders told us as two CSWs were currently on maternity leave this had left a gap in the provision of CSWs. Arrangements had not been made to cover shifts until these staff members returned to work. However, an advert was due to go out to recruit an additional one WTE CSW to increase CSW staffing levels.

The trust reported their staffing numbers below for the period March 2018 and September 2018. It was seen that in March 2018, there was a surplus of nursing staff at 103.4%.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Manor Hospital</td>
<td>65.6</td>
<td>63.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

As at February 2019, there were 57.55 WTE nursing staff and 5.05 WTE CSW staff.

Handover and shift change arrangements ensured patients were safe on the unit. Handovers and safety huddles were regularly held to ensure staff were up-to-date with the needs of patients on the unit. The service followed a standardised handover procedure for nursing staff during shift handovers. Safety huddles had been recently implemented which both medical, nursing and the outreach team attended. All staff had a safety huddle form to ensure they were up-to-date with the activity on the unit at the start of their shift. We observed a morning safety huddle where all relevant information for every patient on the unit was discussed. This huddle had recently been implemented since moving to the new unit. Nursing handovers were held twice a day at the
change of shift every morning and evening. Senior staff allocated patients to nursing staff at each handover.

The unit had dedicated pharmacy support five days a week and pharmacy cover at the weekend.

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 1.0% for nursing staff in critical care.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 12.7% for nursing staff in critical care.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 8.4% in critical care;

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Senior leaders of the service were aware the department had high sickness levels. This rate included some long-term staff sickness. Senior staff supported their staff to return to work by supporting them to initially be non-clinical on their return. Team leaders held regular ‘sickness and confirm’ and human resource meetings to discuss each individual sickness case.

Bank and agency staff usage

From October 2017 to September 2018, the trust reported that bank staff covered 11.2% of qualified nursing shifts, and agency staff covered 0.4%. The proportion of shifts that were unfilled was 6.5%.

From October 2017 to September 2018, the trust reported that bank staff covered 20.0% of non-qualified nursing shifts, and no shifts were covered by agency staff. The proportion of shifts that were unfilled was 40.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Shifts</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
<td>Agency</td>
</tr>
<tr>
<td>Qualified Nurse</td>
<td>5,620</td>
<td>185</td>
</tr>
<tr>
<td>Non-qualified Nurse</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, recruitment of middle grade consultants was a challenge for the department.
Senior staff planned and reviewed their medical staffing levels to keep patients safe at all times. Consultant intensivists, anaesthetists and registrars delivered medical care to patients on the unit. The surgical division managed them. The unit had a clinical lead for the service in line with national guidance. As at February 2019, there were eight consultants and middle grade medical staff. Consultants covered 10-hour shifts and middle grade staff worked 12 hour shifts.

There was adequate medical cover for the unit in line with GPIC standards. Two intensivist consultants were allocated to the unit each week to provide continuity of care to patients. They covered the department during the day with one consultant allocated to looking after bed one to bed nine. This consultant usually started their cover on the Monday and worked through to the following Monday. The second consultant was responsible for patients in beds 10 and 14 to 19. Consultants covered six and a half full cover weeks cover per year. The second consultant conducted staggered days of ICU cover. These staggered days added up to 32 days per year (weekends excluded).

The on-call consultant arrangements consisted of one consultant covering the unit each night. The number of on-call shifts each consultant covered were seven days in an eight-week cycle so the on-call rota was one in eight.

Medical staff told us and we saw from reviewing medical rotas there were no concerns with covering the medical rota. The service complied with the Guidelines for the Provision of Intensive Care Services as a consultant in intensive care medicine was immediately available 24 hours a day and seven days a week and able to attend the unit within 30 minutes when on call. Consultants were on site from 6am to 6pm over the weekend and they were on call for the remainder of the time.

The largest proportion of shifts covered by bank staff was for middle grade staffing. Difficulty recruiting into the middle grade anaesthetic pool of staff due to a national shortage of doctors in the middle grade pool was recorded as a risk on the critical care risk register. This had been a long-standing risk as it had remained on the register since 2015. The service was attempting to resolve this lack of middle grade provision by recruiting from outside the UK from appropriate countries that have a similar training programme recognised by national bodies.

**Vacancy rates**

We requested vacancy rates for medical staff for critical care following our inspection. Data was submitted for medical staff for anaesthetics staff within the Theatres, Critical Care & Anaesthetic Care Group.

As at December 2018, the overall budgeted establishment was 54.4 WTE medical staff with an actual establishment of 48.03 WTE medical staff. The number of vacancies was 6.37 WTE.

**Turnover rates**

We requested turnover rates for medical staff for critical care following our inspection. Data was submitted for medical staff for anaesthetics staff within the Theatres, Critical Care & Anaesthetic Care Group.

As at January 2019, the turnover was 3.00% full time equivalent. Turnover figures were
'normalised' through the exclusion of rotational doctors, students, TUPE transfers and end of fixed term temporary contracts.

**Sickness rates**
We requested sickness rates for medical staff for critical care following our inspection. As at January 2019, the sickness rates for consultants and training grade staff was at 0%. Sickness rates for career grade staff was at 0.22%.

**Bank and locum staff usage**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust did not provide data for medical staff within critical care.

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

We received information following the inspection for the number of medical shifts covered by bank staff from July 2018 to December 2018. In total 16 consultant shifts (10-hour shifts) and 124 middle grade shifts (12 hour shifts) were covered by bank staff during this time period. From the data received, it was not possible to calculate the proportion of medical shifts that were unfilled.

**Records**
The department used a paper records system. Paper records were stored in records trollies when not in use, which authorised staff, had access to by using a secure access coded keypad. We checked the security of the trollies during our inspection and all were locked.

Patient's observations were recorded on large patent charts positioned next to the patients' bed. There was a separate chart for each 24-hour observation period. The charts were easily accessible and visible to staff. Each bed space had a white board which detailed the patients name allocated nurse and consultant. The unit currently used paper-based records however, the service planned to introduce an electronic records system.

The majority of records were clear, up-to-date and easily available to all staff providing care. During our inspection, we reviewed nine patient records. All records were comprehensive and evidenced daily ward rounds had taken place, which included a review with senior clinicians. The majority of entries were clearly written. However, in two of the records the consultant signatures were illegible. Records included risk assessments and there was evidence of input from the multidisciplinary team. The records we checked appropriately documented when mental capacity and DoLS assessments had been conducted.

Staff completed a handover document for when patients were being stepped down from the critical care unit to ensure when patients moved between teams all the patient information required for their ongoing care was available.

**Medicines**

**The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.

Pharmacy provision for the unit was in accordance with the Faculty of Intensive Care Medicine Core Standards. These state there must be a critical care pharmacist for every critical care unit.
The unit had dedicated pharmacy support five days a week and pharmacy cover on call cover at the weekend. Staff had access to the trust’s medicines management policy on the trust’s intranet. A pharmacist with advanced skills and the required knowledge in critical care provided expert advice to the critical care team. They undertook medication reviews to ensure the safe use, prescribing and administration of medicines. As a non-medical prescriber, they were able to undertake any immediate changes to patients’ medicines and any medicines concerns were dealt with directly and followed up.

A daily microbiology ward round ensured that antibiotic prescribing was undertaken in line with trust guidelines. They reviewed patient’s antibiotics and took regular blood cultures.

Medicines including medical gases and emergency medicines were stored safely on the unit and behind a locked door in a restricted area, which were only accessible to authorised staff. The nurse in charge for each shift held the controlled drugs key. However, the internal cupboard doors were not lockable which had already been raised as a risk by the staff on the unit. Service leaders were in the process of ensuring this was addressed in a timely way.

Critical care nursing staff monitored the temperatures of the medicine storage area including two medicine refrigerators. Staff understood what action to take if the temperatures were not safe for medicine storage. Records documented that medicines were stored within the recommended temperature range for safe medicine storage. Controlled Drugs (controlled under the Misuse of Drugs legislation) which require special storage and recording were stored following good guidance procedures including twice daily checks by two nurses.

Staff were aware of the process to report a medicine incident following trust policy. Learning from medicine incidents was shared across the critical care team at team meetings and by including them in incident newsletters.

Staff accurately recorded what prescribed medicines had been administered to patients in line with current legislation. We observed a medicine round and noted two nurses checked each patient’s identity before administering medicines to patients. Patients wore allergy bands as a visual aid to staff to indicate patients had certain allergies. We checked the prescription charts in four patient records. Prescription charts were fully completed, signed, dated and patient allergies were recorded. Records showed the prescribing of antibiotics was in line with current guidance.

**Incidents**

*The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.*

The unit demonstrated it had a good safety performance over time. Data we reviewed regarding incidents in critical care showed the service had a low number of incidents. The service had two reported two serious incidents relating to critical care from November 2017 to October 2018. The unit had a declining trend for incidents reported from December 2016/2017 to December 2017/2018 the department had decreased the number of incidents by 80%.

The critical care unit held monthly mortality and morbidity meetings to discuss patient’s deaths. Learning from these meetings was shared to ensure an improvement to patient outcomes resulted. CCU nurses were invited to attend these meetings.

The service evidenced there was learning from incidents. We saw evidence of learning and change in practice as a result incidents reported. Incidents graded as moderate and above were discussed at the divisional safety huddle. Incidents were a standing agenda at team meetings. The
department planned to have a visual noticeboard displaying information about incidents in the staff room to raise staff awareness of incidents.

Senior staff monitored and reviewed their incident reports each monthly. Incident reports and associated action plans were discussed at the monthly critical care MDT meeting. Senior staff monitored incidents for themes and trends in order to prevent reoccurrence. Ward managers were able to monitor incident themes more easily now the department was one unit as incident data was collated as one data set for the unit as oppose to two sets of data as previously.

Staff understood how to raise incidents on the trust’s electronic reporting system. Staff received feedback from incidents they had raised.

The service had a positive incident reporting culture and learned from incidents. For example, a change of practice was implemented as staff had started using the ‘anchor guard’ method to help prevent hospital acquired pressure ulcers. Staff incident reported when staffing levels were below planned levels. On one of our days of inspection, no CSW was available which staff had incident reported.

Staff learned from incidents that occurred in other departments at the trust. A trust newsletter ‘incidents at a glance’ was shared every quarter to highlight themes in incidents across the trust. Staff were aware of a never event in the emergency department where the bag valve mask was attached to the airflow meter rather than connected to oxygen. Senior staff had ensured all points had been blocked off in the new unit to prevent reoccurrence of this type of incident on the CCU.

The service demonstrated how they met the duty of candour regulation. The duty of candour is a regulatory duty relating to openness and transparency. The duty requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and to provide reasonable levels of support to that person. Staff demonstrated they understood in practice how the duty of candour regulation applied to their service. The service used a duty of candour (DoC) leaflet, which had been implemented across the trust. This described the DoC process and included space to record the key parts of the discussion and whom the patient/relative could contact. The leaflet had a tear off strip for inclusion in the patients’ records. The aim was to reduce some of the paperwork whilst still complying with the duty and to enable staff to enact the duty as quickly as possible. Staff gave a recent example of where the duty had been appropriately applied.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (HCAI/Infection control incident) in critical care, which met the reporting criteria set by NHS England from November 2017 to October 2018.

(Source: Strategic Executive Information System (STEIS))
We reviewed the MRSA Bacteraemia meeting minutes from May 2018 when this incident was reviewed. The meeting was multidisciplinary with attendance by relevant staff such as the lead nurse for infection control at the trust and the critical care matron. This incident involved a patient who was MRSA positive and had previously been MRSA positive. The root cause of the MRSA infection had been identified as unavoidable due to the high-risk patient and emergency surgery that was necessary. The infection source was the surgical site. The lessons learned were to review decolonization information available to GPs and the use of an antibiotic used in the prophylaxis and treatment of serious infections caused by Gram-positive bacteria, including methicillin-resistant Staphylococcus aureus for patients with a history of MRSA. Staff had also attended a central line course in January 2019.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

The service used the safety thermometer results to monitor harm free care. The critical care unit currently displayed their safety thermometer data in a folder for relatives and visitors stored in the relative’s room. The unit did not have this information displayed on noticeboards to ensure it was visible to staff and visitors. Due to recently moving into the unit this was not yet in place; the service had plans to address this.

Data from the Patient Safety Thermometer showed that the trust reported two new pressure ulcers, zero falls with harm and zero new catheter urinary tract infections from October 2017 to October 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Walsall Healthcare NHS Trust**

![Graph showing prevalence rate of pressure ulcers](image)

1 Pressure ulcers levels 2, 3 and 4  
2 Falls with harm levels 3 to 6  
3 Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital)*

As outlined in the data above, the unit had two patients with pressure ulcers from October 2017 to October 2018. Service leaders would discuss these with the trust's tissue viability team. We reviewed the root cause analysis reports for both of these incidents. Both evidenced learning from incidents and actions were identified and monitored to prevent reoccurrence. For example, nursing staff were required to conduct training to ensure they had a sound knowledge that is evidence based to identify, treat and report any pressure damage in an appropriate way.
Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. Follow up clinics were not conducted to support patients after discharge from the unit. We had raised this as a concern at our previous inspection.

The unit did not offer consultant-led follow-up clinics to discharged patients in accordance with the Guidelines for the Provision of Intensive Care Services. This risk was not recorded on the critical care risk register. Patients and relatives were not provided with follow-up clinics after they were discharged from the CCU to provide information and advice regarding what to expect after a stay in the critical care unit. The service had not acted on previous concerns we raised as we highlighted the lack of a rehabilitation follow up service at our previous inspection as patients received limited physical and psychological support following discharge from the unit. Senior leaders had plans in place to address this risk as the intention was for the critical care outreach team to support this service when fully established to allow a consultant sufficient time to conduct the clinics. The aim of this service provision was to prevent readmission to critical care and ensure there was a plan of care in place for high-risk patients. Service leaders had submitted a business case to allow the service to conduct follow up clinics to the trust’s executive team. This was still under review at the time of our inspection.

Staff regularly assessed patient’s physical, mental health and social needs. Staff screened patients for pressure ulcers, falls, venous thromboembolism and delirium on admission and during their stay on the unit.

Staff audited the number of assessments conducted for patients on the unit. As at November 2018, 100% of patients had a completed falls assessment on admission; 100% of patients had an appropriate care plan and 100% of patients had an appropriate risk assessment in place reflecting current bed rail use. This was an improvement from our previous inspection where we identified mental capacity assessments and Deprivation of Liberty Safeguards assessments were not appropriately applied when bed rails were in use. Staff assessed patients for the risk of venous thromboembolism (VTE) on admission to the unit and were given VTE prophylaxis when required in line with the National Institute for Health and Care Excellence (NICE) Quality Standard QS3 statement 5.

Staff monitored patients for signs of deterioration and documented physiological observations in patient records. This was in line with the National Institute for Health and Care Excellence (NICE) guidance CG50, acutely ill patients in hospital. Staff screened patients for sepsis in line with national guidance.

The unit did not have a formal audit programme. However, we saw evidence regular audits were conducted in critical care. These were presented at the trust’s medical audit meeting. The clinical lead used specific audit results to develop the service and improve patient outcomes. Service leaders planned to have an electronic screen displayed in the staff room displaying current audit results. We saw evidence service leaders reviewed audit results and implemented changes in response. Audits were presented at the theatres and clinical group monthly audit meetings. The service had an improvement folder to share results of audits to improve patient care.

Staff completed equality and diversity training as part of their mandatory training. This ensured there was no discrimination on the grounds of age, disability, gender, race, religion or belief and sexual orientation when making care and treatment decisions for patients. Current compliance rates for nursing staff for equality and diversity training exceeded the trust target. However, as at January 2019, the medical staff compliance was below the trust target.
All staff had access to trust policies and procedures but they were not always up-to-date. Several guidelines had not been updated to reflect the patient pathway since relocating to the new unit.

Some critical guidance had exceeded their review date by a number of years. We were not assured staff were following the most up-to-date guidance. There were several local policies, protocols and standard operating procedures available to staff on the trusts intranet for guidance. The documents were based on up-to-date evidence of best practice and referenced NICE, professional bodies and core standards for intensive care units. The majority of critical care specific policies were reviewed regularly and were up-to-date. A number of guidelines were under review to ensure they were representative of the workload of the new unit. For example, the admission and discharge policies for critical care were currently under review as senior staff were integrating them into the overall operational policy for critical care which was also under review. However, we saw the admission and discharge policies for critical care were both due for review in September 2015 and had therefore not been reviewed in a timely way before the new unit had opened. The service lacked some formal procedures for some basic critical care practices, such as the conversion of dry to wet humidification circuit for the ventilated patient.

The service used technology and equipment to enhance the delivery of effective care and treatment. The service had implemented the ‘anchor guard’ holder method as oppose to the use of tape to avoid pressure ulcers to lips and mouth. A consultant who had seen the method used at another trust had alerted staff to this method. This was introduced following an initial trial of the method, which proved successful in reducing the number of lip, and mouth pressure sores patients suffered.

The unit had a Specialist Nurse in Organ Donation (SN-ODs) and had links to the trust’s clinical lead for organ donation. Staff contacted this nurse when the decision had been made to withdraw a patient’s treatment. The SN-OD sensitively discussed organ donation with relatives and supported potential donor families and the operational processes of organ donation. The unit was a negative outlier for organ donation as the number of organ donations from the unit was below the national average. Organ donation was discussed at the daily safety huddle. We saw information leaflets on display in the relatives’ room providing organ donation information. The trust was part of the UK transplant registry and followed NICE guideline CG135 (organ donation for transplantation. We reviewed donor outcomes for data from January 2018 to February 2019. During this time period, there had been eight eligible organ donors. Two organs were retrieved with the intention to transplant from donors. However, this resulted in no patients receiving organs. This data showed when a patient was eligible for organ donation staff referred this case to a specialist nurse in organ donation in 20% of situations when a patient was suspected of neurological death, against a national average of 95%. In cases where ventilated support was to be withdrawn from a patient, staff referred this case to a specialist nurse in organ donation was involved in 58.3% of occasions, against a national average of 86%. For donation from patients after brain death, one patient was eligible, no families were approached, and no approaches involved the specialist nurse for organ donation. For donation after circulatory death, eight patients were eligible, one family was approached, this approach was made with the SN-OD present.

Data provided for 2018/19 showed an improvement and there were solid organ donations resulting in four patients receiving transplants.

**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. The service made adjustments for patients’ religious, cultural and other preferences.

Staff monitored patient’s nutritional and hydration each day and used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients. This was in line with National Institute for Health and Care Excellence guidance (NICE) QS15 (Patient experience in NHS Services) patients’ physical needs were regularly assessed. The department audited MUST screenings conducted on admission. As at January 2019, 89% of patients had MUST screenings on admission, 100% of patients had MUST screenings since admission and 100% of patients with a MUST score of two or above who were referred to a dietitian was 100%.

Staff recorded patients’ fluid balance was in patients’ records to ensure patients received an appropriate amount of fluids. Senior staff conducted monthly fluid balance audits to check staff were complaint with recording patient’s fluid balance charts. As at January 2019, the results were 100%.

A dietitian assessed, implemented and managed the nutrition support patients required. The speech and language therapy (SALT) team assessed patients including patients that were intubated and encouraged patients to eat and drink whilst intubated.

We saw patients were regularly offered hot and cold drinks. The unit had a dedicated kitchen for staff to prepare patient drinks and snacks. Patients who were able to eat and drink were given a menu to choose their meal choices from each day. The menu offered a range of meal choices. Patients who were on a soft food diet were offered pureed or easy to eat food options. Staff made adjustments for patients’ religious, cultural and other personal preferences. Patients we spoke with said that they could ask for food they preferred and we saw adjustments were made to meet preferences.

Hydration stations had been set up for staff on the unit to allow them to remain hydrated without having to leave the unit.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff regularly assessed and managed patients’ pain levels. Staff conducted this as part of the hourly patient observation checks they carried out. Staff assessed patients’ pain scores on a scale from one to ten. Staff used picture aids, visual aids and appropriate pain score assessment tools for patients that were non-verbal or were unable to communicate their pain levels or needs. The service did not currently conduct pain relief audits.

Staff had access to the trust’s specialist pain team if they required specialist support with patient’s pain management.

Staff were competent to administer pain relief to patients. Staff completed epidural training as part of their initial competency booklet. Staff were assessed on administering an epidural block and were competency assessed in the use of epidural pumps. The Electronic and Biomedical engineering (EBME) nurse had conducted refresher training for staff on pump training.

Patient outcomes
The unit participated and submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated administrative staff in the unit collated and monitored data regarding the outcomes of people’s care and treatment. The unit participated and submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The service had a designated administrative team for ICNARC who were responsible for collecting and validating ICNARC data ready for submission. The data contributed by the unit for the most recent reports was incomplete, as some quality indicators were not reported. For example, no data was submitted regarding a patient’s physiology. The lack of some information reduced the extent the data could be reviewed and compared with other units. Staff were aware some of the data submissions could be improved.

We reviewed the most recent ICNARC reports from April 2018 to September 2018. During this time period there had been 374 admissions to the unit. The patient outcomes for patients using this critical care service were similar to other similar units for the majority of the quality indicators. However, the department performed worse than other similar units for bed days of care post eight hour delay and 24-hour delay and patient discharges direct to home. There had been four (1.1%) patient transfers to another unit for non-clinical reasons. This was slightly higher (worse) than the national average (0.3%) and when compared to other similar units (0.2%).

This data showed staff discharged patients appropriately from the unit. During this time period, there were three (1.2%) unplanned readmissions. This was slightly lower (better) than the national average at 1.3% and when compared to other similar units at 1.3%. Unplanned readmissions may occur when a patient was discharged from the critical care unit too soon. ICNARC data showed there had been a declining trend in unplanned readmissions over the last 12-month period. The review of unplanned readmissions was a standing agenda on the monthly critical care MDT meeting.

ICNARC Participation

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)

For the critical care unit at Walsall Manor Hospital, the risk adjusted hospital mortality ratio was 1.1 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.0.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>805 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.0</td>
<td>1.1</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

Manor Hospital

For the critical care unit at Walsall Manor Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.2. This was within expected limits.
The figure in the 2015/16 annual report was 1.0.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>544 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>1.0</td>
<td>1.2</td>
<td>1.0</td>
<td>none</td>
<td>Within expected limits</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The risk adjusted hospital mortality ratio remained consistent and was within expected limits for 2016 to 2017 when compared to other CCUs nationally.

We reviewed the most recent ICNARC quarterly report for the unit with a reporting period from April 2018 to September 2018. We discussed the mortality ratio with senior staff during our inspection. The mortality ratio was consistently near to one due to the demographics of the local population and the complexity of patient’s conditions.

The unit was part of the local critical care network. External members of the network had not conducted a recent review of the CCU at Walsall Manor Hospital. The unit benchmarked their performance with other units in the network.

**Competent staff**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service exceeded the recommended levels of staff that had achieved their post registration qualification in critical care.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff completed the national competency framework for registered nurses in adult critical care to ensure they were competent before caring for critically ill patients without direct and immediate supervision. All registered nurses on the unit had either completed or were in the process of completing step one of the National Competency Framework for Registered Nurses in Adult Critical care.

At our previous inspection we identified the critical care outreach team were not up-to-date with critical care competencies. The PDN had developed a competencies document for outreach staff and all staff were up-to-date with this training.

The Guidelines for the Provision of Intensive Care Services state a minimum of 50% of registered nursing staff should have post registration award in critical care nursing. As at February 2019, the percentage of nursing staff working on the unit with the required qualification was 51% (31 out of 61) staff. This exceeded the GPIC requirements. The service released four staff per year to complete the post registration award in critical care nursing.

A senior nurse mentor supported newly qualified nurses during their six-week supernumerary period. This was in line with GPICS standards. This period could be extended where additional training needs were identified. Any level three trained mentors could sign off trainee competencies and ideally staff who had conducted the post registration award in critical care nursing.
Staff learning needs had been identified. A practice development nurse was in post responsible for coordinating the education, training and continuing professional development framework for the critical care nursing staff. This was in line with the Guidelines for the Provision of Intensive Care Services. If the practice development nurse was aware of staff competency concerns they assisted staff to maintain or gain additional skills to meet the competency levels. The Practice Development Nurses in critical care were mentioned on a number of occasions regarding the high levels of training support they provided. Staff felt this support was more evident especially now the PDNs were situated on the unit. This aided staff to achieve and to maintain their competencies.

Competencies medical staff had completed as at January 2019 were:

- 85% have intermediate or above (EDIC/DICM) critical care training qualification.
- 85% are trained in level one competency for Echocardiography (FICE).
- 100% are trained in level one or above for ultrasound.
- 92% Mandatory Training
- 100% ALS

Clinical support workers (CSW) had a mentor for support purposes and were part of the CSW mentor group. CSWs had a competency booklet to ensure they had the necessary skills for their role.

A pharmacist with advanced skills and the required knowledge in critical care provided expert advice to the critical care team Monday to Friday and was available on call at the weekend.

Appraisal rates

From March 2018 to September 2018, 87.8% of staff within critical care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>57</td>
<td>64</td>
<td>89.1%</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>65</td>
<td>74</td>
<td>87.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

We received up-to-date appraisal rates for critical care nursing staff during our inspection. As at 23 January 2019, 90.63% of nursing staff had received an appraisal. This was above the trust target of 90%.

As at January 2019, 68.57% of medical staff had received an appraisal. This was below the trust target of 90%.

Staff were notified in advance when their appraisal was due. All band six critical care nurses were mentors and conducted appraisals for band five staff.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good patient care.
Consultants conducted daily consultant ward rounds seven days a week which included staff involved in the patient’s care. However, this did not meet the Guidelines for the Provision of Intensive Care Services (GPIC) 2015. These guidelines specify twice daily ward rounds by consultants are required. Records we checked evidenced all members of the MDT assessed patients each day or when necessary to meet patient’s individual needs.

The critical care service was supported by a number of specialist teams to delivery joined-up care to patients. Availability of some allied health professionals (AHPs) staffing did not meet the required levels in line with the Faculty of Intensive Care Medicine (FICM) Core Standards. The unit was complaint for pharmacy cover as they had dedicated pharmacist cover Monday to Friday and available on call at the weekends. However, physiotherapy and speech and language therapist provision for the unit was insufficient and did not meet GPIC guidelines.

Physiotherapists attended the unit to provided respiratory management and rehabilitation to patients each day. The physiotherapy team leader comprised a band seven with two band sixes and three band five staff. Physiotherapists were not dedicated to the CCU as they also covered six medical wards. However, there was only one band six and one band five currently in post. Physiotherapists used the Manchester Mobility Score, which was a structured rehabilitation tool to assess patient’s mobility. Physiotherapists were involved with the planning and delivering of patients care plans and saw patients during their recovery period and post-discharge. Physiotherapists attended the unit each day from Monday to Friday and were available on-call at weekends.

The unit met the requirements of the Faculty of Intensive Care Medicine Core Standards for physiotherapy cover. Physiotherapists should be available 24 hours a day if required, dependent on patient requirements. This was partly met by an on-call service.

The dietician cover for the unit met the requirements of the Faculty of Intensive Care Medicine Core Standards. These state a dietician must be a part of the MDT team in CCU. The dietitian saw total parenteral nutrition (TPN) patients each day and was available on-call if required. TPN is a method used to supply all the nutritional needs of the body by bypassing the digestive system and providing nutrient solution directly into a patient’s vein.

The domestic staff designated to the unit responsible for cleaning all the general areas of the unit. This allowed nursing staff sufficient time to care for patients rather than conducting domestic tasks.

All staff on the unit worked and communicated well as a team. We saw communication between consultants, nursing staff and allied health professionals was effective and respectful at all times. A junior doctor told us when they were new to the unit they felt able to ask more senior staff questions and were well supported. The teamwork on the unit had improved since moving to the new unit as the layout as one unit enabled improved communication as oppose to being separated over the HDU and TU as previously. All patients were reviewed by the outreach team on discharge. The outreach nurses supported the unit by coordinating with other areas of the hospital to ensure patients who met the admission criteria for the unit were transferred to the unit in a timely way. The outreach team attended the safety huddles so they remained up-to-date with the activity on the unit.

However, once patients were discharged from the critical care unit to a ward or to their home patients did not receive MDT physical and psychological support as follow up clinics were not conducted.

Seven-day services
Staff did not always deliver patient care and treatment seven days a week in accordance with national guidance.

The critical care unit was open 24 hours a day, seven days a week.

The on-call consultant cover was in line with GPICS standards as the on-call consultant was within a 30-minute distance from the hospital.

**Physiotherapy staffing was sufficient to provide respiratory management and rehabilitation components of care.** Routine physiotherapy cover was available Monday to Friday, and on-call cover was provided out-of-hours. Physiotherapists should be available 24 hours a day to meet patient requirements, this was being met with on-call cover.

The majority of specialist support teams and support roles provided a seven-day service to the unit. However, the physiotherapy service was not in line with GPIC standards. The critical care pharmacist attended the unit Monday to Friday and there was pharmacy on call provision at weekends. The dietitian and the SALT service attended the unit to cover referrals from Monday to Friday and were available on call at weekends.

The unit had a dedicated administrative team who supported the unit to maintain patient records, entered patient information onto the electronic systems and supported relatives on the unit. Administrative provision had increased on moving to the new unit. Administrative staff now covered weekends, which allowed nursing staff to concentrate on providing patient care. The outreach team did not currently provide 24-hour cover, seven days a week as they covered from 8am to 8.30pm. Out of hours there was a ‘Hospital at night’ team who provided care. There was a handover between the teams at each shift change. A business case has been forward and accepted to introduce a 24/7 critical outreach team.

**Health promotion**

Staff supported patients requiring additional support including patients identified as being in their last 12 months of their lives. The unit had close links with the trust’s end of life team and made referrals as necessary. The unit had a palliative care nurse available seven days a week. They would also offer bereavement support and counselling to relatives. The unit had individualised end of life care plans and Advance Care Plans to record patients and families’ wishes and preferences. These were secured into the patient’s records.

Patient referrals were made to specialist services at the trust and to external agencies. The service had limited provision to provide additional support to patients, as follow up clinics were not conducted.

Records we reviewed showed consultants had held discussions with patients regarding smoking and alcohol intake, as appropriate.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Nursing and medical staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was above the trust target.

The mental health crisis team conducted mental capacity assessments of patients on the unit. These assessments had been appropriately recorded in patient records we reviewed.
Staff understood when a mental capacity assessment was required and how to record best interest decisions. Mental capacity assessments had been appropriately carried out and recorded in the patient records we reviewed.

Staff regularly screened all patients for delirium. The trust had a sedation policy to provide additional guidance to staff. Staff were knowledgeable about delirium and understood the importance of using appropriate patient sedation levels. Staff used sedation mainly for patients needing invasive mechanical ventilation. This was to ensure patients could have an endotracheal tube in place and synchronise with the ventilator. An endotracheal tube is a tracheal tube that is usually inserted through the mouth (orotracheal) or nose (nasotracheal).

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff understood their responsibilities to comply with of legislation and guidance in line with the Mental Capacity Act 2005.

The trust reported that from March 2018 to September 2018 Mental Capacity Act (MCA) training was completed by 100% of staff in critical care compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 98.6% of staff in within critical care compared to the trust target of 90%.

*(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)*

As at January 2019, Mental Capacity Act (MCA) training compliance rates for medical staff in critical care were above the trust target at 97.3%.

As at January 2019, compliance rates for medical staff for Deprivation of Liberty Safeguards training was above the trust target at 91.9%.

Staff told us there was insufficient support provided by the MH crisis team when the unit had patients with MH concerns. Staff provided a recent example of where a patient with MH concerns was being cared for on the unit who had been physically violent to staff. There was limited timely input from the crisis team in this instance.

### Is the service caring?

**Compassionate care**

**Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.

Feedback from patients and relatives about the care staff provided was consistently positive. Staff were passionate about providing high levels of care which was evident from patient interactions we observed.

Staff were respectful towards patients by protecting patient’s privacy and dignity at all times. The new CCU environment had been designed with ensuring patient’s privacy and dignity was protected as a priority. Curtains could be pulled around each bed space, blinds were on all doors and at each window. Confidential discussions about patient’s care and treatment were held away from public areas. Staff respected patient confidentiality by holding confidential conversations
about patient care in private or at the patient’s bedside. We spoke with seven relatives who confirmed staff maintained patients’ privacy and dignity at all times.

Staff were mindful and considerate regarding sharing a patient’s confidential information. If patients were able to communicate, staff asked them who they could share information with. Relatives were requested to nominate one person as a point of contact for the department. this helped to safeguard a patient’s confidentiality.

Staff supported patient’s emotional and social needs during their stay on the unit to help improve their overall wellbeing. Staff gave an example where they had coordinated with the trust’s communication team to arrange for a local football team to visit a patient who had been a life-long fan of the club. The patient had been on the unit a long time and this lifted their mood significantly.

Staff interacted well with patients and those close to them. Patients who were on the unit long term were provided with continuity of care from medical and nursing staff. Staff had providing patients with continuity of care as a clear priority as this helped reduced patient’s anxiety, confusion levels and supported a patient’s overall recovery. Staff introduced themselves to patients and clearly explained their role in line with the National Institute for Health and Care Excellence guidance (NICE) QS15 (Patient experience in adult NHS services). This was regardless of how alert the patient was. Staff wore name badges clearly displaying their name and role.

Relatives were supported on the unit. The new unit had a dedicated relative’s room, which was an improvement from our previous inspection where there was little provision for relatives. Volunteers from a local charity worked on the unit for two hours per day. Volunteers or the ward clerks checked with patients to determine if they wished to see visitors and escorted relatives. Staff ensured patients and relatives received spiritual support from a range of different faith leaders. The new CCU had been blessed by representatives from a number of different faiths before opening. Faith leaders were readily accessible. Staff with support from the trust’s bereavement team could arrange for the rapid release of deceased patients, which is a requirement for certain religions. Relatives gave examples of when their staff supported patients to have their own religious leader attend the unit.

The department had been part of the ‘purple bow’ scheme since October 2018. This scheme aimed to ensure patients were treated with dignity during ‘end of life’ care and relatives and carers received appropriate support. A staff member on the unit was part of the bereavement group. Memory boxes were provided to relatives of deceased patients, which included bags for their loved ones jewellery, and a white bag with a tree symbol was given to relatives to sensitively hold their loved ones belongings.

The unit participated in the NHS Friends and Family Test (FFT) as much as possible considering the nature of the service. The service circulated these results to the trust’s bereavement team so they were aware where performance needed improvement and to acknowledge good practice. The FFT results for December 2018 and January 2019 were 100% for recommending the unit. There were three respondents for December 2018 and six for January 2019. Relative’s comments included: “better care could not have been given anywhere”, “very kind and caring staff” and “this department is fantastic, staff couldn’t do anymore for you.” Before the two separate units combined into the new unit in December 2018, the FFT results were collated separately for HDU and ITU. We reviewed the FFT results for November 2017 to November 2018. The overall score stated 96.7% of respondents (152 total responses) would recommend the unit. The overall FFT score for ITU during this time period was 97.8% (46 total responses).

**Emotional support**
Staff provided emotional support to patients to minimise their distress.

Staff gave patients appropriate and timely support to cope emotionally with their care. We saw staff comforting a patient who was frustrated with their condition. They took into account the patient’s wishes during a physiotherapy rehabilitation session to help alleviate the patient’s discomfort. Staff ensured the patient’s privacy and dignity was protected.

Relatives confirmed staff kept them up-to-date with their relatives care and treatment. Staff explained information in a suitable way for relatives to understand. Staff were available to answer any questions and helped alleviate concerns. The unit had set visiting times for relatives and those close to patients. However, the visiting times were flexible depending on the condition of the patient. This was to allow family and friends to spend as much time with patients as possible.

Information and support was provided to those close to the patient. The patient journey poster displayed in the relatives' room had links to an array of charitable organisations, forums and charities. This was to ensure patients and relatives had sufficient care whilst on the unit and knew how to access additional support on patient discharge or when their family member had passed away. Relatives confirmed staff provided emotional support in a sensitive way when necessary. Staff in the unit had received a number of thank you cards from patients and relatives thanking staff for the care and support provided at a difficult time.

Senior staff supported the wellbeing of staff. Consultants were encouraged to hold formal debriefs and reflections with nursing staff following patient bereavements. Staff supported one another as each staff member had a buddy on each shift for support. The matron had an open door policy for staff if required.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff were knowledgeable about the impact a patient’s care, treatment and condition had on their own wellbeing and on those close to them. Staff regularly reviewed patients’ physical and psychological needs in line with NICE QS15 (Patient experience in adult NHS services). This including pain relief, nutrition and hydration, personal hygiene and anxiety. The patient records we reviewed showed staff had carried out these needs assessments each day. A patient we spoke with us their pain had been adequately managed and staff were regularly checking how they were feeling.

Staff communicated with patients and those close to them in a way they could easily understand. Staff kept patients and relatives involved in their care and treatment. Staff provided patients and relatives with regular updates and were available to answer questions as necessary. Patients who were alert enough for us to speak with told us they were involved with their own care and treatment. Staff kept them up-to-date with what further treatment they could expect. Staff suggested relatives help patients carry out simple tasks to help with their recovery. Despite some patients not being fully conscious, staff ensured they took into account patient’s preferences and needs as much as possible.

Appropriate support was given to relatives when discussing organ donation. Staff ensured the Specialist Nurse in Organ Donation attended to provide specialist support and information.

The opening of the new unit provided a more suitable space and environment to support patients and relatives. In the previous units, space was limited and often not suitable to hold difficult and confidential discussions. The current unit had a dedicated relatives’ room and an interview room to enable sensitive discussions to be held in private.

Staff supported bereaved relatives and carers to spend enough time with their relative on the unit. Where possible, staff would relocate deceased patients to the isolation room or one of the side
rooms so relatives could spend time with them in private. Staff had close links with the trust’s bereavement team, chaplaincy and end of life care teams.

**The unit did not use patient diaries to help fill in gaps of a patient’s memory.**

The unit was not currently using patient diaries. There is some research, which demonstrates how patients who have been sedated and ventilated in critical care benefit from the use of diaries whilst on the unit and following their discharge. In addition, some studies have shown that the use of a patient diary in critical care reduces the risk of patients developing depression, anxiety and post-traumatic stress disorder. Diaries can help fill the memory gap and can promote holistic nursing. A staff member told us diaries had been trialled in the past but their use had ceased as patients had not wanted to be involved. However, another member of staff told us the service was looking into using diaries permanently.

**Is the service responsive?**

**Service delivery to meet the needs of the local people**

**Senior leaders of the critical care unit planned and provided services in a way that met the needs of local people.** The purpose-built facilities and premises were appropriate for the critical care services delivered.

The service had implemented plans to ensure the CCU met the needs of local people. Since our previous inspection of the unit in 2017, service leaders had implemented plans and delivered a purpose-built critical care unit. This opened on 1 December 2018. The new unit complied with current Health Building Notes for critical care services. The new unit allowed bed usage on the unit to be flexed more easily between level two and level three patients. Staff were able to step up or step down patients in a more timely way as the ITU and HDU were combined into the one unit. Staff could react quicker to changes in a patients’ condition on the unit, as there was no longer a need to re-locate patients between the ITU and HDU areas.

Staff could arrange for patient’s relatives to stay on the unit either in the relatives’ room or in a recliner chair directly next to the patient beds. The department was planning to have a sofa bed available for relatives to use to stay on the unit.

There was a dedicated relative’s waiting room with comfortable chairs, a television and drinks facilities. However, the drinks machines were out-of-order during our inspection and had been out of use for a number of days. Staff had raised this with the maintenance department to action. Relatives could purchase hot meals and snacks from the hospital restaurants, cafes and shop. Relatives told us they would sometimes be offered hot drinks by staff during the drinks round.

The formal visiting times for the unit were 12pm to 8pm. However, visiting times were relatively flexible to ensure relatives could stay with their loved ones for as long as they wished. Volunteers and ward clerks assisted relatives on the unit. The unit suggested relatives allow their loved ones on the unit to have a rest period between 2pm and 5pm to aid patients’ health and wellbeing. Staff ensured the noise and lighting levels on the unit was minimal at all times but particularly during this time-period.

The service had clear transfer processes for patients that required more specialist critical care services. The unit was a general critical care unit so did not provide specialist neurology critical care provided. Patients requiring specialist care were transferred to regional centres accompanied by a nurse and anaesthetist who would travel with them for the duration of their journey. The unit did not have a dedicated transfer trolley available. The unit was part of the Midlands Critical Care and Trauma network and used this network’s checklist form for transferring patients.
Meeting people’s individual needs

The service took account of patients’ individual needs. Translation services were readily available to patients whose first language was not English. However, access to written information in other languages was limited.

Translation services were available to assist communication with patients whose first language was not English. Staff understood how to access the translation service and told us interpreters were easily accessible and attended quickly. We requested information from the trust following our inspection detailing the number of occasions translation/interpreter services had been used in critical care over the last 12 months. The service did not routinely collect this data. Leaflets about a range of related subjects, such as organ donation information were available in the relatives’ room. However, all of this material was in English and not available in other languages.

A large poster was displayed in the relatives’ waiting room which provided relatives and visitors with a range of information regarding a patient’s journey in critical care. This poster also included barcode links to related information such as physiotherapy and the outreach team. Technical terms likely to be used in critical care such as ‘sedation’ and ‘central line’ were explained in basic terms. Details included support available for family and friends with links to relevant charities.

Staff had conducted specific dementia training to ensure staff were knowledgeable to care for patients living with dementia. The critical care unit did not use a specific scheme, such as the butterfly scheme to identify patient’s living with dementia. Senior staff told us they were in the process of implementing a similar scheme.

The unit was accessible and suitable to patients and visitors with reduced mobility. The department was accessible to wheelchair users and had wide door access. The isolation room had large en-suite bathroom facilities and a fixed track patient hoist.

Staff were considerate of patients and their families’ cultural and religious beliefs and needs. A staff member provided an example of when they were treating a patient whose religion prohibits blood transfusions. They dealt with this in a sensitive manner. Staff told us the trust faith leaders were easily contactable. Families could arrange to have their own faith representatives attend the unit.

The isolation room had a hoist and overhead track with an en-suite bathroom for patients with reduced mobility. The beds in the new unit were suitable for bariatric patients. Staff did not need to request beds from the West Midlands Critical Care Network as was required in the old unit.

Relatives and carers could access reduced parking prices. Relatives with loved ones nearing the end of their life on the unit did not have to pay to park at the hospital. However, some relatives were unaware of this scheme. We did not see any displays in the relatives waiting area advertising reduced car parking fees.

There service had plans in place to accommodate additional patients in the event of a major emergency. The design of the new unit had been planned with these arrangements as a priority. Each bed space could accommodate two patients in the event of a major incident. We reviewed the trust’s emergency preparedness and business continuity policy and pandemic influenza plan. Both documents were up-to-date and evidenced recent review. Both documents clearly defined roles and responsibilities of staff within the critical care service and the overall hospital in the event of an emergency. The purpose built critical care unit was suitable to accommodate additional patients in the event of a significant increase in activity in the unit.
The service did not have comprehensive follow-up arrangements for patients once discharged from the unit. We did not see evidence of patient forums held for patients and relatives to obtain suitable support.

**Access and flow**

*People could not always access the service when they needed it. Patients were not always admitted, treated and discharged patients in line with good practice and guidance.*

Staff segregated male and female patients wherever possible. However, the unit was sometimes unable to ensure patients were cared for in single sex areas. The service closely monitored the number of mixed sex accommodation breaches. Between August 2018 and January 2019, there had been eight mixed sex accommodation breaches, two for four months: September 2018, November 2018, December 2018 and January 2019. The reason for the breach in each instance was lack of hospital bed capacity elsewhere in the trust. The divisional leaders informed the executive board when breaches occurred and when there was a backlog in the trust.

The department had reduced the number of mixed sex accommodation breaches from 2017/18 to 2018/19. Senior leaders told us this had been achieved by reviewing the whole process and circulating this across the organisation. They had also championed it through the quality meetings and carried out an investigation following every breach.

Critical care outreach staff and senior staff participated in regular reviews of patient flow across the trust. Bed meetings took place three times per day to review bed availability and patient acuity and needs across the hospital. Staff were in regular contact with bed managers to update them regarding patients requiring either admission or discharge from the unit.

From August 2018 and January 2019, there had been zero incidences of cancelled surgeries due to the unavailability of a critical care bed. There were 357 admissions to the intensive care unit at Walsall Manor Hospital between April 2018 and September 2019, of which 73% (273) were non-surgical admissions, 15.8% (59) were emergency surgical admissions and 11.2% (42) were elective surgical admissions.

Patient admission pathways into the critical care unit were clear. However, the admission and discharge policies had not been updated to reflect the patient pathway for the purpose built unit. Patients did not always have timely access to initial assessment, test results, diagnosis and treatment. On admission to the unit, an intensivist consultant reviewed patients. A consultant intensivist assessed patients assessed as needing level two care within 20 minutes of the referral being made. Staff arranged for patient to be admitted to the unit as soon as possible and within four hours of the referral in accordance with GPICS standards. Data provided to us after our inspection for May 2017 – May 2018 indicated that 83.2% of patients were admitted within four hours of the decision to admit. No more recent data was provided to assess current performance.

**Discharges from the critical care unit did not always take place at appropriate times or place.**

Patient discharges from the unit were planned to ensure patients were moved at a suitable time. Staff avoided discharging patients between 10pm and 8am and submitted incident reports if patients were discharged during these timeframes. We reviewed the number of out-of-hours discharges from April 2018 to January 2018 on the dashboard. There were 114 out-of-hours discharges for this time period. Out-of-hours discharges were consistently within the expected range. The most recent ICNARC report from April to September 2018 showed the unit had 2.0% of out-of-hour discharges to the ward. This was slightly better (lower) than similar units at 2.1% and the national average of 1.7%.
Bed occupancy

From October 2017 to September 2018, the trust’s bed occupancy has mostly been higher than or similar to the England average. We had raised high bed occupancy rates as a concern at our previous inspection.


![Graph showing bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Delayed discharges

Patients were not always discharged from the critical care unit in accordance with the national standards. The Faculty of Intensive Care Medicine Core Standards specifies discharges from a critical care unit should occur within four hours of the decision to discharge being made. Service leaders were aware delayed discharges remained a challenge for the department. Staff incident reported delayed discharges above the eight hour threshold in line with GPICS standards. Delayed discharges remained a challenge for the department. Staff told us they struggled to transfer patients to some medical wards and ward 17, the respiratory medical ward in particular. Staff supported patients during their discharge and up to their transfer of care to other services. In accordance with the trust’s non-clinical transfer operational policy, the most stable patient would be transferred to a unit at another trust.

Manor Hospital

The trust had an agreed target of 12 hour discharges with their clinical commissioning group.

For 2016/2017, the percentage of bed days occupied by patients with discharge delayed of more than 8 hours was 6.7%. This was worse (higher) than the national aggregate at 4.9%.

For Manor Hospital, Critical Care Unit at Manor Hospital, there were 4,745 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 6.7%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 13.5%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,745 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>13.5%</td>
<td>6.7%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>
Senior leaders told us reducing the number of delayed discharges was a priority for the service. The unit used a discharge step down process to ensure discharges were appropriate.

Data relating to the percentage of discharges from the CCU that occurred within four hours of the decision to discharge from August 2018 to January 2019 are shown below:

<table>
<thead>
<tr>
<th></th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>30.77%</td>
<td>14.00%</td>
<td>23.08%</td>
<td>29.03%</td>
<td>22.22%</td>
<td>23.91%</td>
</tr>
</tbody>
</table>

Patients may be discharged home from the critical care unit due to lack of available beds on other inpatient wards in the hospital. There had been 41 instances where patients had been discharged from the unit directly to home in the last six months. This was recorded on the critical care risk register. Senior staff told us this reflected pressures across the hospital. An intensive care consultant would review patients before they went home and completed a discharge form. Where patients needed further mobility support and adaptions at home the patient liaison would liaise with the occupational therapy team. For example, for patients with Chronic Obstructive Pulmonary Disease (COPD) arrangements were made to ensure patients had an oxygen supply at home. The COPD nurses would support this process.

**Non-clinical transfers**

**Manor Hospital**

For Manor Hospital, Critical Care Unit at Manor Hospital, there were 865 admissions, of which 0.0% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.7%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>865 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0.7%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Non-delayed out of hours discharges to the ward**

**Manor Hospital**

For Manor Hospital, Critical Care Unit at Manor Hospital, 1.6% of admissions were non-delayed, out-of-hours discharges to the ward. These discharges took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 2.9%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>609 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to</td>
<td>2.9%</td>
<td>1.6%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>
Patients were not always discharged to the most appropriate place. Between August 2018 and January 2019, the critical care dashboard showed there had been 64 patients discharged directly from the unit to their home.

**Learning from complaints and concerns**

**From October 2017 to September 2018, the service had not received any complaints and had seven compliments.**

**Summary of complaints**

The critical care service had not received any recent complaints. As no complaints had been received, we could not fully assess the service’s complaints investigation process. Relatives we spoke with were comfortable to raise any concerns with staff directly. The unit displayed a Patient Advice and Liaison Service (PALS) poster in the relatives’ waiting room outlining how to make a complaint.

Staff tried to address complaints immediately in an informal way before it became a formal complaint. Information was displayed in the relatives’ room outlining if relatives raised a complaint or concern, this would not be detrimental to the care their relative would receive.

From October 2017 to September 2018, there were no complaints about critical care.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

The critical care operational minutes for January 2019 referenced one informal complaint had been received regarding the relative’s room as relatives were not sure what was happening to the family members. Further information and posters were planned to try to address this problem.

**Number of compliments made to the trust**

From October 2017 to September 2018, the critical care unit had received seven compliments.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

We saw staff in the department had received a number of thank you cards from patients and relatives.

**Is the service well-led?**

**Leadership**

**Managers of the critical care service had the right skills to lead the service.** The service had a clinical lead for critical care.

The critical care service was part of the surgical division and the theatres, anaesthetics and critical care group.
The care group had a clinical director who was recently appointed. The clinical lead who was a consultant intensivist (a consultant specialising in intensive care medicine) led the critical care service. The care group had triumvirate leadership, which comprised a matron, a clinical lead and care group manager. Two ward sisters managed the day-to-day running of the CCU supported by two practice development nurses. Band six nurses acted as mentors for less senior staff and conducted band five staff appraisals. An administration team leader managed administration staff. They told us they were well supported by their managers and would approach them if they had any concerns.

Senior staff told us there were clear lines of communication both up-to-the board and to ward level. This was achieved through regular communication and attendance at monthly management meetings.

The unit had a visible, approachable and supportive leadership team. Staff told us there were clear lines of accountability and they felt comfortable to raise concerns. Staff at all levels told us the executive team were visible and accessible. Staff felt there had been a new emphasis with the recent executive board changes to effect changes in their own services. Staff knew who members of the executive team were, including in particular the Chief Executive and Director of Nursing.

The service ensured relatives knew who were leaders of the service. A folder containing information for relatives was available in the relatives’ room included pictures and titles of the service leaders.

The service had clear priorities for ensuring inclusive and effective leadership. Senior staff developed their leadership skills to ensure they had the necessary skills to run the service. A band seven nurse was part of the trust’s leadership programme to gain further leadership behaviours and skills to own their wards and change.

Leaders understood the challenges to quality and sustainability for the service. However, actions needed to improve the service further had not been implemented promptly. The priority for service leaders had been to ensure the building of the purpose-built critical care unit was completed in a timely way. The completion of the unit had alleviated many of the challenges and concerns we had raised at our previous inspection, mainly due to the limitations of the previous environment. However, this was to the detriment of addressing other concerns and risks we had raised at our previous inspection, such as lack of follow up clinics and staffing of the outreach team. At this inspection we identified follow up clinics were still not held and the outreach service cover was not in line with GPIC guidance.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and workable plans to turn it into action.** Staff at all levels felt engaged with the future plans for the unit.

Leaders of the service had a clear vision and strategy for the unit since the recent opening of the new unit in December 2018. The team regularly reviewed long-term plans with the clinical director for the division. Staff had been actively involved in the overall design and layout of the unit. The vision and strategy was in line with the overall trust’s recently renewed vision and strategy. The trust had recently revised the trust vision to be ‘Caring for Walsall together.’ Staff were aware of the trust’s vision and values as there had been a lot of communication. There was a clear leadership structure however, there was not a hierarchical culture. All staff respected each other and communicated effectively.

Service leaders had clear plans for the second phase for the new unit. This included re-launching the outreach team, moving towards paperless records system and providing additional nurse training sessions led by anaesthetists. Nursing staff wanted to increase patient capacity to 18 for the unit as part of the future plans for the unit.

**Culture**
Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale had improved since relocating to the new critical care unit.

Staff were proud to work for the critical care service and the trust. Staff had providing the highest level of care to patients as their main priority.

Staff had been actively involved in the opening and planning of the new unit. Staff had been offered a tour every Friday for four weeks before the unit opened. The service introduced a ‘worry book’ for staff to raise any concerns they had about the new unit. This was with the aim of alleviating these concerns before the move.

We saw evidence of a strong teamwork culture. Staff from different specialties pulled together to ensure all patients were safely transferred to the new unit over a weekend. Staff felt the newly formed team worked well together as one cohesive team. Despite the administrative staff being managed by a different team, they felt very much included as part of the team on the unit. Staff were most proud of the teamwork on the unit and across the whole trust. Other departments had supported the team when moving to the new unit. A staff member described the unit as “one big happy family.” Another staff member told us they “loved coming to work every day.”

Junior doctors on rotation felt well supported by staff that are more senior and were able to ask questions or raise concerns.

Staff reported there had previously been a strained relationship between the ICU and the outreach team. The outreach team were now managed by the surgical division and formed part of the ICU team, which had improved their relationship. However, further improvement was required to ensure the outreach team felt fully part of the team.

The department had an open and honest culture relating to incident reporting. Staff at all levels were encouraged to speak up and raise any concerns. Senior staff investigated concerns in a sensitive and confidential way. Lessons were learned when appropriate. Staff were aware the trust had three Freedom To Speak Up Guardians who they could raise concerns with if required.

**Governance**

The critical care service did not always use a systematic approach to continually improve the quality of the service and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The service had been concentrating on combining the two previous ITU and HDU areas into a cohesive and streamlined critical care service. Service leaders had successfully achieved the relocation of these units into the purpose built unit in a timely way.

However, whilst the service had effective structures, processes and systems of accountability to support the delivery of the strategy, the overall oversight of the leadership team to ensure the service continually improved and provided good quality and sustainable services needed further improvement.

Senior staff regularly reviewed governance arrangements however, they did not always review in line with current guidelines. Some parts of the service, for example the critical care service outreach team were not managed in accordance with Guidelines for the Provision of the Intensive Care Services (GPICS).

We did not see evidence the service leaders audited their service against the GPICS standards to assess areas of compliance and non-compliance.

**Management of risk, issues and performance**
The service had effective systems for identifying risks. However, the trust had not yet addressed a number of concerns we had raised at our previous inspection.

Service leaders understood the main risks to the service. The service had systems to accurately identify and record the majority of the relevant risks to the service. The most up-to-date version of the critical care risk register we reviewed was representative of what staff told us were their main risks and concerns for the service. For example, the inability to currently provide a 24 hours a day, seven days a week outreach service and the potential for mixed sex breaches due to capacity issues elsewhere in the trust were recorded risks. Each risk had a risk level and risk owner responsible for monitoring each risk and actions put in place to help mitigate each risk. A recruitment programme was in progress to ensure the outreach team was up to full establishment as soon as possible.

However, some identified risks were not recorded on the critical care risk register for monitoring purposes. For example, the unit did not offer consultant-led follow-up clinics to discharged patients in accordance with the Guidelines for the Provision of Intensive Care Services was not recorded as a risk. Therefore, we were not fully assured service leaders were sufficiently monitoring and reviewing all relevant risks to the service.

The risk register had some long-standing risks recorded. For example, the difficulty in recruiting middle grade staff had been on the risk register since 2015. However, there was evidence each risk was regularly reviewed and remained on the register for monitoring purposes until the risk was fully mitigated.

The risk register was regularly reviewed and adapted to ensure it was reflective of the most current risks. The risk register was a standing agenda and was discussed each month at risk meetings. The risk manager attended and maintained an action plan. These meetings also included mortality reviews and incident discussions.

The service planned ahead with the aim of avoiding future risks for the service. For example, senior leaders discussed at the critical care operational group meeting in January 2019, the Royal College of Surgeons had sent information to all of its members that all patients above 5% mortality should go to ITU following surgery. Senior staff anticipated this would have a high impact on the capacity of the unit as these patients were not normally admitted. Discussions were held as soon as this information was received to help ensure as much mitigation was put in place as possible.

The service had its own critical care clinical dashboard service leaders used to record and monitor clinical effectiveness and patient outcomes. Metrics on the dashboard included delayed discharges of patients with delays of over four hours,12 hours and 24 hours, out-of-hours admissions and discharges and mixed sex breaches. However, the dashboard did not record comparison targets to benchmark their service’s performance against other similar units.

Monthly assurance meetings were held each month which evidenced incidents had been thoroughly reviewed. Senior staff communicated risks to staff on the unit during team meetings.

The service was aware of their financial constraints. The service worked with the procurement team to ensure it was as efficient as possible. Senior leaders told us now the unit was one unit rather than two separate areas this would make it easier to purchase consumables in bulk which would be more cost effective.

The trust had feedback mechanisms for sharing information about incidents. The trust’s governance team shared incident information via a risk newsletter. We reviewed the quarterly risk
roadshow presentations for December 2018 and January 2019. Each of these detailed the main risks to the critical care service and incident themes for these months.

Information management

The service did not always collect, analyse, manage and use information well to drive improvement in the service.

Staff completed information governance training as part of their mandatory training. However, nursing and medical staff compliance was below the trust target. The trust had an up-to-date data protection policy. This included reference to the General Data Protection Regulation. Staff conducted information governance as part of their mandatory training. Staff were aware of the policy and how to access it. If staff had any data protection concerns, they would raise this with their team leader or refer to the guidance.

Staff could readily access policies, procedures and guidance on the trust’s intranet. Theatres, anaesthetics and critical care (TACC) had their own shared drive for all staff in the care group to access performance data.

The service used a paper based records system. Some trust systems did not currently communicate with one another. For example, the IT system used for the ICNARC data did not communicate with the patient records system. This meant some data needed to be duplicated onto both systems. The service aimed to move to a paperless system in future to allow more timely access to information. There was no indication when this would be in place.

A 0.5 equivalent post covered the collation and submission of ICNARC data. Staff felt this was insufficient for the number of admissions per year. A business case had been submitted to increase this to one WTE post.

Technology in the unit was generally fit-for-purpose. All of the beds in the unit were connected to the internet so a patient’s condition could be monitored on the screen at the nursing station. The service aimed to introduce electronic tablets for the outreach team so they were up-to-date with bed capacity and availability to help with flow and timely discharge. However, at the time of our inspection the unit had some initial technical problems with the telecoms system on the unit. This meant the service only had one phone with the ability to contact bleeps.

We requested a large amount of data from the service to review following our inspection. This was to further assess the performance of the unit in addition to the information we had collected on site. Service leaders were able to provide us with the majority of this data in a timely way. However, the service was not able to provide some data in a time efficient way. We were not assured the data collation process for the service was sufficiently efficient and suitable to enable the service to easily and effectively monitor the performance of the service.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The department had held a number of engagement events for the opening of the unit, which included local stakeholders, the Walsall mayor and a local MP and local mayor. During the building of the new unit, builders had dug up a previous time capsule that was buried in the West Wing in 1989 which formed part of the celebrations. The CCU team decided to bury another time capsule to mark the completion of this major building project.

Staff were actively involved in the planning and design of the new critical care unit in the new hospital. Staff felt their views and preferences were taken seriously for the new build. Leaders of the service had kept staff up-to-date with developments regarding the opening of the new unit. Service leaders had sent all staff a letter with details regarding re-locating to the new unit. There was a countdown clock to the opening of the CCU on the trust’s intranet. Staff were more engaged with the new unit. Service leaders told us there had been no challenging behaviour to manage...
when moving to the new unit. Staff had welcomed the combining of the previous ITU and HDU teams. The ward clerk team were able to choose their own uniform and chose their name as the ‘admin team.’

The department had strong links with the local community. Staff had coordinated with the trust’s communications team to arrange for members of a local football team to visit a patient staying on the unit. Senior leaders had included families of previous patients in the planning of the unit. The relatives’ room had been named the ‘Francoise Suite’ in memory of a former patient whose family had made a charitable contribution for the room. However, there was not an active patient forum group for the service to enable patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment.

The service collated patient feedback by recently a monthly audit tool. This involved asking ten patients their opinions each month. The results were used to improve the service. The service participated in the NHS Friends and Family test to assess patient satisfaction of care received on the unit.

The service was involved with a role model award where staff could recommend each other to recognise good practice and behaviours.

CCU and long term condition representatives attended delivery group meetings. Staff told us had improved the engagement with the medical division.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong. The service promoted specialist critical care training, research and innovation.

The service was proactive in sharing learning from incidents and improvement for the department. Senior staff engaged with other critical care units locally and nationally by participating in research projects.

The whole of the critical care team were innovative and motivated in its approach to the design and planning of the new unit. Senior leaders ensured the building complied with current regulations, the Health Building Note (HBN 04-02) on critical care units: planning and design. Senior staff approached a local trust who had recently built a new CCU to discuss approaches and learning.

The team were sharing project management learning from their experience of planning and re-locating the unit with other departments that were due to undertake new build products, such as the emergency department.

The manufacturing company for the adjustable beds that had been installed into the new unit was using the CCU at Walsall Manor Hospital as a test site. Senior leaders were presenting this piece of work at the next CCU network meeting.

The department continued to develop their major incident plan to ensure they were as well prepared as possible in the event of a major incident.

Staff provided examples of where learning from incidents resulted in implementing change. One example was around the introduction of the ‘anchor guard’ method to help prevent hospital acquired pressure ulcers implemented in November 2018. A member of staff brought the technique from working at another trust.

The service was a member of the Black Country and Birmingham Critical Care Network. The matron for the unit attended network meetings and band seven staff rotated who attended. Staff gave examples of where they had presented research data and discussed critical care related topics at the meetings, such as organ donation. The unit was part of the Midlands Critical Care and Trauma Network. This allowed the service to share best practice and benchmark patient outcomes at their unit with critical care network members with the aim to improve patient care. The
unit’s PDNs attended the Black Country PDN network to share best practice for critical care training.

The department had strong links with other local trusts, such as neurology units and thoracic. The unit had volunteered to be part of a bereavement study ran by the local critical care network. The network required local district general hospitals to be involved in the study reviewing bereavement care in critical care units. The department had applied for research funding for the study. Some staff from the unit attended conferences and external training days to ensure they remained up-to-date with theoretical and practical skills within critical care. The service had led a critical care transfer study day in October 2018 for the ‘A theoretical and practical day to develop knowledge and skills in the transfer and retrieval of critically unwell adults and children utilising a systematic approach.’ This was held at the trust.

The service was currently involved in a national research project called the ‘REST’ trial (pRotective vEntilation with veno-venouS lung assisT in respiratory failure). This trial was a national research project funded by the National Institute for Health Research UK. (NIHR) The aim of the trial was to review new ways of treating respiratory failure. The research included examining the damage to patient’s lungs resulting from mechanical ventilation in patients with respiratory failure compared to the use of a new device used to remove carbon dioxide from the blood allowing gentler mechanical ventilation.

The critical care service did not have any accreditations from critical care accreditation schemes.
Maternity

Facts and data about this service

The service has 52 maternity beds across two sites:

- The Manor Hospital has 49 maternity beds, these are located within 2 wards and Delivery Suite.
- The Freestanding Midwifery Led Unit (MLU) has 3 maternity beds. The MLU was currently closed for women to give birth there. Some community outpatient clinics took place at the MLU.

(Source: Trust Provider Information Request – Acute sites)

We inspected maternity services as part of the next phase of our inspection methodology.

We last inspected maternity services at Walsall Healthcare NHS Trust in June 2018. We rated each domain for safe, effective, responsive and well-led as requires improvement and caring was rated good. The overall rating for the service was requires improvement.

This inspection was an unannounced inspection of maternity services on 11, 12, and 13 of February 2019.

We visited all areas of the maternity service at Manor Hospital, community midwifery services and the standalone midwifery led unit.

We spoke with twelve patients and relatives, and 44 staff members at all levels, including consultants, midwives, student midwives, maternity support workers and administration staff. We reviewed four prescription charts and 15 patient medical records.

A range of data was requested from the service as part of this inspection.

We also held maternity staff focus groups for all staff levels and community staff
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

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

Mandatory training completion rates

The service set a target of 90% for completion of mandatory training.

Manor Hospital maternity department

All qualified nursing staff were fully compliant with mandatory training.

We reviewed the compliance for October 2018 to December 2018 and found staff had exceeded the compliance target in all the months. This showed compliance was embedded within the service.

A breakdown of compliance for mandatory training courses as of September 2018 for qualified nursing staff in the maternity department at Manor Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load Handling</td>
<td>145</td>
<td>145</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Update</td>
<td>143</td>
<td>145</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>143</td>
<td>145</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>143</td>
<td>145</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>142</td>
<td>145</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>139</td>
<td>145</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>137</td>
<td>145</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>137</td>
<td>145</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>133</td>
<td>145</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>131</td>
<td>145</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Community midwifery mandatory training compliance had improved since our previous inspection. Managers had achieved this by allocating protected time for staff to attend training and through providing community based workbooks.
Community midwives received specialised mandatory training so that they could respond to patient emergencies. They conducted community midwifery emergency skills and drills training to maintain their skills to manage a range of obstetric emergencies. This included maternal collapse, cord prolapse, breech, and shoulder dystocia. In addition, managers had arranged a community specific skills drills training day with Baby Lifeline in May 2019. This consolidated community staff emergency skills. This was an improvement since our previous inspection in June 2018.

Staff were supported to maintain, improve and broaden their knowledge and skills and develop the professional and personal qualities required in their professional lives. The service had a specialist continuing professional development midwife who was the lead for training and development. Staff completed their mandatory training through face-to-face sessions and online courses. Midwives and medical staff attended an update study day each year.

Managers had systems in place to monitor and address staff compliance with mandatory training. Senior staff monitored training rates regularly. The continuing practice development midwife sent staff reminder emails in advance to inform them their training was expiring. If staff failed to comply, the CPD midwife emailed the manager. Managers could take disciplinary action if required.

Community and inpatient staff told us they were given protected time to complete their training. This was an improvement since our previous inspection in June 2018.

Although most midwives were up-to-date with almost all specialised midwifery training, overall compliance rates were still below the service target for cardiotocography (CTG) training between June and October 2018 and from January to February 2019. Midwives were required to complete annual mandatory cardiotocography (CTG) training as part of nationally recognised fetal monitoring training programme (K2). This training included for example, antenatal and intrapartum CTG and fetal physiology.

Training compliance as of January/February 2019 was:

<table>
<thead>
<tr>
<th>Area</th>
<th>January 2019 compliance</th>
<th>February 2019 compliance up to and including 19/02/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Suite</td>
<td>84.2%</td>
<td>↑90%</td>
</tr>
<tr>
<td>Wards</td>
<td>77.5%</td>
<td>↑86.2%</td>
</tr>
<tr>
<td>ANC/FAU/Screening</td>
<td>68.75%</td>
<td>↓61.6%</td>
</tr>
<tr>
<td>CMW &amp; WREN team</td>
<td>89.9%</td>
<td>↑92.4%</td>
</tr>
<tr>
<td>Consultants</td>
<td>91.7%</td>
<td>↑92.3%</td>
</tr>
<tr>
<td>Overall compliance</td>
<td>82.4%</td>
<td>↑84.5%</td>
</tr>
</tbody>
</table>

Although staff were not fully compliant with the K2 training, CTG was covered on PROMPT (Practical Obstetric Multi-Professional Training). Staff were fully compliant with this (96%). The
national requirement was for one annual update. The service chose to introduce the K2 package to enhance CTG knowledge and skills. Compliance was monitored weekly via the performance meeting led by the Divisional Director of Midwifery, Gynaecology and Sexual Health and Care Group Manager.

Managers had put many other measures in place ensure compliance in this area such as weekly CTG review meetings and review of clinical incidents by the ward manager and audit teams.

The specialised training was comprehensive and met the needs of patients and staff. The training included a wide range of modules designed to keep patients and staff safe, as well as making sure staff knew how to use systems within the trust. These included environmental, professional, and legal aspects that impact on the midwife’s role, how to carry out appropriate risk assessments, antenatal screening including fetal/neonatal health assessment, and management of women in crisis.

Staff knew how to reduce preventable harm for mothers and their babies. All maternity staff were fully compliant with PROMPT (Practical Obstetric Multi-Professional Training) as recommended by national guidance. As of February 2018, compliance rates were 97%. Within this training staff took part in skills and drills sessions to gain and maintain the relevant skills staff required to manage a range of obstetric emergencies. These included: new-born basic life support, breech delivery (a breech birth occurs when a baby is born bottom first instead of head first), shoulder dystocia (where the infant's shoulder is obstructing labour and manipulation is required”), perineal repair (during delivery the perineum can tear) and sepsis. The training included staff from different disciplines to promote multi-disciplinary learning.

Staff knew the signs and what to do in cases of bacterial sepsis in pregnancy. Staff completed sepsis training during their annual training day and skills and drills training so could tell us what the escalation procedures were. They had access to the sepsis policy on the trust’s intranet.

All medical and clinical support staff had completed all aspects of mandatory training deemed essential for safe and efficient service delivery and personal safety. As of February 2019, compliance was at 92% for medical and 94% for clinical support staff.

**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.

All staff were up-to-date with safeguarding training. All staff we spoke with had the knowledge and skills to confidently deal with safeguarding issues.
Safeguarding training completion rates

The service set a target of 85% and 95% for completion of safeguarding training.

Manor Hospital maternity department

A breakdown of compliance for safeguarding training courses as of September 2018 for qualified midwifery staff in the maternity department at Manor Hospital is shown below:

Although the table below shows no qualified nursing staff were trained in the government’s counter-terrorism ‘Prevent’ programme (Level one and two), this was because there was only one staff eligible. By 15 February 2019, all eligible staff were fully compliant with this training. This was an improvement since our previous inspection in 2018. Prevent is part of the UK’s Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>122</td>
<td>126</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>134</td>
<td>144</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>133</td>
<td>144</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and clinical support staff were fully compliant with safeguarding training. As of February 2019, safeguarding training compliance for medical staff was:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>100%</td>
</tr>
</tbody>
</table>

As of February 2019, safeguarding training compliance for support staff was:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (level 2)</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>100%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>98%</td>
</tr>
</tbody>
</table>

From November 2018 to January 2109, community staff made 31 safeguarding referrals and acute staff did not make any.
Effective arrangements were in place to safeguard women with or at risk of female genital mutilation (FGM) and these were in line with national guidance including DH Female Genital Mutilation and Safeguarding: guidance for professional’s, March 2015. Staff supported and safeguarded women with FGM needs throughout their maternity pathway. For example, staff routinely asked about FGM at the pre-natal booking appointment, reported and shared information with other agencies and followed safeguarding procedures.

The service provided specialist care and support for patients who had experienced female genital mutilation. A consultant held a weekly clinic for pregnant women who had experienced female genital and, staff signposted them to a FGM support group.

The service had systems in place to check whether families were subject to a child protection plan. Staff asked patients at their first booking appointment if there had been any involvement with child protection services.

Staff worked in partnership with other agencies to ensure patients with safeguarding needs received the appropriate support and protection. Staff attended the monthly multidisciplinary unborn network meeting where professionals discussed any concerns for an unborn baby and provided a framework for responding to safeguarding concerns and safe planning by practitioners working together, with families, to safeguard the baby at birth.

Staff provided asylum seekers, travellers and migrants with specialist advice and support. The Women Requiring Extra Nurturing (WREN) team offered support to all vulnerable women for their routine care. This team of five midwives provided continuity of care for vulnerable families.

The service safeguarded unborn babies. The health visitor added the details of unborn babies at risk to a network database to ensure all agencies involved could monitor the risk and put actions plans in place safeguard them.

Staff followed systems to make sure no unauthorised people could take babies outside the maternity area. Staff gave all babies an electronic safety tag whilst in the maternity department. They removed the tags at time of discharge. Staff were aware of their responsibilities during a possible abduction incident in line with the trust’s abduction policy. Five abduction drills had taken place since June 2018. This was an improvement since out previous inspection where we found none had taken place. Managers had provided an action plan to address areas of non-compliance. For example, a new entry was added onto the team leader shift report and ward daily check sheet to confirm that all baby security tags had been checked at the beginning of each shift change.

The service provided additional support for staff dealing with the most vulnerable patients. For example, the service wide safeguarding team provided supervision to staff and they attended a specialised two-day training session. The safeguarding team staffed an advice line seven days a week and maintained a database of vulnerable women.
Community midwives had protected time and support to conduct their safeguarding duties. Staff could access and receive advice and support regarding safeguarding issues. Staff said they could contact the service wide safeguarding leads for support. The safeguarding midwife, who was part of the trust’s corporate safeguarding team, supported them to complete court reports. Four midwife safeguarding supervisors and the WREN team provided extra support to staff with safeguarding concerns. Managers were investigating the potential of group supervision to offer community midwives formal quarterly supervision in line with national guidelines.

The Divisional Director of Midwifery, Gynaecology and Sexual Health monitored safeguarding training compliance and reported this in their Divisional Director of Midwifery report. The December 2018 report showed all areas were compliant except wards 24 and 25 which were 85% for safeguarding children level 2. This equated to two members of the clerical team which had been escalated to the matron.

**Cleanliness, infection control and hygiene**

**The service did not always control infection risk well.** Staff did not always keep themselves, equipment and the premises clean. They did not always use control measures to prevent the spread of infection.

Although all the wards and areas we visited, were visibly clean, managers had identified issues with staff compliance with infection prevention control procedures (IPC) on the inpatient wards on the risk register. This was of concern as senior staff had still not taken sufficient timely action to improve IPC compliance in the unit.

Managers produced action plans to address this. For example, the maternity service infection control team undertook joint monthly audits of the maternity areas and all maternity staff received a letter highlighting their individual responsibility regarding infection control.

The inpatient environment supported staff to minimise the risk of the spread of infection between patients. Isolation rooms were available should they be required for patients with infectious diseases.

We saw staff using infection prevention control techniques to prevent the spread of infection such as hand-washing, use of antibacterial hand gel and personal protective equipment such as gloves and aprons, hand hygiene audit results. From July 2018 to December 2019 in patient staff fully complied with handwashing in all months apart from in two where there was compliance rate of 50% and 80 %. Staff asked all visitors and inspectors to the ward to use hand gel before entering and leaving. All staff looked well presented in visibly clean and smart uniforms and were bare below the elbows.
Although the division’s internal audits found sharps bins were not always dated and signed we found staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the sharps bins were dated and were not filled more than halfway.

Staff carried out a range of audits to monitor staff compliance with infection prevention control processes and techniques to ensure they protected patients, visitors and staff from the risk of hospital-acquired infections. For example, audit results showed there were no hospital acquired infections, ward and bay closures due to infection breakouts and catheter acquired infections from April 2018 to January 2019. The annual audit carried out by the infection control team on 15 February 2019 showed 94% compliance with IPC techniques on ward 24 and 93% on ward 25. There were no cases of hospital acquired infections. Patients were routinely screened for MRSA and C.Difficile.

Environmental audits showed staff did not always comply with best practice for keeping the division clean. From April 2018 to December 2019, clinical housekeeping audits ranged widely from 36% to full compliance Overall environmental compliance between July 2018 and December 2019 ranged from 57% to 95%. Managers produced action plans to address areas of non-compliance. For example, managers cascaded Ward 25 audit findings to the team at the January 2019 ward meeting. Staff changed all curtains in the ward area to disposable curtains and managers planned to escalate findings to the housekeeping team.

Staff followed processes to protect patients from experiencing acute inflammation of a vein when receiving intravenous therapy. The Visual Infusion Phlebitis (VIP) score audit from July 2018 to December 2019 showed staff fully complied with best practice in every month apart from one which showed 84% compliance. The target was 90%. The VIP score is an essential tool that facilitates the timely removal of short peripheral intravenous catheters at the earliest signs of infusion phlebitis (acute inflammation of a vein).

Staff did not protect women from infections and legionella. Delivery suite staff did not consistently clean and water flush the birthing pool. There were significant gaps on the daily cleaning logs. For example, between 1 February and 27 February 2019 staff had only checked and cleaned the pool five times and the pool was in use on one of these occasions. There was no checklist to evidence staff had followed procedures to minimise the spread of infection. The service told us a new checklist had been developed in response. This would enable checks of daily cleaning, cleaning immediately following delivery and water flushing. A policy was being drafted.

Managers presented infection control compliance and action plans in staff forums such as team meetings. Managers identified actions to address areas of non-compliance such as sending a letter to all staff indicating quality measures and managers to carry out monthly uniform audits.
The division had a system in place to ensure all staff received updates regarding IPC information. The unit had an infection control link midwife. They cascaded relevant infection control concerns and information to staff following link meetings.

Environment and equipment

The service mostly had suitable premises and equipment and mostly looked after them well.

Although equipment conformed to the relevant safety standards which met the needs of staff and patients in line with national guidance, there was shortage of some equipment needed to keep patients safe. Some inpatient staff said they didn’t always have enough basic equipment such as fetal monitoring machines and thermometers to carry out their roles effectively. Managers also identified an increased number of women were not having carbon monoxide checks at bookings due to a lack of machines, straws, batteries and mouth pieces. However, community staff told us they had access to all the equipment they required. A midwifery support worker had responsibility for maintaining equipment across the department.

Although resuscitation trolleys and defibrillators were accessible to all staff in line with Resuscitation (UK) guidance, staff did not consistently check neonatal equipment on the delivery suite was safe to use. Managers identified this as a risk on the risk register. The specialist governance midwife had oversight of this and said they had put systems in place to address this. For example, actions and prompts were in place and support staff double checked safety checks had been carried out.

Staff complied with fire safety regulations. This was an improvement since out previous inspection where we identified fire safety risk assessments for the department did not accurately reflect some of the risks and did not consider significant changes on the antenatal and postnatal wards.

The service had systems for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.

Managers identified the physical estates capacity was inadequate for demand and that this impacted on services such as the neonatal unit. Staff addressed this by using a room as a secondary theatre to meet demand. They acknowledged this was a risk as it did not comply with standards for obstetric theatre provision. During our inspection we saw building work for a second obstetric theatre and neonatal unit expansion was continuing.

The environment supported the timely transfer of patients to emergency units. The delivery suite was located near the obstetric theatres and neonatal unit.
Although the community midwifery led unit (MLU) remained closed for births, patients were now offered some outpatient clinics from the unit such as the mental health clinic.

On the divisional risk register, managers identified the lone worker policy did not effectively cover midwifery staff working alone in the community. They had put systems in place to address this such as providing community midwives with mobile phones.

Staff ensured both patients and visitors were kept safe on the inpatient and community areas. Visitors gained access to the delivery suite and the maternity wards via an intercom and buzzer system. Staff had swipe card access to gain entry to the department. Security cameras were in place at the entrance to each area of the department.

Although the division had two bereavement rooms with en-suite facilities, they were situated on the delivery suite main corridor which meant recently bereaved parents might encounter new-born babies. This could prove upsetting for bereaved women and their families.

Staff provided patients with equipment to help them express milk so they could store it and feed it to their baby later. The Health in Pregnancy team also arranged breast pump loans to women who required this support.

Most staff were now competent with the use of the active birth beds for promoting active birth. This was an improvement from out previous inspection when staff told us they did not feel competent in this area. All staff were required to complete a self-assessment form and 90% reported that they were compliant and confident with the use of the equipment. Managers planned to arrange additional training sessions for staff to attend for an update.

We saw that staff discussed environmental and equipment issues in staff forums such as team meetings. For example, managers discussed the non-compliance with housekeeping standards at the October 2018 team meeting. Despite escalating issues several times to the housekeeping management team, including old-style bins which were now rusting and low staffing levels for housekeeping, managers recognised this was still a major concern for the unit.

**Medicines**

**The service did not always follow best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.

Staff did not always secure and check controlled drugs in line with current national guidance and legislation. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. For example, although two registered midwives completed the required daily checks and all medication was in date and matched the controlled drugs register on each ward, staff did not consistently record wastage of epidural bag wastage. In
January 2019 they did not record the wastage 24 times. This was not in line with the Misuse of Drugs legislation.

Audit results for controlled drugs (CD) from July to December 2018 showed staff did not consistently comply with best practice standards. Areas audited included whether the key to the CD cupboard was held by the appointed nurse in charge of the ward or a delegated midwife acting as deputy and whether calculations of the running balance were correct and reconcilable. The results showed staff compliance ranged from 50% to 88%.

Since November 2018, the weekly ward self-audits completed by ward staff had showed improvements. Managers had oversight of the audit results. Audit areas included key medicines storage standards, the monthly drug trolley audit and four CD audit standards. There had been a noticeable improvement in percentage compliance from the commencement of the self-audit in November 2018 to that submitted in January 2019. The standards where action was still required to improve compliance included, medicines stored in original container, all open bottles of liquids in drug trolleys have a 'date opened' and drug fridge/freezer temperatures are checked and recorded daily.

Staff achieved full compliance with the drug trolley audit from August 2018 to January 2019 apart from one month (September 2018) where compliance was 90%.

The pharmacy technician assigned to maternity carried out monthly spot checks on ward medicines storage in all ward areas. The spot checks focussed on areas such as key storage and drug trolley audit standards and highlighted the areas of non-compliance; the spot checks were intended as a validation of the routine audits carried out on the wards. An email was sent to the ward manager to notify them of action required.

Staff did not consistently escalate when they recorded room temperatures that were out of range. For example, between 4 February and 12 February 2019 staff recorded the room temperatures were out-of-range on eight days. This was only escalated in line with their policy and guidelines on one occasion. We escalated our concerns to senior staff during our inspection. In response, the service pharmacist immediately assessed the medicine storage arrangements in this room and confirmed medications would not be adversely affected because of the fast pace of the stock rotation of medications. The trust wide medicine group said she would be revisiting the guidelines so that they reflected a more realistic trigger point for escalation. Managers had put an action plan in place to address the risks we identified. For example, an improvement action point identified was to monitor the room temperature daily. It was the responsibility of the ward manager or manager on call to check each day that room temperatures had been monitored. The update was that a ward managers / manager on call template had been developed for daily checking and commenced. This was being reviewed and reported daily at the safety huddles.
Although inpatient staff monitored medicines refrigerator temperatures daily to make sure medicines were stored appropriately, poor monitoring and maintenance of fridges in the midwifery led unit meant drugs and patient specimens / samples could not be stored appropriately. Managers had identified this as a risk on the risk register.

Staff we spoke with knew what actions to take if the fridge temperatures were outside of the expected range. We saw evidence that the fridge temperature on the in-patient wards were checked daily and there were no out-of-date medicines. This was an improvement since our previous inspection in June 2018 where we found the fridge temperatures in the clean utilities on the wards exceeded maximum levels.

Managers monitored whether patients received the right medicine, at the right dose, at the right time. Managers audited completion of accurate legible drug administration charts. We reviewed an audit completed in October 2018 which was a re audit following the May 2018 audit. Areas of compliance included staff recording allergy status and documenting wards and dates. Areas of non-compliance included staff not recording the patient's weight and consultants not documenting their names on charts.

Managers produced action plans to address areas of non-compliance. For example, it was recommended to pilot and then re-audit a revised prescription chart and to gain staff feedback on it.

Staff did not consistently record patient weights or allergies. We found this to be the case on all four of the prescription charts we reviewed. We escalated this to a midwife in charge. They assured us they would investigate this further.

Staff stored medical gases safely and in line with guidelines such as the Health and Safety at Work Act 1974. They stored them in ventilated rooms and had warning notices on doors. This was an improvement since our previous inspection.

Managers attended meetings such as the Medicine Safety Groups Governance meetings to reduce medication-related errors and potential harm to patients. We reviewed divisional staff attendance at these meetings from April 2018 to March 2019.

Staff had systems in place to ensure they were alerted to patients with allergies. Patients wore red wristbands detailing any allergies.

The service now promoted self-care for patients. Staff could offer patients lockers for safe storage of their medications.

**Records**

**Staff did not always keep detailed records of patients’ care and treatment.** Records were not always clear, up-to-date and easily available to all staff providing care.
The systems that managed information about patients did not always support safe care and treatment. Staff told us the co-ordination of different electronic systems and paper-based systems often took them away from direct patient care. However, records accurately recorded the patient’s choices, risk assessments and care plans were clear and up to date and staff signed and timed documents.

Staff did not always comply with antenatal assessment paper documentation. For example, records of fetal movements were inconsistently recorded. Whilst some of this information may be recorded on the electronic maternity records system, the service had continued using paper records which should be fully completed. Managers identified non-compliance in the January 2019 community midwife team meeting such as missing signatures and wrong names. Managers identified there was poor retrospective retrieval of clinical information from the maternity records system due to inconsistent data completeness. This potentially posed a risk to patients. For example, staff may find difficulty accessing accurate and comprehensive patient notes when reviewing incidents, concerns and complaints. This corroborated what we found and showed managers already have oversight of this risk.

Locum doctors could not always access patient care records. They had no direct access to electric patient information systems. Managers were looking at ways to address this. For example, they considered having a band seven staff member always on duty for assistance with this.

Staff ensured patients received continuity of care in the community. Staff sent discharge and care plan information to GPs upon the patients discharge from the maternity services.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Senior leaders and stakeholders worked together to ensure patients were kept safe. They collaboratively agreed a cap on births at 4,200 as the maximum number of births allowed in the service in March 2016. This followed discussions between leaders of the maternity service and stakeholders to address shortfalls in staffing numbers and increased demand for services. Staffing numbers had improved as the midwifery led unit had been closed since July 2017 to improve staffing levels on the acute maternity site. The cap restrictions were being gradually lifted. Some staff still expressed concern with increasing deliveries up to 5,000 births at the service again as they believed this would still put a strain on the service. However, the trust told us they had no plans to increase to 5000 births.
Nurses took a holistic approach to their patients and acknowledged and addressed the physiological, psychological, sociological, developmental and cultural needs of the patient. Risk assessments at booking included a social and medical assessment and referral as well as mental health.

Patients could seek advice and treatment immediately in an emergency. Midwives ran a triage unit and could make referrals to appropriate medical professionals and others if they detected deviations from the norm.

Staff ensured high risk antenatal patients received appropriate levels of care. An antenatal lead consultant and manager triaged referrals and referred patients to the appropriate pathways.

Staff had the opportunity to share key information in a systematic and safe way. Effective handovers took place. For example, midwives, consultants, junior doctors and clinical support workers attended the daily board round. We attended a board round and saw staff conducting summary discussions of the patient journey and what was required that day for it to progress using the SBAR technique. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Staff were clear about the process of dealing with a patient whose condition had deteriorated. The procedure for escalation depended on the level of the problem but varied from seeking advice from managers or facilitating immediate admission to the acute department at the trust.

Midwives and support workers monitored vital signs for new-borns and mothers as clinically required and took time-appropriate action(s) to prevent an avoidable deterioration in a patient. Staff used the Maternal Early Warning System (MEWS) with the aim to reduce maternal morbidity and mortality, and improve clinical outcomes. Managers completed audits to check whether staff had complied with these requirements. We reviewed the warning score audit for maternity wards 24 and 25 between October 2017 and September 2018. This showed compliance ranged from 91% to full compliance. Audit results for November 2018 to January 2019 were:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>25</td>
<td>97.5%</td>
<td>95%</td>
<td>93%</td>
</tr>
</tbody>
</table>

We reviewed the patient files for four new-born babies who had their vital signs monitored. We found full compliance. This supported the audit results.

Community staff could respond to community patients effectively when their condition deteriorated. The on-call community midwife had emergency bags for on-call visits.
Staff followed processes to assess and put the women who needed antenatal and postpartum thromboprophylaxis on the correct pathway of care. Thromboprophylaxis is a mechanical method used to treat venous thromboembolism (VTE). Venous thromboembolism (VTE) refers to a blood clot that starts in a vein. Staff assessed the risk of venous thromboembolism (VTE) during pregnancy and post-delivery. Staff on ward 24 and 25 fully complied with completing VTE risk assessments from July 2018 to December 2018. The delivery suite staff achieved full compliance in four of the months.

Staff had the knowledge and skills to assess and respond to patients with suspected or confirmed sepsis. The services’ sepsis pathway was in line with current guidance. The service had recently implemented a national sepsis screening tool. Staff conducted sepsis training during their annual training day and skills and drills training.

Most staff involved in surgical procedures followed a surgical safety checklist (World Health Organisation (WHO) surgical safety (‘Five Steps to Safer Surgery’). While audits completed between August 2018 and January 2019 showed staff fully complied with the checklists, not all surgeons attended all crucial stages of it when carrying out emergency caesareans. Some staff expressed concerns about this and shared examples of when this had compromised patient safety. This meant patient safety may not have been maximised and protected.

Staff followed embedded systems in place to understand each patient’s condition and anticipate future risks to improve patient safety and care. Safety huddles took place four times a day. These were short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care. The Divisional Director of Midwifery, Gynaecology and Sexual Health reviewed the safety huddle reports and out action plans in place to address areas of non-compliance. This included missed or delay care and delays in administering pain relief. A managers huddle also took place to discuss areas such as staffing, activity and escalation.

There were effective systems to ensure staff offered parents a thorough physical examination for their baby within 72 hours of giving birth, in line with national guidance. Managers identified on the risk register in November 2018 there was a potential risk to neonates due to an ineffective failsafe system of their new-born and infant physical examination (NIPE) and referral process. The examination includes screening tests to find out if the baby has any problems with their eyes, heart, hips and, in boys, the testicles (testes). The most recent data showed the service achieved full compliance for timely assessment.

The service did not always follow up women who did not attend antenatal clinics. This meant these women and their babies were at risk of poorer outcomes and safeguarding concerns may be missed. Managers had identified this on the divisional risk register and had identified actions to
address this. These included arranging a multi-agency meeting to discuss appropriate timing of multi-agency referral form referrals and call and reports and to amend the DNA audit.

Antenatal women did not always receive treatment or timely treatment following abnormal test results. This was due to a lack of agreement over whether GPs or maternity staff were responsible for prescribing treatment. Managers identified this as a risk on the risk register. Staff addressed this by contacting the women to inform them their prescriptions were ready for collection. They would attempt contact several times if need be and document this on the patient information system.

Staff followed procedures to minimise the risk of still births. They undertook scans required in line with guidelines such as the ‘Saving Babies Lives’ bundle to detect babies that were too small for their gestational stage

Staff followed robust systems to protect women and their babies from avoidable harm. They monitored, recorded and escalated concerns regarding cardiotocography (CTG) reviews. A CTG measures babies’ heart rates and monitors the contractions in the uterus. The service has many safety systems in place to improve CTG monitoring compliance. For example, team leaders carried out spot checks of CTGs and peer reviews of completed CTGs post-delivery took place. Staff used stickers that summarised the key points in the guidelines and acted as an aide-mémoire, as well as a record of staff classification of the CTG.

Staff monitored the growth rate of unborn babies. Staff monitored fetal growth from 24 weeks in line with national guidelines such as MBRRACE-UK 2015. If staff had concerns regarding fetal growth they would refer the patient to a consultant for a full assessment.

Staff carried out investigations and produced actions plan to address risks identified. The trust’s post-natal readmission rates were higher than the national average in 2018. A consultant conducted an audit to explore the reasons why. The three main reasons were anaesthetic related (22%), retained products (20%) and caesarean wound complications (20%). They produced an action plan to address areas of concern and non-compliance which included improvements compliance with the protocols and for all consultants to be involved in the decision-making process.

Managers now identified areas of good practice and poor documentation through audits and made recommendations based on their findings. This was an improvement since our previous inspection where managers were not completing these. The Divisional Director of Midwifery, Gynaecology and Sexual Health told us they would be completing a documentation audit monthly in each area as part of the new matron’s quality audits. These would be presented at Nursing and Midwifery Advisory Forum each month. This commenced in February 2019 and results were pending.
An audit was completed in July and August 2018 and managers presented the results at an audit meeting in September 2018. Areas of documentation reviewed included gestational age, onset of delivery, swab and needle count and intrapartum fetal heart monitoring reviews. Managers found full compliance with all documentation for gestational age, parity and onset of labour, early warning scores (although there was evidence of delayed observations) and intrapartum fetal heart monitoring assessments. Areas of non-compliance included swab and needle count where staff compliance ranged from 66% to full compliance, pressure ulcer assessments showed 80% compliance. Action plans to address areas of non-compliance included to give staff documentation refresher training and to re audit.

CTG documentation audits occurred weekly with five sets of records audited. The latest audit for January 2019 is shown below:

<table>
<thead>
<tr>
<th>Fetal Heart</th>
<th>Maternal pulse</th>
<th>Date &amp; Time</th>
<th>Name and Unit Number</th>
<th>Signed and Printed Name of Clinician</th>
<th>Reason for CTG</th>
<th>Hourly Assessment Complete</th>
<th>2 Hourly Fresh Eyes</th>
<th>Signed by Clinician on completion</th>
<th>Date and Time of Completion</th>
<th>Reason CTG has been Discontinued</th>
<th>Mode of Delivery</th>
<th>Documented on Badgernet</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>10</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>85</td>
<td>90</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>

There was non-compliance in one element of the fetal heart monitoring documentation audit in January 2019. The Divisional Director of Midwifery, Gynaecology and Sexual Health had requested action plans from the matrons to ensure compliance improved. Overall compliance was 96%.

**Nurse and midwifery staffing**

The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

**Planned vs actual**

Although managers identified non-compliance with national recommended midwifery staffing levels as a risk on the divisional risk register, the service currently had enough staff to support women in labour and provide safe care for them and their babies. An experienced midwife was available for each shift on the labour ward and the division had student midwives in line with safer childbirth guidance. The national target for midwife to birth ratio was 1.28. From July 2018 to December 2019, compliance ranged from 1.25 to 1.29. Between July and December 2018, all women received one-to-one care whilst in established labour. This was in line with NICE NG4: Safe Midwifery Staffing guidance.

From July to December 2018, the percentage of shifts appropriately staffed on the labour ward ranged from 80% to 94%. Full compliance was achieved in three of the months. The target was 85%.
The service reported the following qualified midwifery staff numbers as of March 2018 and September 2018 for maternity services:

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th></th>
<th></th>
<th>September 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Manor Hospital emergency department</td>
<td>142.9</td>
<td>160.1</td>
<td>89.3%</td>
<td>138.1</td>
<td>156.3</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Staff provided critically ill patients with safe care. The local target for the percentage of enhanced maternal care (EMC) trained midwives on duty was 90%. Data was only recorded on the dashboard for November and December 2018 and showed 94% and full compliance respectively. Managers had put many systems in place to ensure compliance. For example, the requirement for an EMC competent midwife had been added into the rostering template to ensure at least one trained EMC midwife was rostered on every shift with the aim to achieve two per shift to add resilience for short term sickness. Staff monitored whether a woman requiring EMC care was being cared for by a non-EMC competent midwife in safety huddles.

The Divisional Director of Midwifery, Gynaecology and Sexual Health monitored compliance in this area.

Managers planned and reviewed staffing levels and skill mix to ensure patients received safe care and treatment always. Managers used a tool endorsed by the National Institute for Health and Care Excellence (NICE) which was developed for midwives to assess their “real time” workload in the delivery suite. NICE provides national guidance and advice to improve health and social care.

Staff followed an escalation policy to protect patient safety when the division had below the national recommended midwifery staffing numbers. For example, staff would be diverted from other areas of the division. Managers identified during that during intrapartum care the escalation procedures detracted care provision from other parts of the service. This could affect patient satisfaction and there was a risk to additional pressures on staff. The escalation policy was triggered seven times in November 2018.

There was a failure to provide the required appropriate theatre team in every instance of maternity theatre sessions. Managers identified on the risk register this was due to inadequate maternity clinical support workers being experienced and trained as runners in the maternity theatres.

Actions had been put in place to address this risk. For example, an incident report was completed for all cases where there was inadequate cover and bank or agency staff were requested when needed.
Community staff provided safe care to patients and felt supported in their roles. Community Staff told us the smaller team structure had increased the continuity for patients. The community midwifery team consisted of seven community teams and the Women Requiring Extra Nurturing (WREN) team. This was an improvement since our previous inspection.

Managers supported community midwives to provide safe care through allocating a manageable caseload of women. Each midwife had sole responsibility for their own caseload but with the opportunity to manage a work/life balance by working within a supportive and flexible buddy system. The average caseload of community midwives was 1:85 which was in line with the national recommendation. The WREN community midwives had a caseload of 25 patients each.

Managers gave community staff protected time to carry out their roles effectively. Community staff told us they were no longer regularly called into the maternity unit to support staffing levels on the delivery suite when they were on-call. They said staffing levels had improved across the maternity department and they felt more supported. This was an improvement since our previous inspection in 2018.

Clinical support workers relieved pressure on the midwife appointments. The community team had nine band two and three maternity support workers covering the teams. They ran a separate clinic where they took and recorded patient’s blood tests, height and weight.

Managers had processes in place to address and increase their staffing numbers. For example, they had a rolling recruitment programme in place and progression programmes for current staff. Managers monitored the number of midwives on leave (WTE) as part of the maternity dashboard.

Maternity staffing was reviewed during board meetings. We reviewed the ‘Safe Staffing, Staff Incidents and Quality and Safety Key Performance Indicators’ section of the nurse staffing paper for board (November 2018). Wards were reviewed where the staffing fell below the 90% target for fill rates. These were reviewed in relation to the quality and safety key performance indicators (KPI). For example, in November 2018 wards 24 and 25 showed no correlation between staffing, incidents and key performance indicators. This showed staffing was addressed at all levels of the governance systems.

The service had systems in place to address previous CQC inspection concerns around shortfalls in staffing and increasing births. We reviewed the operational plan (2018-2019). The service had increased recruitment and agreed a cap on deliveries in contracts with commissioners. Birth numbers reduced far greater than anticipated and there had been severe underperformance on contracted numbers. Outpatient performance and theatre utilisation were targeted as part of the recovery work-streams identified with external reviewers.
Managers were transparent with patients, staff and visitors regarding their staffing levels. Staffing numbers were displayed outside all inpatient areas. This was in line with NHS England / CQC: Hard Truths guidelines.

**Vacancy rates**

From October 2017 to September 2018, the service reported a vacancy rate of 12.4% for qualified midwifery staff in maternity.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Leaders had rolling recruitment programmes in place and progression programmes for current staff to address this.

**Turnover rates**

From October 2017 to September 2018, the service reported a turnover rate of 15.8% in maternity. This was higher than the service target of 10%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Leaders had rolling recruitment programmes in place and progression programmes for current staff to address this.

**Sickness rates**

Although staff sickness rates were high, managers had action plans to address this.

From October 2017 to September 2018, the service reported a sickness rate of 4.8% for qualified nursing staff in maternity services. This was higher than the service target of 3.39%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The target for sickness rates across all staffing groups was set at 3.39. We reviewed sickness rates between July and December 2018. Sickness absence in the antenatal clinic ranged from 3% to 7%, and rates for community midwives ranged from 5% to 13%. Ward 24/25 ranged from 1% to 5% and from 6% to 8% on the delivery suite (ward 27).

As of January 2019, the community midwifery team long term sickness rates had improved. It had lowered to 4%.

Managers had oversight of sickness rates. Sickness rates for midwifery staff were monitored and discussed in governance meetings and plans were put in place to address non-compliance. For example, the outpatient matron had recently started meeting weekly with the human resource department to address sickness in their team. They were putting support plans in place for staff returning to work after periods of sickness.
Bank and agency staff usage

Although the service used bank staff, this was to ensure safe staffing numbers. Managers had systems in place to ensure they were competent in their roles.

From October 2017 to September 2018, the service reported a bank usage of 14%, an agency usage rate of 0.1%, and an unfilled rate of 13% for nursing staff in maternity. A break down by qualified and non-qualified nurses is shown in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Shifts</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
<td>Agency</td>
</tr>
<tr>
<td>Qualified nurse</td>
<td>5,647</td>
<td>100</td>
</tr>
<tr>
<td>Non-qualified nurse</td>
<td>12,319</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

The service had enough midwives to support their patients safely.

From April 2018 to March 2019 the service had a ratio of one midwife to every 22.2 births. This was similar to the England average of one midwife to every 25.7 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The midwife to birth ratio ranged between 1.25 to 1.29 between July and December 2018. The national target was 1.28.

Although high levels of activity within the service and resulting failure to comply with nationally recommended midwife to birth ratio was recorded as a risk on the divisional risk register, managers maintained oversight of the midwife to birth ratio and had action plans in place to address areas of non-compliance.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The division had enough medical staff to provide patients with safe care and treatment.

The obstetrics and gynaecology department currently had 11 substantive consultants. One was part time. A further consultant was employed on a locum basis. The service had plans for this post to become and another post to become substantive bringing the department up to 13 consultants.
There were enough consultants to provide patients with safe care and treatment 24 hours a day. The labour ward had approximately 110 hours of consultant presence per week which was more than the National Standards (98 hours) recommended by Safer Childbirth. Eight consultants contributed to 24-hour consultant presence on the labour ward Monday to Thursday each week. All consultants and clinical leads such as labour ward, diabetes and fetal medicine leads had protected time to carry out their duties safely and effectively. They all had job plans. Consultants job plans included both obstetrics and gynaecology duties.

The weekly hours of anaesthetic cover on the labour ward had a national target of 50 hours. The data from July 2018 to December 2018 showed full compliance every month.

Although managers identified insufficient number of middle grades as a risk to the service, managers had addressed this effectively. The middle tier for the department comprised of nine whole time equivalent posts. Four trust doctors and five specialty trainees staffed them. This tier had recently been challenged by two gaps provoked by maternity leave and out of programme time for research. The department addressed this by creating a clinical fellow to work in conjunction with the service wide Human Factors Training Department and an additional trust grade doctor.

The junior tier of trainees comprised of 11 whole time equivalent posts made up of speciality trainees and GP registrars. The department provided training for medical students and Physician Associates from a nearby university.

Sickness rates for obstetricians and gynaecology consultants ranged from 0% to 9.68% and for obstetricians and gynaecologist non-consultants there was no sickness.

**Staffing skill mix**

The staffing skill mix in the division provided patients with safe and effective care and treatment.

In July 2018, the proportion of consultant staff reported to be working at the service was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

**Staffing skill mix for the 31.8 whole time equivalent staff working in maternity at Walsall Healthcare NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>43%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
Registrar Group = Specialist Registrar (StR) 1-6
Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

The junior tier of trainees comprised of nine whole time equivalent posts made of specialty trainees, foundation trainees and GP registrars.

**Incidents**

**The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. 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.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the service reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the service reported six serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from October 2017 to September 2018.
Of these, the most common types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with three (50.0% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (16.7% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with one (16.7% of total incidents).
- Slips/ trips/ falls incident meeting SI criteria: mother only with one (16.7% of total incidents).

(Source: Strategic Executive Information System (STEIS))

There were good systems and processes in place to ensure incidents were reviewed and investigated safely and duty of candour was embedded in the services patient culture. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Staff conducting investigations found out what happened, got beyond ‘the obvious’ to the bottom of why the incident happened and identified underlying system and process issues that caused or contributed to the incident. We reviewed the root cause analysis for four incidents which occurred in 2018. The investigations were multi-disciplinary, root causes and contributory factors were identified, there was evidence of learning from incidents and action plans detailed where improvements were needed in response to the incidents.

Managers maintained appropriate oversight of incidents and learning from them through effective governance systems. The consultant governance lead and lead governance midwife reviewed and
maintained oversight of all the incidents reported. Incidents were discussed at the maternity MDT weekly meetings and in weekly divisional huddles, monthly governance meetings and the divisional quality team meetings. Staff told us managers fed back learning points from incidents to staff via a poster called ‘incidents at a glance’ and weekly safety alerts which highlighted incident themes and learning from incidents, by feeding back at handovers, huddles and team meetings and through a risk newsletter. This showed the clinical governance systems and processes helped staff achieve their organisational objectives of delivering both safety and quality within the division.

All staff we spoke with demonstrated the importance of being open, honest and transparent with their patients. Duty of candour was embedded in the services patient culture. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. There was evidence of investigation followed by action planning and staff told us duty of candour was followed to keep patients and those involved in their care informed with how incidents were managed. Duty of candour was integrated into the electronic reporting system.

Senior and ward staff demonstrated an understanding of the duty of candour regulation and what kinds of incidents would trigger this regulation.

We reviewed the occasions where staff had applied the duty of candour from June 2018 to date. Staff had applied this regulation 17 times. Managers recorded that they gave verbal explanations followed by written duty of candour.

The service had introduced a system to enable them to enact the duty as quickly as possible. The service offered eligible patients a duty of candour (DoC) leaflet. This described the DoC process and included space to record the key aspects of the discussion and who the patient/relative could contact. There was also a tear off strip for inclusion in the health record.

Managers had processes in place to review patient deaths to ensure these did not occur due to unsafe clinical practices. Managers reviewed deaths as part of professional learning and provided the trust’s board with assurance. The service held monthly multidisciplinary perinatal mortality and morbidity meetings, which fed into service improvement. We reviewed three sets of minutes, which confirmed a multidisciplinary team discussed outcomes and learning and recommendations were made.

Managers did not correctly benchmark the number of still births. Between July 2018 and December 2018, the service reported the rates of stillbirths to be under the national target of six in every month. However, we found managers were measuring compliance against the wrong target.
The actual target was 4.2. When we reviewed the data against the actual target we found non-compliance in this same period. We raised this with The Divisional Director of Midwifery, Gynaecology and Sexual Health and they agreed their recorded target was wrong.

At the clinical commissioning group’s request, the service was in the process of reviewing all stillbirths from the last two years by using a fresh eyes approach to determine if they could identify if any changes in care or practice may have altered the outcome. This was a multidisciplinary review including the bereavement midwife, risk midwife, Clinical Director and Divisional Director of Midwifery, Gynaecology and Sexual Health.

Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Staff were committed to providing a care environment free of harm for their patients.

Staff used the Safety Thermometer to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Safety thermometer data from July 2018 to December 2018 showed the proportion of women that had a maternal infection since the onset of labour or within ten days of birth all fell below the national target of six and ranged from zero to four.

The proportion of women who reported they had concerns about safety during labour and birth that were not taken seriously was below the national target of six in all months apart from July 2018. In three of the months no women reported this.

Women’s perception of safety ranged from 92% to full compliance against the national target of 92% in all the reporting months.
Is the service effective?

 Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. For example, policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and professional bodies.

Although managers had identified ‘out of date clinical guidelines’ was still a risk on the divisional risk register, systems had been put in place to address this. We reviewed 16 maternity policies and guidelines available on the trust’s intranet. Fourteen were up-to-date and two were past their review date. The policy for referral to and process for arranging interpreter services in the maternity service was due for review in January 2018. The policy for FGM: within Walsall maternity services was due for review in August 2018. The midwife led unit (MLU) operational policy had been updated to accurately reflect the unit was used for antenatal and postnatal outpatient clinics. However, some policies had not been updated to reflect patients could not currently give birth at the MLU.

A policy group midwife was responsible for ensuring guidelines were updated. The lead governance consultant told us the backlog of 89 out-of-date policies had been reduced to 13 and that they expected this number to reduce significantly in the upcoming group guideline meeting taking place later that week. The trust’s audit team monitored guideline compliance with NICE guidance. The trust’s librarian team monitored when guidelines required updating in response to NICE or national guideline updates and circulated to the appropriate individuals for updating.

Consultants now took ownership and responsibility for reviewing guidelines in a timely way. This was an improvement since out previous inspection in 2018. Staff signed to confirm they had read guideline updates. Policy updates were shared in team meetings. For example, in the January 2019 team meeting, managers shared the standard operating procedure for lone workers had been completed and it would be discussed prior to launch.

Staff had processes in place to find out if their care was being provided in line with standards and to inform themselves and patients where their service was doing well, and where there could be improvements. Staff were involved in a range of clinical audits. For example, obesity in pregnancy, audit of endometrial cancer, emergency lower (uterine) segment caesarean section and emergency caesarean section were ongoing audits.

Staff followed guidelines to reduce the number of maternal deaths in the unit. Staff planned and provided for women with multiple pregnancy in accordance with NICE quality standards for the management of twin and triplet pregnancies in the antenatal clinic. These women were provided with the care of a consultant obstetrician with support from a specialist team. Maternal deaths
include those which occur during pregnancy and within 42 days of delivery. These include deaths which occurred at this trust and deaths where the delivery was at this trust but the death occurred elsewhere.

Staff followed Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK) (2015) guidelines. For example, staff offered all women with risk factors for gestational diabetes a tests and midwives and obstetricians emphasised the importance of fetal movements to women during antenatal appointments. We saw leaflets ‘feeling your baby move is a sign they are well’ detailing what to do if women were worried about their baby’s movements.

Staff practiced evidence-based care and treatment. For example, staff monitored fetal growth from 24 weeks and midwives and obstetricians emphasised the importance of fetal movements in antenatal appointments. Staff displayed posters and leaflets about this in the antenatal clinics.

All staff were compliant with sepsis training and knew the signs and treatment options.

Staff took patients psychological and emotional needs seriously. Women’s mental health needs were discussed at handovers and pregnancy and delivery plans routinely addressed the mental health and emotional well-being of patients and patients who were at risk of perinatal mental health issues were addressed appropriately. For example, patients with enduring mental health issues were seen by a psychiatrist.

Staff were working towards offering patients an evidence-based bereavement pathway to improve the overall quality and consistency of bereavement care for parents and families. The service was a pilot site for the National Bereavement Care Pathway (NBCP) and was supporting wave two sites. As part of the pilot, the pathway included five pregnancy or baby loss experiences including miscarriage, termination of pregnancy for fetal abnormality, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.

**Nutrition and hydration**

**Staff mostly gave patients enough food and drink to meet their needs and improve their health.** Special feeding and hydration techniques when used when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Although staff did not consistently support women to breastfeed, managers had put action plans in place to address this. The service did not comply with the locally set target of 66% of women who initiated breastfeeding within 48 hours of birth. Between July 2018 and January 2019, staff achieved compliance in one month only. To improve breastfeeding initiation rates, an infant feeding coordinator had now been appointed, some early pregnancy clinics had been piloted in some health centres and an infant feeding e-learning training module had been introduced. All
midwives were trained in giving support in breastfeeding. The breastfeeding guideline was on the intranet for staff to access.

Staff could offer patients extra support with breastfeeding or their chosen feeding method. Staff could refer women needing support to the health in pregnancy (HIPS team) and the local infant feeding support group. Maternity support workers assisted patients to feed their babies in the community. Community midwives led some breastfeeding clinics held at the midwifery led unit.

The service had an up to date new-born infant feeding guideline. In addition, the maternity service was working towards gaining UNICEF Baby Friendly accreditation. Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services.

Women’s breast milk was stored in line with recommended temperatures. Staff monitored and recorded temperatures of the fridges containing breast milk.

Staff could still not be assured the potential for tampering with the breast milk had been eliminated. Although the fridges were now locked, staff did not consistently check this. For example, we reviewed the records for 1 February to 12 February 2019 and found 18 omissions out of 48. From 1 February 2019 to date 13 February 2019, the milk fridge on ward 24 had missing entries for two full days. However, staff were required to carry out checks four times a day which may have made it problematic for staff to comply with.

Staff identified, monitored and put plans in place to address patient’s nutrition and hydration needs. Staff checked and recorded patient’s hydration levels during and post-delivery using fluid balance charts, gave dietary and nutritional advice during antenatal appointments and offered inpatients hot and cold food and drinks.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.** They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff offered patients effective medical and non-medical pain relief options, 24 hours a day. Staff could offer patients medical pain relief such as epidurals and opioids and holistic options such as reflexology and aromatherapy 24 hours a day. Staff could offer patients a water birth to aid with pain relief. The WREN team arranged for vulnerable women to receive complimentary therapies to help with pain relief such as hypnobirthing.

Women receiving epidurals received timely pain relief. From November 2018 to date the number of women who received an epidural sited within 60 minutes was in line with national guidelines.
Although managers still did not routinely audit pain relief specific to women undergoing inductions, they audited delays in administering pain relief. Data for November 2018 showed there were no delays reported.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit Manor Hospital performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 142 eligible cases identified for inclusion, 92.8% of mothers were given a complete or incomplete course of antenatal steroids.

  This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital met the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were 24 eligible cases identified for inclusion, 4.2% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

  This was lower than the national aggregate of 43.5% and put the hospital in the bottom 25% of all units.

  *(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

The 2017 data showed there were 20 eligible mothers identified for inclusion in this audit measure for the unit. Of the mothers with a recorded outcome, 58% were given magnesium sulphate in the 24 hours prior to delivery.

Between 1 February 2018 and 31 January 2019, the rate of administration of magnesium sulphate for babies born below 30 weeks gestation discharged from NNU was 82%. There were 11 eligible mothers and nine of them received Magnesium sulphate. There was no missing data in these figures.
Standardised Caesarean section rates and modes of delivery

From April 2017 to March 2018 the total number of caesarean sections, the standardised caesarean section rates for elective sections and the rates for emergency sections were all similar to expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>WALSALL HEALTHCARE NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>410</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>549</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>959</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, April 2017 to March 2018)

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>WALSALL HEALTHCARE NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>959</td>
<td>28.4%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>346</td>
<td>10.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>2,074</td>
<td>61.4%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>3,379</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, April 2017 to March 2018)

Notes: This table does not include deliveries where delivery method is "other" or "unrecorded".
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

From April 2017 to March 2018, the total caesarean section rates were similar to the England average. The instrumental delivery rates were lower than the England average. The normal (non-assisted) delivery rates were higher than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The percentage of women receiving induction of labour ranged from 36% to 42% between July 2018 and December 2018. This was above the national average of 29.3%. Managers had identified this as risk on the divisional risk register and had put systems in place to address this. For example, rates were reviewed and addressed at governance meetings such as the maternity inpatient forum maternity governance group.

Managers continually monitored and analysed rates of caesarean section, third and fourth degree tears and induction of labour. The maternity unit had now introduced the use of statistical process...
control charts to determine whether these rates were high or low or whether the fluctuations were of concern. Based on the previous charts the service concluded in February 2018 that it was evident that the current rate of caesarean section was showing normal variation and did not need further review at the time.

Consultants facilitated daily reflective reviews of caesarean sections that had been carried out in the previous 24 hours with staff. Learning was shared with staff at multidisciplinary teaching meetings, as part of CTG review meetings and in daily in handovers.

The service still did not routinely audit babies born before arrival (BBA) data. However, there were 14 BBAs recorded via the maternity patient information system during this period of which 43% were reviewed. These were reviewed appropriately and the service were assured these cases could not have been avoided.

The number of women seen antenatally by 10 weeks in accordance with NICE QS22 statement 1 guidance ranged from 63% to 70% compliance. However, the service told us the maternity electronic patient record changes the estimated date of delivery (EDD) once the scan has been completed therefore some of the data was currently not yet validated and awaiting updated EDD once the dating scan has been completed.

**Maternity active outlier alerts**

All maternity patients received safe care in the appropriate setting always. As of November 2018, the service reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)**

Staff were committed to reducing the number of stillbirth, new-born and women deaths. The service took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.43.

This was up to 10% higher than the average for the comparator group rate of 4.95. Managers had addressed areas of non-compliance with an action plan. For example, managers identified to achieve the various UK Governments’ ambitions, renewed efforts needed to be focused on reducing stillbirths and continuing the slow but steady decline in neonatal mortality rates observed since 2013. The action to address this was implementation of the Saving Babies Lives Care Bundle. Progress of the actions were recorded on the action plan along with the evidence and completion dates.

(Source: MBRRACE UK)
Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and could, if need be, offer supervision meetings with them to provide support and monitor the effectiveness of the service.

The service had effective systems in place to support and develop staff. Staff said the appraisal system supported them and their managers in setting clear objectives, and recognised their performance as well as the behaviours they had exhibited in their roles. Staff said they found the process personal and valuable.

Appraisal rates
From April 2018 to September 2018, 94.3% of staff within maternity services at the service received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>59</td>
<td>62</td>
<td>95.2%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>132</td>
<td>141</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

All consultants received annual appraisal described in interviews as ‘challenging and worthwhile’.

The service has adopted a formal model of supervision. One of the main roles of the Professional Midwifery Advocate (PMA) was to support midwives in their clinical practice and advocate for women. The objective of the role was to provide restorative clinical supervision; advocacy and support quality improvement activities, education and leadership for midwives.

Within nursing, senior nursing teams held a weekly ‘Safety Huddle’. This gave individual team members the opportunity to express items of concern and receive peer support and supervision. There was a monthly matron’s forum which was preceded by a matron’s pre-meet where they provided supervision and support to each other. A ward sister’s forum took place which provided the same opportunity. The Director of Nursing was exploring models for clinical supervision. One-to-one supervision was available for staff if they wanted it but was not routinely offered. All staff were part of de-brief sessions following events such as a serious incident to ensure they received care and support.

Staff kept their skills and knowledge up-to-date and ensured they continued to work safely, legally and effectively. The division offered a wide range of personal and professional development opportunities to help staff manage their own learning and growth. The table below shows the training events / continued professional development for staff over the previous 12 months. This included both staff being trained and staff being released to train others as part of their CPD.
<table>
<thead>
<tr>
<th>CPD</th>
<th>Group attendees</th>
<th>How many attended (where data recorded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCM study days</td>
<td>Midwives</td>
<td>143 midwives</td>
</tr>
<tr>
<td>PROMPT Study Days</td>
<td>Midwives, Obstetric Consultants, Anaesthetists, speciality Dr's, Registrars, ODP's, Registrars, ODP's, Student midwives, CSW's</td>
<td>276 since April 2018</td>
</tr>
<tr>
<td>PMA external course</td>
<td>midwives</td>
<td>3</td>
</tr>
<tr>
<td>NLS course</td>
<td>midwives</td>
<td>13 midwives with a further 20 funded</td>
</tr>
<tr>
<td>NIPE course</td>
<td>midwives</td>
<td>7</td>
</tr>
<tr>
<td>PROMPT train the trainer</td>
<td>Midwives, obstetric consultants, anaesthetists</td>
<td>6 midwives; 3 Obstetric consultants and 3 consultant anaesthetists</td>
</tr>
<tr>
<td>GAP/GROW training</td>
<td>midwives</td>
<td>10</td>
</tr>
<tr>
<td>Enhanced Maternity Care In House training</td>
<td>midwives</td>
<td>18</td>
</tr>
<tr>
<td>Enhanced maternity Care External Course</td>
<td>midwives</td>
<td>2</td>
</tr>
<tr>
<td>Skills Training day, including cannulation, suturing and PCEA theory and practical</td>
<td>New starter midwives band 5</td>
<td>13</td>
</tr>
<tr>
<td>Human factors live skill drills Delivery Suite</td>
<td>Midwives, doctors, anaesthetists, ODP’s, CSW’s, student midwives</td>
<td>Run monthly and all on duty attend if not required clinically</td>
</tr>
<tr>
<td>1-2-1 NLS training sessions CPD MW( NLS instructor)</td>
<td>midwives</td>
<td>8</td>
</tr>
<tr>
<td>RCM aspiring team leader study day</td>
<td>midwives</td>
<td>4</td>
</tr>
<tr>
<td>Post graduate diabetes course</td>
<td>midwives</td>
<td>1</td>
</tr>
<tr>
<td>Edgcumbe leadership study days</td>
<td>Midwives, CSW’s, Consultant Obstetricians</td>
<td>Approx 60</td>
</tr>
<tr>
<td>Human Factors study days run by QI faculty</td>
<td>Midwives, Obstetric Doctors, anaesthetists, NNU nurses, CSW’s, Student Midwives</td>
<td>Approx 90</td>
</tr>
<tr>
<td>Whose Shoes Events</td>
<td>Midwives</td>
<td>Approx 10</td>
</tr>
<tr>
<td>Step up programme for band 2-6</td>
<td>Midwives &amp; CSW’s</td>
<td>3</td>
</tr>
<tr>
<td>Childbirth Emergencies in the Community</td>
<td>Community Midwives</td>
<td>25-30- date booked 14/05/19</td>
</tr>
<tr>
<td>Course</td>
<td>Instructor</td>
<td>Participants</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Midwife Prescribers course</td>
<td>Midwife</td>
<td>1-continuity carer funds</td>
</tr>
<tr>
<td>Trust values in-house study day</td>
<td>All MDT</td>
<td>Uncertain number</td>
</tr>
<tr>
<td>GIC Instructors Course (Resus Council UK)</td>
<td>Midwives</td>
<td>2</td>
</tr>
<tr>
<td>NLS Instructors released to teach</td>
<td>Midwives</td>
<td>5</td>
</tr>
<tr>
<td>Faculty for in house PROMPT</td>
<td>Midwives</td>
<td>3 each month</td>
</tr>
<tr>
<td>Newborn Life Support – Setting up the course in Slovenia on behalf of European Resuscitation Council</td>
<td>Midwife (DDOM)</td>
<td>1</td>
</tr>
<tr>
<td>CSW’s in-house competency study days</td>
<td>CSW’s</td>
<td>40</td>
</tr>
<tr>
<td>Mary Seacole leadership Programme</td>
<td>Midwife</td>
<td>1</td>
</tr>
<tr>
<td>Director of Midwifery Talent Programme NHSE – commencing March</td>
<td>Midwife (DDoM)</td>
<td>1</td>
</tr>
<tr>
<td>Aspiring HOM programme</td>
<td>Midwife (deputy DDoM)</td>
<td>1</td>
</tr>
<tr>
<td>HEEWM CPD day</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>RCOG Annual professional development conference</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Normality in labour</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Postural tachycardia syndrome in pregnancy</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Exam Man: Using QR codes to connect medical students to education materials</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>DRCOG exam questions and attendance at Subcommittee</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>MOET</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>EIDO consent</td>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>QSIR practitioner course</td>
<td>Midwives in maternity to join teams</td>
<td>4</td>
</tr>
</tbody>
</table>
The service offered staff opportunities to develop and encouraged skills exchange between different staff roles. All midwives we spoke with told us there had been an increase in secondment opportunities.

Community midwives rotated onto the hospital-based delivery suite and maternity wards for one shift per month. Community midwives conducted eight hour shifts to ensure cover for the community was not affected. Community midwives maintained their skills and competencies and helped to fill unfilled shifts on the maternity department. The practice delivery nurse supported staff to be competent to work on the delivery suite. Community staff felt well supported by the hospital based maternity staff as they now had a buddy for support and were allocated more low risk women. They now felt they had the necessary skills to assist with births on the delivery suite and in theatres which was an improvement from when we previously inspected the service in June 2018. The introduction of the safety huddle had ensured community staff felt up-to-date regarding the activity on the unit.

The service introduced new staff to the values and objectives of the organisation so they understood essential safety and risk management information and gave the new employee the practical information they would need to begin their new jobs. All new members of staff were integrated into their role, team and the trust. All new starters completed an induction.

Managers now ensured staff were competent to care for critically ill patients. All enhanced maternity care (EMC) midwives completed an EMC competency framework.

Staff had to evidence they were competent before being supported to progress. Band five midwives had to complete preceptorship competency frameworks before progressing.

The service now offered clinical support workers (CSW) opportunities to practice clinical skills, gain competence and standardised their skill sets. All clinical support workers (CSW) had completed competency frameworks. This was an improvement since our previous inspection.

The service ensured student midwives practiced safely and within their competence. Student midwives were supervised always throughout their training and colleagues and managers were supportive and approachable. Student midwives conducted a comprehensive four-week induction programme when starting their role on the unit. In addition, student midwives followed a detailed preceptorship programme.

Processes were in place to provide midwives with restorative, personal action for quality improvement and education and development. The Professional Midwifery Advocate role replaced the previous Supervisors of Midwives (SoM) to support midwifery staff. Four midwives were conducting the training for this role (one was from the community). The service had three fully qualified PMAs. This was an improvement since our previous inspection.
Systems were in place to help staff focus on their areas of accountability and responsibility and work on what was important and to provide clarity of their roles. Delivery Suite, antenatal clinic and community team meetings took place. The agenda was structured around the CQC’s five domains of safe, effective, responsive, caring and well led. Areas discussed included lesson learned, risk register, training, workforce and patient feedback results.

**Multidisciplinary working**

**Staff of different kinds worked together as a team to benefit patients.** Consultants, midwives and other healthcare professionals supported each other to provide good care.

They worked closely using each other’s skills and expertise and with other agencies to deliver effective care and treatment. Staff worked collaboratively with external local providers to ensure patients received person-centred care based on their personal needs and preferences.

There were good examples of multidisciplinary working throughout all services. Patients had access to specialist teams and specialist midwives across all areas who supported patients. They provided specific support, training and development to staff to improve their skills and patient care.

Staff worked positively with clinical commissioning groups (CCGs), local authority social workers and third sector organisations to support patients. Social workers, GPs, and other healthcare staff worked together to enable appropriate support upon discharge. Multidisciplinary team meetings were held weekly.

Inpatient and community staff worked closely to ensure patients received the right treatment in the right place at the right time.

Staff developed links with the voluntary sector to ensure patients had access to support and care from their local community.

We observed effective communication between staff at all levels. For example, consultants, junior doctors and midwives shared patient information in the huddles.

**Seven-day services**

Women received appropriate care at the appropriate times.

Staff provided care and treatment to patients and their babies 24 hours a day, seven days a week.

The fetal assessment unit was open from 9am to 5pm, Monday to Friday.

The early pregnancy assessment unit was open Monday to Thursday from 8.30am to 5.30pm and on Fridays from 8.30am to 1pm.

The triage unit provided patients with 24-hour, seven days a week access to a midwife and/or an obstetrician.
Although the midwifery led unit (MLU) remained closed for women to give birth there, it was now used as a community hub, offering antenatal, postnatal and perinatal mental health clinics.

Community midwives worked flexibly to offer women seven-day services. Community midwives ran the home birth service and were available 24 hours a day, seven days a week. They no longer carried out home bookings routinely as these were now held in GP surgeries. This meant patients had to attend clinics and there was no availability for weekend appointments. However, if there was a requirement for community midwives to conduct home visits, there was some flexibility to accommodate this. The community midwife allocated as on-call would be available to patients at night and would form part of the service’s escalation plan if required.

Community midwives now offered weekend antenatal classes.

Health promotion

Staff supported women with a wide range of health needs.

Staff identified and helped patients who needed extra support such as those with diabetes or mental health conditions. Community and inpatient midwives worked closely with the health in pregnancy (HIP) staff to promote health promotion initiatives. Community midwives signposted all patients to this team at 12 weeks gestation.

Staff screened all patients for MRSA. There had been no cases of MRSA or *C. Difficile* during the last 12 months.

The HIP staff met with women following their 12 and 20-week scans to discuss their health needs and any emotional or practical support women and their families might need. This included smoking cessation, breastfeeding support, diet, dental health and emotional wellbeing. Staff supported women and empowered women to manage their own health and to maximise their independence.

Staff worked collaboratively with the teams to promote health. For example, in January 2019 the smoking cessation team arranged to come to the office once a week to check carbon dioxide monitors.

Although babies were waiting too long for their BCG (Bacillus Calmette-Guérin) vaccines, managers had put action plans in place to address this. The waiting list for BCG vaccination was approximately 6 weeks. Additional clinics were being scheduled. The service target waiting time was no longer than 4 weeks and once 3 weeks was reached additional clinics would be set up to reduce the wait. The BCG is usually offered to babies who are at a higher risk than the general population of contracting tuberculosis (TB).
Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff were knowledgeable about the basic principles of consent and Mental Capacity Act 2005. We saw staff appropriately gained patient consent for treatment in accordance with legislation and guidance.

Mental Capacity Act and Deprivation of Liberty training completion

Staff were fully compliant with their mental capacity act training. As of September 2018, Mental Capacity Act (MCA) training was completed by 98.4% of staff in maternity services compared to the service target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 96.3% of staff in within maternity compared to the service target of 90%.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Summary

Compassionate care

Staff had mechanisms to highlight both good and poor patient experience and used this information to improve their services. Staff used a feedback tool called The Friends and Family Test (FFT)

Friends and Family test performance

Friends and family test performance (antenatal), Walsall Healthcare NHS Trust

![Graph of Friends and Family test performance from Sep-17 to Sep-18](image)
From September 2017 to September 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally worse than the England average. In February 2018 the trusts response rate was too low to report. The latest month, September 2018 the service scored similar to the England average.

**Friends and family test performance (birth), Walsall Healthcare NHS Trust**

![Graph showing Friends and family test performance (birth), Walsall Healthcare NHS Trust]

From September 2017 to September 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average. In June 2018 the trusts response rate was too low to report.

**Friends and family test performance (postnatal ward), Walsall Healthcare NHS Trust**

![Graph showing Friends and family test performance (postnatal ward), Walsall Healthcare NHS Trust]

From September 2017 to September 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

**Friends and family test performance (postnatal community), Walsall Healthcare NHS Trust**

![Graph showing Friends and family test performance (postnatal community), Walsall Healthcare NHS Trust]
From September 2017 to September 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

Staff interacted with patients, visitors and each other in a caring and compassionate way. For example, we saw community staff speaking to a woman and her partner in a caring way following an outpatient postnatal appointment. They ensured they understood the information they had been given.

Staff treated patients with dignity and respect always. For example, they pulled curtains around patients when carrying out intimate examinations. Staff provided support to bereaved patients in a separate and private ‘quiet’ room. They could refer patients to a specialist bereavement midwife for further support and advice.

Three patients we spoke with told us they chose to receive maternity care at Walsall Manor Hospital as friends and family members had given birth there and had highly recommended it to them. Two patients lived out of area but chose to travel a longer distance to receive care at the maternity department.

CQC Survey of women’s experiences of maternity services 2017

Managers gathered feedback from patients through the CQC maternity questionnaire and put action plans in pace to address areas of concern.

The service performed similar to other trusts for 14 out of 15 questions in the CQC maternity survey 2017 the service reported on. The remaining one question performed worse than other trusts.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.56</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.37</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>7.84</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.19</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it</td>
<td>7.94</td>
<td>About the same</td>
</tr>
</tbody>
</table>
worried you?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.71</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.23</td>
<td>About the same</td>
</tr>
<tr>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.57</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.41</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>8.98</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.65</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.17</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.37</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.58</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>7.93</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Managers maintained oversight of patient feedback including the maternity survey and put action plans in place to address areas of non-compliance. Managers recorded reputational impact on the department demonstrated by the FTT as a risk on the risk register. One area which needed improvement was midwives asking patients how they felt emotionally during their ante natal appointments. Actions put in place to address this included to ensure that women were asked about their emotional wellbeing at booking, 28 weeks and 34/36 weeks as a minimum. The maternity patient information system was updated with automated prompts for staff to ask patients how they felt emotionally. This enabled managers to monitor staff compliance.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Staff provided emotional support to bereaved parents. Staff referred patients who had experienced pregnancy loss to an external specialist counselling and support services for support. The bereavement midwife had close links with a bereavement charity.

The service offered maternity staff debrief sessions following neonatal and maternal deaths. Staff recently involved in a session, told us the service kept the bereaved parents updated of
investigation findings and offered them support throughout the process. The bereavement midwife also offered staff, women and their families additional support.

Staff spoke to patients and their loved ones in a calm, reassuring and professional manner always. Numerous thank you cards were displayed across the department which supported the positive feedback women and their families gave us about the level of emotional support they received from staff.

**Understanding and involvement of patients and those close to them**

The service ensured bonding between mother and baby was not disrupted and promoted the establishment of feeding which was crucial in the early postnatal period. A transitional care unit offered women facilities to stay with babies requiring extra support before they could be discharged from hospital.

Staff offered patients continuity and quality of care over time. Patients and their consultant led care teams were cooperatively involved in ongoing health care management. Staff said they were allocated a named midwife at their initial booking appointment.

Ensuring patients had continuity of care was a priority for community midwifery staff. Community midwives supported patients they had visited in the community when they were giving birth on the delivery suite whenever possible. They could also arrange visits in the community for the following day. Between day 10 to day 12 post-delivery, patients would see their named community midwife at home or in the antenatal clinics in GP surgeries.

Patients’ partners and family members felt fully informed about care and treatment of patients. Patients were supported in choosing their birthing method which was indicated in personalised care plans.

Staff involved patients and those close to them in decisions about their care and treatment. Staff communicated with women and their families so that they understood information shared with them. Staff took the time to make sure women and their patients understood all information they were given. Staff introduced themselves, explained tests and procedures in simple terms and gave them opportunities to ask any questions they might have. Staff discussed benefits and risks of each location for birth to help women make an informed decision the service continually sought feedback from women who used services. They encouraged women to take part in the friends and family test and encouraged feedback through other channels such as complaint forms.

Staff made women’s families and carers feel welcomed and part of the women’s care. We saw visitors including partners, friends and family supporting women on wards.
Staff offered support options to all women who experienced pregnancy loss and still births. Staff signposted these individuals to the bereavement midwife and/or external support agencies.

Bereaved families were supported to make memories with their babies if they wanted to. Staff with the support of the bereavement midwife provided bereaved families with appropriate information and support about this.

### Is the service responsive?

#### Service delivery to meet the needs of local people

The facilities and premises were generally appropriate for the services that were planned and delivered. The services provided reflected the needs of the population served and offered patients flexibility, choice and continuity of care.

The service met the needs of the diverse local population. The service employed specialist midwives and offered specialist services. The division had women requiring extra nurturing (WREN) midwives, a professional development, diabetes, bereavement, risk (governance) and antenatal screening specialist midwives. A better births specialist and new-born screening midwife post was to be filled soon. The vulnerable woman midwife role provided teenage pregnancy support for the service. Specialist antenatal clinics were provided such as:

- HIV
- epilepsy
- infectious diseases
- twin/multiple births
- female genital mutilation
- fetal medicine
- diabetic
- mental health clinics.

The service had a dedicated maternity physiotherapist. The service offered a free weekly drop-in session for antenatal women to obtain physiotherapy advice throughout pregnancy and to help deal with aches and pains.

However, since the midwifery led unit closed for women to give birth there, we were still not assured the low risk pathway or choice for patients was embedded in practice. Patients identified as low risk were now being cared for in a mainly consultant-led environment on the delivery suite.

Maternity staff worked closely with parents and stakeholders to development and improve their services at the service and regionally to meet the local population needs. The maternity service was part of with the ‘Walsall Maternity Voices Partnership. The Maternity Voices Partnership
(MVP) is a forum for maternity service users and local maternity staff to come together to design services that meet the needs of local women and families in the Black Country.

Members include mums, dads, parents-to-be, grandparents, NHS doctors and midwives from the local area and members of local community groups who provide their services and support to mums-to-be and new parents and babies.

Leaders worked closely with neighbouring providers to ensure their patients received safe care when their service could not meet patient needs. There was a local agreement with a neighbouring trust for the referral of women deemed high risk or requesting access to cell salvage for birth events.

**Bed Occupancy**

Managers had systems in place to address times where the unit had to close or when the delivery suite was at full capacity. Staff followed an escalation policy and diverted to neighbouring trusts. There had been no occasions where managers had to divert patients between July 2018 to date.

From April 2017 to September 2017, the bed occupancy levels for maternity were generally higher than the England average. From October 2017 to September 2018 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

![Bed Occupancy Chart](chart.png)

(Source: NHS England)
Meeting people’s individual needs

The service took account of patients’ individual needs.

Staff offered support to women and their families who experienced bereavements such as fetal loss or the death of a baby. The bereavement midwife and a WREN specialist midwife were completing an external accredited counselling course with the view to setting up an internal service. They could signpost patients and relatives with spiritual and religious needs to the trust’s chaplaincy service.

All women were given information about the purpose and potential outcomes of antenatal screening tests to detect fetal abnormalities and had the opportunity to discuss their options, before the test was performed. A screening specialist midwife screened mothers for fetal abnormalities. High-risk women could attend the fetal assessment unit after 20 weeks gestation. The early pregnancy assessment unit was available to patients up to 20 weeks gestation. Patients could access these clinics almost immediately when required.

Screening compliance data for September 2018 showed screening staff fully complied with their targets. The specialist screening midwife said the department received a quality assurance visit around two years ago and that recommendations made following the visit had been addressed such as having NIPE leads in the division.

The service now had suitable arrangements in place for people needing translation services. This was an improvement since out previous inspection where there was limited availability of accessible information in different languages. Staff could now access information in a variety of languages.

Translation telephone services were accessible always for patients whose first language was not English. Portable phones were available so conversations could be held in private. This was an improvement from our previous inspection in 2018. Maternity staff supported patients whose first language was not English on the hospital site and in the community. Maternity support workers spoke several different languages and assisted community midwives in the areas they covered where certain languages were most common.

The service now offered accessible information for people with communication difficulties. Staff could arrange sign language and face to face interpreters as required.

The antenatal clinic front desk was equipped with the appropriate devices on each receptionist base to support conversations with the hearing impaired. Staff name badges were on yellow background to support the visually impaired. Guide dogs could also attend. Pictorial aides were also available.
The service had appropriate support systems in place for vulnerable patients. At the time of booking, midwives asked patients a series of risk assessment based questions on mental health concerns, substance misuse, learning disabilities, refugee status, domestic abuse and Female Genital Mutilation (FGM).

Systems were in place so staff would be alerted if patients had pre-existing conditions such as learning disability of mental health condition. A flagging system was embedded into the electronic patient information system for staff to record these.

A team of five specialist WREN (Women Requiring Extra Nurturing) midwives supported women with identified vulnerabilities and/or additional needs. The team were planning to increase the care for vulnerable women by being on-call for births in line with the Better Births guidance.

The WREN team had set up a baby bank in conjunction with the trust’s charity. This was due to launch in April 2019 and would provide women with clothes and baby equipment from charitable donations. WREN midwives could also provide patients with food bank vouchers.

Although the number of women receiving home births was low, managers had already put actions in place to address this. The table below shows the number of births from April 2018 to February 2019:

<table>
<thead>
<tr>
<th>Month</th>
<th>Homebirth Booked</th>
<th>Homebirths achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 18</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>May 18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>June 18</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>July 18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>August 18</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sept 18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>October 18</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>November 18</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>December 18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>January 19</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>February 19</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

There had been no recent suspensions of the home birth service. Managers had already put actions plans in place to increase the number of patients receiving home births. Community midwives had home birth champions to promote the service and they wore ‘ask me about home birth’ badges to highlight to patients this service was available. A questionnaire was given to all community midwives in June 18 to explore how they felt about supporting homebirths to identify any training needs. The service had booked a community skills drill training day for homebirth scenarios as a supplement to mandatory training.

Staff also offered women the choice of water births.
Staff said the closure of the midwifery led unit affected patient choice. Some patients asked community midwives if they could give birth at the midwifery led unit. Staff told us it was difficult telling patients they could not currently give birth at the MLU. Staff informed women they could give birth on the delivery suite however, they may not have access to the same facilities and equipment to support a midwifery-led birth as they previously would at the MLU. Managers had already identified this on their risk register.

**Access and flow**

**People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Leaders worked effectively with stakeholders to address access and flow issues. For example, the service worked closely with a neighbouring trust to divert some maternity activity to their service to address staffing issues, this was being effective.

Managers had put systems in place to focus on flow to improve the quality of care and use available capacity effectively. The maternity triage was an assessment area adjacent to the labour ward which was staffed by a midwife 24 hour a day, seven days a week, for women 16 weeks pregnant and onwards that required further care or assessment that could not be provided by the routine community midwifery service. Staff assessed patients’ needs in the triage area on arrival to the maternity department. Patients were triaged to the most appropriate area of the maternity unit according to their pregnancy stage. Patients could contact the triage department for advice. Calls were recorded so that there was a record of advice given. Patients could call the triage unit up to a maximum of three occasions in one 24-hour period. On the third call, staff would always advise the patient to attend the unit in person or before if assessed as needed.

Although managers had identified long waiting times for antenatal clinic appointments as a divisional risk, patients in the antenatal clinic told us they could make appointments at a convenient time and didn’t wait for a long time to be seen by staff. Patients were offered one-stop visits so that they could have tests as well as an appointment with the consultant or midwives on the same day. This usually entailed some waiting but meant patients weren’t inconvenienced by having to come to the clinic on separate days for different appointments.

Women’s access to their maternity care was not compromised in the previous 12 months. The service had not closed due to issues such as staff shortages.

The maternity service offered patients beyond 20 weeks gestation a termination of their pregnancy for medical reasons in line with national guidelines.
The service offered patients who had previously had caesarean sections opportunities to discuss their next birth options. The service ran a midwifery led vaginal birth after caesarean (VBAC) clinic.

The service cared for neonates who required an additional level of care to that of normal well newborns. The trust’s neonatal unit cared for babies above 28 weeks gestation. If babies required more intensive care staff could transfer them to a specialist neighbouring trust.

Patients were discharged as soon as they no longer needed acute care to free up beds for those that did it. A discharge room was next to the antenatal and postnatal wards for patients to wait whilst staff completed the discharge paperwork.

Staff discussed access and flow issues during staff forums such as team meetings and put action plans in place to address them. For example, in the November 2018 meeting it was shared that on the 12 November 2018, the fetal assessment unit would be opening on a Saturday to reduce the amount of activity coming through triage at weekends. Managers identified antenatal clinic waiting times as a risk on the divisional risk register. To address this, managers had put systems in place such as sending the clinic numbers for the week ahead to doctors on the rota to ensure adequate clinician attendance.

**Learning from complaints and concerns**

The service mostly treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. However, complaints were not investigated and closed in line with their complaints policy.

People who used the services were encouraged to raise concerns and make complaints. Staff tried to resolve complaints locally and informally before proceeding to formal processes. Issues raised were investigated and lessons learned were shared with all staff to improve the quality of care. Patients and carers were advised how they could make a complaint or raise a concern on a leaflet or feedback form. They could also complain using the trust’s internet site. Information about how to feedback a concern, complaint, comment or compliment was displayed clearly in all the wards we visited.

**Summary of complaints**

Although managers dealt with complaints thoroughly, appropriately and proportionately, patients may have been caused unnecessary distress waiting for updates, and for confirmation that their concerns had been addressed.

From October 2017 to September 2018, there were nine complaints about maternity. The service took an average of 52 days to investigate and close complaints. The trust’s complaints policy
states 70% or more complaints should be completed within 30 working days. The service took an average of 38.1 days to investigate and close complaints.

A breakdown of complaints themes is given below:

- Treatment/ care/ supervision: five
- Treatment suitability: two
- Communication failure: one
- Diagnosis wrong: one

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff were responsive to patient feedback and committed to ensuring services met the needs of their patients. For example, staff identified a patient demand for healthy weight and diet classes from referrals. In response they started classes in 2018.

**Number of compliments made to the trust**

From October 2017 to September 2018 there were 35 compliments within maternity.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw numerous thank you cards from patients on the staff display board in the patient corridor.
Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service was part of the Women's, Children's and Clinical Support Services (WCCSS) division. The Divisional Director of Midwifery, Gynaecology & Sexual Health and the Clinical Director led the service.

The service had effective leadership structures which provided direction and support to staff. A new Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health had recently started. Staff felt this role was a positive addition to the team and provided them with extra support. Two newly recruited community leads oversaw the seven community midwifery teams. A team leader led the WREN team. This was an improvement since our previous inspection.

All community and inpatient staff we spoke with said the Divisional Director of Midwifery, Gynaecology & Sexual Health, Clinical Director and matrons and area leads were visible and approachable. Staff felt leaders appreciated the day-to-day pressures they experienced. They felt supported to develop in their roles. For example, there was a preceptorship programme for band five midwives to progress to band six positions.

The Divisional Director of Midwifery, Gynaecology and Sexual Health held a one-to-one with every new starter in the department and the Deputy Director of Midwifery, Gynaecology and Sexual Health also visited the wards every day.

Leaders saw the importance of building capability and capacity of its leaders and staff as being essential to meet the challenges facing maternity services. Staff were supported to develop their managerial and leadership skills. Midwives could attend a strategic leadership programme. The programme aimed to provide midwives with learning support to enable them to develop the critical midwifery leadership competencies including such as develop a vision, to think strategically and systematically, drive change, influence others and to communicate effectively. Around 90% of the midwives had attended the Royal College of Midwives training. Reasons for non-attendance included maternity leave and sickness absence.

Leaders displayed the engagement and relationship skills important in leading improvement and enabled and facilitated others to make their contribution to making positive changes. Since being placed in special measures in 2015, from April 2018 the department had received the input of the intensive support programme for maternity services driven by NHS Improvement. In September 2018, the department were withdrawn from that programme as the service had made
improvements on all the original safety and quality concerns highlighted by the CQC in 2015 and 2017.

Leaders benchmarked their data as a way of ensuring they were providing their patients with safe and effective care. Leaders viewed data collected from providers in England and regularly compared their own clinical outcomes to identify areas for quality improvement. The maternity dashboard enabled maternity clinical staff to regularly compare total deliveries, C-sections, induction of labour and third and fourth degree tears. Leaders statistically analysed these. When the variations were significantly significant the clinical director completed an audit. For example, following variations with the induction of labour data the clinical director carried out an audit. They found that 95% of the inductions were within guidelines and the five percent that were not they planned to investigate further.

Leaders and senior staff had oversight of the challenges the maternity service was facing and had actions in place to address them. Senior staff were all knowledgeable about the CQC action plan resulting from the previous inspection. The Divisional Director of Midwifery, Gynaecology and Sexual Health and other senior staff engaged with and empowered staff at all levels to implement the changes needed. This was supported by the evidence of positive changes that had been made since our last inspection.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**

We reviewed the service wide five-year strategy. The service took coordinated action to address the challenges faced by its population in terms of maternal and infant health, and planned to create a single Black Country maternity plan that inter-related with Birmingham and Solihull where necessary.

Staff collaborated with stakeholders to ensure the region had improved maternity services and outcomes based on the Better Births guidance. Service leaders had close links with maternity units and commissioners in the Black County region called Local Maternity Systems (LMSs).

Staff felt engaged with the strategy for the service. Community staff were aware of the options paper for the future of the midwifery led unit which was due to be presented to the executive board. This included an option of a co-located midwifery-led unit (MLU).

Staff at all levels were committed to representing the service vision and strategy. A staff member during a huddle requested templates for complaints to be changed as they found that they did not represent the values of the trust. The trust’s updated vision and values were displayed in the MLU.
The Trust’s Strategy was aligned to the principle of working in partnership to achieve system-wide transformation through their Vision of “Caring for Walsall together”. We reviewed the Strategic Improvement for 2021/22 services. To deliver the transformation of services for 2021/22, the high level strategic plan focused on transforming the care they provided through seven strategic themes of which maternity and children was one. For example, one strategy was developing a sustainable transformation programme clinical strategy which was clinically led. This would inform service delivery across the Black Country and West Birmingham and reduce unwarranted variation and duplication across the system.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We found a supportive and enthusiastic culture in teams we inspected. Staff were proud of the quality of service they delivered and spoke positively about the organisation. There was constructive engagement with staff; staff at all levels were encouraged to raise concerns. Staff felt well supported by their line managers and they promoted a culture of openness and inclusivity amongst all levels of staff. This was an improvement since our previous inspection.

All staff we spoke with at all levels told us the culture had shifted and was more positive. Staff felt supported, respected and valued. They described a no blame culture. This was an improvement since our previous inspection.

We found the culture centred around the needs and experiences of the patients. Staff felt they were offered more development opportunities and felt managers valued their safety and wellbeing. We found staff and teams working effectively and supporting each other. The huddles created an environment where staff regularly communicate and feel safe to raise concerns about patient safety.

A culture of speaking up being business as usual was promoted Maternity staff could contact the trust’s freedom to speak up guardians. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in “Freedom to Speak Up” in 2015. Ensuring that the needs of staff are met and that Freedom to Speak Up develops in a way that responds to local circumstances, are fundamental principles of the role.

Community midwifery staff were proud of the strong teamwork in the community team. They also felt part of the overall maternity service at the service and told us maternity staff supported each
other, particularly in response to increased activity on the unit. The WREN team were extremely proud of the support they provided to vulnerable women in the challenging demographics of Walsall.

However, community staff regularly supported the staffing levels of the hospital-based maternity service and told us they understood the challenges and workload of hospital-based midwives. Staff gave an example of when a midwifery team leader on the acute site had thanked staff for their assistance as they had increased staffing levels on the delivery suite when on-call. They felt welcomed and part of the team when working on the delivery suite.

Community midwives could suggest ways to improve the autonomy of the community midwifery service and make changes to the service. However, some community staff felt the acute based midwifery team did not have a full understanding of the challenges of the community midwifery team.

Executive staff members were actively involved in promoting a positive culture. In September 2018 the chair held meetings with the outpatient team to assist the maternity service to develop its multi-professional working culture. They received expert advice and support from the medical director who was previously tasked with cultural turnaround at Mid Staffordshire FT, following the Robert Francis Report. The support of the medical director from mid staffs ceased in early 2018 and was replaced by the ex medical director from a specialist women’s trust.

An external provider held individual development sessions scheduled with consultants to improve cultural attitudes. Consultants were very positive about the division and the improvements made so far. Midwives, support workers, and junior doctors said they had positive working relationships with consultants.

There were examples which supporting the improvement in culture. Some long-standing staff due for retirement had decided to continue working in the department as they enjoyed working in the department. Some staff had left to work at other trusts but returned to work in the department.

The department had several new recruits in post which was refreshing for the department as recently trained midwives had brought new ideas. Some long-standing staff described the delivery suite as a “much happier place” where staff had “laughter and fun”. Staff described a much more vibrant and exciting place to work. This was an improvement since our previous inspection in 2018.

Leaders sought support from external sources to provide them with objective assurance to themselves, stakeholders, and the public as to whether any patients have been harmed because of their systems, processes, and/or practices and to avoid future harm to patients. The service had external reviews taking place to review the governance, serious incidents, and stillbirth investigation processes.
Consultants attended individual development sessions between July and September 2018 with an external consultancy company who had conducted a review of culture in the maternity department. A consultant workshop took place on 18 January 2018. All interviewed consultants attended the session.

Staff displayed the service values. The service had developed a set of values to reflect how they expected their staff to treat patients, visitors and each other. These were respect, compassion, professionalism, teamwork. The service vision was to ‘provide safe, high-quality care, deliver care at home, work with partners, value our colleagues and use resources well.’ We saw staff keeping to the vision and values. For example, staff were polite, courteous and respectful when interacting with patients and visitors.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Managers had a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. The service now had a specialist governance consultant. This was an improvement since our previous inspection.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. There were clear divisional governance arrangements and there were teams and accountable personnel to oversee governance. There were clear and effective processes for managing risks, issues and performance. This was in seen in their evidence based practice, competency and skills mix of staff and in their documentation and minutes from meetings such as the quality and safety and maternity oversight committee updates. Areas of good practice were being shared on a weekly basis at the CQC preparation steering group where the maternity team had taken part.

The Divisional Director of Midwifery, Gynaecology and Sexual Health maintained appropriate oversight of governance in the maternity division. They attended care group governance meetings, divisional quality meetings, risk management committee and could escalate to the trust management board. These were well attended by staff from many disciplines, including obstetricians, anaesthetists and midwifery staff. This demonstrated staff interacted effectively and held useful discussions concerning areas such and incidents, patient experience, complaints and compliments.
The Divisional Director of Midwifery, Gynaecology and Sexual Health produced a monthly report to review activity within the maternity unit including midwifery staffing and acuity, safeguarding training, fetal heart monitoring documentation audit results, provision of enhanced maternity care trained staff and the safety huddle report.

Staff conducted team meetings in a consistent manner. Team meeting minutes across the division followed the same format and actions from the meeting were allocated to staff to be responsible for the actions. This was an improvement since our previous inspection.

Management of risk, issues and performance

The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the risk register was fully reflective of the current risks.

Although there were arrangements for managers to identify, record, manage risks and provide actions plans to address them, the maternity risk register did not fully represent the current risks to the maternity service. Some risks that had been mitigated and were no longer current risks were still recorded on the register. For example, one of the risks identified was ‘the midwifery and support teams within maternity services are failing to achieve the trusts/ service recommended standard (90%) of mandatory training compliance’. However, staff were now fully compliant with mandatory training. The Divisional Director of Midwifery, Gynaecology and Sexual Health said they chose to keep risks that had been addressed on the risk register for some time before removing them to ensure these changes were embedded. We found the risk register did not reflect the scope of what staff and managers identified as risks during our visits, such as, the closure of the midwifery led unit (MLU) and the impact this had on patient choice and staffing issues. We discussed this with The Divisional Director of Midwifery, Gynaecology and Sexual Health who agreed these were risks to the service and should be on the register. They addressed this in a timely way as they revisited the risk register and provided us with an updated risk register on the same day. This reflected up-to-date and accurate risks, however this register did not record mitigations in place. We requested mitigations for the risks recorded on the register following the inspection. The service sent us an up-to-date risk register which contained current risks with actions and review dates.

The Divisional Director of Midwifery, Gynaecology and Sexual Health used a maternity dashboard and clinical audits to continuously monitor quality, operational and financial outcomes. They took actions to address areas of concerns.

There was maternity representation at board level. This was in line with national guidelines.
The Divisional Director of Midwifery, Gynaecology and Sexual Health and their team were responsive to addressing risks identified by external stakeholders. They produced a monthly CQC report detailing their ongoing review of the areas which were highlighted within a Care Quality Commission Section 29a warning notice in September 2017. This was lifted in August 2018 as the CQC inspection of maternity services in June 2018 identified these concerns had been addressed.

Leaders considered factors such as the impact on quality when making changes to the service. For example, they liaised with stakeholders and ensured the birth cap and closure of the MLU did not compromise patient’s safety.

The service took potential risks into account when planning services such as the winter season and unexpected fluctuations in demand. The service had winter plans in place and managers could follow escalation procedures to keep women safe if they were up to full capacity and couldn’t accept any more patients.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Managers demonstrated a holistic understanding of performance which looked at people’s views with information on quality, operations and finance. Managers had a framework to oversee the quality and safety of patient care. They reported a range of service performance measures and discussed quality and sustainability in all governance meetings.

The service had effective arrangements to ensure data or notifications were submitted to external bodies. The service had routinely provided weekly and monthly data to CQC as required regarding the concerns we raised in the 2017 maternity services inspection.

Arrangements ensured availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Staff followed the General Data Protection Regulation (GDPR) which came into force on May 25, 2018, and was designed to modernise laws that protect the personal information of individuals.

The unit had arrangements in place to maximise the use and functions of the maternity patient information system such as monitoring the clinical activity of the department. A specialist midwife supported the lead with the electronic patient data management system. The service was carrying out an audit project trialling a patient data management system application (app).

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
Leaders gathered patients and staff views and experiences and acted on them to improve their services. Staff used a feedback tool that supported the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This showed staff listened to the views of patients and staff to help identify what was working well, what could be improved and how. The patient experience Friends and Family Test (FFT) results from July 2018 to December 2018 showed the percentage of patients who said they would recommend the antenatal services ranged from 82% to full compliance, the percentage who said they would recommend birthing there ranged from 89% to 97% and the percentage of patients who said they would recommend the post-natal ward ranged from 88% to full compliance. The target was 95%.

antenatal care staff surveyed women using an electronic tablet device which staff felt was working effectively. It was mandatory for staff to inform managers when responses were less than five. Managers would then investigate responses further and address them.

FFT results were presented and discussed at board level. For example, the February 2019 board papers showed maternity the antenatal responders ‘would recommend’ target was achieved for the first month since August 2018.

During February 2019, women using antenatal services at Walsall Manor Hospital were given the opportunity to tell staff what works well and where improvements needed to be made.

The “What Matters to You?” session was held and saw members of the antenatal team join the patient experience officer to speak to around 20 service users.

The service held events as a way of engaging and empowering them to make improvements that would improve the care they give to their patients. Staff told us about the listening into action events. The purpose of LiA was to listen to staff and support them to make the changes, removing any barriers so they could take the lead and contribute to the success of their trust. The first phase of its work has been focusing on human factors in maternity and gynaecology with additional areas being considered.

Staff showed the experiences of patients, carers or family members was important to them. Staff displayed ‘You said we did’ information in the department’s waiting areas.

Leaders took an inclusive approach to involving community staff. The division conducted a dedicated community midwifery patient survey and collated the results monthly. Comments were shared with community staff. Comments from January 2019 included “felt very welcomed”, midwife was excellent and explained everything properly.”

Community staff attended a community forum each month led by the community team leaders. The agenda included safeguarding concerns, incidents, the risk register, performance and
vacancies. Specialist subjects such as trafficking of women were also discussed. The team allocated specific champions from each team to attend the forum.

Community staff used a group mobile phone app to communicate and support one another and held regular social events.

There were caring and supportive relationships amongst staff at all levels. A specialist midwife for bereavement provided guidance and support to midwifery and medical staff when caring for women experiencing pregnancy loss, stillbirth or neonatal death.

Staff told us they attended a support session facilitated by a trained counsellor following a recent distressing event. All staff were invited to attend the session which was facilitated away from the unit including theatre staff. Staff said they appreciated this and found it supportive.

Staff could nominate each other for the employee of the month award scheme to recognise and celebrate staff contribution to the service. We saw nominations and winners on the staff noticeboard.

The service had a positive board to celebrate their achievements.

A separate patients and liaison service (PALS) report was shared with maternity matrons who shared this with relevant teams for information only.

Staff were offered exercises where they had the opportunity to discuss obstacles in their day-to-day work lives and to determine ways to overcome them. These were carried out every two months to ensure problems identified were fully addressed and acted upon appropriately.

Managers told us change and implementation meetings were to be held monthly to involve staff in changes.

Staff were provided with training which helped them understand about human behaviour and performance. Human factors knowledge was used to optimise the fit between people and the systems in which they work to improve safety and performance. Delivery suite staff attended human factors live skills drills held monthly and the quality improvement faculty offered staff human factors study days.

The service celebrated international day of the midwife in May 2018 with many different events held on the unit.

Staff at executive level engaged with maternity staff. In December 2018, the service Chair gained insight into those working on the frontline. They spent time with teams across the service and out in its community services, shadowing staff in a variety of settings. They said of maternity services “It was fantastic to see the progress being made in maternity and it was wonderful to meet so many passionate leaders focused on driving continuous improvement across this service. It was a pleasure to meet the wider team”. Maternity staff attended the ‘trust connect’ engagement event
which was chaired by the chief executive and included key themes and discussions regarding the service value updates.

Learning, continuous improvement and innovation

Although we found staff had made many service improvements in the short time since our previous inspection in 2018, such as compliance with mandatory and safeguarding training and staffing and cultural level improvements, there were still areas of improvement that needed to be addressed. For example, despite CTG training compliance forming part of our 2017 warning notice we still could not be assured leaders of the service had prioritised this training as CTG training overall compliance levels were below the service target.

The positive changes we found need to be maintained and leaders need to address outstanding areas of risk swiftly so that the service can be confident it is providing safe and effective care for patients, always.

Leaders put quality improvement plans in place to progress the service. These included plans to improve response times and delays in relation to C-sections and inductions and to consistently evidence safe staffing levels.

Staff promoted baby loss awareness week, with events within the main atrium. Also, a staff member attended an event in London for this, along with other pilot leads.

Staff could now offer patients a quicker recovery following caesarean sections. The service now offered an enhanced recovery pathway.

As part of the divisions 2018/2019 operational plan the task force approach continued working with the maternity service to drive improvement and support the new management team to achieve a rating of at least ‘good’ in the next CQC inspection. They met monthly with the Chief Executive and trust leadership team and provided oversight of the range of actions required. They recorded their progress. This included: improved compliance with CTG monitoring, implementation of the Birth-rate Plus Acuity Tool to ensure continuous evaluation and provision of safe staffing and HDU trained midwives on every shift. What we found corroborated this.

Divisional management leads reported progress, which was monitored at local level and through regular confirm and challenge meetings with the Director of Nursing and Medical Director. These covered the Quality Commitment, and risk registers and in so doing, ensured all leads could discuss progress with their plan in detail. Progress reports were made to the trust management board and the Quality and Safety Committee (QSC) of the service Board.

The service implemented workforce improvement schemes and provided support to the current workforce. For example, the development of maternity support workers (MSW’s). It was envisaged
they would work within post-natal services and have the right skills and competencies to work effectively as part of a multi-skilled team required to deliver safe and effective care.

Maternity staff were in the process of piloting a maternity electronic application (app). The aim was for the app to replace the hand-held patient notes and to provide patients with information such as scan appointment reminders. This would ensure patient’s confidential medical records could be more securely held.

The WREN team had been recognised for their work at a ‘child in need’ conference the team attended.

Staff from the delivery suite were encouraging the WREN team to be nominated for a Royal College of Midwives award.

Staff engaged with external reviews to gain external and objective feedback. Due to longstanding concerns within the maternity service Health Education England (HEE) conducted an external review and met with 15 student midwives across all three years of training who had undertaken a clinical placement at the trust. The HEE educational review provided positive feedback about the service and it’s support of student midwives.

The service also considered and acted on external reports such as the MBRRACE-UK: Saving Lives, Improving Mothers’ Care.

### Sexual health services

Information about the sites and teams, which offer sexual health services at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location / site name</th>
<th>Team/ward/satellite name</th>
<th>Services provided</th>
<th>Address (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manor Hospital</td>
<td>Sexual Health</td>
<td>Genitourinary Medicine</td>
<td>Walsall Centre Sexual Health, Pleck Road WS2 9PS</td>
</tr>
<tr>
<td>Wharf Building</td>
<td>Sexual Health</td>
<td>Community services for adults</td>
<td>Walsall Centre Sexual Health, Pleck Road WS2 9ES</td>
</tr>
<tr>
<td>Wish Building</td>
<td>Sexual Health</td>
<td>Community services for adults</td>
<td>Wish Clinic, 36 Navigation Street, Walsall WS2 9LT</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The sexual health service is part of the Walsall Integrated Sexual Health Services (WiSH), which includes sexual health, HIV, long-term contraception and family planning. The trust provides an outreach service following acquisition from the local authority and a contraception and sexual health (CASH) outreach service for young people, which is part of the team based at the locations listed above. The CASH team works from a hub offering a weekly appointment service on Thursdays from 2pm to 6pm. We included this service in our inspection and it operates from:
Willenhall Health Centre
Field Street
Willenhall
WV13 2NY

The main clinic is located adjacent to the trust’s acute hospital and provides services at the following times:

- Monday: 8am to 8pm
- Tuesday: 9am to 8pm
- Wednesday: 9am to 8pm
- Thursday: 8am to 8pm (2pm to 7pm for under 25s only)
- Friday: 9am to 4pm

WiSH operates a satellite clinic from Walsall town centre. At the time of our inspection it provided services at the following times:

- Monday to Thursday: 9am to 5pm for pre-booked appointments
- Friday: 9am to 12pm for pre-booked appointments
- Friday: 12pm – 4pm for walk-in patients
- Saturday: 9am to 4pm for walk-in patients (1pm to 3pm for under 25s only)

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses as of September 2018 for qualified nursing staff in sexual health services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Update</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls Awareness</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load Handling</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>13</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In sexual health services, the 90% target was met for eight of the 10 mandatory training modules.
for which qualified nursing staff were eligible.

As of September 2018, the trust reported no medical staff for sexual health services.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

We confirmed during our inspection medical staff were part of the sexual health service and met or exceeded the 90% target rate for mandatory training completion.

The senior sister for sexual health managed mandatory training within the team and provided staff with protected time to complete updates. Staff spoke positively about the mandatory training and told us it helped them to provide safe care to their patients. Staff said fire safety was particularly good as it was practical and they had to demonstrate the ability to use fire extinguishers and coordinate an evacuation in a whole-team exercise. The contraception and sexual health (CASH) outreach team were 100% compliant with mandatory training requirements at the time of our inspection.

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.

The trust set targets of 85% and 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of September 2018 for qualified nursing staff in sexual health services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Level 1 &amp; 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 3</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In sexual health services, the 85% and 90% targets were met for all of the safeguarding training modules for which qualified nursing staff were eligible.

As of September 2018, the trust reported no medical staff for in sexual health services.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Prevent is a national programme aimed at equipping staff with the skills and knowledge to identify people at risk of radicalisation. Staff had a good understanding how the principles of the programme helped to protect patients from the local community.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.
Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The trust was unable to provide referrals broken down by core service.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

The trust safeguarding team did not have consistent involvement or oversight of sexual health services as staff more commonly liaised with the local authority team. We discussed this with the safeguarding team after our inspection and found systems were in place to minimise safeguarding risks. For example, although the trust was unable to provide the total number of safeguarding referrals made from the service, we found consistently good standards of safeguarding practice and documentation. This included a clear recognition of risk and immediate action to support patients.

A safeguarding link nurse was based in sexual health and acted as a point of contact and liaison between the trust safeguarding teams and those in the local authority. The link nurse worked with school nurses and community teams to ensure young people received appropriate safeguarding support, including in urgent crisis situations. The various teams worked collaboratively with other agencies, such as the police and specialist non-profit organisations, to protect young people involved with sexual exploitation and grooming.

Processes were in place to implement urgent safeguarding protocols when patients lived outside of the catchment area of the service. Staff held the contact details for the crisis and out of hours teams for surrounding local authorities and followed their procedures for referrals. For example, patients often presented to this service because it was outside of their local area, which meant they could attend with more confidence of anonymity. However, this also meant staff could not use local safeguarding processes where they had concerns. We saw they had ready access to the processes of services in surrounding boroughs and had established working relationships with them.

Staff had developed clinical policies for assessing and examining patients to reduce safeguarding risks. For example, where young people attended with parents or friends, staff saw them alone and asked those accompanying them to wait outside of the clinical area. This ensured the patient had a safe, private space to discuss any concerns.

The safeguarding team had developed new level 3 training for staff as part of the trust’s work towards full compliance with the Intercollegiate Document – Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018). This was due to be completed by 2021 and included renewed focus on key areas such as adults with learning disabilities and legal responsibilities.

Arrangements were in place for young people who attended the clinic that enabled staff to manage their needs while assessing their safety. For example, if a teenager under the age of 16 who was not known to the service presented in the clinic, staff provided them with a private area to wait and
contacted the duty safeguarding nurse. A care support worker (CSW) waited with the patient so they were not left alone and the clinical team prioritised them for review.

Processes were in place to provide immediate care to patients who disclosed rape, or where staff suspected this.

An acute liaison nurse in the trust safeguarding team met with patients living with a learning disability to help support them through care and treatment.

Staff had access to continual support from the trust safeguarding team. A senior trust nurse was always on call for adult and child safeguarding and a corporate adult safeguarding quality lead nurse led care quality in the context of safeguarding. A designated doctor for safeguarding children was always available on call. At weekends this service was provided under a service level agreement by another NHS trust. An on-call director was always available to escalate serious safeguarding concerns and staff had good working relationships with the local authority and police.

Outreach and CASH staff undertook more advanced training in safeguarding, child sexual exploitation and Prevent to reflect the increased risk they worked with in the community. Social workers were based in the hospital discharge team and provided support as needed. Sexual health staff referred patients with safeguarding needs or risks to social workers and required them to have a review before being discharged from the service.

We observed excellent standards of safeguarding awareness during our inspection. For example, a patient booked into a future appointment at the satellite clinic visited and asked to be seen earlier. The patient was booked to attend with an interpreter and on this occasion attended with a relative translating for them. The clinical support worker (CSW) on duty recognised this as a safeguarding concern and explained discreetly and sensitively why they could not be seen with a relative interpreting for them. The CSW established the patient had no urgent or immediate clinical risk during this process, which ensured their safeguarding concern did not detract from clinical needs.

Staff demonstrated rapid, proactive action to safeguard young people, including when they lived in an area under the jurisdiction of a local authority unfamiliar to the team. For example, they liaised with the trust child safeguarding team and social services from the patient’s home area to intervene in a situation where the patient had been placed at risk online.

Outreach and CASH nurses underwent monthly supervision with the trust safeguarding team and the link nurse attended monthly safeguarding meetings to help the team stay up to date. The team ensured they knew the safeguarding point of contact for the day when they worked from schools and worked with pastoral staff to coordinate care. The local authority safeguarding team visited the service every three to six months and carried out supervision and guidance sessions.

The trust employed school nurses who acted as liaisons between the CASH team, school administrators and young people at risk to ensure necessary safeguarding action was taken.

Staff had improved the consistency of safeguarding processes following previous incidents involving child sexual exploitation. For example, a member of staff completed a safeguarding assessment for patients under the age of 16 each on each occasion they presented in the clinic. They completed an assessment for patients aged between 16 years old and 18 years old on their first contact and again if they had concerns about safeguarding risks. The sexual health safeguarding lead audited the completion and quality of documentation for under 16s monthly and worked with staff on areas for improvement.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

During our inspection we observed consistently good infection control practices, such as adherence to hand hygiene best practice and adherence to the bare below the elbows policy in clinical areas. Antibacterial hand gel was available in all clinical areas and at reception desks and signs reminded visitors to use these. We observed staff washed their hands between patient examinations and staff working outside of clinics carried hand gel with them.

We reviewed the compliance of clinical areas with the Department of Health and Social Care (DH) Health Building Note (HBN) 00-10, in relation to infection control in the built environment. We found full compliance with effective cleaning processes in place.

Staff managed clinical sharps in line with the requirements of the Sharps Instruments in Healthcare Regulations 2013 and the DH Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste. For example, all sharps bins were labelled, signed and dated. The trust had adopted the use of a safer sharps needle-less system, which was compliant with EU Legislation 2010/32/EU in relation to the prevention of sharps injuries in hospitals.

The matron and senior sister carried out a monthly hand hygiene audit, which included a minimum of 15 observations of each staff group. The audit assessed staff for their use of hand washing techniques in compliance with trust policy and the World Health Organisation five moments to hand hygiene standards. From April 2018 to February 2019, the service achieved 100% compliance with hand washing standards and over 99% compliance with the trust’s bare below the elbows policy. The senior sister carried out a monthly uniform audit to ensure staff were compliant with trust standards, which contributed to good infection control practices.

A sexual health nurse acted as a designated link with the infection control team and attended periodic meetings and updates. This enabled them to act as a local expert in the clinic and provide guidance and support to colleagues.

Staff used bright green ‘I am clean’ stickers to indicate when an item of equipment was clean and ready for use. This applied to equipment used for patient contact.

Staff maintained records of cleaning according to established schedules, including a weekly deep-clean schedule of clinical areas and a nurse station cleaning schedule. We reviewed this documentation for the previous three months and found no gaps in recording.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The service maintained up to date Control of Substances Hazardous to Health (COSHH) Regulations (2002) documentation and staff ensured colleagues from other departments adhered to these standards. For example, microbiology staff regularly worked in the sexual health clinic laboratory and we saw evidence the sexual health team ensured they followed trust standards.

Staff in each clinical area demonstrated a good working knowledge of local fire safety and evacuation procedures. This included the CASH team, who ensured they understood the local
emergency procedures for each school or college they worked from. A fire warden carried out a monthly inspection of the main clinical site and assessed safety standards against 15 key criteria. The most recent inspection took place in January 2019 and found full compliance with trust standards. The satellite clinic was operated in a building under a lease agreement, which meant the owner carried out fire risk assessments locally. Although staff demonstrated a good understanding of local procedures, risks were presented by local parking arrangements. For example, during our environment we found a car parked in front of one emergency exit from the building. This would impede a rapid evacuation and meant anyone in the building who used a wheelchair or with a mobility problem would not be able to use the exit. We escalated this to staff on site. A trust fire warden carried out a monthly assessment and we saw evidence this included a check of fire escape routes.

The outreach team worked within an environment risk assessment for each location they provided services from. This included public venues such as clubs and sex-on-premises locations, each of which had a specific risk assessment. A sex-on-premises location is a commercial venue with a license and facilities for customers to engage in sexual activities. The trust also maintained general risk assessments for lone working, violence and sexual harassment. Staff used a buddy system for lone working to ensure they always had a point of contact and someone always knew where they were.

The clinical sterile services department was co-located with the main sexual health clinic and staff reported a timely turnaround for equipment decontamination. In the 12 months prior to our inspection there had been no instances of delayed or cancelled treatment due to the delayed turnaround of equipment.

The reception desk in the main clinic was not fitted with a panic alarm or equivalent call system. If the team needed help from security or the police they needed to make a telephone call, which could potentially place them at risk. There was no rapid-close mechanism for the shutters at the desk, despite staff regularly reporting abuse and threats of violence. We spoke with the senior team about this who said they would review the situation.

The satellite clinic was better equipped for instances of violence and panic alarms were installed in appropriate places. Entry to the clinic required visitors to use a video entry system and the trust had reduced the opening hours following increased security concerns in the vicinity of the clinic.

The facilities team maintained an up to date schedule of equipment servicing and maintenance. At the time of our inspection all equipment was serviceable and had been serviced according to the schedule. This included electrical safety testing CSWs were responsible for stock rotation and ordering of consumables and we found good practice in this area. Stock was readily accessible, well organised and all items were within the expiry date.

The CASH team used a clinical room in a GP practice for pre-booked appointments with young people. The room was not used by any other service or staff from the GP practice, which meant the team had adapted and customised the layout to be of greatest benefit to their patients. The room had an en-suite bathroom, which meant patients did not need to use the GP service facilities to provide samples for testing.

Staff maintained appropriate hazardous waste storage and streaming in line with DH HTM 07/07, which requires hazardous waste to be secured with restricted access. Hand wash sinks complied with DH HBN 00-09 in relation to design that reduced the build-up of bacteria and the spread of infection.
Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The reception team used a triage process during walk-in session registration. This meant the clinical team were alerted to the urgency of patient’s needs and could prioritise those most at risk. For example, staff would always see patients who disclosed rape, reported testicular pain or reported symptoms of certain sexually transmitted infections (STIs) as a priority.

The main clinic provided patients with emergency access to post-exposure prophylaxis (PEP). PEP is a short course of HIV treatment that may prevent infection if started within 72 hours of exposure to the virus. The trust’s emergency department (ED) provided PEP where patients presented when the sexual health clinic was closed and patients followed up with the specialist team for further treatment and guidance. Where the CASH, satellite or outreach teams identified a patient may have come into contact with HIV, they referred the patient to the nearest available provider of PEP.

The service arranged short-notice prescriptions for patients who took anti-retroviral medicine to manage HIV when they were about to run out. The service managed patient medicines so that this should not happen but certain circumstances sometimes meant patients called the clinic with only a few days’ supply of medicines left. In such cases staff managed the patient’s risk by providing an interim prescription and arranging to see them as soon as possible for routine monitoring.

Outreach and CASH workers called ahead to the reception team or single point of access (SPA) team during walk-in clinics and could reserve slots for patients with urgent needs. The SPA team provided a dedicated telephone service to coordinate access to the various clinics the service offered.

The safeguarding team had adapted the existing clinical situation, background, assessment and recommendation (SBAR) tool for use by the security team when attending calls for help. The tool meant the security team could prepare themselves for the situation and plan a response based on what staff knew about the patient, such as mental health diagnoses or problems.

Staff had implemented strategies locally to protect patients experiencing domestic violence. With the patient’s consent they provided a photograph of the alleged perpetrator to the security team, who actively monitored the service’s CCTV system to identify if the person tried to access the site. This meant the team could intervene to prevent a potentially violent situation before the alleged perpetrator reached the patient.

Emergency equipment was available in the main clinic and satellite clinic. This included a cardiac arrest kit, oxygen with masks in various sizes and first aid equipment. Staff documented daily safety, maintenance and stock checks on the equipment. An emergency medicines trolley was stored in the main clinic. This was closed and sealed and staff documented a daily security check on the seal. Staff broke the seal once each week to check the contents. We looked at the documentation for these checks for the previous three months and found them up to date with no gaps.

Appointment duration was scheduled to match the level of care patients needed for specific issues to minimise risk. For example, contraceptive implant appointments were scheduled for 30 minutes and intrauterine device (IUD) appointments were set for 45 minutes. Staff said this allowed them to provide high quality care and to ensure patients had all the information they needed to understand their treatment and provide informed consent. Clinical nurse specialists led implant and IUD care
and said the low levels of request for implant removal reflected how well-prepared patients were for adverse side effects.

A consultant was always available on call for staff in the satellite clinic and CASH teams. Staff spoke positively of this and a nurse said the on-call consultant had been fast to respond when they had needed help on a Saturday.

**Staffing**

The service did not always have enough staff to provide the right care and treatment. Staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm.

The trust reported the following qualified nursing staff numbers as of March 2018 and September 2018 for sexual health.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Manor Hospital</td>
<td>15.1</td>
<td>16.8</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

A team of 20 contraception and sexual health nurse specialists (CASH), senior staff nurses and staff nurses worked in the main clinic and in the satellite clinic, led by a senior sister. Three full time consultants led care in the service, including two consultants in HIV and genitourinary medicine (GUM) and one consultant who worked on an honorary basis. A GP trainee and foundation year one (FY1) doctor were based in the main clinic.

A senior CNS health promotion outreach nurse and two registered nurses in young peoples’ contraception and sexual health provided the CASH service. The team worked to key performance indicators for chlamydia screening amongst people under 25 years old and arranged staffing schedules on demand for services in schools, colleges and universities.

From October 2017 to September 2018, the trust reported a vacancy rate of 9.5% for nursing staff in sexual health services.

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

The trust set a target of 10% for turnover rates. From October 2017 to September 2018, the trust reported a turnover rate of 15% for nursing staff in sexual health services. This did not meet the trust’s target.

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

From October 2017 to September 2018, the trust reported a sickness rate of 10% for nursing staff numbers in sexual health services. This was higher than the trust target of 3.39%.

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

Sickness levels remained higher than the trust target during our inspection. Staff said months of
persistent short staffing and excessive workloads, along with uncertainty about the future of the service had resulted in high levels of stress and anxiety. The senior sister was new in post and had begun to address many of these issues with a new, substantive focus on improving staffing levels. However, they were substantially restricted in the action they could take due to a recruitment freeze imposed due to a significant reduction in commissioned funding.

From July 2018 to January 2019 staff submitted 35 incident reports relating to the impact of staff shortages and sickness. This had resulted in the closure of the satellite clinic and cancellation of outreach clinics on six occasions. Other instances resulted in the reduction of capacity in walk-in clinics, re-booking of patients when trained staff were unavailable and extended waits to be seen for pre-booked appointments. The reports also indicated inconsistencies in the appointment-booking process for consultants and a failure to modify appointments on the booking system when staffing levels were reduced. In July 2018 services were significantly reduced due to the sickness absence of four nurses and vacancies for seven CSWs. In the same period staff sickness and shortages resulted in a reduced of capacity in the SPA team, which added pressure to the non-clinical team in answering calls and led to longer wait times for call handling. In October 2018 the service cancelled 35 coil and implant appointments up to the end of December 2018 due to a shortage of advanced nurse practitioners. Consultants and trained nurses offered alternative appointments where possible although this added significantly to their existing workload.

A core team of nurses led care in the satellite clinic. This team worked on rotation between the two clinics and a CNS was based substantively in the satellite with some shifts at the main clinic. This ensured the satellite clinic had consistent senior nurse presence with regular visits from the senior sister.

From October 2017 to September 2018, the trust reported no bank or agency usage in sexual health services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

The service used bank CSWs occasionally to cover shortages but had been unable to source bank or agency nurses with the specialist skills needed to safely provide care.

As of September 2018, the trust reported no medical staff for sexual health services.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Although this information was missing from the RPIR we confirmed there was adequate medical cover in the service.

During the reporting period from September 2017 to September 2018, sexual health services reported that there were no cases where staff have been either suspended or placed under supervision

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Two health advisors provided 1.56 whole time equivalent (WTE) cover in the main clinic and on a community outreach basis.
The service had introduced a dual support worker (DSW) role. DSWs were trained as receptionists and CSWs, which meant they provided clinical support and staffed reception desks to manage bookings and walk-in patients.

A guardian of safe working monitored the safety of doctors’ working hours and reviewed exception reports, which junior doctors submitted when they had worked excessive or unsafe hours. Between January 2018 and January 2019, junior doctors submitted no exception reports for unsafe hours.

The SPA team worked from the satellite clinic and coordinated access to appointments and the various walk-in sessions. This was a new team that provided significant support to the existing reception and clinical teams.

**Quality of records**

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Staff used an electronic records system that was separate from the rest of the trust. This ensured confidentiality and meant only sexual health staff could access patient’s records. HIV records were paper-based and stored securely in the main clinic. The service had a future plan to digitise the records and to initiate all new records using the electronic system. This was in the pilot phase at the time of our inspection.

We reviewed a sample six patient’s notes; four electronic sexual health notes and two paper-based HIV notes. In each case records were of a good quality, well-ordered and had been regularly updated. Staff had completed a detailed, individualised care plan for each patient. Staff recorded detailed qualitative notes that included assessments and consultations and used new dynamic templates that allowed more coherent recording.

Staff adhered to trust standards and national standards when completing records, such as those identified by the British Association for Sexual Health and HIV (BASHH), when preparing notes. A clinician planned to undertake an audit of records to assess adherence with BASHH standards in April 2019.

A dedicated HIV administrator managed all aspects of patient administration, including scripts for pharmacy dispensers.

The electronic patient records system enabled staff to flag patients who were known to have specific vulnerabilities or where previous concerns had been raised. For example, we saw staff used a flag for adults with an on-going active safeguarding concern and for children who were looked after.

Staff used a multi-agency referral form (MARF) to refer and escalate care of a young person with safeguarding or additional needs. This enabled the team to quickly contact all appropriate professionals and teams to begin the coordination process for safeguarding action. We reviewed three examples of completed MARFs and found staff demonstrated consistent standards of completion and quality.

**Medicines**
The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff maintained consistent standards of medicine management, including secure storage with restricted access. The team recorded a daily temperature check of storage areas to ensure this remained within the safe limits set by pharmaceutical manufacturers. This included for refrigerated medicines. We reviewed the records for temperature recording for the three months leading to our inspection and found consistent standards with no gaps. Staff knew how to escalate a situation in which storage temperature exceeded the safe maximum.

The pharmacy team carried out a weekly audit of medicines storage to measure standards against trust policy. From November 2018 the sexual health team took over audit responsibilities from the pharmacy team. Between February 2018 and January 2019 sexual health achieved 92% compliance. This was an average figure and reflected nine months of performance at or above the trust target of 90% and three months of performance between 80% and 88%. Compliance in the three months in which the sexual health team had self-assessed was 98%, compared with 90% when the pharmacy team carried out the audit. The audit identified trends in non-compliance. For example, from February 2018 to November 2018 there were 11 episodes in which medicine storage cupboards or fridges were not locked. There had been no instances of theft or missing stock and there was evidence in governance processes the senior team had oversight of this issue.

In February 2019 the service introduced a monthly antimicrobial audit to assess standards against four trust best practice criteria. In the first audit, sexual health exceeded all minimum standards with 100% compliance in documentation including of the stop-and-review date and allergies.

Staff were proactive in reporting near misses and errors involving medicines. For example, in November 2018 a member of staff reported an incident in which a medicine cupboard was found unlocked, which presented a risk of theft or unauthorised access. The senior sister worked with the team to embed the correct safety procedures and liaised with the facilities team to install electronic keycode locks to medicine cupboards. In January 2019 staff reported an incident in which the electronic lock failed. Staff responded appropriately by moving medicine to a secure area until the facilities team could resolve the equipment failure.

The CASH team stored medicines locally in their offices in a GP practice. We reviewed local practices and found them to be in line with trust standards, including with secure storage and restricted access. The team had worked with pharmacy colleagues to supply medicines with a long shelf life as clinics operated only once per week from the location.

In January 2019 the clinical team identified a shortage of to take away (TTO) medicine packs, including antibiotic stocks that would be exhausted within two months. They worked with the pharmacy procurement and distribution team to identify alternative treatment options caused by a national supply problem.

An HIV specialist pharmacist provided dedicated cover three days per week, two days of which they spent in the main clinic. The pharmacist had extended their role to cover all of sexual health, which meant staff had a single point of contact for medicines queries and support. The pharmacist was undertaking an independent prescribers’ course, which would further support service delivery.

Nurses with appropriate training prescribed medicines using patient group directions (PGDs). PGDs enable non-medical prescribers to dispense named medicines to patients with specific conditions and under defined circumstances. The pharmacy team reviewed PGDs on a two-yearly cycle and all of them were up to date at the time of our inspection. A PGD review group reported
to the medicines management committee as part of the governance and oversight process. However, there were no audit processes in place for PGDs. This meant the senior team did not have assurance of the standard and quality of PGD processes.

A trust-wide nurse prescribers group met regularly to deliver updates and support to nurses and non-medical prescribers contributed to an annual meeting.

Processes were in place to review changes in national guidance for medicines, including where new medicines had been licensed for different purposes.

**Safety performance**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. However, managers did not always use this to improve the service.

Staff acted quickly when they identified risks to the service or to patient care. For example, in July 2018 the team withdrew a specific type of transport media from testing processes following issues identified by staff. Transport media is used to transport biological samples from a clinical area to a laboratory and requires specific management to be useful and safe.

The clinical lead worked with the pharmacy team to maintain up to date knowledge of changes to medicine recommendations and the British National Formulary. The trust monitored National Patient Safety Alerts and cascaded these to each service to review against their service provision.

Between January 2018 and January 2019, the trust security team reported four incidents in sexual health services. Local security management specialists were part of the security team and provided support to staff, including through implementation of the yellow and red card system. This was a system used to formally warn patients who had been aggressive or violent that their behaviour had been unacceptable. The four incidents included threats, violence and verbal abuse towards staff and demonstrated a rapid response from the security team and skilled de-escalation from the staff involved. Senior staff investigated each incident and implemented restrictions on patients where this was in the best interest of staff safety. For example, where a male patient had behaved inappropriately towards a member of staff, the service imposed a restriction that only male clinical staff could see them in the future. This protected staff from risk and ensured the patient could still access health care. Although the reception team at the main clinic was trained in de-escalation and conflict management, they said cases of aggression and abuse were common.

During our inspection we spent time with this team during walk-in sessions and observed the crowded environment, which was too hot and poorly ventilated, combined with waiting times had the potential to escalate some patients’ behaviour. Staff safety in the satellite clinic was noted in the risk register and the senior team had addressed this by restricting opening hours but it was not evidence they had a grasp of the issues at the main site.

Managers used a monthly health and safety toolkit to monitor safety in the service using trust standards. From November 2018 to January 2019 the service achieved an average of 74% compliance. However, this included gynaecology, inpatient and outpatient maternity, paediatrics and neonatal services. While individual departments submitted data, the presentation of the combined audit data meant the trust could not identify local results from the audit.

From February 2018 to January 2019 four low-harm incidents related to staff injuries or mishaps at work. In two incidents there was evidence of engagement with a senior member of the team although it was not evident the trust health and safety team had been contacted or if a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) report had been made to the Health and Safety Executive, which is a national requirement in some circumstances.

The nature of the service meant some staff worked alone or remotely and were not always on site with access to trust IT systems, including the incident-reporting system. Systems were in place to manage this and staff could complete an incident form verbally over the phone to a senior member.
of staff or could complete this as soon as they had access to the intranet. A senior manager was always available on-call in the event of an emergency.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events within sexual health services.

(Source: Strategic Executive Information System (STEIS))

Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in sexual health services, which met the reporting criteria, set by NHS England between, September 2018.

(Source: Strategic Executive Information System (STEIS))

From October 2017 to September 2018, trust staff within sexual health services reported no serious incidents.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Staff used an electronic incident reporting system accessible from any trust computer or laptop used by the CASH team. The system enabled staff to assign the incident to a named, accountable investigator who provided a final report and action plan for learning and change. The team reviewed incidents and lessons learned and agreed to changes in practice during monthly team meetings.

Staff demonstrated a clear understanding of the duty of candour and of their responsibilities relating to this. The incident reporting system prompted staff when they were required to implement the duty of candour and required an explanation of how this was used.

From February 2018 to January 2019 staff reported 97 incidents. Of these, 77 were classified as no harm, 12 resulted in low harm and eight were near misses. No incidents resulted in moderate or serious harm.

A key theme in low harm incidents related to delays in contacting patients with test results, including an instance in February 2018 of a patient testing positive for an infection but not being advised for one month. In another instance the laboratory rejected a test sample because the vial was unlabeled and in another instance a patient waited over two months to be advised they had a severe vitamin deficiency. Another incident involved a failure to recall a patient who had tested positive for an infection due to sickness in the staff team. In each case the senior team investigated the incident and identified areas for improvements in the administration, tracking and communication systems. The incidents were not caused by the same issues and the senior sister
implemented training and reflective practice with each member of staff involved to avoid a future repeat of the same incident. Where the investigation identified a new or more robust care pathway would be beneficial, the senior team developed and implemented this.

A key finding from the investigation of a delay involving a misplaced specimen highlighted the lack of an electronic tracking system or trail. This meant staff could not readily identify where a sample was in the laboratory process, which would be addressed with a restructure of the laboratory service in April 2019.

It was evident staff used near misses to improve standards of care and treatment. For example, one near miss occurred when a patient was advised to seek post-coital contraception (PCC) from a pharmacy because the walk-in service was so busy. The patient phoned back to the clinic to state they had been unable to find a pharmacy and instead said they would return to the clinic. However, staff did not see them again. The senior team identified this as a potential missed opportunity and failure to provide care. As a result, the team implemented more robust processes.

The senior sister prepared a monthly quality and safety update that included details of incidents, the progress of investigations and key learning outcomes. All staff who worked in the service or provided services in the clinic received this, including staff from other departments that periodically provided care.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff delivered advice, care and treatment in line with best practice guidance issued by relevant organisations and clinical bodies. This included on-going review of guidelines issued by the British Association for Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive Healthcare (FRSH), the British HIV Association (BHIVA) and the National Institute for Health and Care Excellence (NICE). Where guidance changed, staff used an effective system to reflect these in practice. For example, BHIVA issued new guidance in 2018 that required services to provide an HIV viral load blood result within 72 hours of testing for patients known to be HIV positive. The team identified potential barriers to meeting the criteria, such as if a patient was admitted to the hospital out of hours in an emergency. In response the service worked with colleagues across the hospital to ensure they would meet the new standard and established a back-up system.

The microbiology team adhered to standards set by the UK Accreditation Service (UKAS) and worked with colleagues in sexual health to continually meet the most up to date requirements. For example, the team identified a need to audit test results to verify that a specific brand of instant syphilis test was reliable and provided results with a high level of confidence.

Staff worked with colleagues in microbiology and other medical specialties to implement improvements to existing process within the requirements of national standards. For example, obstetricians had asked that the service provide faster results for herpes in pregnant patients to help with decisions about delivery. This would require DNA and serology testing at the same time, but current processes meant it could take up to two weeks. The clinical lead was working with microbiology consultants to change the processes necessary to speed up testing whilst adhering to Royal College of Obstetricians and Gynaecologists standards.
The sexual health senior sister carried out a peer review of the contraception and sexual health (CASH) young people’s service in November 2018 as part of a strategy to benchmark care. The review found standards of engagement with young people were very good with high standards of knowledge amongst the team and excellent promotion of sexual health screening amongst hard to reach groups. Senior staff planned to repeat the exercise periodically.

Staff developed and delivered clinical and educational services to young people across the borough in line with public health indicators and trends in demands. For example, the CASH team targeted the schools with the highest rates of teenage pregnancies for intensive, on-going sex and relationship education (SRE).

The divisional quality team maintained continuous oversight of changes to NICE guidance and central alerting system (CAS) alerts during monthly meetings. The group used this process to ratify trust policies and guidelines as a strategy to ensure they remained up to date and reflected the latest treatment guidance. For example, in November 2018 the team ratified a new standard operating procedure to deliver the human papillomavirus (HPV) vaccine to men who have sex with men (MSM), a patient group with specific sexual health needs, and a community management policy for vulvovaginal candidiasis. The trust maintained up to date policies and procedures, which staff accessed through the intranet.

The service had a wide-ranging audit plan for 2018-20. This included five local audits, two national audits and four audits as part of the divisional ‘forward plan’. The audits related to either the sexual health or HIV care group and reflected the team’s work to continually meet the changing needs of patients and to maintain compliance with national best practice. For example, the audit plan included the BASHH 2018 audit to monitor care for HIV-positive adults over the age of 50. Audits as part of the forward plan included a review of the management of HIV-positive pregnant women and re-audits of the management of syphilis and non-gonococcal urethritis. Local audits reflected the understanding of the team of the local population and included a re-audit of the management of syphilis and non-gonococcal urethritis. The service was proactive in sharing the outcomes of audits and research broadly across the sector to improve understanding and practice. In April 2018 the service presented the outcomes of...
a project to identify how clinicians in different departments treated the same condition. This was a collaborative project with other departments in the hospital and the team presented it at an international HIV and sexual health conference. The outcomes of the project meant patients received more consistent, evidence-based treatment wherever their condition was detected in the hospital.

A nurse audit found variable standards of practice in the treatment of genital warts when following BASHH guidelines. They discussed this during a staff meeting and supported colleagues in developing strategies to meet the national guidance, including through the use of a new treatment template.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Staff monitored incidence rates of sexually transmitted infections (STIs) and reviewed trends to better plan and coordinate care. For example, in January 2019 the team identified the incidence rate of new syphilis infections had consistently remained at between 80 and 100 cases per year. As part of a periodic review the team identified a reduction in inappropriate testing with some instances of delayed laboratory results, which they addressed through training and quality reviews.

The sexual health team maintained oversight of HIV testing elsewhere in the trust, including community services and operated an opt-out service for HIV testing. This meant all patients who presented in the main clinic for an STI screen were encouraged to include an HIV test. From February 2018 to January 2019 the service achieved an 82% uptake of HIV testing.

The colposcopy team audited cervical cytology samples taken in the sexual health clinic. From January 2018 to December 2018, 91% of samples were adequate. The team reviewed the 9% of samples that were inadequate to identify areas of improvement in practice for sample takers.

The CASH team monitored patient outcomes through the number of STI tests and patient interventions they carried out. From July 2018 to September 2018 the CASH team carried out 187 chlamydia and gonorrhoea tests, including through the postal testing service and as part of sex education sessions.

From September 2018 to January 2019 the outreach team carried out 178 HIV tests across the venues they visited in addition to 147 tests during National HIV Testing Week in November 2018. In the same period the team carried out 503 STI tests or screens.

From February 2018 to January 2019, 13% of patients with a pre-booked appointment did not attend (DNA). Staff used a text message system that sent out a reminder to the patient the day before their appointment. The service identified that a high proportion of patients who DNA had booked an appointment online. They also found patients with an appointment for contraception maintenance were much more likely to DNA than patients booked for HIV appointments. The performance management team were scoping opportunities to address this as part of broader work to reduce the DNA rate. Initial work towards this included a hold on booking follow-up IUD appointments at six weeks and changes to the ano-genital wart treatment pathway.

The outreach team worked to 20 key performance indicators (KPIs) based around the needs of the local population and on national evidence of sexual health needs. The KPIs included the improvement of sexual health literacy amongst college students, the provision of point of care testing for high risk groups and increased uptake of Hepatitis A and B vaccinations. The team
contributed to broader work in the region through HIV testing and education to reduce transmission and increase early testing. The team monitored their activity levels in relation to the KPIs but most measures were qualitative, which meant quantifiable performance or impact could not be calculated.

Staff operated a contact-tracing service where a patient tested positive for an STI. This meant the clinic contacted previous sexual contacts of the patient whilst managing their confidential personal information. This was a preventative measure to help reduce an increase in infections when people did not know they may be at risk.

Staff demonstrably used care pathways and multidisciplinary working to promote good health outcomes. For example, staff on an inpatient ward identified a patient who had been admitted had been diagnosed with HIV recently but had refused to start treatment. The ward team worked with the HIV team to provide support for the patient and the outreach worker visited them daily to identify contributing factors to non-compliance with medication.

The clinical lead was a senior appraiser and a member of the local medical committee and used these roles to drive improvements in clinical practice and patient outcomes.

The service was the first in the region to have a monthly specialist dermatology clinic and the clinic led provided a weekly erectile dysfunction clinic. A psychologist provided a weekly clinic, which the team had secured after identifying up to 33% of patients were living with a mental health condition.

**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 monitor the effectiveness of the service.

The trust had not adopted a standardised formal model of supervision. The trust senior nursing team held a weekly safety huddle, which gave individual team members the opportunity to express items of concern and receive peer support and supervision. There was a monthly matron’s forum, preceded by a matron’s pre-meet to provide supervision and support to each other. A senior sister’s forum had been developed to provide the same opportunity and the trust offered one to one supervision on request.

*(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)*

From March 2018 to September 2018, 96.3% of staff within the sexual health core service received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>26</strong></td>
<td><strong>27</strong></td>
<td><strong>96.3%</strong></td>
</tr>
</tbody>
</table>

*(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)*

Staff had access to advanced and specialist training to ensure they maintained competency and clinical skills. All nurses and health advisors had up to date certification in the BASHH STI Foundation (STIF) competency programme at a level commensurate with their role.
The colposcopy service had two nurse colposcopists and the laboratory team in sexual health maintained up to date smear test training. In November 2018 the team appointed a cervical training lead to ensure the colposcopy service remained viable with well-trained, competent staff.

The safeguarding team had provided training to the security and porter teams to help them better manage situations involving patients with needs and behaviour relating to safeguarding, acute mental health and drugs and alcohol. This helped staff in those teams to understand vulnerabilities relating to abuse and neglect and how such issues can manifest themselves in aggression. The training included identifying the symptoms of delirium, dementia and learning disabilities and provided non-clinical staff in critical roles with skills to better look after patients and protect colleagues from harm.

Staff had access to a range of education and learning programmes. For example, the HIV specialist pharmacist led weekly lunchtime teaching sessions for sexual health staff. The clinical lead provided a clinical meeting for staff 3 times a year that included external speakers from other trusts and organisations. Most recently this had included an expert presentation on the treatment of recurrent candidiasis.

A consultant and a CNS were trained in ultrasound and led a weekly gynaecology clinic. This helped the team remain up to date with national best practice standards.

The senior team encouraged staff to access training and development opportunities and to make new connections through conferences and events. For example, four nurses attended a regional CASH event, one member of staff was completing a non-medical prescribing course and a staff nurse was completing level 7 (advanced) CASH training.

Staff used network memberships to access training and achieve accreditation and certification. A clinical nurse specialist (CNS) was a member of the FRSH and had gained certification in treatments such as IUD management.

The microbiology service had trained staff for dark microscopy, which the sexual health team could arrange on-demand for patients. Dark field microscopy is a diagnostics method used less frequently and in specific circumstances.

**Multidisciplinary working and coordinated care pathways**

**Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment.**

Multidisciplinary working was clearly embedded in all aspect of the service and staff had established coordinated processes and care. Staff in each part of the service spent time together in their respective areas to build an understanding of each other’s responsibilities. For example, the senior sister and an outreach worker, transferred from the local authority under a Transfer of Undertakings (Protection of Employment) Regulations 2008 (TUPE) arrangement, set up a new outreach service together. Health advisors spent time in each service and nurses, CSWs and reception staff worked between the main clinic and the satellite clinic.

Clinicians participated in trust ‘grand rounds’ and invited GPs to attend. Grand rounds are an educational method used to discuss specific cases with medical colleagues. The team identified specific trends in patient presentations and diagnosis rates as learning points for presentation. For example, in January 2019 the team planned to present their most recent learning of syphilis testing and results in the next grand round.
Staff worked to improve coordinated care pathways and processes with colleagues across the trust. For example, the health advisor identified a patient who had seen a consultant on an inpatient ward and needed more specialist care from the sexual health service. The ward team had not completed a full referral or assessment and the health advisor implemented communication to ensure this was addressed.

Staff used care and referral pathways to ensure patients were seen by the most appropriate professional. This included pathways for pre- and post-test counselling for HIV and syphilis, psychosexual services and brief alcohol interventions. Clinical services were well-coordinated, and staff used relationships with colleagues in other organisations to ensure patients accessed the most appropriate care.

A designated HIV team worked in the main sexual health clinic although were not available each day the clinic was open. Clinical staff would always see HIV-positive patients, or those at risk of infection, if the HIV team was not available.

Staff worked with colleagues across the hospital to carry out STI and HIV screening, testing and counselling. Colleagues on inpatient wards contacted them where they had a patient with such needs and staff from the sexual health clinic visited patients wherever they were in the hospital. The service had established links with antenatal services and worked with colleagues to deliver support to pregnant patients who were newly diagnosed during initial health screening.

Consultants delivered seminars to local GPs as part of a strategy to improve their confidence and knowledge of STI screening and to improve access for their patients. This was in response to calls from GPs on a regular basis asking for advice on treating straightforward STIs and aimed to reduce the pressure on the service for issues that could be resolved in primary care.

Sexual health staff worked with a specialist provider of alcohol and drug support services and coordinated care pathways for patients under the care of both organisations. The team provided training to the trust security team to help them effectively provide support to clinical staff in the management of patients under the influence of alcohol and drugs and patients experiencing withdrawal. This reflected a robust multidisciplinary approach to providing care for patients with complex and unpredictable needs.

The sexual health, safeguarding and emergency department (ED) teams worked together to plan care for patients who frequently presented in the ED with complex care. This cohort of patients usually needed support for issues relating to homelessness and drug use and were at high-risk of STI and HIV infections. As part of the care pathway, staff contacted the local authority housing team to identify if the patient was known to them. This helped the team to coordinate wider social care needs.

Staff escalated outbreaks of STIs to public health colleagues to help implement a rapid, coordinated response. Health advisors were skilled in identifying the potential centres of outbreaks, which helped them provide a targeted response. For example, the service identified an outbreak of Hepatitis in some sex-on-premises venues (SOPVs) in 2018 and responded with focused, intensive outreach programmes.

The clinical lead joined monthly meetings with colleagues at another NHS trust in the region to discuss trends in patient presentations and coordinate strategies to deliver care.

**Health promotion**
Staff worked in partnership with local organisations to plan and deliver health promotion campaigns and interventions. This included a substantive role in the operation of a multi-agency postal chlamydia testing service for people under the age of 25 and a range of programmes designed to improve the sexual health and literacy of specific population groups.

A dedicated outreach worker and health advisor delivered direct health promotion work in a range of local facilities such as pubs, clubs and SOPVs. This included targeted work within the MSM community and was based on the need for more frequent testing in this population group. The outreach worker led a responsive service and modified weekly hours at individual venues based on demand. They worked with the senior divisional team and sexual health partnership operations group to resolve issues locally. For example, due to a cost increase of condoms, the service had reduced the supply to an SOPV. At the same time the SOPV had started to charge customers to buy condoms. Overall this had reduced the likelihood of customers using condoms when in the venue, which the outreach worker identified as an urgent risk. The multidisciplinary team was working with public health colleagues to identify a resolution.

The service worked opportunistically to plan health promotion work during special events or to build on national health developments. For example, the outreach team took part in a Pride event in summer 2018 and carried out 11 HIV tests. The outreach worker was also providing education on the use of pre-exposure prophylaxis (PrEP) as an HIV-prevention strategy across venues and signposted patients to national resources that could help them access the medicine.

Staff provided pre-packed bags of condoms on demand for anyone who requested them. To better understand demand on the service and patient needs, staff tracked condom distribution by postcode, which patients were asked to supply when they visited the clinic. Reception staff at the main clinic and satellite clinic and all outreach staff were trained to give out condoms and they provided a wide range of different sizes and types based on patient preference, including latex-free condoms for patients with allergies. Young people under the age of 25 registered in the clinic for a condom scheme and staff issued them with a keychain barcode. This enabled them to quickly collect packages in the future without providing any further information.

Patients had access to a wide range of printed health promotion materials in the clinics. These were provided by specialist local and national organisations and provided guidance and advice on subjects such as STIs, HIV and age-appropriate sexual behaviour. Information was targeted at specific groups of people based on gender, sexual behaviour and sexual identity. Staff sourced information for HIV-positive patients such as on how to obtain a mortgage and life insurance when living with the condition. Printed information was up to date and CSWs managed leaflet stocks to ensure staff did not give out expired guidance. The information available reflected the latest understanding of sexual health nationally and internationally, including new research that indicated patients living with HIV and whose virus was undetectable due to good medicine compliance were unable to transmit the virus.

Two dedicated health promotion administrators worked with the CASH team to support nurses. Along with nursing colleagues the team maintained an extensive stock of health promotion materials. This included advice and guidance for specific genders, ages and sexual behaviours such as information geared towards teenagers about the differences between love, feelings and sex.

The CASH team provided condoms on request to students during school drop-in sessions. Each school’s senior team established age limits for these and identified processes for nurses to follow to ensure sexually active students had access whilst minimising disruption. For example, the senior team in one school found younger students took condoms to play with and cause
disturbances in class. To address this the CASH team agreed to give condoms for students in classes under a specific year group to a named member of school staff who would then issue the pack to the student before they left for the day. If students had not previously accessed condoms from the service the CASH team required them to demonstrate they understood how to use them safely on a demonstrator designed for sex education. This helped to ensure students could use condoms and reduce the risk of them breaking. Staff also demonstrated the British Standard kite mark and explained why it was important.

During one-to-one SRE sessions the CASH team used a structured curriculum to deliver age-appropriate guidance and education to young people. They adapted this based on whether the individual was sexually active or beginning to think about this for the first time. For example, topics included control and coercion, pressure to have sex, teenage mood swings and unhealthy relationships. This was balanced with discussions on having fun with new partners and feeling safe and comfortable with sex. The team also discussed topical issues such as mental health for girls and boys and the differences between contraception and abortion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust reported that from as of September 2018 Mental Capacity Act (MCA) training was completed by 100% of staff in sexual health compared to the trust target of 90%.

Over the same period Deprivation of Liberty Safeguards training was completed by 100% of staff in within sexual health compared to the trust target of 90%.

(Source: Universal Routine Provider Information Request - P38 Training)

From October 2017 to September 2018 the trust reported that 204 provider-wide Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. The trust did not provide a breakdown by core service.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Senior staff told us there had been no DoLS applications from the sexual health service. As an outpatient service, sexual health services would not have the authority to use DoLs.

The trust communications team had worked with the sexual health team to implement a new consent form for participants in health promotion activities, including those taking part in digital media campaigns and recordings.

Staff had identified a new challenge of patients presenting in the clinic whilst under the influence of cannabis. This presented an issue with the consent process and staff carried out additional checks to identify if they could retain information as part of the process to check if it was safe to provide care and treatment. Staff used a similar process for patients who presented under the influence of alcohol and based their approach on the urgency of the patient’s clinical needs and their behaviour.

Staff followed established consent processes for sending results to patients. This enabled patients to choose how they wanted to receive their results, including by text message or e-mail.
Staff discussed the level of risk with each patient, such as if they had been at increased risk of an infection, and ensured they understood this when choosing their preferred communication method.

Consent and safeguarding processes were demonstrably linked and all staff were trained on the use of the Fraser guidelines. The Fraser guidelines enable staff to give contraceptive advice and treatment to young people under the age of 16 without parental consent. For example, staff initiated immediate safeguarding processes if a patient under the age of 13 disclosed they were sexually active because this meant they were unable to consent. The team had a clear understanding of how young people interpreted and practiced consent and had established safety mechanisms where young people disclosed sexual activity without an appropriate consent process in place.

CASH nurses discussed consent with each young person they provided advice and guidance to. For example, nurses checked students’ understanding of trust and helped them to identify scenarios in which someone may be trying to control or coerce them. They also talked about the legal age of consent and related issues such as drug and alcohol use and how these could affect consent. We observed discussions between a CASH nurse and school students and saw they adapted communication to help each individual understand the meaning and importance of consent. For example, students presented situations in which they felt consent was not straightforward and the CASH team used this to discuss ‘blurred lines’ in relationships or with sexual partners and how students could keep themselves safe.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Sexual health services participated in the NHS Friends and Family Test (FFT) and used monthly data as a measure of patient experience. From January 2018 to December 2018 1,109 patients completed an FFT survey, of whom 96% recommended the service. Staff attitude and the implementation of care were the two most common themes in patient’s reasons for recommending the service. Comments included, “The staff are friendly. Always happy to help even though it is busy, my appointments never feel rushed” and, “Very friendly and informative. Relaxed environment and non-judgmental.”

A dedicated member of staff monitored all FFT responses, including the response rate and identified opportunities for staff to encourage more patients to complete a survey. Response rates varied widely and in December 2018 between 19 and 147 patients filled in a survey each week.

Staff were acutely aware of the need for consistent standards of privacy and dignity and to manage patients confidentially.

The reception team managed the walk-in service in the main clinic in a way that promoted privacy and dignity. For example, one member of staff provided a meet and greet service and provided patients with a triage form to complete. A second member of staff registered each patient after they had completed their details. This process took place in a closed reception area and the team ensured only one patient was present to ensure their personal details were not overheard by
anyone else. We observed staff manage this well in practice, which was appreciated by patients who were nervous or anxious.

Staff used a codeword system for patients when they needed an urgent HIV test but were concerned about their privacy in the clinic. For example, if a patient phoned the clinic for advice or had seen a member of the outreach team, staff gave them a specific sentence to say with a codeword so that reception staff knew what they needed. This was beneficial for patients who were anxious or nervous and provided additional privacy and confidentiality.

Empathy, understanding, friendliness and politeness were integral parts of the vision and strategy the team had developed for the service. During all our observations of care we observed staff adhere to these. Staff at all levels showed kindness and adapted their approach to patients based on how the patient presented. For example, we observed the reception team in a walk-in clinic gently and subtly help a patient who was very uncomfortable being in the environment. They used appropriate humour and reassurance to calm the patient enough to complete a triage form and showed them where they could get some water and a quiet seat.

During our observation of a consultation, a nurse demonstrated excellent practice in managing the patient’s expectations and their high levels of anxiety. The nurse facilitated a private space for the patient to undress and provided compassionate reassurance throughout.

We spoke with a patient who said staff were, “Kind and approachable”. They said staff worked hard to treat patients with respect and said, “This is a brilliant team.” Another patient said, “I feel fortunate to have had such great treatment from a team that seems to really care.” Both patients said they felt they were always treated with dignity. We spoke with one patient who said on their first visit to the clinic that had felt overwhelmingly nervous. However, they said the kindness and humour of the reception team had reassured them and worked to build a rapport.

We observed sessions delivered to school students by the contraception and sexual health (CASH) team and saw the nurse readily adapted their communication and approach to each individual. This helped to build an immediate rapport with students they saw for the first time and maintained continuity with students they had already met. Where students were nervous or disclosed problems staff listened empathetically, provided reassurance and immediate advice or guidance.

### Emotional support

**Staff provided emotional support to patients to minimise their distress.**

Patients reported their mood as a key negative theme in the FFT and staff were aware of the impact poor sexual health could have on patients’ feelings of self-worth. The whole team promoted a positive atmosphere to reduce the stigma and preconceptions of visiting a sexual health clinic. They delivered this using communication adapted to specific age groups, in recognition of the different levels of comfort patients demonstrated in talking about their sexual health.

The outreach worker provided ad-hoc counselling on demand and as needed, such as when discussing high-risk sexual behaviour or sex addiction. They were also trained in providing medication counselling, such as around the use of pre-exposure prophylaxis (PrEP).

Staff provided a range of emotional support to patients based on their individual needs. For example, the CASH team supported young people who were sexually active but not at risk. This...
ensured the team provided care and support to young people who did not need a medical or safeguarding intervention but would still benefit from guidance and a point of contact during personal development.

Staff provided one-to-one support and counselling to patients when discussing the need to disclose new infections to sexual partners. For example, patients typically felt anxiety about this but staff ensured they understood the legal ramifications of not disclosing potential risks to people they had been sexually active with.

During our observation of CASH one-to-one sessions, we found staff had the skills to provide appropriate emotional support, such as to a student who was worried about a situation at home and others who wanted personal advice. The team demonstrated an acute understanding of the differences in effective emotional support based on age and gender and adapted their approach accordingly.

Staff adapted services to ensure they could meet patient’s emotional needs. For example, outreach staff did not offer instant HIV testing in certain settings as they were unable to provide appropriate post-test counselling if a patient reacted badly to a test result. Instead the team offered a test that meant they could recall patients to the clinic to discuss the results in a more confidential environment.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Patients commented that staff were understanding and listened to their needs in the FFT survey results. During all our observations staff demonstrated good listening skills. Clinicians knew patients well and were prepared for consultations. During a consultation we observed the patient was reassured because the nurse was knowledgeable about their medical history and explained what they expected to happen during the procedure. The nurse was clear that the patient may need to see a doctor at a later date and explained the reasons for this reassuringly.

The outreach team worked with commercial sex workers, including in the entertainment industry, and clearly made efforts to understand and meet their needs. For example, workers required proof of STI and HIV testing to be able to work as part of safety strategies to reduce the risk of infection. To meet these staff set up regular testing schedules and provided written proof of test results to each patient in a format their employers would accept.

During our inspection we spent time with the single point of access (SPA) team and observed their work. Patients often called about opening times of clinics and expressed frustration at the waiting times for pre-booked appointments. Staff demonstrated a friendly and amenable approach and explained to patients why some types of appointments had longer waits.

Patients often called the SPA team to ask for clinical advice. We saw the team explained to patients they were not clinically-trained and so could not provide this but offered the most efficient and appropriate alternatives. The team delivered a service with consistent attention to detail. For example, we observed a member of the team explain to a caller they had gone quiet while they looked for appointment slots.
The SPA team provided information for patients to help them plan their appointment. For example, they ensured patients understood the restrictions on car parking on both sites. We observed a member of the SPA team advise patients not to have sexual contact one week before appointments to remove a contraceptive implant. This was in line with national guidance and reduced the risk of an unwanted pregnancy; which staff clearly explained to patients.

Patients said they felt involved in their care and treatment planning. One patient said they had discussed their on-going HIV treatment with staff and wanted the consultant to explain what the best options were from their point of view.

Staff demonstrated attention to detail when working with young people to coordinate care and advice. For example, the CASH team documented notes during consultations and meetings on paper instead of electronically because they had identified using a laptop in front of teenagers as a barrier to communication and openness.

Staff persevered in engaging with teenagers and recognised the challenges in communicating with them around their preferences and availability. Staff in the outreach team made three successive attempts to contact these patients following a referral. If there were no safeguarding concerns they suspended their attempts to make contact and let the referrer know why they had done this. Where the referral included information about a safeguarding concern, staff led this process more urgently and coordinated contact with the referrer.

Staff working with young people said it was essential they kept up to date with sexual health information on social media, in current affairs and in popular culture. For example, following the release of a new film that included graphic references to sex amongst young people, staff said they received a significant increase in questions from students. Young people in schools and colleges regularly presented with a wide range of questions about sex and sexual health and staff prided themselves on understanding different terminology and being able to provide specific information. This included on general sex and relationship education as well as on sexual behaviour and experimentation.

Our review of patient records provided evidence of the efforts of staff to support patients in their treatment. This included detailed evidence of discussions about health and social care needs and sexual activity following a diagnosis.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

**The trust planned and provided services in a way that met the needs of local people.**

The service provided appointments to patients based on how they self-identified their needs. For example, patients could book into a health advisor clinic without the need to see a nurse or doctor if they primarily wanted advice to discuss their sexual health or long-term condition management. Health advisors were registered nurses, which meant they could identify where patients needed more clinical input.

Staff maintained up to date awareness of the services offered by other providers and clinics in the region to ensure they could meet demand and offer additional care where needed. For example, in October 2018 the sexual health and microbiology teams identified a potential gap in testing for syphilis and Hepatitis B and C amongst intravenous drug users because of difficulties in obtaining
routine serology. Staff identified key demand for these tests came from the satellite clinic and found another sexual health service nearby did not routinely offer syphilis testing. The team identified this as an area of priority after the completion of an imminent management restructure.

The sexual health and microbiology teams worked together to identify changes in population needs and behaviour. For example, they noted an increase in instances of syphilis in October 2018 and reviewed patients to identify if this was attributed to a specific group of people.

The sexual health team worked collaboratively with multiple local services, including specialist non-profit organisations, to share information and expertise. For example, the team worked with partners in the postal chlamydia testing service to monitor information such as the ages of people who tested and the patterns of testing between males and females. This helped the service to plan resources and direct health interventions.

The outreach team had a key performance indicator to engage with hard-to-reach groups, such as sex workers and people from Black and minority backgrounds (BAME) and people with a disability or mental health problem. Such groups typically have a greater need for sexual health education and support in accessing services. The team engaged with these groups through community meetings, public events and specialist organisations.

The contraception and sexual health (CASH) team adapted sex education sessions to the locations and organisations they worked with. For example, they worked with professional organisations to deliver sex education sessions in addition to schools and further and higher education institutions. The team attended colleges and universities during fresher’s week to begin relationships with students new to the area and introduce local testing services. This was a popular, recurring service and in two fresher’s visits in September 2018 the team carried out 189 chlamydia and gonorrhoea screens.

The outreach team was proactive in identifying the emerging and changing needs of specific population groups and adapting services to meet these. For example, the team identified the benefits a certification clinic would bring to adult entertainment performers who were vulnerable to infection and exploitation.

The service provided access to post-exposure prophylaxis (PEP) for patients from another trust whose emergency department would not prescribe the medicine for patients who had come into contact with HIV. PEP is a medicine that can prevent HIV infection if taken within 72 hours of exposure to the virus. The clinical lead was working with the other trust to identify the barriers to the medicine and in the meantime this service provided care and treatment.

Staff had identified a significant increase in new HIV infections amongst intravenous drug users and were working with a local drug and alcohol service to provide care and preventative measures. The teams had a reciprocal agreement to provide direct referrals to each other and a nurse from the drug and alcohol service provided daily care in the hospital to ensure the teams could meet their needs.

Outreach staff had expanded the range of testing available based on demand. For example, the team had started with syphilis testing and Hepatitis vaccinations in sex-on-premises venues and added HIV testing based on local need and feedback from patients.

The clinical lead offered a weekly erectile dysfunction clinic and provided this from the hospital’s main outpatient’s department. Staff from the sexual health clinic and GPs referred patients to this service.
A dedicated outreach worker provided care for HIV-positive patients in the community, including coordinating their care, signposting them to specialist services and facilitating access to health services.

The adult safeguarding team was developing a transition pathway for victims of sexual exploitation who were moving from childhood to adulthood. The team recognised this group of patients was highly vulnerable and needed a multi-agency approach to ensure the service could continue to meet their needs.

Staff from a specialist organisation provided a pathway-based harm detox programme for patients in the trust with needs relating to alcohol and drug use. The team worked with the child safeguarding team to deliver pathways specific to children and young people, including those experimenting with substance use.

The CASH team had long-standing relationships with schools, colleges, universities and hostels and planned drop-in sessions to meet local demand. For example, the team had increased the frequency and intensity of drop-in sessions at the five schools with the highest rates of pregnancies in the area.

Staff demonstrated an acute understanding of the challenges and influences on the local population and on young people more broadly. For example, the CASH team identified the impact of health inequalities on young people from lower socioeconomic groups and provided advice and guidance appropriate to their needs.

### Meeting the needs of people in vulnerable circumstances

The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients indicates allocating named clinicians to each patient is national best practice. This is most commonly used in inpatient care. However, the sexual health team had established a similar staffing framework in certain circumstances to ensure patients received continuity of care. For example, where a patient received a positive test result for a sexually transmitted infection (STI) the same member of staff who tested the patient maintained ownership of their treatment and follow-up appointment. This member of staff also met with the patient’s partner(s) to discuss testing and care. Staff organised this as a pre-booked appointment to ensure patients were seen in a timely manner.

Staff coordinated clinics to meet patient’s needs and national guidance. For example, the Faculty of Sexual and Reproductive Health recommended patients seeking new contraception had an initial appointment lasting at least 30 minutes. To meet this requirement the service arranged appointments for new contraception on days nurse availability meant they could meet the minimum time limit.

Staff had sourced posters advertising services in polish, Punjabi, Bengali, Urdu and Romanian to reflect the languages spoken in the local population. The senior team identified a need to have the website in similar language options and were working with the trust communications team to implement it.

Patients could order chlamydia testing kits online and arrange to collect these from any of the service’s clinics. Staff implemented this process for patients who were unable to receive sensitive post at home, such as those with domestic safety concerns or those who were worried about confidentiality. Testing packs were sent in unmarked packages that meant the contents could not
be identified and the option to collect them from a clinic provided patients with additional reassurance.

Staff used screening and referral pathways for patients in vulnerable circumstances. This included those who needed intervention for alcohol and drug use, domestic abuse and sexual exploitation and coercion. This meant clinic and outreach staff initiated care pathways when they first saw a patient that aimed to meet their holistic needs, reducing the risk patients would not follow up with services themselves.

Health advisors provided post-test counselling for patients newly diagnosed with HIV or syphilis immediately after the test result. The team used a non-medical approach to ensure patients had their holistic and psychological needs met and support coping skills for the first 24 hours after diagnosis. The medical team then met patients after this period to establish a treatment plan. This approach meant staff supported the immediate psychological needs of patients and ensured they were in a stable position before they began medical treatment.

The HIV team provided dedicated care to pregnant patients diagnosed with HIV or syphilis during antenatal health screening. The team established a treatment plan that meant patients did not need to attend the sexual health clinic and would receive HIV care in the maternity service. HIV clinicians introduced themselves to patients early in the pregnancy process to ensure they could deliver complex clinical care to protect the patient and their child.

Staff used an online booking system to schedule interpreters in advance of booked appointments. This meant staff could choose between a female or male interpreter and contact them in advance with any information important for the appointment.

The trust safeguarding team was working with the sexual health team to improve care for patients with learning disabilities through more advanced training. The team provided three training days annually based on the national ‘Getting it right first time’ strategy and had increased support following a rise in the number of adults with a mild learning disability presenting in the sexual health service. The CASH team had worked with a school to deliver sessions on puberty and sexual consent to young people living with autism in recognition of their vulnerabilities when seeking to explore their sexuality. The team worked with professional colleagues to facilitate one-to-one sessions with young people living with complex needs, including social needs. For example, one young person attended drop-in sex and relationship education sessions with a family support worker after the local authority identified concerns about their safety at home and understanding of sexual behaviour. In all cases the CASH team adapted their communication to ensure young people understood critical information, such as their legal and personal rights.

Three waiting areas were available for patients in the main clinic, including a general waiting area and one each segregated by gender. There was a single waiting room in the satellite clinic and staff had provide privacy screens following patient feedback. This made the waiting area feel smaller and less exposed to the reception desk and people coming through the main entrance.

Staff provided home care visits for patients with specific needs. This included HIV-positive patients who had not accessed care for 12 months and patients living with learning disabilities.

Staff used an assessment tool to help them better understand the needs of young people and to identify when they had vulnerabilities. For example, they used a system of red flags to trigger more advanced support and discussion. This included when young people disclosed issues such as regular truancy, meeting people for sex online, accepting money or gifts in exchange for sex or an unusual number of sexual partners. Staff also considered more subjective measures, such as if the person looked unkempt or behaved erratically.
The CASH team used online resources to help discussions on topics such as consent, sex and the law and pornography to young people. For example, one nurse maintained access to a portfolio of digital media produced by appropriate organisations, including a UK police force, on how to keep themselves safe when they were sexually active or pursuing sexual activity. During our observations of one-to-one and group sessions with young people we saw this worked well and students appreciated the nurse’s use of recognisable brands and spokespeople to discuss topics of importance to them.

The CASH team used appropriate technology to support young people in managing their needs and protecting themselves. For example, they worked with one young person who had received unwanted graphic text messages (referred to as ‘sexting’) from another student. The team liaised with the school administration to ensure local procedures were followed and helped the student utilise technology to stop receiving such messages. They also helped young people who took the female contraceptive pill to use smart phone apps to remind them when to take their medicine to ensure it remained effective.

**Access to the right care at the right time**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The largest ethnic minority group within the trust catchment area was Indian with 6.1% of the population.

<table>
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<tr>
<th>Ethnic minority group</th>
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<td>Second largest</td>
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(Source: Universal Routine Provider Information Request – P48 Accessibility)

The trust did not identify any sexual health wards/teams as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

From February 2018 to January 2019, the service cancelled 2204 appointments and patients cancelled 3156 appointments. The service did not monitor the reasons for cancellations or the time to re-booking. However, the SPA team contacted patients with a new offer time immediately after a service cancellation and clinicians ensured patients with urgent needs were always seen as a priority.

The electronic appointment system was integrated with each clinic location and staff group. This meant, for example, nurses could book patients into a health advisor appointment. The reception team used triage codes on each patient’s electronic record during the walk-in clinic to assign them to the most appropriate clinician. The team demonstrated a good understanding of the roles and competencies of each clinical member of staff and this enabled them to accurately schedule appointments.
Where the CASH team saw young people on an outreach basis, such as in school, they referred them to the main clinics for appointments where necessary.

From January 2018 to January 2019, the single point of access (SPA) service handled 20,652 calls with an average time to speak to a member of staff of one minute and 53 seconds.

From February 2018 to January 2019 staff identified two incidents in which consultations had been duplicated unnecessarily. In each case the patient had been seen in the clinic by a consultant and was then recalled a short time later having left the clinic. The consultant team identified this as an unacceptable duplication and implemented a new system to ensure the practice ceased.

Walk-in sessions were offered daily in the main clinic Monday to Friday and twice-weekly in the satellite clinic. This was a busy service and demand was unpredictable. The reception and clinical teams worked together to manage capacity by prioritising patients with the greatest clinical need. The senior nurse implemented a cut-off point for non-urgent cases where patients were asymptomatic and had no pain and offered them the next available scheduled appointment instead. This enabled the service to reduce the risk of extended delays and working beyond safe capacity.

Staff used a variety of testing methods, including point of care testing, dry blood spot (DBS) testing and blood testing, based on patient’s level of risk and urgency. Patients received results for chlamydia and gonorrhoea testing in the clinic within two working days or 14 working days when using the postal service. Staff used a more reliable blood test for HIV when a point of care test showed a positive (infection present) result, which provided a conclusive result within seven days. Some tests, such as DBS tests, were unreliable and provided a high level of false positives but offered staff to safely test people in a range of community and public locations. The health advisors managed this system well and followed up false positives and the need for re-testing with each patient.

In February 2019 there was a wait of up to four weeks for patients to access long-term contraception. This was due to several months of staff shortages and the lack of trained nurses available in the staff bank or agency supply. Senior staff expected this delay to reduce following the recent appointment of two nurses.

During our inspection we observed staff worked together to ensure patients could access to service as conveniently as possible. For example, a patient presented at the satellite clinic who needed to see a nurse urgently. However, the clinic was not operating a walk-in session and all appointment slots were full. A member of the SPA team called the main clinic and secured a slot for the patient in the main clinic during the walk-in session that was underway.

Specific clinics could be pre-booked and operated weekly. These included HIV clinics and clinics for coils and implants and clinics for young people under 25 years old.

Health advisors provided a results line from 1.30pm to 3pm Monday to Friday.

Parking at both clinics was very limited and receptionists were mindful of this when helping patients who arrived late for an appointment. We saw this in practice during our inspection of the main clinic site when visitors had parked across the entrance to the car park. This prevented others from entering or exiting the car park and patients trying to access the clinic were confused by poor road markings and a payment notice signs. Reception staff let clinicians know when a patient was on site but unable to access the clinic because they could not find parking and we saw the team worked around this ensure patients were still seen.
Staff demonstrated a responsive approach to adjusting clinic times in response to demand. For example, the team recognised the young person’s clinic held at the main hospital site was increasingly busy and patients frequently presented with complex needs that could not be met within the 15-minute slot. The team reviewed the feasibility of offering some 30-minute slots, which they could meet when a new member of staff joined the service shortly.

The CASH team led a programme of walk-in sessions in schools, colleges and universities. This involved visiting education sites and providing drop-in advice sessions for students. The team also pre-booked students into appointment slots to access information and advice sessions that took place over three weeks. The team offered weekly appointments at their health centre base. This provided additional capacity and meant patients had access to a wider range of testing and screening opportunities than could be offered at the drop-ins. The team offered this service from 2pm to 6pm on a Thursday to enable students to attend without disrupting their studies. The team gave out contact details for the text ‘OKAY’ service to young people, who could contact them by e-mail, phone or text message. OKAY was a campaign specifically designed to engage more readily with, and to meet the needs of, young people. Where the person could not see staff during scheduled drop-ins or during appointment slots on a Thursday afternoon, staff worked around their schedule to offer one-to-one sessions to meet their needs and availability.

Staff delivered a highly flexible service that demonstrably adapted to the needs of the young people they provided care for. Social workers, non-profit community teams, schools and parents could refer young people to the service, who could also self-refer from the service’s website or information provided at their school or college. The contact details for the CASH team, including the OKAY programme, were on display in schools so that students could contact staff in advance of drop-in sessions.

From September 2018 to February 2019, CASH nurses saw up to 37 students per drop-in session. This varied widely and the team provided monthly figures to the school’s leadership team to track demand on the service.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From October 2017 to September 2018, there were two complaints about sexual health, one regarding information quality, and the other regarding treatment/procedure. The trust took an average of 14 days to investigate and close complaints. The trust’s overall target is for 70% or more complaints to be completed within 30 working days, and they have a target of 45 working days for complex complaints or complaints with a higher level of harm.

A breakdown of complaint subject with seven or more complaints are below:

- Treatment, care, supervision: 16
- Treatment suitability: 10
- Treatment/procedure: six

From October 2017 to September 2018 there were no compliments within sexual health.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)
Staff proactively recognised areas for improvement in service provision and acted on informal feedback from patients. For example, one patient noted they had waited some time to speak to staff by phone. In response the service apologised and refunded the patient’s call charges. Delays in contacting the clinic had been reduced with the expansion of the SPA team.

During our inspection staff were open and honest about wait times during walk-in sessions and to patients calling to make a future appointment. Staff explained why there were delays and what the patient’s options were. The SPA team explained to patients the function of the patient advice and liaison service (PALS) and provided their contact details when patients expressed dissatisfaction.

As a result of learning from a complaint, staff implemented a range of improvements in how they maintained confidentiality. This included the introduction of ‘room in use’ signs for clinical rooms and a new consent process led by receptionists when a patient would see a junior doctor instead of a nurse or consultant. Staff introduced a new policy for accessing clinical rooms when in use and identified how they could discuss cases more discreetly.
Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

A senior sister and clinical lead were responsible for the day-to-day operation and leadership of the service. The senior sister was responsible for all elements of the service and a clinical nurse specialist (CNS) in health promotion led the young person’s contraception and sexual health (CASH) team. A leadership triumvirate was responsible for sexual health services at divisional level, made up of a divisional director of midwifery, gynaecology and sexual health, a matron for sexual health and gynaecology and a care group manager.

Staff attended whole-team meetings every four to six weeks and said this helped them to maintain an understanding of the leadership priorities and challenges on the service. However, the single point of access (SPA) team did not consistently have access to team meetings because phone lines for the service could not be diverted or suspended. This meant a core group of staff were regularly excluded from meeting colleagues in a structured and planned manner. The senior sister ensured the team received the minutes and outcomes of meetings through bulletins and one-to-one meetings.

All the staff we spoke with were positive about local leadership and said the implementation of a new senior sister had significantly improved working conditions and support. One member of staff said, “I have a great manager. She’s made it a much better place to work and now I look forward to it.” Another member of staff said, “There’s great support in place now. This was missing before, but I feel like we’re in a much better place.”

Awareness of the senior leadership team was more variable. One member of staff said, “I didn’t know who the matron was until I’d been here for six months, they’re not around very much.” Another member of staff said, “I haven’t met any of the senior leadership team although the chief executive (CEO) often walks around to meet people.” However, other staff described more positive experiences. One individual said, “They [senior managers] have an open-door policy and I can go and speak to them anytime. I get positive feedback from staff since taking on more responsibility in my role.” Another individual said, “I wouldn’t have said this a few years ago but we’re all keen to share good practice and work as a team now. This down to the new CEO and the medical director. There’s more listening and more interaction.”

Staff provided variable feedback in the 2018 pulse check survey regarding management and leadership. For example, 64% of staff said managers and leaders asked their views about they could improve the service and 41% of staff said communication from senior management was effective. The senior team acknowledged challenges in the service in the previous year and a change management plan had been approved shortly before our inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
The sexual health team had established a vision and strategy based on the principles of respect, compassion, professionalism and teamwork with the overarching goal of providing high standards of care. This complemented the trust’s overall vision, of which all staff demonstrated good working knowledge.

The senior team had attended a leadership conference to identify strategies to address the key issues in the department and to develop future plans. The time identified staff engagement and visibility of the senior team as key areas for attention and had implemented strategies for improvement.

In the 2018 pulse check survey, staff responded variably about their relationship with the trust and its vision and strategy. Although 77% of staff said they understood how their role contributed to the wider organisational vision, only 45% said they felt the trust communicated well about its priorities and goals. At the time of our inspection there was no evidence the trust had acted on this feedback.

The outreach team worked to a vision of providing patients with care closer to home and to provide more coordinated care in the borough. The team worked within established relationships with specialist service organisations, which meant they had the resources to signpost and refer patients according to their needs.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service was experiencing significant changes, including a requirement to make a substantive cost-saving on instruction from commissioners, completion of a management restructure and the loss of the on-site laboratory. This had created anxiety and uncertainty amongst staff. We asked the senior leadership team about their plans for staff support and communication. The matron had an open-door policy and the divisional director and their deputy had given their phone numbers and e-mail addresses to staff and said they were happy to meet to talk about their concerns. The trust had a Freedom to Speak Up Guardian and their contact details were readily available. The trust had initiated a formal management of change process and as part of this the senior team planned to implement rolling weekly engagement meetings with staff.

All staff we spoke with demonstrated a good working knowledge of the duty of candour and of their responsibilities within this. We saw examples of the duty of candour used appropriately when reviewing incident reports and investigations. For example, an incident in February 2018 resulted in a one-month delay of sharing test results with 12 patients. This included one patient who tested positive for an infection but had not been told and had not received treatment. Staff contacted the patient, apologised and explained what had happened. They also immediately arranged for the patient to receive treatment and worked with them to identify any risks caused by sexual activity since the test result.

Staff spoke variably about their involvement with the wider trust. While some staff we spoke with said they felt part of the trust, others said they felt sexual health was not well integrated with the ethos and plans of the trust as a whole. Other staff felt more positive. One individual said, “This is a brilliant, nice place to work.” Another member of staff said, “There’s excellent team working.”
Staff responded variably about the working culture in the 2018 pulse check survey. For example, only 41% said the organisational culture allowed them to contribute to change and 41% said organisational structures and processes enabled them to do a good job. Although an action plan was in place to address some areas of the results, this did not include how staff felt about the culture of the trust.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Clinical services within the division were organised into care groups. Sexual health was an integrated service incorporating family planning, sex and relationships education through outreach services and HIV care.

We looked at the minutes of the three most recent interdepartmental meetings between sexual health and microscopy, which took place between August 2018 and January 2019. A range of appropriate staff attended each meeting including a consultant microbiologist, senior laboratory staff and clinical staff from the sexual health service.

Staff attended a monthly sexual health integrated meeting, which was structured around four strategic objectives of the trust and service. All staff involved with the service were invited to attend, including the CASH and SPA teams, who were not based at the hospital, and bank staff. We reviewed the minutes of the three most recent meetings, which took place from November 2018 to January 2019. At each meeting staff discussed incidents, including near misses and the sexual health dashboard.

A divisional governance advisor and governance lead maintained oversight of governance processes in each clinical service.

The sexual health partnership operations group met bi-monthly with representation from the senior service team and colleagues from partner organisations.

The safeguarding team used a governance system to review incidents that involved patients known to the team, including incidents specifically related to safeguarding. This enabled the team to review occurrences such as missed multidisciplinary information sharing and discharge failures.

The HIV specialist pharmacy maintained up to date understanding of the latest developments in medicine safety through the medicines management committee and the joint formulary committee.

The service maintained links with other specialties to facilitate timely referral, including dermatology, cardiology, urology, psychology and gynaecology.

The CASH team leader attended service meetings at the main clinic site and provided feedback to the outreach team if they were unable to attend. The team was part of the same governance structure as site-based services, which meant clinical governance was standardised across all sexual health, contraception and HIV services.
Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected

The team worked closely with microbiology colleagues to identify predicted changes in demand on the service. For example, the team anticipated an increase in patients presenting for microscopy following changes to national guidance. To address the significant financial impact this would have on the service, the team was working with the laboratory and business continuity team.

The divisional team used risk registers to document and track risks to the service, both at care group level and divisional level. Staff attributed risks to the risk register most appropriate for the likelihood and impact of the individual risk and the divisional quality team and sexual health team reviewed these monthly.

At the time of our inspection there were five risks attributed to sexual health services. The risks related to the significant changes imposed on the service, including a funding reduction, recruitment freeze and loss of on-site laboratory services. Short staffing and violence or aggression towards staff was also on the risk register. Each item on the risk register had an agreed risk rating, a named member of staff assigned and a had been reviewed within the last month.

A multidisciplinary team of clinicians and senior staff formed the divisional quality team. This included the senior divisional team and colleagues from other services such as paediatrics, neonatal services and school nursing. We looked at the minutes of meetings held between November 2018 and January 2019 although there was limited focus on sexual health and the service had not submitted a care group quality assurance report in December 2018 or January 2019.

A corporate nurse for quality and safeguarding represented the trust and sexual health services at the Walsall safeguarding board, which brought together multiple local providers. A learning and development sub-group led safeguarding sessions to discuss local issues including domestic violence, female genital mutilation and child sexual exploitation. All staff in the trust could access the information and guidance generated from such activity and the trust communications team sent the information out to improve awareness and access.

A safeguarding committee met monthly with representation from child and adult safeguarding teams, community safeguarding professionals, school nurses, the sexual health team and senior divisional staff. The committee reviewed the outcomes of board meetings and acted on local trends and incidents to drive staff training and guidance. Attendees identified learning events available to staff or teams in the region and the group coordinated the most appropriate staff to attend.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

We observed consistently good standards of information governance during our inspection. For example, staff locked computer screens when not in use and stored paper records securely.
The reception team had implemented a new password system for patients to protect their identify and information when communicating with the service by phone. This required patients to set a password that was documented in their electronic records. Staff checked this with them whenever the patient called for information on test results or to book an appointment. We observed this worked well in practice and staff explained why the system was needed when patients were resistant or dismissive.

In January 2019 the divisional quality team had ratified standard operating procedures to guide communication with young people and their parents.

The trust communications team supported the sexual health service to comply with the EU General Data Protection Regulation 2016/679 (GDPR). This included when using videos, photos or recordings of patients and members of the public as part of multi-agency health promotion work.

Staff used a unique service user ID code when booking an interpreter. This protected patient identity and meant interpreters only found out the patient’s name with consent during the appointment.

Staff demonstrated a proactive approach to improving information management using methods that improved efficiency without creating risk. For example, the trust information management team had created a new HIV electronic patient record template to replace the existing paper records system. They were working with the HIV clinical team to trial the new system with a sample of 10 patients initially to ensure the system worked as expected and identify any immediate fixes needed before implementing it across the service.

**Engagement**

**The service engaged well with patients, staff, the public and local organisations and collaborated with partner organisations effectively.**

The service had experienced a period of short staffing that had added significant pressure and challenge to staff. This was in the process of being resolved through temporary nurse recruitment and the senior team had implemented a change of management process, which was due to be implemented in April 2019.

Staff routinely engaged with other trusts and service providers to coordinate and establish common working practices. For example, the microbiology team was working with other NHS trusts to agree on methodologies following a change in laboratory provider.

Some staff said there were limited opportunities to present new ideas to the senior team. For example, one member of staff said they had researched and planned some ideas that could reduce costs and improve service but senior staff did not respond to such information.

Staff had led events during the national Sexual Health Awareness Week and HIV Testing Week events, including table-top health promotion sessions in the trust’s main hospital.

The health advisor had added information for sexually transmitted infection (STI) testing to the NHS Choices website to help the public better understand the services available before they visited a clinic.

Staff continually engaged with patients beyond the need for clinical contact to improve the service and develop specialist pathways. For example, the safeguarding team and sexual health team
worked with a previous victim of sexual exploitation to arrange a trust event on the topic. The previous patient presented on their experience and reflection to staff from across the trust. More staff wanted to attend than could be accommodated in the venue and the presenter would return to repeat the presentations in the future.

Staff arrange a rolling programme of engagement events for colleagues and visitors across the trust. This had recently included a domestic violence forum, visits from community street teams and child sexual exploitation awareness events.

The service made changes based on patient feedback. For example, the trust established a SPA team to reduce waiting times to contact the service to make appointments.

Staff said opportunities for additional training and development had been suspended due to the service undergoing a tender process. However, they said access was usually very good and they hoped this would start again in the near future.

There was an ethos of reflective practice in the service and staff clearly valued feedback from colleagues after training events and meetings. Sixteen staff completed feedback forms after a November 2018 update meeting. All staff said the meeting was relevant to them and that presenters were well prepared and knowledgeable.

Junior doctors completed ‘doctors as teachers’ feedback after working with the clinical lead or consultants. This was an anonymous, confidential process that enabled junior doctors to reflect on their learning experience and facilitate reflective practice amongst senior colleagues. We reviewed the most recent feedback for the clinical lead, which was very positive. Comments included that the clinical lead was an expert in their field, facilitated interactive and engaging teaching opportunities and was inspirational in their approach.

A user group had been established for over 10 years and met regularly to contribute to service development and improvement. We spoke with a member of the group who said they had focused recently on improving patient experience following a period of high staff turnover and challenges in matching patient expectations of confidentiality. The user group had a well-established relationship with the trust and a member said it had asked for a psychologist and HIV specialist pharmacist for several years, both of whom were now in post.

The team had implemented an action plan based on outcomes from the 2018 patient satisfaction survey. This included five key actions around improving confidentiality, patient communication and staffing levels. During our inspection we saw staff had implemented all five actions and were in the process of fully embedding them into the service. For example, reception staff used new systems to improve confidentiality and clinicians kept patients up to date with expected waiting times.

In 2018 senior staff carried out a pulse check of the team. This was designed provide a snapshot of the morale of staff in the service and to identify how the trust could better support the team. The results indicated areas of dissatisfaction. For example, 59% of staff said they felt happy and supported and only 45% said they felt valued for their contribution. The senior sister and matron had prepared an action plan to address the key issues, including improving access to structured support when working under continuous pressure. This involved empowering staff in their areas of responsibility, providing more straightforward methods of communicating with managers and to recognise the contribution of each individual. During our inspection we saw some progress had been made, such as with the introduction of peer-nominated staff awards.

The senior team had carried out a consultation with the HIV user group to implement arrangements to collect regular medicines after the pharmacy moved from the service. This was
planned to occur as part of a restructure of the service and involved the transfer of the trust dispensary to another organisation. Patients had raised concerns this would compromise their confidentiality as they would be required to collect prescriptions for HIV antiretroviral medicine from the main hospital pharmacy. As a result of the consultation, the senior team arranged for patients to collect their prescription from the sexual health clinic as usual the day after the main pharmacy issued them.

Learning, continuous improvement and innovation

The service was committed to improvement by learning from when things went well and when they went wrong, promoting training, research and innovation.

Staff were research-active and the team identified opportunities to contribute to international care standards and improved patient outcomes. For example, staff had recently presented their research on managing young people’s contraception needs at the International Federation of Professional Abortion and Contraception Associates conference. The team was participating in an international study to review the efficacy of a new HIV medicine combination. The trust would begin a study in 2019 in collaboration with another NHS trust to monitor the long-term cardiovascular health of people living with HIV.

The service was a participant in the national PrEP impact study, with 35 patients enrolled at the time of our inspection. This included a mix of gay men and commercial sex workers, which reflected key target groups of the treatment.

The senior sister distributed a ‘learning from excellence’ communication as part of the monthly quality and safety update. This was part of a strategy to identify and promote positive practice to balance information on incidents and risks. The communication included a rolling programme of peer-nominated awards.

In 2020 the on-site laboratory would be transferred out of the area and to another provider. The senior team was preparing for this by looking at the work of other hospitals whose nurses were trained in microscopy.

The work completed by safeguarding and sexual health staff to empower and upskill security and porter staff reflected a culture of promoting robust, fully embedded multidisciplinary working. The strategy provided greater opportunities for individual staff development and for new team relationships and meant patients received substantially better-coordinated care. The initiative had resulted in better outcomes for the trust. For example, one security officer had successfully completed training to become a dementia support worker after the training initiative by the safeguarding team led them to explore more involvement in this area of care.

A change in local commissioning meant the service was losing its dedicated laboratory in April 2020 when it would be merged with another provider and moved off-site. In addition, pending tender and management structure changes meant there was a freeze on recruitment. This meant provided the team with significant challenges in meeting key performance indicators required by the local commissioning team and added pressure to staff.

All members of the team demonstrated the importance of understanding new and emergency threats and trends to sexual health and HIV, at a local and population level. This included where international standards of care and treatment guidelines differed from the UK and patients were typically well-versed on both. For example, national and international guidance on the use of pre-exposure prophylaxis (PrEP) varied widely. This medicine was typically targeted at men who have
sex with men (MSM) and as an additional preventative measure to avoid HIV infection alongside consistent condom use. However, the team recognised in practice many patients used PrEP instead of condoms, which had led to resistant strains of common STIs, including gonorrhoea and syphilis. As a result, the team coordinated care and treatment for more complex infections and for patients with more complex needs relating to psychosexual behaviour.