Sandwell and West Birmingham Hospitals NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Sandwell and West Birmingham Hospitals NHS Trust is a provider of both acute hospital and community services for the people of West Birmingham and across six towns in Sandwell, serving a population of around half a million people.

Services are provided from two main acute locations, City Hospital (to the West of Birmingham)l and Sandwell General Hospital. On the City Hospital site there is also the Birmingham Treatment Centre (BTC) and a Birmingham Midland Eye Centre (BMEC). The trust also provides community services to include Adult services, End of life care, Inpatient services at Rowley Regis Hospital and Children and Young people services. For the purposes of this inspection we visited two community services; End of life care services and Inpatient services.

We inspected this trust using our comprehensive methodology in October 2014. At that time we rated the trust requires improvement overall, and we had particular concerns about Medical services, Surgery services and Outpatient and Diagnostic Imaging services across both City Hospital and Sandwell General Hospital sites. Since our last inspection, we have seen that the trust has made significant improvements in a number of areas, we saw some areas of outstanding practice, however there is still more work for the trust to do.

We carried out an unannounced visit to Medical service across both hospital sites on 16 February 2017, because we had concerns about safety and quality of care, followed by a short notice announced inspection on 28-30 March 2017. This inspection included the following core services; Emergency Department (ED), Medical services, Surgery services, End of Life Care services, Outpatient and Diagnostic Imaging services and the Birmingham Midland Eye Centre. Following the inspection, we returned to carry out an unannounced inspection on 6, 11, 12 and 13 April 2017.

We made judgements about eight core services across acute and community,

Our key findings were as follows:

- Incidents were reported, investigated, and learned from to improve safety and staff were committed to being open and honest with patients when things went wrong but this varied across both sites and core service.
- The trust held 10 quality improvement half days (QIHD) per year during which time staff shared learning and attended relevant training.
- Infection control had improved since the inspection in 2014, however, this varied across both sites.
- Urgent and emergency care service trust wide met the RCEM standard of patients being treated within one hour of arriving.
- The trust's monthly average total time in ED for all patients was consistently lower than other English trusts and this was a stable position.
- The trust held 10 quality improvement half days (QIHD) per year during which time staff shared learning and attended relevant training.
- Robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist was visually monitored on a daily basis.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- Multi-disciplinary team (MDT) working was evident throughout the hospital.
- The trust end of life care service had a holistic approach to patient care, care was tailored to meet patient's individual specific needs. The service regularly reviewed the complex care needs of patients to promote coordinated, safe, and effective palliative and end of life care.
- The mortuary on both sites had improved its environmental condition since inspection 2014

Summary of findings

- The trust provided access to care and treatment 24 hours a day, seven days a week.
- An IRMER committee monitored, analysed and reported incidents in the diagnostic imaging department. All IRMER documentation was in place a vast improvement since inspection 2014.
- We had concerns for ward D26 at city hospital around care and attitude of staff towards the patients.

We saw several areas of outstanding practice including:

- The palliative and end of life care service ensured that patients and their families were involved in their care and their choices and preferences were upheld, including where they would prefer to be for their care and when they died.
- The palliative and end of life care service integrated coordination hub acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week 24 hours a day.
- The service reacted speedily to referrals by providing an urgent response team in order to meet patient's needs quickly.
- Staff went the extra mile to ensure patients received the right care in the right place at the right time.
- Staff showed great compassion, empathy and an understanding of patient's needs and preferences.
- Newton 4 at Sandwell displayed a high-level person centred care approach. The staff on this ward were very enthusiastic and passionate about the care they delivered and the patients they served. There were a number of innovative practices developed on this ward, which included the breakfast therapy club to aid with patient rehabilitation, rewarded by the stroke association. The development and implementation of the JEL model for staff progression, the development of the delirium pathway and of the patient care bundles to aid patient progression and so patients could own their own goals.

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

Importantly, the trust must:

Sandwell General site

Emergency Department

- The trust must take action to ensure storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- The trust must take action to improve the standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and increased risk to patients.
- The trust must take action to ensure patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.
- The trust must take action to ensure there is a clearly agreed and resourced system in place for safely managing the condition of patients queuing on trolleys when the ED is very busy.
- The trust must take action to ensure staff identify patients at risk of sepsis and follow the sepsis pathway in place.
- The trust must take action to ensure doctors use the appropriate proforma in place for effective clinical pathways.
- The trust must take action to ensure sufficient substantive registrar cover overnight for the safety of patients.
- The trust must take action to ensure there is a designated appropriately safe room available within which to care for patients with mental ill health
- The trust must take action to ensure the security and safety of staff working in the ED at all times.
- The trust must take action to ensure unplanned re-attendance rate to the ED within seven days is reduced.
- The trust must take action to ensure information about patients' assessment and condition recorded by consultants and doctors is sufficiently detailed, precise and legible.

Summary of findings

- The trust must take action to ensure patients are admitted, transferred or discharged within four hours of arrival in the ED.
- The trust must take effective action to mitigate the increasing risks to patients from overcrowding in the ED.

Medical Care service

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

Surgery

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- Ensure that records of care and treatment provided to patients are accurate and complete.

Outpatient Department and Diagnostic Imaging

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

City Hospital site

BMEC-Emergency Department

- Increase availability of specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.
- Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.
- The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.
- Patient records must meet standards for general medical record keeping by physicians in hospital practice.

Medicine:

- Ensure compliance with the Mental Capacity Act (2005) is documented.
- Ensure attendance at mandatory training is improved.
- Take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- Improve the consistency of multi-disciplinary processes and ensure the implementation of consultant led board and ward rounds.
- Ensure patients have access to translation services when required.
- Ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

Surgery including BMEC:

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- BMEC mandatory training targets for all clinical staff are met and recorded.

CYP BMEC:

- Improve local governance and ensure risks to the service are escalated, recorded, acted upon and reviewed in a timely manner.
- Medical staffing meets needs of patients and the service.
- Review the storage of emergency drugs and equipment for children and young people

Summary of findings

- Age appropriate facilities are provided with separation of adult and children waiting areas and treatment areas.
- Mandatory training targets are met and recorded including paediatric life support.
- A framework for staff to develop and demonstrate competencies to care for children is in place.

OPD including BMEC:

- Resuscitation trolleys are locked and secured with tamperproof tags.
- Patient notes are kept securely and confidentially.
- Sharps bins and clinical waste are stored securely and safely.
- Consulting rooms in BMEC protect patients' dignity and privacy, and prevent people from overhearing conversations between staff and patients.
- There are improvements with staff completion of mandatory training.
- All staff who carry out root cause analyses are trained to do so.
- The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation; Staff told us that the patients only used the room if they raised the issue.

Community Inpatients;

- Review the process for assessing and documenting assessments in accordance with the Mental Capacity Act 2005.
- Ensure patients are not deprived of their liberty for the purpose of receiving care or treatment without lawful authority, in line with Deprivation of Liberty Safeguards 2010.
- Ensure that all staff have regard for the protected characteristics under the Equality Act 2010, and support patients in a way that is respectful and promotes their dignity.
- The service must comply with the requirements of the Data Protection Act 1998, and ensure staff keep service user's personal data safe and secure at all times.
- Ensure risk assessments and safety reviews are considered and undertaken where changes to service provision is made.
- Ensure risk registers are accurate, contemporaneous, and reviewed and update routinely, as required.

Ted Baker
Chief Inspector of Hospitals

Summary of findings

Background to Sandwell and West Birmingham Hospitals NHS Trust

The trust describes themselves as an integrated care organisation, and recognises there is more work to be done to sustain this. The new build hospital of the Midland Metropolitan is under way and was due to be opened in early October 2018, but since inspection we have been informed this is delayed by six months.

The trust launched their 2020 vision in 2015 following extensive engagement with clinicians, managers, patients, third sector organisations, and wider stakeholders. The trust's goal is to 'become renowned as the best integrated care organisation in the NHS', this work is an ongoing project and is a priority for the trust.

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

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

The hospital was originally an infirmary added to the West Bromwich union workhouse in 1884. After improvements during the 1920s and 40s, the infirmary then became a separate institution named Hallam Hospital. After rebuilding in the 1970s, the hospital was renamed Sandwell District General Hospital.

City Hospital (formerly Dudley Road Hospital, and still commonly referred to as such) is a major hospital in the city of Birmingham, England. It is located in the Winson Green area of the West of the city, and has 304 beds. City hospital was first built in 1889 as an extension to the Birmingham Union workhouse. It was originally known as the Birmingham Union Infirmary, which later changed to the Dudley Road Infirmary before becoming Dudley Road Hospital. The Birmingham Treatment Centre opened on the City Hospital site in November 2005. It includes an Ambulatory Surgical Unit with six theatres and extensive imaging facilities. The site also includes the Birmingham and Midland Eye Hospital that we included as part of this inspection.

Sandwell and West Birmingham NHS Trust was formed in April 2002 and serve a population size of around 530,000 residents across West Birmingham and six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

Our inspection team

Our inspection team was led by:

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

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

CQC analysts, and a planner also supported the inspection team.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an unannounced visit on 16 February concentrating solely on the medicine core service followed with a short announced visit 28 to 30 March 2017 and unannounced visits on 6, 11, 12, and 13 of April 2017.

During the visit we held focus groups and interviews with a range of staff who worked within the service, such as, palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use the services.

What people who use the trust's services say

From the information held by Healthwatch in January 2017 from the public, care was rated as satisfactory or better by 92% of respondents, and good or excellent by 69%. Comments were made that care is attentive and appropriate to the needs of the patient. However, 8% reported care as poor, and stories were related describing poor practice in the areas of access to water, toileting, medication, availability, and quality of food and staff behaviour. Healthwatch also informed us that main issues were with patients' experience of the complaints procedure.

The trust's Friends and Family Test performance (percentage recommended) was about the same as the England average between January and April 2016, however performance fell below the England average for the next six months before improving in October and December 2016. In December 2016, trust performance was 96% compared to an England average of 95%.

The CQC In-patient Survey 2015 showed the trust was performing about the same as other trusts for patient involvement as much as they wanted to be in decisions about care and treatment.

The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to; cleanliness, food, privacy, dignity and wellbeing, facilities and dementia care provision. City Hospital site scored the highest in four out of five areas in comparison to Sandwell General hospital. However, overall scores were extremely close between the two sites.

Facts and data about this trust

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

In addition to standard specialties at the trust such as Acute Medicine , Cardiology and Neurology, the trust provides the following Specialist services:

- Behçet's Syndrome Service (trust is National Centre of Excellence).
- Faecal Incontinence and Constipation Healthcare (FINCH) service.
- Integrated Care Team for people with Long-Standing Conditions (ICares).

The trust serves two main local populations Sandwell and Birmingham with a population of over 530.000. The health of people in Birmingham is generally worse than the England average. Birmingham is one of the

Summary of findings

20% most deprived districts/unitary authorities in England, and about 29% (72,000) of children live in low-income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.3 years lower for men and 5.9 years lower for women in the most deprived areas of Birmingham.

Activity

- The trust has 921 acute beds, including 70 maternity beds and 19 critical care beds.
- The trust has a further 44 beds in its community services.
- In December 2015 to November 2016 across both sites,
  - 102,151 patients were admitted to the trust as inpatient.
  - 1,014,513 people attended outpatient clinics.
  - 234,359 attended both emergency department including the trusts eye casualty centre called the Birmingham and Midland Eye Centre (BMEC).

The opening of the new Midland Metropolitan Hospital (Midland Met) is currently delayed by six months, and is due to be opened in April 2019. Hospital is being built close to the boundary between Birmingham and Sandwell and the delay is because of engineering issues. This delay has been communicated to staff trust-wide.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as Requires Improvement because: On the Sandwell General Hospital site, Emergency Department (ED), medical, and surgery services were rated as 'Requires Improvement' for the 'safe' domain. Within the City hospital, ED, Surgery and Children and Young People at BMEC were rated as 'Requires Improvement' for safe, Medical care was rated Inadequate. Community Inpatient services were rated Inadequate for safe and Community adult service was rated requires improvement. Within Emergency Department at City and Sandwell General, we found that Storage and availability arrangements of emergency medicines required for resuscitation was inconsistent, The overall quality of patient notes at City Hospital ED was variable, with adult notes being less consistent. Patient records at BMEC ED did not meet standards for general medical record keeping by physicians in hospital practice. We found BMEC prescription pads left on desks in open and accessible areas and storage of fluids at BMEC was not tamper proof and was not in line with resuscitation council guidelines. The medical service at City and Sandwell General, were one of the areas of most concern at the trust and had been so for the past two years. Although there had been significant improvements across this service since the last inspection 2014, progress was slow. We found a range of concerns in relation to the safety of care including the prescribing of medicines and low staff attendance at some mandatory training such as basic life support training. Some wards were reliant on the use of temporary staff to fulfil safe staffing requirements. There were no formal systems for ensuring sufficient competency of temporary staff, and the way in which the hospital used temporary staff did not always ensure that people's safety was protected. Within surgery at Sandwell General, some supervisory staff in theatres had a poor understanding of what constituted a serious incident. That meant that we could not be assured that incidents were always classified appropriately. Mandatory training was inconsistent and particularly poor in theatres. Resuscitation trolleys were not locked and contained fluids and ampules, which could potentially be tampered with. Patient records contained errors and omissions.	**Requires improvement** 

Summary of findings

Within Children and Young Person at BMEC, Children's and young peoples' services were delivered in a predominantly adult environment. There were no separate children and young people waiting areas, designated play areas, or children's toilets in the day surgery unit (DSU) emergency department, or outpatients' department. Medical staffing levels fell below national standards, particularly consultant staffing. There was no seven-day cover from a consultant paediatrician and no agreed plans to increase the number of paediatric ophthalmology consultants. There was no separate storage of adult and children and young people emergency medicines and equipment.

The trust were sighted on the areas within the medical services that gave them most concern. their concerns were largely consistent with our findings. One of their main priority was to improve the 'medical services'.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations. The electronic reporting incident form included Duty of Candour, giving staff additional fields to complete on the form regarding verbal notification to the patient. The risk management team monitored all incidents to ensure the Duty of Candour regulations were adhered to.
- We saw the duty of candour was complied with and the trust met its obligations to patients. We looked at ten patient letters relating to serious incidents, all contained detailed responses, incorporating investigations carried out and lessons learned as well as an empathetic apology individual to each patient.
- The trust offered patients or relatives where appropriate the opportunity to have a meeting to discuss the investigation report. These meetings were recorded and provided to patients.
- The majority of staff we spoke to were aware of the need to be open and transparent under the duty of candour regulation.

Safeguarding

- The trust had recently appointed a new Adult Safeguarding nurse and dementia lead nurse.

- The safeguarding nurse sat on relevant safeguarding boards with executive support from the Chief Nurse.
- The Safeguarding Steering Group chaired by the Chief Nurse interpreted responsibilities and monitored patient outcomes, which was shared across the trust.
- There were 590 Safeguarding referrals made by the trust for safeguarding vulnerable adults in April 2016 to March 2017. We had no information available for referral rates for children.
- Strong links with police have been developed as part of the PREVENT strategy and adult safeguarding lead to be part of the Chanel Panel at screening and flag post stages of assessment of referral.

Incidents

- Never Events are wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between February 2016 and March 2017, the trust reported five surgical incidents, which are classified as Never Events. Two never events occurred at Sandwell General Hospital and were related to arm operations; one incident where an operation was started on the radial side of the arm when it was supposed to be held on the ulna side and the other involved failure to remove a metal drill guide from an operation site.
- Medicine management was a concern for community inpatients, with 28 medication related incidents in 2016. We requested the action plan following the high levels of medication incidents across Rowley Regis Hospital. The trust told us the concerns regarding medication incidents in January and February 2017 were related to medication omissions across Henderson and Eliza Tinsley, and both wards had improvement plans. However, the trust did not provide CQC with the improvement plans when requested; therefore, we were unable to make a judgement on the quality or progression with the improvements.
- However, community adult services had a robust process in place and managers reviewed all incidents to highlight themes and patterns.
- Learning was shared amongst teams trust-wide. We saw how policy and practice had been updated following one historic never event. The issue had involved retention of a 'pack' used to control bleeding. A new practice was introduced which saw patients wearing fluorescent wristbands when packs were purposefully left in situ. The number of bands corresponded to

the number of packs left in situ. On this occasion, bleeding had been difficult to control and two packs had been used. When staff later came to remove the packs, they only removed one. Following the RCA the procedure was changed such that if two or more packs were used then the corresponding numbers of wristbands were used. This meant staff who may not have been present when the packs were inserted would know how many packs had been used and could ensure the correct numbers were recovered.

- The trust were also receiving support from theCCG regarding these never events to continue to in-bed lessons learned and avoid a further repeat.
- In accordance with the Serious Incident Framework 2015, the trust reported 75 serious incidents (SIs) which met the reporting criteria set by NHS England between February 2016 and January 2017. Of these, the most common type of incident reported was falls (28 incidents) followed by pressure ulcers (14 incidents).
- There were 10,721 incidents reported to NRLS between February 2016 and January 2017, proportions of incidents by severity can be seen below. There were three deaths reported by the trust over the period.
- There were 10,721 incidents reported to NRLS between February 2016 and January 2017, the proportions of incidents were categorised according to severity. The largest proportion of incidents at the trust were no harm incidents of which there were 6,803 (63 % of total incidents) during this period. For the remainder of incidents, 3,544 (33%) were low harm, 358 (3%) were moderate harm, 13 (0%) were severe harm and the trust reported three deaths (0 %).
- The trust used an electronic 'Safeguard Incident Reporting System' to record, monitor and manages the administration of all incidents within the trust.
- Incident report training was included in corporate induction sessions and the Risk Management Team provided assistance and support to ad hoc incident reporting requests. "How to" guidance for staff to support reporting was displayed within the Safeguard Incident Reporting System.
- The risk management team continuously monitored action plans developed as a result of incidents and coroner's reports, within the Safeguard Incident Reporting System.
- Since October 2016 a summary of serious untoward incident (SUI) investigation findings was presented to the executive

team on a weekly basis. These incidents were reviewed in detail and group directors were responsible for creating an action plan and ensuring the information and lessons learned was disseminated to front line staff.

- Investigations into incidents were carried out using root cause analysis methodology. We looked at five SUI and five Never Event investigation reports. The never events all related to surgical incidents. The reports showed there were structured reviews carried out and the relevant staff were involved. The trust had developed specific, measured, achievable, realistic and timely (SMART) action plans including immediate and long-term actions to address lessons learned.
- We reviewed four coroner's reports and related responses from the trust. Each response contained a SMART action plan that covered all areas highlighted by the coroner.

Staffing

- We found that generally there were sufficient staff to meet the needs of patients across the majority of services. Staff were flexible in meeting demand caused by unplanned absences and bank and agency staff were used to fill planned vacancies.
- As of April 21, 2017 data provided by the trust showed actual level of whole time equivalent (WTE) staff in post in comparison to the planned levels. The actual level of consultant grade medical staff in post was 281.87 WTE, which was lower than the planned level of 316.03 WTE. The actual level of medical staff of other grades (including doctors in training) was 451.35 WTE, which was lower than the planned level of 539.95 WTE.
- The actual level of senior nursing and midwifery staff (band 8 and above) in post was 76.98 WTE which was higher than the planned level 75.72 WTE. For middle grade nursing and midwifery staff (band 7 and below) the actual level was 1833.21 WTE which was lower than planned level of 2078.85 WTE.
- For other non-medical, clinical staff (including health care assistants) the actual level was 1450.07 WTE, which was lower than the planned level of 1579.76 WTE. The shortfall between actual and planned was backfilled with bank and agency staff.
- As of January 2017, trust recorded 5.03 for sickness of registered ward nurses and 1.27% for medical staff**.**
- The trust undertook regular acuity reviews using the Safe Staffing Acuity Tool (Shelford Group). The tool enabled nurses to assess patient acuity and dependency and work out a suitable nursing establishment. Trust-wide, senior ward sisters collated the staffing numbers on a daily basis and reported these figures on a monthly basis to the Chief Nurse so the trust could use the data for their staffing fill rate indicator return.

Summary of findings

- Community inpatient wards had high agency usage during 2016, with an average of 37.8% of shifts filled by agency staff. However, community adult services had sufficient staff numbers and skill mix were planned, implemented and reviewed to ensure that people received timely care and treatment.
- During the unannounced inspection in February 2017 we saw Lyndon 4 ward and Lyndon 5 ward both at Sandwell General hospital were extremely busy and understaffed.Lyndon 5, was reliant on a daily basis to pull nurses in from other wards to back fill gaps in the rota.Staff on this ward told us they did not have the time to carry out audits and we saw other areas of concern that suggested the staff were too busy to carry out other required tasks. For example, inconsistent checks on fridge temperatures, resuscitation trolley checks and CD checks. On our return in March, we saw vast improvements on this ward and also Lyndon 4. There had been a newly appointed interim matron for Lyndon 5 and since the appointment, the establishment of nursing and HCAs had risen with an extra two HCAs specifically for focused care. Staff on this ward told us that they had seen and felt vast improvements to the ward within the previous four weeks.
- The NHS Staff Survey showed that in 2016, the trust was better than the national average for percentage of staff appraised in the last 12 months, with a score of 91% compared to the national average of 86% However, the same survey showed the trust scored below the national average for the quality of the appraisals staff received.

Records

- In 2014, the trust's board revised its long-term strategy and financial plans to make material investments in information technology (IT). During 2016, the age of the IT infrastructure resulted in a series of major IT problems that impacted on productivity in the trust and staff confidence. Improvement in the service and a 40% reduction in the backlog of IT service tickets were reported during 2017.
- We found initial and subsequent assessments were completed and observations were completed and recorded appropriately across the majority of services. However we saw variance with completion of DNACPR forms specifically at SGH End of life care services, for example, Not all forms had been completed in line the national guidance published by the General Medical Council. Out of six forms, two had no information about the

patient's capacity and one of these had no information recorded against a team discussion. Information regarding capacity was contained in patient's medical notes but had not been transferred across to the DNACPR form.

- Medical documentation across community inpatient services was lacking in detail in all 28 records looked at and often difficult to read. All records reviewed had limited medical documentation within them and with limited clear, contemporaneous medical plans.
- We looked at the notes of 11 patients admitted to the Acute Medical Unit A (AMU A)from SGH and found seven were poorly and inadequately completed/scant and or illegible/with extensive use of three letter acronyms that we could not interpret and/or missing signatures or names of the clerking doctor. In addition, we saw at SGH OPD, Staff did not always keep patient notes safe. We checked the lockable cupboards in corridors in the outpatients department and found that staff had left three cupboards unlocked. This meant that staff did not keep patients records secure and that they could be vulnerable to unauthorised access.
- The trust had an E-learning project with a completion date of October 2016 with assessments due to commence in December 2016. The trust was delayed in completing this project and was still in the process of implementation. The reason for the delay was due to one of the modules not working properly and the trust trying to align the training straight to the electronic staff record (ESR) system. As at 28 April 2017, the trust had resolved these issues. The changes with going paperless were causing many issues for staff especially the consultants working across both sites.

Are services at this trust effective?

We rated effective as requires improvement because:

At the City Hospital site, Emergency department and Surgery were rated Good, Medical care and CYP were rated Requires Improvement and EoLC was rated Outstanding. We do not rate Outpatient Department for the effective domain. At Sandwell General hospital site we rated Medical care, Surgery and CYP as Good, Emergency department was rated Requires Improvement and EOLC was rated Outstanding.

We saw. National 'bowel cancer audit' performance was recorded as 100% in 2016. Patient risk assessments were completed in line with national guidance. Patients were satisfied that their pain control had

been well managed. The trust planned and delivered patient care in line with current evidence based guidance. The service monitored the care delivered to ensure consistency of practice and compliance with relevant guidelines.

Action plans were in place to address non-compliance and progression had been made. BMEC demonstrated positive outcomes for patients undertaking surgery. Staff were provided with a robust induction programme and undertook training to ensure they were competent within their roles. Multi-disciplinary team working had improved at City Hospital Emergency Department since our last inspection in 2014 and we saw medical and nursing staff worked well with each other and communication with other specialities was good. Identified pathways were used across the trust, we noted that identification of deteriorating patients was used to good effect in most instances.

We found within the medical service, the requirements of the Mental Capacity Act (2005) were not well understood and applied. There was confusion amongst staff in relation to the Act and the Deprivation of Liberty Safeguards (2007). There was variability in the attendance at multi-disciplinary board rounds and ward rounds and therefore in the effectiveness of multi-disciplinary communication. ED had no designated safe room where patients with mental ill health could be cared for and treated while they waited for mental health assessment or admission to a limited availability of specialist beds. Shortage of nursing staff meant a number of newly qualified nurses were allocated to the ED and experienced staff struggled to support them effectively in such a challenging environment. The information about patients' assessment and condition recorded by consultants and doctors was often scant, lacking in detail and precision, or illegible. CYP service at BMEC there was limited engagement by staff to monitor and improve quality outcomes The leadership team raised this with us. However, since the appointment of the new consultant paediatric ophthalmologist in January 2017 work had commenced to undertake more specific monitoring of the children and young people service starting with a review of the emergency pathway for children.

Evidence based care and treatment

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- Care and treatment were delivered throughout the trust in accordance with evidence-based guidelines. The trust had a

system for receiving, recording, assessing and monitoring compliance with NICE guidance. Quarterly reports were provided for commissioners as part of the quality contract requirements.

- The trust participated in a range of clinical audits, and actions were taken in response to the findings to improve patient outcomes. The audit programme was developed annually in partnership with the clinical lead from each group and support from the clinical audit team. The programme included trust priorities, responses to incidents, national audits, audits against NICE guidance and any re-audits that were due during the year. Implementing the audit plan was monitored by the clinical audit team and reported to the divisions and governance committees.
- Across both ED's we saw all procedures and policies were based on the 'Clinical Standards for Emergency Departments' guidelines with staff being able to access them appropriately.
- We were shown the use of a sepsis-screening tool that identified patients at risk of sepsis and allowed staff to robustly manage treatment and care.
- The emergency department was part of the trauma audit and research network (TARN). The audit network allows comparisons to be made with other trusts and consistency in treatment and care maintained.
- The lead consultant was a member of the committee for the British Emergency Eye Care Society; which had been set up to recognise emergency eye care in ophthalmology. This meant staff could contribute to developing practice in line with national benchmarks and guidance.
- Within BMEC the trust had undertaken an audit of retinal detachment rates between September and December 2016 to demonstrate they were meeting national standards. This audit identified that UK British and Eire Association of Vitreoretinal Surgeons (UK BEAVRS) guidelines and standards were being met, such as 'acute 'macula on' Retinal Detachment will undergo surgery within 24 hours of diagnosis'. For this standard, the trust achieved 96.5% compliance, which equated to 55 out of 57 patients.
- We saw the palliative and end of life care service provided end of life care and patients had their individual needs assessed and their care planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Palliative and end of life care services was delivered in accordance with best practice as per NICE guidance CG140,

QS13 and 5 Priorities for Care. We saw the palliative and end of life care services achieved the priorities for Care of the Dying Person as set out by the Leadership Alliance for the Care of Dying People.

- We saw evidence that the trust conducted audits to assess compliance with NICE guidance. This included the assessment of compliance with NICE CG153 for the assessment and management of psoriasis. The audit was conducted in March 2015 and found that the national standards were not being met. Recommendations included the design and implementation of a new psoriasis baseline/annual proforma to cover all cardiovascular screening questions and to establish a dedicated psoriasis clinic. A re-audit had not been completed to assess any improvements following actions taken.
- A re-audit of compliance with NICE Quality Standard 52 peripheral arterial disease in March 2016 showed that the standard of all patients being offered angioplasty when imaging confirmed suitable was being met. However, due to the limited number of patients referred for angioplasty it was not possible to gain a true reflection of clinical practice within the service.
- The interventional radiology checklist adopted from the World Health Organisation (WHO) surgical checklist was used within interventional radiography.
- Local Diagnostic Reference Levels (DRLs) had been established. They were reviewed regularly and reduced by the medical physics service whenever possible. We saw evidence that DRLs were discussed in IRMER committee meetings and we saw that mostly these were lower than the national average.

Patient outcomes

- The Trust's Mortality and Quality Alerts Committee met monthly and undertook a detailed scrutiny of the mortality data available. These data were broken down further to specialty level and to some specific diagnostic groups. Any statistical alerts or trends were investigated, along with preventable deaths identified through the mortality review system (MRS). This MRS process involved a qualitative overview of each death by a senior clinician. Each case was examined for errors or deficiencies in care, the death was categorised as expected or unexpected, and whether the death was considered preventable.
- The trust collected monthly data on outcomes of patient care and treatment and incorporated it into a monthly performance and quality report. There was clear evidence of involvement in local and national audit to monitor and improve patient

outcomes. Outcomes throughout the trust were similar or above national averages. The trust had an active outlier alert as at February 2017 one active mortality alert of Pleurisy pneumothorax and Pulmonary collapse. Generally, an outlier is a measure that lies outside the expected range of performance and which we identify using statistical techniques.

- Health promotion care plans were being introduced on to the surgery wards to promote individuals general health, alongside their surgical procedures.
- Advanced care plans and specialised care plans were used across the trust for end of life patients. They were used as a person centred individual care record to include all the needs and wishes of a patient and their family.
- The outreach service was effective in supporting deteriorating patients appropriately and accessing in a timely manner.
- The hospital routinely collected and monitored information about patient care and treatment and their outcomes. Most outcomes for people who used services were positive and met expectations. They participated in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. Results were used to improve care and treatment and patient outcomes.
- The trust had a Confidential Enquiry into Perioperative Deaths (CEPOD) classification, the need for immediate, urgent, expedited or elective surgery. One CEPOD specific theatre was staffed 24 hours a day, seven days a week for immediate life, limb or organ-saving intervention including the intervention for acute onset or clinical deterioration of potentially life-threatening conditions. CEPOD started from a pilot study of mortality associated with anesthesia now a joint venture between surgery and anesthesia that covers all specialties, near misses as well as deaths. The Department of Health requires NHS Trusts and health boards to participate.
- We saw the palliative and end of life care service audit programme included audits such as: 'Percentage of appropriate patients for whom the Supportive & Palliative Care Indicators Tool (SPICT) tool is applied and an advanced care plan is made' (April 2016 – March 2017) and 'Audit of Macmillan therapy team supervision' was due to commence in April 2017. We saw the service monitored the palliative and end of life care service to improve patient outcomes and used the information from audits to make improvements to the service.

Summary of findings

- Sandwell Hospital ED submitted data to the trauma audit and research network (TARN) for 2015 and 2016Reports were produced every three months with process and outcome measures for Sandwell Hospital compared against the database.
- In the 2014/15 RCEM audit for initial management of the fitting child, Sandwell General Hospitalwas in the upper quartile compared to other hospitals for one of the five measures (eye witness history recorded, 100%) and was in the lower quartile for one of the six measures although the hospital scored 98% for the measure (presumed aetiology recorded). Sandwell Hospital met the fundamental standard of checking and documenting blood glucose of all patients actively fitting on arrival in the ED.
- The hospital contributed to national audits including the National Diabetes Inpatient Audit, the National Cancer Patient Experience Survey, the Lung Cancer Audit and the Sentinel Stroke National Audit Programme.
- The trust did not perform so well in the 2016 Lung Cancer Audit. They performed worse than the minimum standard (80%) for patients seen by a cancer nurse specialist (67.3%). They performed significantly worse than the national level (63.6%) for fit patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy (48.6%) and slightly worse than the England average (38%) for the survival rates at the hospital (36%). The trust did perform better than the level suggested for 2016 for patients with small cell lung cancer (SCLC) receiving chemotherapy.
- The trust used a hand held device Vital Pac as well as other tools to identify a deteriorating patient.
- The trust failed to achieve Joint Advisory Group (JAG) accreditation for gastro-intestinal endoscopy in 2016. JAG sets national standards for gastro-intestinal endoscopy and accreditation provides assurance that a service is meeting the required standards.
- The trust had developed an action plan to gain accreditation in 2017. We reviewed the action plan and discussed it with the clinical leadership team. They felt achievement of those standards related to access and waiting times had the greatest level of uncertainty, due to increased demand for the service. However, additional consultant sessions had been introduced to mitigate the impact.
- We requested information on local and national audit programmes for community inpatient serviceshowever, the

trust did not respond to our request. We found no evidence of learning from outcomes of audits and the service could not evidence changes because of the lack of participation in national or local audits.

Multidisciplinary working

- Effective multidisciplinary team (MDT) working was well established across the wards and departments inspected. It was evident from discussions with staff, observations of inspection and reviews of records that there was a joined-up and thorough approach to assessing the range of people's needs.
- Assessments were focussed on securing good outcomes for patients in the majority of services we inspected; they were regularly reviewed by all team members and kept up to date.
- It was evident that professionals from all disciplines valued each other's contribution and that relationships between them were positive and productive.
- Some staff told us of a previous disconnect between the nursing and medical staff on some medical wards, which since the last inspection had made significant improvements.
- A complex discharge team was in place and a member of the team attended some ward rounds. They received referrals by word of mouth and by attending the "Red to Green" daily meetings which were held to review patient progress and delays to discharge.
- There were electronic systems in place to share relevant information amongst professionals in different departments.
- Allied Healthcare professionals were used to ensure that patients' outcomes were optimised. Across all sites, we saw good examples of cross-professional work. The community services appeared to work well within the local healthcare community and worked to overcome obstacles to ensure that patients received the service they required.
- There was a clear process for the transfer of care of patients from hospital to community services including care plans and medication.
- ED consultants expressed concern about delays accessing radiology reports and the availability of porters when patients needed them.
- A hospital liaison officer from West Midlands Ambulance Service was available at peak times in the ED.
- There were no formal service level agreements within the accident and emergency directorate relating to BMEC and their interactions with other units.

Summary of findings

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- As of April 2016 to February 2017, trust made 64 Deprivation of Liberty Safeguards (DoLS) referrals.
- As of April 2016 to February 2017, trust made 62 Mental Capacity referrals.
- Staff knowledge of the implications of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) on decision-making was variable throughout the trust and there was a lack of understanding of the difference between mental capacity and deprivation of liberty.
- Care records for some patients who lacked capacity to make some decisions for themselves did not contain a record of a mental capacity assessment or any evidence of how decisions had been made in relation to the care and treatment which had been provided. This was particularly evident across community inpatient services where staff had mixed knowledge and understanding of Deprivation of Liberty Safeguards 2010 across all areas visited. We identified four patients across the hospital that medical staff had assessed as lacking capacity and reviewed their medical records. Two patients on Eliza Tinsley ward lacked capacity. The medical staff had documented “no capacity” within both patient records; however, medical staff had not documented a formal mental capacity assessment or stated the situation in which the assessment related. Therefore, we could not be sure that the patients’ rights had been protected.
- Between January 2016 and December 2016, the trusts consent audit report showed that of 7,384 patients, 17% of patients were consented on the day of procedure, however it was identified that some patients who did sign consent on the day, following specific admission guidelines. This report also identified that 80% of patients received an information leaflet to consider the operation proposed, a report conclusion recommended that the trust should consider amending consent forms to be clearer about signatures for the provision of information, receipt of information and consent for procedures.
- Consent for care and treatment was obtained from children and young people or an appropriate adult, where applicable. The principles of Gillick competence were applied. Gillick competence is an assessment process where any child under the age of 16 can give consent for treatment if they have reached a sufficient understanding and intelligence to be capable of making up their own mind.

Summary of findings

Are services at this trust caring?

We rated caring as outstanding because:

We rated end of life care service as 'outstanding' for care in community and Sandwell General hospital because The trust surveyed end of life patients and their loved ones to identify their experiences of the care they received. We saw that staff discussed the completion of this survey and asked the patient to complete and explained it. This enabled them (the trust) to see what they were doing well and any improvements needed. We saw families were given the opportunity to carry out their own last offices for their relative.

Staff told us there was no pressure from bed managers to remove deceased bodies from the wards. This ensured there was sufficient time for relatives to see their relative and perform last offices if they wished without being rushed. Staff from the palliative care Hub gave patients clear information about their treatment, care, and support.

We observed a specialist palliative care nurse explaining to a family how they could come and stay with their loved one (patient in side room) and a family member would be able to sleep over as a put-up bed would be provided for them. The nurse also told the family to make the room homely and "bring in what they needed".

We found staff and patient interactions to be good. All levels of staff who had patient contact were polite and treated patient with dignity and respect. We observed interactions across the trust and in the community and spoke to numerous patients and relatives whom said they were treated well and kept up to date and well informed about their treatment and plan of care.

Compassionate care

- All patients we spoke with were complimentary about the care staff provided across acute and community services. They all said staff were courteous and respectful and that staff treated them with kindness and compassion. One patient said, "Staff are so pleasant and helpful," another patient said, "Staff are out of this world, couldn't do any better."
- Patients and family members said that the care was not only excellent but that staff always went that extra mile. A family member said, "They (the staff) go above and beyond what you would expect".
- We spoke with family who thought that all the nurses on the ward communicated well with them. A family member said, "They (the staff) are very good at keeping us informed about what is going on".

Summary of findings

- One patient told us they arrived late in the evening and was cared for well despite the ED being busy. They described the care as “excellent and said that the staff did an incredible job.
- Other patients told us that that the staff were kind and helpful. One said that he was confused and nervous but a nurse had explained what was happening and this had put them at ease.
- The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2015 and 2016 for assessments in relation to food, privacy/dignity/ wellbeing and facilities and about the same as the England average in relation to cleanliness
- The trust’s Friends and Family Test performance (percentage recommended) was about the same as the England average between January and April 2016, however performance fell below the England average for the next six months before improving in October and December 2016. In December 2016, trust performance was 96% compared to an England average of 95%.
- In the Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for six of the 34 questions, in the middle 60% for 24 questions and in the bottom 20% for four questions.
- The questions where the trust performed in the top 20% of trusts were:
  - Possible side effects explained in an understandable way.
  - Hospital staff told patient they could get free prescriptions.
  - Staff told patient whom to contact if worried post discharge.
  - Patient’s family definitely had opportunity to talk to doctor.
  - Always or nearly always, enough nurses on duty.
  - Given clear written information about what should or should not do post discharge.
- The questions where the trust performed in the bottom 20% of trusts were:
  - Saw GP once/twice before being told had to go to hospital.
  - Nurses did not talk in front of patient as if they were not there.
  - Hospital staff did everything to help control pain all of the time.
  - Always treated with respect and dignity by staff.

Understanding and involvement of patients and those close to them

- The CQC In-patient Survey 2015 showed the trust was performing about the same as other trusts for patient involvement as much as they wanted to be in decisions about care and treatment.

- Trust provided a formal in-house training specifically to cover communication skills training for care in the last hours or days of life for medical and nursing staff.
- Staff fully explained the process for assessment, examination and diagnosis and treatment in a clear way for patient to understand.
- Patients told us they were fully involved with consultations with medical and nursing staff and had felt they had received all of the information required about their diagnosis and treatment.
- Trust worked with other agencies to arrange for patients to receive the correct support. For example domestic support from Age Concern and day respite care from Crossroads.
- Twice each year the hospital chaplains joined together with the staff from the critical care unit and held memorial services for patients who had died on the unit. We saw that this had been very well attended by relatives and there were many appreciative comment cards left by relatives.
- When patients were in the last few days of their life families were given open visiting rights.

Emotional support

- The Chaplaincy consists of a team of trained hospital chaplains from four major faiths, Christianity (including Roman Catholic), Muslim, Hindu and Sikh, who provide a 24 hour emergency call out service. There were 2.7 WTE staff employed within the chaplaincy service; although other people supported this team as volunteers.
- A regular programme of pastoral visiting was undertaken by chaplains and authorised chaplaincy volunteers to cover all wards and departments.
- Weekly communion services are held and all major faith festivals are celebrated, including Easter, Christmas, Eid, Vaisakhi and Diwali. Chaplains of all faiths support each other's' festivals.
- Patients received compassionate and emotional support from staff, we witnessed many interactions that showed that staff were respectful and kind to patients across acute and community services.

Are services at this trust responsive?

We rated responsive as 'requires Improvement ' because:

Across both hospital sites Surgery and OPD were rated Good, Medical care at Sandwell General Hospital was also rated Good. At

Summary of findings

Sandwell General hospital ED was rated Requires Improvement and EoLC was rated Outstanding. At City Hospital, CYP and were rated as 'Inadequate' and EoLC at this site and community EoLC was rated Outstanding.

ED was rated Requires Improvement' for responsive because of issues relating to flow of patients through the hospitals system. The current layout of the ED was a challenge for staff managing patients with complex needs and who needed supervision. When the ED was very busy patients in the major injuries and illnesses stream had to queue on trolleys in the corridor after triage and wait for treatment. ED managers struggled to get support from the senior managers to deal with these risks safely. We found a range of factors that negatively impacted on the patient journey from admission to discharge including delays in obtaining medicines to take home (TTOs), and transport issues. The overall progress of patients was hampered by delays in obtaining blood results and delays in diagnostic investigations. The service was not operating at its optimum capacity as there was only one paediatric ophthalmologist in post, and elective (planned) surgery lists were contained to two sessions on a Monday and Thursday. There was no contingency arrangement for covering anticipated or unanticipated leave of the paediatric ophthalmologist, which meant an increased risk of cancelled surgery.

We saw the trust was one of three local NHS trusts that participated in The Black Country Alliance (BCA) partnership. This partnership was a new model of acute service collaboration committed to improving quality of health care . The trust had developed a homeless patient pathway to ensure care continued after acute treatment.

There was an internal interpreter service, which consisted of 90 bank interpreters and covered the most commonly used 10 non-English languages within the local population.

The trust is involved with the Making Every Contact Count (MECC) programme, which was a national programme run by NHS England. The programme encouraged both clinical and non-clinical staff to engage with patients, family, friends and colleagues about healthy lifestyles, including smoking, healthy diet and weight, exercise and alcohol intake. It is a means of achieving long-term behaviour change for better health and wellbeing among individuals and building an organisational culture that supports continuous health improvement and reduces health inequalities

Summary of findings

The trust currently has a five-year dementia strategy project, 'a dementia/personhood' project plan of 2016/17. The trust have invested in a course provided by University of Worcester which provides level 6 and 7 modules in dementia care to support dementia awareness and development of services.

Service planning and delivery to meet the needs of local people

- The trust was one of three local NHS trusts that participated in The Black Country Alliance (BCA) partnership. This partnership was a new model of acute service collaboration committed to improving health care quality. The BCA partnership had an agreement with a local university to host a health research bus on one of the BCA trust's sites over a 12-month period. The bus was situated at Sandwell General Hospital in September 2015. The research bus enabled scientists to research and study specific health conditions of the population in the Black Country, to improve the service planning and delivery for the local people.
- We saw that GP's were based in ED so that patients' could access primary care if that was more appropriate than emergency treatment.
- We saw in ED there was a paediatric liaison lead who worked closely with safeguarding team.
- Staff told us at City hospital there was currently a turnaround time of two and a half to three hours from receipt of the TTO in pharmacy to the medicines arriving back on the ward. The trust was working towards reducing this time to two hours.
- A programme to improve patient flow, timeliness of discharge and reduce length of stay was ongoing in the trust. As a result, eight work streams were identified and each was being taken forward by a team within the trust.
- One of the work streams was to improve the timeliness of access to diagnostics. This included education for staff to ensure appropriate requests, a triage system, and changes to the pathways for inpatient echocardiograms. Staff were also given access to the booking system to enable them to see when patients were booked. The management team said patients could wait for up to four days for an echocardiogram and the work would reduce waiting times.
- A trial of a seven day service for patients with chronic obstructive pulmonary disease (COPD) was initiated to reduce repeated admissions for patients with this long term condition. The trial ended due to a shortage of specialist nurses, however, following the success of the service, staff were being recruited to enable the service to be re-instated.

- The trust had developed a homeless patient pathway to ensure care continued after acute treatment. It recognised the need to help treat mental health and social illness alongside acute illness for this group of patients. The trust worked with other health providers and partners in the local area to offer help and support for the homeless. Early statistics showed that the pathway had reduced readmission rates for patients who had been frequently admitted to hospital.
- The senior management team were reviewing the number of medical beds and capacity for each specialty by looking at demand, in preparation for moving to the new Midland Metropolitan hospital, due to be opened in October 2018.

Meeting people's individual needs

- The trust was involved with the Making Every Contact Count (MECC) programme, which was a national programme ran by NHS Health England. The programme encouraged both clinical and non-clinical staff to engage with patients, family, friends and colleagues about healthy lifestyles, including smoking, healthy diet and weight, exercise and alcohol intake. We saw this in practice when visiting the wards, with one consultant encouraging a patient to make good choices regarding smoking. The patient had been admitted due to chronic obstructive pulmonary disorder, a condition related to smoking. We also read a good example in the trust's staff news magazine, 'Heartbeat'. The article described how a member of the pharmacy team had helped and encouraged a patient with HIV to lose a stone in weight, by making the patient aware of a local council run healthy lifestyle scheme.
- The trust had recently implemented a 24-hour a day, seven days a week service for patients with hearing impairments and worked with an organisation to introduce a text relay system. This text relay system allowed patients to make changes to their appointments by texting the organisation working alongside the trust who would make the changes on their behalf.
- The trust had an internal interpreter service, which consisted of 90 bank interpreters and covered the top 10 languages spoken within the local population. These were Punjabi, Polish, Urdu, Bengali, Arabic, Romanian, Slovakian, Kurdish, Czech and Somali. The trust filled approximately 53,000 face-to-face interpreter bookings per year with a fill rate of 99.5%. this means that almost all patients who requested an interpreter were able to be provided with someone who could speak their language.

- The interpreter service was open weekdays 8am to 5pm and out of hours staff could also access 'Language Line', which was a telephone interpreter service. Staff and patients could assess language line with any handset, however; the wards and departments all had dual handset telephones they could use. The trust used agency interpreters if bank staff were unable to fulfil a request or if the bank staff did not cover the language.
- Special arrangements were in place for people with a learning disability for example; in theatre, a patient was given time to attend the department to meet with staff and talk about what happens on the day of surgery. Patients were encouraged to bring a carer to support them during their appointments.
- The service supports people with other complex needs with accessible wards and entrance to the hospital, clear signage, and support from volunteers was arranged when attending without a carer.

Dementia

- The trust have recently appointment a Dementia lead Nurse and have recently appointment a Learning Disability nurse on the City Hospital site.
- Carers of people with dementia carer survey were recently added to iPad to conduct a more specific views from people.
- The trust currently has a five-year dementia strategy project, The trust have invested in a course provided by University of Worcester which provides a level 6 or 7 module to support dementia awareness and development of services.
- There was no specific dementia ward at the trust however; most patients living with dementia were treated on Lyndon 4 at Sandwell general hospital, which was an elderly care ward. All staff on this ward had received dementia specialist training.
- There was a pop-up bus stop on this ward, which was a place for staff to take patients to for a short while when they became confused and asked to go home. Research had shown that this was a good way to calm patients living with dementia. We saw this worked well in practice.
- The PLACE 2016 audit scored the trust at 83% for the wards being dementia friendly, which was better than the comparative England average of 73%. Some of the failures on the audit were due to bays not having larger clocks or clocks with multiple faces to allow visibility from all angles.
- Adaptations had been made to the environment at City hospital to better meet the needs of patients living with dementia and an activities coordinator provided therapeutic activities for those living with dementia or with delirium and those without outside contacts.

Summary of findings

- A dementia screening tool was used to aid in nursing assessments.
- A senior nurse told us that the hospital supported and used John's Campaign, which they found useful for involving family. John's Campaign applies to all hospital settings to enable carers to stay with their relatives in hospital, particularly when patients are living with dementia. The campaign recognises that it is crucial for a patients' health and wellbeing for relationships to remain connected whilst the patient is in a hospital setting.
- Patients with special needs received appropriate support; staff understood how to support patients with dementia or other memory problems.
- There were a number of care pathways in place on the ambulatory care unit and the hospital had recently introduced a dementia and delirium pathway.
- Staff on specialist wards undertook specialist training for example, staff on Lyndon 4 had external and internal specialist training for dementia.
- Nursing staff on the elderly care ward had undertaken specialist dementia training, which included advanced training in consent.
- An activities coordinator had recently been appointed to "promote therapeutic activity." They told us they worked mainly with patients with dementia or delirium or those with no outside contacts. The majority of their time was spent on wards D11 and D26 at City hospital. Activities depended on the patient and their interests. For example, they offered activities such as painting, card games and other games, and used reminiscence boxes and cards. They said they also read newspapers to people or spent time chatting with them.
- Trust had implemented a service for patients' and staff, called Better Understanding of Dementia (BUDS) and the trust's psychiatric liaison team for patients with mental health concerns.
- At City hospital we reviewed the investigation report for the incident of unauthorised absence of a patient and found there was an analysis of the incident and contributory factors. An action plan was developed to reduce the risk of a similar incident occurring in the future. The patient involved in this incident was living with dementia and their confusion contributed to their leaving the ward. However, when we visited wards during the inspection, we found there continued to be gaps in staff knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007) which protect people when they cannot make some decisions for themselves

and patients' records did not fully document the impact of their dementia on their behaviour. There was no evidence of the use of a dementia/delirium pathway. As a result we could not be confident lessons from the incident had been fully learnt.

Access and flow

- Between January 2016 and December 2016, Geriatric Medicine (100% vs 98.6%), Rheumatology, Cardiology were above the England average for admitted Referral to Treatment (RTT) times. Geriatric Medicine achieved 100%.
- Between January 2016 and December 2016, Gastroenterology, Neurology, Dermatology, Thoracic Medicine (90.1% vs 95.5%) were below the England average for admitted Referral to Treatment (RTT) times.
- The Department of Health standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard each month between January 2016 and December 2016. Performance against this metric showed a trend of decline, falling from 91% in January to 82% in December.
- Between January 2016 and December 2016 the Trust monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average.
- Between December 2015 and November 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was similar to the England average. During the period performance fluctuated in line with the England average.
- Between December 2015 and November 2016 the trust's monthly median total time in A&E for all patients was consistently lower (better) than the England average.
- Between January 2016 and December 2016 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance and on a downward trend. This largely represents outpatient services. Six specialities were better than the England average including Surgery and Trauma and Orthopaedics. Eleven specialities were worse than the England average including dermatology, cardiology, cardiothoracic surgery and thoracic medicine.
- The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.

Summary of findings

- The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.
- Between January 2016 and December 2016 the percentage of patients waiting more than six weeks to have a diagnostic test carried out was lower (better) than the England average.
- Bed occupancy at the trust was below the England average each quarter between Q1 2015/16 and Q2 2016/17. In Q2 2016/17, the trust's bed occupancy was reported to be 85% which was better than the England average of 87%.
- As of April 2017, trust has seen an increase of 7% in their children activity of inpatient from 10,750 November 2016 to 11,454 in April 2017.
- As of April 2017, trust has seen an increase of 2% in their oncology services from 15,723 in November 2016 to 16,004 in April 2017.
- The main reasons for delayed transfer of care at the trust were 'awaiting nursing home placement or availability' (28 %), followed by 'completion of assessment' (18.6%). This was recorded between January and December 2016
- Proportion awaiting Community Equipment and Adaptions is also higher than the national rate (9.2% compared to 2.3% nationally).
- The Trust employs a team of chaplains to provide spiritual care to people of all faith and none.
- Pastoral care is offered to patients, staff and visitors to the hospital.

Learning from complaints and concerns

- The trust used an electronic system called, "Safeguard" to record all complaints, investigations, and complaint responses. Between January 2016 and December 2016 there were 1110 complaints trust-wide. 110 related to attitude of staff, 54were complaints about cancelled operations or appointments and 365 related to medical treatment and nursing care.
- The head of complaints reviewed all complaints received on a daily basis and graded them. Complaints were either dealt with by the complaints team or sent to the relevant clinical area for investigation. However, we had concerns community across inpatient services, for example, group governance meetings discussed complaints monthly and fed into ward level improvement plans. We reviewed ward improvement plans during the February 2017 unannounced inspection and found

many improvement actions overdue or ongoing. We did not see any details, shared learning or changes made following complaints documented within the group governance meeting minutes.

- An acknowledgement of receipt letter was sent to all complainants within three days and investigated and responded to within 30 days. The head of complaints was able to increase the response time in case of complex investigations required.
- The head of complaints reviewed all complaint responses to ensure they were of the required quality.
- All complainants received a complaint satisfaction survey to help the trust improve their complaints process.
- We reviewed twelve complaints from different directorates and both hospital sites (City and Sandwell) as part of our inspection. We discussed the findings of our review with the trust. The head of complaints acknowledged that on reflection one of these should have been upheld, one partially upheld and one sent out in the patient's first language rather than English. This demonstrated an open, honest and transparent approach to ongoing improvement of the complaint's process.
- The complaint responses all contained detailed and thorough investigation of the areas highlighted in the original complaint and demonstrated empathy and an apology to the complainant.
- If complaints involved several organisations such as different hospitals, a GP and social services the complaints team ensured the whole complaint was investigated and information sort from the relevant organisations.
- The response letters contained lessons learned and how they were shared with staff to prevent reoccurrence.
- Complainants were offered the opportunity of having a meeting to discuss and try and resolve their concerns and meet relevant clinical staff involved. These meetings were recorded on disks and provided to complainants to take home.
- The head of complaints had presented learning from a specific complaint to a group of orthopaedic surgeons on one of the trust's, "Quality Improvement half days". This demonstrated a commitment by the trust to ongoing learning and development through complaints.

Are services at this trust well-led?

We rated well-led as 'Good' because

Summary of findings

The Trust has made progress towards a seven-day model. Trust has a seven-day medical, surgical, paediatric and obstetric input for emergency admissions.

The Board Assurance Framework (BAF) which forms part of the NHS England risk management strategy and is the framework for identification and management of strategic risks was appropriate. We were assured that the BAF clearly showed who had responsibility of specific risks and that risks were fully identified, understood and managed appropriately.

Staff across many services reported a positive, open culture and were passionate, committed and proud to work as part of the trust. Across many services, particularly across the community we saw staff demonstrated they were genuinely happy providing care to patients.

We saw many arrangements that showed good management however, we reviewed seven sets of executive files and saw there were omissions and gaps in several of them. For example, three files contained no DBS (Disclosure and Barring service) check, which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw two of the executive files had no references in place. We were not assured the trust had a robust process in place to meet this regulation. The trust took remedial action to address this breach by requesting DBS checks for outstanding staff. We can confirm as of June and July 2017 all exec and non-exec staff have a cleared DBS check in place.

CYP, Medical services, Surgery services and OPD at City site was rated as 'Requires Improvement for the well led domain because the risk register provided by the trust contained no risks for medical services other than oncology and ward staffing levels. A risk staff thought was on the risk register was not included. We had concerns about the escalation of risks and the timeliness of response.

Staff told us the executive team were not visible at the Birmingham Midland Eye Centre and could not recall when they had last visited. There was no separate strategy for the children and young people service or any succession planning for nursing staffing. At Sandwell General Hospital, ED, medical services, surgery services and OPD was rated as good, CYP was rated as requires Improvement and EoLC across both sites and community was rated as Outstanding.

Leadership of the trust

Summary of findings

- The Trust Board comprises of seven Non-Executive Directors and seven Executive Directors, including the Chief Executive Officer, five of whom are voting directors. This is an established board with majority of the board members being in post for over two years.
- The Board meetings are open to the public and are held on the last Thursday of every month, alternating between City and Sandwell hospitals. The trust also holds a public Annual General Meeting (AGM) in September each year.
- We saw that the Chief Executive was highly visible within the organisation. Staff told us they felt engaged with the trust.
- There was a newly appointed Chief Nurse in post, who was well regarded by both front line staff and peers.
- Staff told us that leaders were approachable and supportive.
- There was a clear leadership and management structure and this was widely understood.

Culture within the trust

- Staff across many acute and community services reported a positive, open culture and were passionate, committed and proud to work as part of the trust. Across many services, particularly across the community we saw staff demonstrated they were genuinely happy providing care to patients.
- Staff were appropriately supported and trained to meet the requirements of Duty of Candour for patients and gave examples of how service leaders provided this.
- The trust's sickness absence rates between October 2015 and September 2016 were higher than the England average. Rates improved in line with the England average over the same period.

Vision and strategy

- The trust vision is to be renowned as the best integrated care organisation in the NHS.
- We saw that the board had set strategic objectives to support the delivery of this vision. These were
  - We will ensure our services are provided from buildings fit for 21st Century health care.
  - We will provide the highest quality clinical care.
  - Working in partnership with primary and social care we will deliver an increasing range of seamless and integrated services across hospital and community settings
  - We are committed to reducing our impact on the environment and have set up an action plan to incorporate sustainability into all of our functions.

Summary of findings

  - An engaged and effective NHS organisation will underpin all we do.
  - We will provide services that are quick and convenient to useand responsive to individual needs.
- We saw that the work of the trust was set around these strategic objectives and that they were meaningful to the board and its directors.
- To support staffs approach to patients and visitors, the trust worked with staff groups to agree standards that the trust called 'promises'. This were

  'I will …
  - make you feel welcome
  - make time to listen to you
  - be polite, courteous and respectful
  - keep you informed and explain what is happening
  - admit to mistakes and do all I can to put them right
  - value your point of view
  - be caring and kind
  - keep you involved
  - go the extra mile'
- We saw that in the main, staff understood these and valued them.
- Opening of the new Midland Metropolitan Hospital was due in October 2018, this has been delayed for approximately six months due to engineering issues. The building and opening of the new hospital was a part of the trusts strategyfor its new model of care.
- We saw that generally staff across acute and community services were aware of the trust's priorities and challenges, and understood the plans and actions needed to address them.
- The trust is currently undergoing a project to co-ordinate care that depends on connections through technology as part of their 2020 vision and plans are underway to invest over £50million in technology in coming years. Their vision is to work across geographical and organisational boundaries and supports 'Your Care Connected', which provides access to a summary care record for GPs and hospital staff.
- The Trust has made progress towards a seven-day model, whilst audit data suggests performance slightly above UK average. Trust has a seven-day medical, surgical, paediatric and obstetric input for emergency admissions.

- For the October 2018 opening of the new Midland Metropolitan Hospital plan is to provide such cover of seven-day model on all wards for every patient. There is further work to do ensuring diagnostic and non-clinical support services are configured across the week for emergency but not urgent patients.
- In 2017-18, this includes better MRI and endoscopy (non-GI bleed) access, as well as changes in pharmacy and transport.
- The Trust has most of its commissioning budget via Clinical Commissioning Groups (CCG), with around 10% coming from NHS England directly.The trust have completed and discussed within their board the implications of changes in tiered specialised services commissioning.
- The trust sits within the Black Country STP (Sustainability and Transformation Partnerships). STPs are a way for the NHS to develop its own, locally appropriate proposals to improve health and care for patients. They are working in partnership with democratically elected local councils, drawing on the expertise of frontline NHS staff and on conversations about priorities with the communities they serve. We saw that the key issues for the trust (for example The Midland Metropolitan Hospital) were recognised and progressed within the STP.

Governance, risk management and quality measurement

- We found the (BAF) which forms part of the NHS England risk management strategy and is the for identification and management of strategic risks was appropriate. We were assured that the BAF was clear who had responsibility of specific risks and that risks were fully identified, understood and managed appropriately.
- There were 21 risks that featured on the trust-wide risk register. Following interviews with exec staff we saw the risks had been escalated and reviewed by management teams through to the Clinical Leadership Executive Committee and trust board. Trust board was responsible for the decision whether risks were removed for them to managed at the relevant Clinical Group / Corporate Directorate. The trust risk register was comprehensive and largely contained the risks that we recognised. The risk register had clear accountability with named leads and completion dates. The risk register also included controls (actions taken by the trust to mitigate the risks) and as assessment of the residual risk once controls and cations had been taken. Out of 21 risks, following mitigation, six risks remained red, these included; lack of tier 4 beds for children and young people with mental health conditions, additional opened beds and the ability to staff them and waits for nursing home beds.

Summary of findings

- We saw that the risk register formed part of the trust overall control plan. We saw that risks that were recorded on the trust risk register had been considered through local management groups and reviewed by the trust clinical leadership executive committee. This demonstrated a strong risk management process in the organisation.
- An internal audit on incident reporting dated March 2017 concluded there were some weaknesses identified with regard to policies and the recording of the incident reported date. However, the safeguard incident reporting system provided reliable monitoring and management of incidents within the trust. The audit concluded that the monthly serious incidents summary presented by the Director of Governance and Integrated Quality and Performance report presented by the Finance Director to the Patient Safety Committee, Quality and Safety Committee and the Trust Board were reviewed, discussed and challenged appropriately.
- We had con erns with the identification and assessment of risks across community inpatient services. We found two examples where senior staff had not undertaken a risk or impact assessment on a situation prior to, or following, a change or implementation; for example, the change and reduction of hospital wide staff overnight and having no immediate access to a defibrillator within all clinical areas. The review of documented risks at ward level was limited, and we were not assured staff updated the risk registers regularly and that they reflected the risks identified during inspection.
- We saw a committee report that the Deteriorating Patient and Resuscitation Committee produced dated September 2016. The report covered a number of areas involved in assessing and responding to patient risk. The key agenda items included the identification of a number of gaps in meeting the Resuscitation Council UK Quality standards for cardiopulmonary resuscitation practice and training, clinical audit reports for resuscitation status, and patient safety alerts for example. We saw there were action plans put in place to mitigate risk, with clear ownership of actions, deadlines for completion and explanation of the current position in meeting the actions. The report also covered issues with the electronic system's early warning score data, review of key policies and procedures, and an overview of the deteriorating patient and resuscitation dashboard from April 2016 to September 2016. The dashboard looked at emergency medical response team calls and cardiac arrest numbers, percentage of resuscitation status discussions with patients and family, patient vital observation data, training rates and team attendance rates for EMRT calls.

Summary of findings

- The Trust's Mortality and Quality Alerts Committee met monthly and undertook a detailed scrutiny of the mortality data available. These data are broken down further to specialty level and to some specific diagnostic groups. Any statistical alerts or trends were investigated, along with preventable deaths identified through the mortality review system (MRS). This MRS process involved a qualitative overview of each death by a senior clinician. Each case was examined for errors or deficiencies in care, the death was categorised as expected or unexpected, and whether the death was considered preventable.
- The Trust's Board took an active overview of mortality rates, which were reported monthly in some detail. Changes to reporting methodology are explicitly authorised via the Board. A process, which had arisen twice in the last eighteen months.
- The Dr Foster Unit at Imperial College recently notified the Trust that their analysis had indicated that the Trust had higher than average mortality rates in the diagnosis basket of pleurisy, pneumothorax, and pulmonary collapse. Relevant deaths were reviewed through the Mortality Review System that found that in the opinion of reviewers that there was appropriate clinical assessment and ongoing management in the majority of cases and none of the deaths were considered to be preventable.
- The trust produced an integrated performance report for medical services that was discussed at trust board. This included measurement of performance against national and local targets and ward level information related to key performance indicators.
- The trust had reported five Never Events since January 2016. 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.
- All five never events related to surgical procedures in surgery, maternity and BMEC. We saw that both NHS Improvement and the CCG were working alongside the trust to prevent these happening again.
- There has been an ongoing issue regarding the pathways for some Oncology patients. We saw that there was an ongoing difference of approach between this trust and a neighbouring trust. We understood that this was now resolving.
- In April 2015, the trust launched its programme of Quality Improvement Half Days (QIHD's). These are protected learning

time for teams where non-essential clinical services are stopped for four hours, one afternoon every month. We saw this worked well in practice across the trust and involved all acute and community staff.

- The programme has been designed to improve cross-organisational learning trust-wide and followedrecommendations after the Mid Staffordshire Hospitals inquiry, on how to improve the safety of patients in England. Content of the learning afternoons covered;Lessons learned from incidents and near misses, how to make basic safety standards consistent across all areas, Improving patient experience, Training and development and Latest research updates

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the new Workforce Race Equality Standard (WRES) programme, we have added a review of the trusts approach to equality and diversity. The WRES has nine specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of its Black and Minority Ethnic (BME) staff. As part of this inspection we looked into the WRES and race equality within the organisation.
- The trust published its WRES Report as required by NHS England in June 2016.
- WRES report shows that there were 7024 staff members total head count and 35% (2454) staff members in total of BME representation in the overall workforce.
- Ninety two percent (6464) staff members in total self-reported their ethnicity.
- The data showed us the number of short-listed applicants was 680. BME (262) white (401). Across the trust, the report showed that white candidates that are shortlisted to vacant roles were 1.55 times more likely to be appointed than BME candidates.
- The report showed us the percentage of clinical BME staff in each clinical working level. Under Band 1 - 0%, Band 1 -6%, Band 2 - 6%, Band 3 - 25%, Band 4 - 19%, Band 5 - 45%, Band 6 - 30%, Band 7 - 21%, Band 8A - 18%, Band 8B - 17%, Band 8C - 13%, Band 8D - 10%, Band 9 - 0%, VSM - 2%.
- The report showed us the percentage of non- clinical BME staff in each clinical working level. Under Band 1 - 50%, Band 1 - 29%, Band 2 - 14%, Band 3 - 9%, Band 4 - 7%, Band 5 - 3%, Band 6 - 2%, Band 7 - 2%, Band 8A - 5%, Band 8B - 0%, Band 8C - 5%, Band 8D - 0%, Band 9 - 0%, VSM - 11%.

- The data indicates that just over half (52%) of all formal conduct/disciplinary casework related to White staff. This staff group represent up to 57.04% of the total workforce profile which represent the workforce employed by Sandwell and West Birmingham Hospitals NHS Trust.
- The next largest proportion of conduct cases relate to Asian staff at 18% who similarly account for 20% of the Trust's workforce which can be considered representative. Fifteen percent of conduct cases relate to Black staff, however they account for 10.06% of the workforce which is above the workforce profile. Similarly staff members who have chosen not declared their ethnicity represent 7.95% of the total workforce and account for 13% of conduct cases.
- In 2015 an increase of 1% in the number of BME staff indicated harassment, bullying or abuse from patients, relatives or the public in the previous 12 months when compared with 2014. This is in comparison of a 6% increase for white staff members.
- The NHS Staff Survey results for 2016 showed that the trust performed about the same as other acute trusts for staff believing the organisation provided equal opportunities for career progression and promotion. The same survey showed the trust scored better than average for the percentage of staff experiencing discrimination at work in the last 12-months. However, whilst on inspection a member of staff raised concerns about racial discrimination when considering staff for promotion.
- The Live and Work programme received 'Excellence in Equality' award, by the SWB CCG Equality Awards and won The Employee Engagement and Support – Sandwell Business Awards.

Fit and Proper Persons

- Since 27 November 2014, all NHS bodies that are required to register with the Care Quality Commission (CQC) must consider the fit and proper person requirements when making appointments to director level positions.
- We reviewed seven sets of executive files and saw there were omissions and gaps in several of them. For example, three files contained no DBS (Disclosure and Barring service) check which

Public engagement

- The trust worked in partnership with a local esteem team, which provided support groups for the local population. A consultant physician at the trust developed a group for male patients living with diabetes alongside the local esteem team. The support group, called 'Man Well', is an opportunity for male

diabetic patients to socialise and discuss their condition. The idea of the group is to aid the patients' self-management, self-esteem, and emotional wellbeing. Since the group established in 2013, there had been between eight and 10 regular members. The hospital had seen a positive difference in how the patients managed their conditions and their wellbeing.

- The hospital was in partnership with the local college to provide a service that the hospital called 'Kissing it Better'. This service included volunteers and college students who came into the hospital to sit with patients and gave them beauty treatments. Staff gave examples of the hair and beauty students coming on to the medical wards to curl patients' hair, to give hand massages and do their make-up. The volunteers and students undertook training in fire, health and safety and infection control before visiting the wards.
- The trust was one of three local NHS trusts that participated in The Black Country Alliance (BCA) partnership. This partnership was a new model of acute care committed to improving health quality clinical research in order to translate into medical practice. The BCA partnership had an agreement with a local university to host a health research bus on one of the BCA trust's sites over a 12-month period. The bus was situated at Sandwell General Hospital in September 2015. The research bus enabled scientists to research and study specific health conditions of the population in the Black Country, to improve the service planning and delivery for the local people.

Staff engagement

- The 2016 NHS staff survey showed the trust better than the national average for 9 of the 32 questions, including staff feeling confidence to report unsafe clinical practice, number of staff receiving appraisals and six questions relating to violence bullying and harassment.The trust scored below (worse than) the England average for 14 of the 32 questions including quality of appraisals, agreeing that their role in the organisation makes a difference to patients, effective use of patient feedback and 5 of six questions relating to job satisfaction.
- The NHS Staff Survey 2016 had a response rate of 29% for this trust compared to a national average of acute trusts at 43%.
- The NHS Staff Survey results for 2016 showed that the trust was below the national average for staff who thought that feedback from patients and service users was used effectively.
- The overall staff engagement score from the National NHS Staff Survey 2016 shows a fall to 3.71 from the 2015 position of 3.77. This was lower than the national average for combined acute

and community trusts of 3.80 in 2016. The trust recognised this and in part believed the awaited move to the new Midland Metropolitan Hospital (and the associated uncertainty) was in part responsible. We saw the trust was working hard to deliver a good communication strategy to support staff in this area.

- We saw the trust produced a monthly news magazine called 'Heartbeat'. The magazine included lots of information for the staff about progress against the trust's strategy as well as identifying and praising individuals for their good work.
- City Hospital has an Active Health Club which is available to all staff across the trust. The gym features cardiovascular machines, treadmills, steppers, cycles, cross trainers and rowing machines. There is a small membership charge for general use, staff with medical referrals can use the club free for six weeks. Referrals may be made if staff with the following conditions have been advised that physical activity would be beneficial for their health:

- diabetes
- cardiovascular disease
- stress, anxiety and depression
- weight management
- muscular/skeletal problems
- post-operative recovery

Innovation, improvement and sustainability

- The Trust is considered by NHSI to have made demonstrable strides towards a seven-day model, whilst trust audit data suggests performance slightly above UK average. Trust has in place a seven day medical, surgical, paediatric, and obstetric input for emergency admissions.
- In October 2018, Midland Metropolitan Hospital plan is to provide such cover on all wards for every patient. There is further work to do ensuring diagnostic and non-clinical support services are configured across the week for emergency but not urgent patients. In 2017-18, this includes better MRI and endoscopy (non GI bleed) access, as well as changes in pharmacy and transport.
- Occupational Therapy Breakfast Group won Stroke Awards West Midlands, Stroke Association.
- The Live and Work programme received 'Excellence in Equality' award, by the SWB CCG Equality Awards and won The Employee Engagement and Support – Sandwell Business Awards.

Summary of findings

- Respiratory service selected to take part in the Future Hospitals Project, (RCP) aiming to deliver an integrated care and 'whole system' approach to respiratory care in Sandwell and West Birmingham.
- Trust set up a Homeless Patient Pathway team to ensure good care after treatment.
- Imaging department has launched a seven-day Interventional radiology nephrostomy service, becoming the first within the Black Country Alliance to do so.
- New Robotic X-ray scanner, which delivers higher quality images and generates a much lower dose of radiation.

Overview of ratings

Our ratings for City and BMEC Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Requires improvement	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
End of life care	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Sandwell General

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

Our ratings for Sandwell and West Birmingham Hospitals NHS Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Community health inpatient services	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Community End of Life Care services	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall Community	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outstanding practice and areas for improvement

Outstanding practice

Medical Service at Sandwell site

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

End Of Life Care at Sandwell site

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

End Of Life Care at City site**:**

- The palliative and end of life care service integrated coordination hub acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week 24 hours a day.

Areas for improvement

Action the trust MUST take to improve
Sandwell General site

Emergency Department

- The trust must take action to ensure storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.
- The trust must take action to improve the standard of records completed by doctors when patients were admitted to wards from the ED compromised the clerking process and increased risk to patients.
- The trust must take action to ensure patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.
- The trust must take action to ensure there is a clearly agreed and resourced system in place for safely managing the condition of patients queuing on trolleys when the ED is very busy.
- The trust must take action to ensure staff identify patients at risk of sepsis and follow the sepsis pathway in place.
- The trust must take action to ensure doctors use the appropriate proforma in place for effective clinical pathways.
- The trust must take action to ensure sufficient substantive registrar cover overnight for the safety of patients.

Outstanding practice and areas for improvement

- The trust must take action to ensure there is a designated appropriately safe room available within which to care for patients with mental ill health
- The trust must take action to ensure the security and safety of staff working in the ED at all times.
- The trust must take action to ensure unplanned re-attendance rate to the ED within seven days is reduced.
- The trust must take action to ensure information about patients' assessment and condition recorded by consultants and doctors is sufficiently detailed, precise and legible.
- The trust must take action to ensure patients are treated within one hour of arriving.
- The trust must take action to ensure patients are admitted, transferred or discharged within four hours of arrival in the ED.
- The trust must take effective action to mitigate the increasing risks to patients from overcrowding in the ED.

Medical Care service

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

Surgery

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- Ensure that records of care and treatment provided to patients are accurate and complete.

Outpatient Department and Diagnostic Imaging

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

City Hospital site

BMEC-Emergency Department

- Increase availability of specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.
- Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.
- The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.
- Patient records must meet standards for general medical record keeping by physicians in hospital practice.

Medicine:

- Ensure compliance with the Mental Capacity Act (2005) is documented.
- Ensure attendance at mandatory training is improved.
- Take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- Improve the consistency of multi-disciplinary processes and ensure the implementation of consultant led board and ward rounds.
- Ensure patients have access to translation services when required.
- Ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

Outstanding practice and areas for improvement

Surgery including BMEC:

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- BMEC mandatory training targets for all clinical staff are met and recorded.

CYP BMEC:

- Improve local governance and ensure risks to the service are escalated, recorded, acted upon and reviewed in a timely manner.
- Medical staffing meets needs of patients and the service.
- Review the storage of emergency drugs and equipment for children and young people
- Age appropriate facilities are provided with separation of adult and children waiting areas and treatment areas.
- Mandatory training targets are met and recorded including paediatric life support.
- A framework for staff to develop and demonstrate competencies to care for children is in place.

OPD including BMEC:

- The trust must ensure resuscitation trolleys are locked and secured with tamperproof tags.
- The trust must ensure patient notes are kept securely and confidentially.
- The trust must ensure sharps bins and clinical waste are stored securely and safely.
- The trust must ensure consulting rooms in BMEC protect patients' dignity and privacy, and prevent people from overhearing conversations between staff and patients.
- The trust must ensure there are improvements with staff completion of mandatory training.
- The trust must ensure all staff who carry out root cause analyses are trained to do so.
- The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation; Staff told us that the patients only used the room if they raised the issue.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Measures to prevent further Never Events had been implemented to protect patient's safety. These newly implemented actions must be maintained, monitored and reviewed. • Emergency resuscitation trolleys were not all secure there were no security tags on the drawers to alert staff to tampering with the contents. • Ensuring that persons providing care or treatment to service users have the qualifications, competence skills and experience to do so safely. • The provider did not ensure that all staff were up to date with paediatric life support training. • The provider did not ensure there was a framework for staff to develop and demonstrate competencies to care for children is in place. • There were not enough specialist medical staff and anaesthetists in BMEC to minimise the risk that children, particularly those younger than three years of age, who attended the department received timely and appropriate treatment. • Staff combined the resuscitation trolley for adults and paediatric patients. We found storage of fluids was not tamper proof in line with resuscitation council guidelines • The provider did not ensure there were enough specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended the department received either timely or appropriate treatment.` • ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

This section is primarily information for the provider

Requirement notices

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

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Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met** The provider was not ensuring systems and processes were established and operated effectively to prevent abuse.

This section is primarily information for the provider

Requirement notices

This was because:-

We reviewed individual department data from the trust and saw that cross sectional imaging radiology, radiography and ophthalmology had only a 50% compliance rate in safeguarding adult's level 2.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15 (1) (c) Suitable for the purpose for which they are being used.** The provider did not ensure there was an age appropriate facilities provided with separation of adult and children waiting areas and treatment areas. Staff working in the ED were vulnerable to aggression and assault from persons entering the premises through the unsecured ambulance admission doorway. There was insufficient storage space for equipment in a number of areas throughout the medical service.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17(2)(b)(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014** assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Where risks were identified the provider did not introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

This section is primarily information for the provider

Requirement notices

Not all assessments, triage records, management plan/ comments, observations and outcomes were fully completed for all patients.

The provider did not ensure that Adult and Children Safeguarding information was properly recorded

Regulation 17(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.
2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
   A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
   B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
   C. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

How this regulation was not being met:

- Appropriate proforma were in place for effective clinical pathways but doctors were not always using them.
- There was a systemic weakness in medical note making and clerking. Information about patients' assessment and condition recorded by consultants and doctors was often scant, lacking in detail and precision or illegible.

This section is primarily information for the provider

Requirement notices

- Further actions identified by senior trust managers to mitigate the increasing risks to patients from overcrowding in the ED, did not address the problem as a hospital wide systems issue and the ED leaders were left to manage it.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met** Staff did not receive appropriate supervision as is necessary to enable them to carry out the duties they were employed to perform. Not all BMEC staff were up to date with mandatory training and /or training was appropriately recorded **This was because:-** Staff in the outpatients department did not have their competencies assessed to ensure they were confident and competent to carry out their role. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. The provider did not always ensure there was enough staffing or appropriate skill mix. Some wards were reliant on the use of temporary staff to fulfil safe staffing requirements. The provider did ensure temporary staff had sufficient competency.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here....