[Author]

# City Hospital

## Evidence appendix

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

# Acute services

## Urgent and Emergency care at City Hospital and Birmingham Midland Eye Centre (BMEC)

### Facts and data about this service

#### Departments

There are two emergency departments (ED) that operate on city site, one at city hospital with a separate entrance and another at Birmingham Midland Eye Centre (BMEC), which is an ophthalmology emergency department, both take adults and children.

As part of Sandwell and West Birmingham hospital trust-city hospital provides a 24-hour emergency and urgent care service to the diverse local population in Birmingham, children's emergency department is open 10 am until 10 pm any child presenting to ED outside these times are seen at the main emergency department.

BMEC provides a 12-hour emergency and urgent care service, patients were advised to go to the nearest ED outside those 12 hours. BMEC is one of the largest centres of its kind in Europe, the service receives referrals from hospitals, General Practitioners (GPs) and self-referrers across the

Region. BMEC provides full range of ophthalmology services, including a dedicated eye ED. Other services include:

- Corneal Services.
- Glaucoma Services.
- Medical Retina Service.
- Neuro Ophthalmology Services.
- Uveitis Services.
- Vitreo Retinal Services.
- Paediatric Ophthalmology.
- Retinopathy of Prematurity (ROP) Screening.
- Fast Track (red eye) ED service.
- Fast Track Age-Related Macular Degeneration Service (AMD).

A GP services runs from city ED, a nurse from a separate provider assess all ambulatory patient upon arrival and directs them to either ED or GP service. This service runs concurrently with ED as an alternative treatment pathway from ED. BMEC provides an emergency service along with urgent care clinic.

The hospital was last inspected in March 2017, the report was published in October 2017, at which time urgent and emergency care service at city and BMEC were rated 'Requires Improvement' in the safe, responsive and well-led domain and 'good' for both effective and caring. During 2018 inspection, we have seen some improvements since the last inspection.

We visited the emergency department on 4, 5 and 6 September 2018. We spoke with 31 members of staff, including matron, consultant, doctors, nurses, health care assistance and domiciliary staff. We spoke with 14 patients and seven family members. We reviewed 41 sets of patient records across both ED at city site.

The main ED consisted of five resus bays and a dedicated cubicle for paediatrics, five cubicles and two infection rooms in majors and four cubicles in the ambulance offload area, and two rapid assessment treatment (RAT) cubicles, with five minor's cubicles.

The paediatric emergency department was of a good size within the main department and consisted of a small size reception area with a child friendly area to play, five cubicle spaces with one being used as a 'see and treat' service, and one triage room. The paediatric department was segregated from the main department by lockable doors.

ED had access to the Ambulatory Medical Assessment (AMA) with four trollies and 14 seats for fit to sit patients waiting on results and discharge. At main ED at both sites, there was a reception desk with two receptionists and two triage nurses. Ambulatory patients with minor illnesses or injuries were diverted either to be seen by GP or to the minors' area within the emergency department.

The trust saw 218,904 attendances, 30,000 were children including GP streamed patients in 2017 and achieved 83.38% against the four-hour standard. The trust emergency departments across sites have a GP front end pathway provided for the trust through a separate provider commissioned by the Clinical Commissioning Group (CCG).

The trust admitted over 40,000 patients as emergencies in 2017, which was a significant rise. They grew ambulatory alternatives by over 300% in the year. Bed based outward flow was to the acute medical units, paediatric assessment units (PAU), an emergency gynaecology unit and a surgical assessment unit (based at Sandwell General site).

Mental health urgent care is supported by Sandwell and West Birmingham NHS hospital trust by two Mental Health providers.

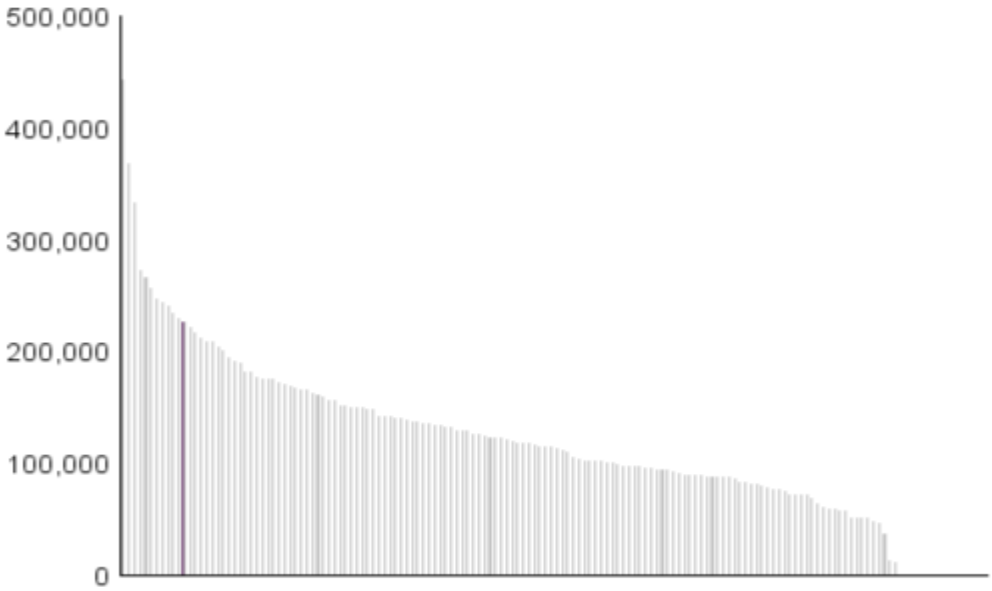
During our inspection we saw BMEC within urgent care had seen over 29000 patients from September 2017 to August 2018, with 60,000 attendances in ED with an average of 3,650 children. BMEC accepts all children with emergency eye problems, they are seen by a general ophthalmologist doctor in ED and then referred to a paediatric ophthalmologist if required, children who are required an inpatient admission for any clinical intervention such as intravenous antibiotic or surgery they are transferred and admitted to main city hospital on D19 a children ward with a daily review by BMEC staff and consultant.

*(Source: Routine Provider Information Request (RPIR) – Context acute)*

## Activity and patient throughput

From July 2017 to June 2018 there were 226,152 attendances at the trust's urgent and emergency care services as indicated in the chart below.

### Total number of urgent and emergency care attendances at Sandwell and West Birmingham Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018

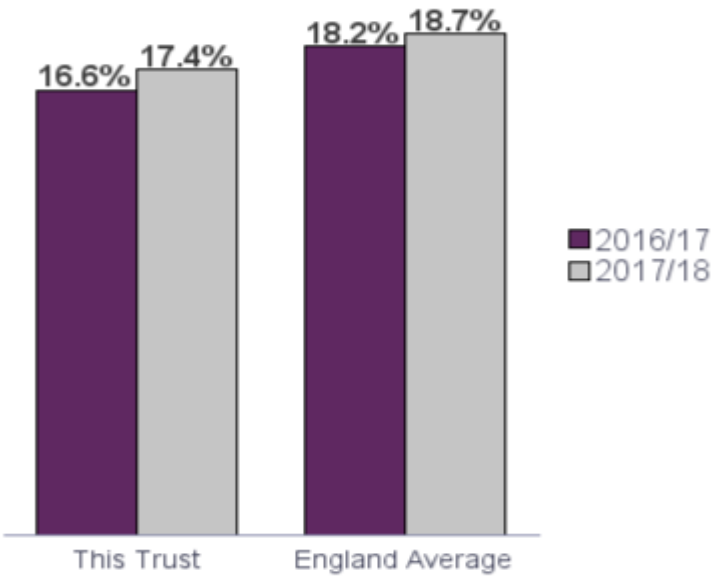



*(Source: NHS England)*

## Urgent and emergency care attendances resulting in an admission

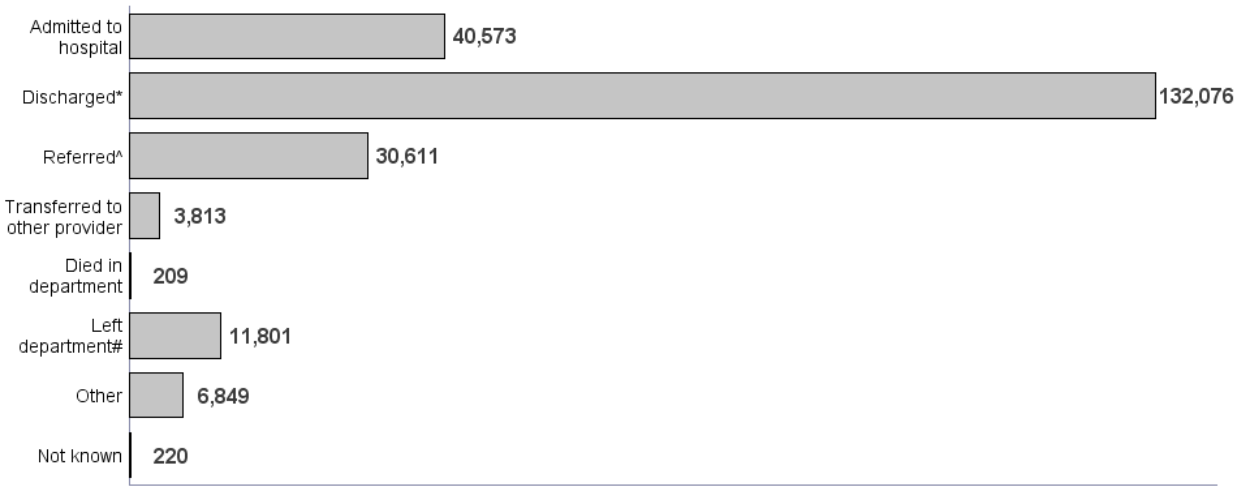
The percentage of A&E attendances at this trust that resulted in an admission increased slightly in 2017/18 when compared to previous year. In both years, the proportions were lower than the England averages.

### Percentage of A&E attendances at Sandwell and West Birmingham Hospitals NHS Trust 2016/17 and 2017/18




*(Source: NHS England)*

## Urgent and emergency care attendances by disposal method, from April 2017 to March 2018




* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

*(Source: Hospital Episode Statistics)*

## Is the service safe?

### Mandatory Training

**The trust target for mandatory training compliance was not met for nursing or medical staff in some subjects. However, the service had action plans in place, these were monitored regularly, and the trust had set a high percentage target of 95%.**

The service did not meet the 95% target. The service was aware of the areas that required improvements in uptake levels and were in the process to address these. However, the trust annual training start from September to September and therefore not all staff had yet completed their training from the July 2018 data.

We received, a detailed action plan on how to improve ED staff mandatory training compliance. At BMEC we saw mandatory training current performance is at 95.4% against the trust standard of 95%, to further improve performance the following actions would be undertaken:

- Outstanding Safeguarding training to be progressed or completed by 31st October 2018 by staff either at work or phased return.
- Moving and Handling refreshers to be completed by 30th November 2018 by staff either at work or phased return.
- Conflict Resolution updates to be completed by 30th December 2018 by staff either at work or phased return.
- Basic Life Support updates to be completed by 30th November 2018 by staff either at work or phased return.
- Information Governance updates to be completed by 30th October 2018 by staff either at work or phased return.
- Training to be booked for all staff falling due for reviewal in the next 6 months by 30th September 2018.

We saw latest figures for BMEC nursing team currently at 54% compliance rate for Paediatric Intermediate Life Support (PILS) and was assured by 24 September 2018 rate will be at 88% and 100% by 22 of October 2018.

City Site ED action plan to further improve performance the following actions will be undertaken:

- Band 7 team leaders to chase and manage teams training compliance.
- In house sessions for manual handling by approved trainer (also must complete online module alongside other training).
- Assisting staff to complete on line modules.
- Formal Letters to be sent to staff that are not completing mandatory training- discussion about conduct and professional issue.

Exceptions:

- Data includes New starters (some who have not yet had corporate induction).
- Data includes staff who are on long term sickness.
- Some staff have completed some of the modules, but this is not represented on the report as remain red.

Basic Life Support: -

- 11 staff out of date- four have completed and have training record-remains not updated electronically.
- Two staff members on long term sick- one was previously on maternity leave for a year previously.
- One staff member just returned from maternity leave.
- One staff member transferred from another area-now leaving to undertake nurse training.

Staff told us that they could access mandatory training when they required it. Senior staff in the emergency department (ED) monitored their staff training information.

Junior Doctors we spoke with said they could access training and felt supported to access additional training if needed.

## Mandatory training completion rates

## Trust level

## Nursing staff

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/ No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Moving and handling – non-patient limited load handling | 1 | 1 | 100.0% | 95% | Yes |
| Medical devices competency form | 190 | 193 | 98.4% | 95% | Yes |
| Equality & diversity | 188 | 193 | 97.4% | 95% | Yes |
| Harassment & bullying level 1 | 187 | 193 | 96.9% | 95% | Yes |
| Fire safety - workplace training | 186 | 192 | 96.9% | 95% | Yes |
| Health & safety | 182 | 193 | 94.3% | 95% | No |
| Introduction to information governance | 80 | 85 | 94.1% | 95% | No |
| Blood collection | 78 | 86 | 90.7% | 95% | No |
| Conflict resolution initial training | 175 | 193 | 90.7% | 95% | No |
| Resuscitation: basic life support | 162 | 185 | 87.6% | 95% | No |
| Infection control | 162 | 193 | 83.9% | 95% | No |
| Medical devices training | 151 | 182 | 83.0% | 95% | No |
| Medicines management | 152 | 193 | 78.8% | 95% | No |
| Conflict resolution update | 78 | 101 | 77.2% | 95% | No |
| Moving and handling - patient handling | 143 | 189 | 75.7% | 95% | No |
| Transfusion | 107 | 166 | 64.5% | 95% | No |
| Information governance refresher module | 55 | 108 | 50.9% | 95% | No |

In urgent and emergency care at the trust, the 95% completion target was met for six of the 18 mandatory training modules for which qualified nursing staff were eligible. Two of these courses had a completion rate of 100%, although these are based on only one eligible member of staff having completed the training. The lowest completion rate was for the information governance refresher module, which had a rate of 50.9%.

## Medical Staff

In urgent and emergency care at the trust, the 95% completion target was met for two of the 18 mandatory training modules for which medical and dental staff were eligible. Two of these courses had a completion rate of 100%. In contrast, only 43.6% of the eligible medical and dental staff had completed the introduction to information governance and only four of the 12 eligible staff (33.3%)

had completed the conflict resolution module.

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - basic consent | 16 | 16 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 48 | 50 | 96.0% | 95% | Yes |
| Medical devices competency form | 45 | 50 | 90.0% | 95% | No |
| Infection control | 43 | 50 | 86.0% | 95% | No |
| Moving and handling - medical staff | 31 | 42 | 73.8% | 95% | No |
| Equality & diversity | 34 | 50 | 68.0% | 95% | No |
| Information governance refresher module | 7 | 11 | 63.6% | 95% | No |
| Fire safety - workplace training | 31 | 50 | 62.0% | 95% | No |
| Resuscitation: basic life support | 30 | 50 | 60.0% | 95% | No |
| Conflict resolution initial training | 29 | 50 | 58.0% | 95% | No |
| Health & safety | 27 | 50 | 54.0% | 95% | No |
| Medicines management | 27 | 50 | 54.0% | 95% | No |
| Transfusion | 22 | 47 | 46.8% | 95% | No |
| Medical devices training | 20 | 44 | 45.5% | 95% | No |
| Introduction to information governance | 17 | 39 | 43.6% | 95% | No |
| Conflict resolution update | 4 | 12 | 33.3% | 95% | No |

## City Hospital (including BMEC)

## Nursing staff

A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below.

At City Hospital's urgent and emergency care department, the 95% completion target was met for six of the 18 mandatory training modules for which qualified nursing staff were eligible. The lowest completion rate was for the information governance refresher module, which had a rate of 72.1%.

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 74 | 75 | 98.7% | 95% | Yes |
| Equality & diversity | 74 | 76 | 97.4% | 95% | Yes |
| Medical devices competency form | 74 | 76 | 97.4% | 95% | Yes |
| Harassment & bullying level 1 | 74 | 76 | 97.4% | 95% | Yes |
| Infection control | 74 | 76 | 97.4% | 95% | Yes |
| Conflict resolution initial training | 72 | 76 | 94.7% | 95% | No |
| Health & safety | 72 | 76 | 94.7% | 95% | No |
| Introduction to information governance | 31 | 33 | 93.9% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Medical devices training | 67 | 74 | 90.5% | 95% | No |
| Resuscitation: basic life support | 67 | 76 | 88.2% | 95% | No |
| Medicines management | 66 | 76 | 86.8% | 95% | No |
| Conflict resolution update | 38 | 44 | 86.4% | 95% | No |
| Blood collection | 31 | 37 | 83.8% | 95% | No |
| Transfusion | 42 | 56 | 75.0% | 95% | No |
| Moving and handling - patient handling | 54 | 73 | 74.0% | 95% | No |
| Information governance refresher module | 31 | 43 | 72.1% | 95% | No |

## Medical staff

A breakdown of compliance for mandatory training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - basic consent | 9 | 9 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 27 | 29 | 93.1% | 95% | No |
| Medical devices competency form | 26 | 29 | 89.7% | 95% | No |
| Infection control | 25 | 29 | 86.2% | 95% | No |
| Information governance refresher module | 4 | 5 | 80.0% | 95% | No |
| Moving and handling - medical staff | 16 | 23 | 69.6% | 95% | No |
| Equality & diversity | 18 | 29 | 62.1% | 95% | No |
| Fire safety - workplace training | 17 | 29 | 58.6% | 95% | No |
| Resuscitation: basic life support | 17 | 29 | 58.6% | 95% | No |
| Conflict resolution initial training | 17 | 29 | 58.6% | 95% | No |
| Medicines management | 16 | 29 | 55.2% | 95% | No |
| Health & safety | 15 | 29 | 51.7% | 95% | No |
| Transfusion | 12 | 26 | 46.2% | 95% | No |
| Medical devices training | 11 | 25 | 44.0% | 95% | No |
| Introduction to information governance | 10 | 24 | 41.7% | 95% | No |
| Conflict resolution update | 2 | 9 | 22.2% | 95% | No |

At City Hospital's urgent and emergency care department, the 95% completion target was met for one of the 16 mandatory training modules for which medical and dental staff were eligible. Only 41.7% of the eligible medical and dental staff had completed the introduction to information governance and only two of the nine eligible staff (22.2%) had completed the conflict resolution module.

## 'Other' urgent and emergency care department

Please note that the trust provided a small amount of data for nursing staff for which the site has assigned to 'other'. These are staff working across multiple sites.

## Nursing staff

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing

staff in the urgent and emergency care department at sites classified as 'other' by the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/ No) |
|---|---|---|---|---|---|
| Information Governance: Introduction to Information Governance | 1 | 1 | 100.0% | 95% | Yes |
| Blood Collection | 1 | 1 | 100.0% | 95% | Yes |
| Medical Devices Competency Form | 7 | 7 | 100.0% | 95% | Yes |
| Health & Safety | 7 | 7 | 100.0% | 95% | Yes |
| Equality & Diversity | 7 | 7 | 100.0% | 95% | Yes |
| Conflict Resolution Initial Training | 7 | 7 | 100.0% | 95% | Yes |
| Moving and Handling - Non Patient Limited Load Handling | 1 | 1 | 100.0% | 95% | Yes |
| Conflict Resolution Update | 7 | 7 | 100.0% | 95% | Yes |
| Resuscitation: Basic Life Support | 7 | 7 | 100.0% | 95% | Yes |
| Fire Safety - Workplace Training | 7 | 7 | 100.0% | 95% | Yes |
| Harassment & Bullying Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Infection Control | 7 | 7 | 100.0% | 95% | Yes |
| Medicines Management | 6 | 7 | 85.7% | 95% | No |
| Moving and Handling - Patient Handling | 5 | 6 | 83.3% | 95% | No |
| Medical Devices Training | 5 | 6 | 83.3% | 95% | No |
| Information Governance: Information Governance Refresher Module | 3 | 6 | 50.0% | 95% | No |

In urgent and emergency care at sites classified as 'other' by the trust, the 95% target was met for 12 of the 18 mandatory training modules for which qualified nursing staff were eligible. All 12 of the courses which met the target attained a 100% completion rate, although it should be noted that the number of eligible staff for each course was smaller than at other sites. Therefore, each staff member represents a higher proportion of the total.

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

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most nursing staff had received the required level of safeguarding training, however, only just over half of medical staff had completed safeguarding children level 3 course.**

## Trust level

## Safeguarding training completion rates

The trust set a target of 95% for the completion of safeguarding training.

Staff understood how to protect patients from abuse and the service worked well with other agencies.

Staff told us within the department that a member from the safeguarding team and domestic violence lead visited the department on regular basis. Staff were aware of their role and responsibilities in making safeguarding referrals.

Staff showed us their clear safeguarding guidance on the trust internet and told us this was easy to follow. Staff we spoke with demonstrated good understanding around safeguarding and knew whom to contact within the safeguarding team.

Staff used a flagging system to highlight concerns through the triage system and any concerns raised, information was then highlighted and shared with all relevant people on duty.
We spoke with the domestic violence lead, who supported staff with awareness training around Female Genital Mutilation (FGM), child sexual exploitation (CSE), modern slavery and human trafficking. Staff spoke very highly of this service and were fully aware how to use the support if needed.

We found incomplete records around safeguarding and domestic violence proforma, we observed staff asking relevant questions during patients' assessments; however, the documentation was not always completed. We also found the domestic violence proforma were aimed mainly towards female patients but despite this staff we spoke with said they would include all patients. The domestic violence lead told us this project is steering towards all patients.

## Nursing staff

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 30 | 31 | 96.8% | 95% | Yes |
| Safeguarding Children Level 3 | 101 | 120 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 59 | 73 | 80.8% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with two of these courses achieving a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 80.8%.

## Medical Staff

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 11 | 13 | 84.6% | 95% | No |
| Safeguarding Adults Level 2 | 16 | 20 | 80.0% | 95% | No |
| Safeguarding Children Level 2 | 23 | 37 | 62.2% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both of these courses achieving a 100% completion rate. The safeguarding children level 2 module had the lowest completion rate, at 62.2%.

## Safeguarding at City Hospital (including BMEC)

## Nursing staff

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 76 | 76 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 76 | 76 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 12 | 13 | 92.3% | 95% | No |
| Safeguarding Children Level 3 | 48 | 57 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 16 | 19 | 84.2% | 95% | No |

At City Hospital's urgent and emergency care department, the 95% completion target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible, with both courses achieving a 100% completion rate. The safeguarding children levels 2 and 3 courses both had completion rates of 84.2%.

## Medical staff

A breakdown of compliance for safeguarding training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 29 | 29 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 29 | 29 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 10 | 14 | 71.4% | 95% | No |
| Safeguarding Children Level 2 | 16 | 27 | 59.3% | 95% | No |
| Safeguarding Children Level 3 | 1 | 2 | 50.0% | 95% | No |

At City Hospital's urgent and emergency care department, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both courses achieving a 100% completion rate. The safeguarding children level 3 course had the lowest completion rate, at 50%; however, this was based on only one of the two eligible staff members not completing the course.

## 'Other' urgent and emergency care department:

Please note that the trust provided a small amount of data for nursing staff for which the site was assigned to **'other'**. These are staff working across multiple sites.

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at sites classified as 'other' by the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Children Level 2 | 6 | 7 | 85.7% | 95% | No |

In urgent and emergency care at sites classified as **'other'** by the trust, the 95% completion target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 85.7%.

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

## Cleanliness, infection control and hygiene

**The service controlled infection risks within the department. Staff kept themselves, equipment and the premises clean. They used appropriate control measures to prevent the spread of infection however we found concerns around disposal of clinical waste.**

Infection prevention and control (IPC) measures were in place to ensure patients were protected against hospital-acquired infections whilst in the department. Staff received infection control training as part of their mandatory training.

We saw staff across both ED site, adhered to IPC and were bare below the elbows. Trust IPC policies and guidance were based on national guidance and best practice.

On display in the children's waiting area at ED BMEC, we saw a daily cleaning schedule for children's' toys, we saw this was signed and up to date.

As part of the trusts on going initiative for reducing and preventing healthcare associated infections, all clinical areas were required to undertake hand hygiene audits. We requested hand hygiene audits and this did not include ED.

We saw staff wearing Personal Protective Equipment (PPE) such as gloves and aprons. Staff used alcohol sanitizers and washed hands between patient contacts. We saw there were isolation cubicles available for both adults and children. However, during our inspection majority of the alcohol sanitizers gel were empty at main ED site, we asked varies members of staff the reasons behind this who said there were issues with the supplier, we did not find this being an issue at BMEC and other wards on city site.

We observed ambulance crews, security staff, police officers washing their hands and using hand sanitizers before and after entering the departments.

During our inspection we saw domiciliary staff were visible throughout ED, we observed staff requesting areas to be cleaned. Staff used appropriate clinical waste bags and was stored appropriately.

Domiciliary staff across both ED told us they follow cleaning schedules for each department at the hospital, this included deep cleaning. We saw these schedules were on display throughout the hospital; Staff told us that they do not use 'I am clean' stickers anymore as every staff were responsible to clean daily and complete the logs. We observed the cleaning logs in majors and minors – these were signed and dated daily.

## Environment and equipment

**The service had suitable premises and equipment and these were well maintained. There was adequate availability of emergency and specialist equipment for patients'.**

We saw emergency department was clearly signposted and access for visitors were easy to follow from each department to the next. During our inspection at BMEC we had to help a patient who was struggling to walk from the taxi drop off outside hospital to the main entrance, we were unable to find wheelchairs-we asked at reception and they informed us they don't have any wheelchairs available on site they will have to call round the hospital to find one. We raised our concerns and senior staff told us this was an issue and that they have requested wheelchairs and have applied to charities for assistance.

We found all cubicles to be visibly clean and tidy with minor wear and tear damage across both ED. However, Single used items such as sharps bins at city hospital ED were unlocked, full, not dated or signed, and was easily accessible.

We observed in minors, plaster room and by the ambulance entrance that cylinder gases were not kept secure, we found a mixture of oxygen cylinders all kept together half full, full and empty.

The plastering room in main ED was visibly clean and was located close to minors. We followed a child who presented to ED who required admission, the journey from majors to patient assessment unit (PAU) was not easy to follow, narrow corridor and wet floor signs were in the way.

The waiting area in the main ED was visibly clean with dedicated seats for patients-reception staff ensured that ambulatory patients were kept up to date on waiting times during booking process.

ED reception has three panic buttons under the desk and access to buttons to shut the shutters on windows of the reception desk. Staff told us they have been issued with personal security alarms following an assault in the car park. Doctors on ED resus told us that they could have a security chaperone to the car park if working late or night shifts. Staff in ED told us that they were concerned about going outside to the car park and main road they did not feel safe.

During triage at city hospital we observed patients' confidentiality at times were not fully respected, for example the door to the triage room was wide open with nurses walking in and out of the room whilst a patient was being assessed, patients' conversations could be heard from triage room to the main department.

At BMEC ED we saw waiting times were communicated with patients at main reception and a poster on display if the wait exceeded two hours. BMEC did not have a dedicated 'children only' waiting area. In the main waiting area there was a corner with a moveable wall partitioned for children to wait, with a small playing area and seat for parents to sit on. Matron informed us that this has improved since the 2017 inspection, while there was a clear indication that staff had tried to make a separate waiting area for children, not all the recommendation from Royal College of Emergency Medicine and Royal College of Paediatrics and Child Health around separation of children sight and sound were met. We were told by senior nurse that a new build of BMEC was planned and a separate waiting room for children was in the plan.

We visited the children's emergency department at city hospital, we found it to be of a good size and consisted of a small size reception area with a children area to play with toys, five cubicle spaces including a cubicle allocated for 'see and treat', and one triage room.

The children department was segregated from the main department by lockable doors, however, during our inspection the main doors to the department were open at all times. We observed members of the public 'wondering' in and out of the department, we raised our concerns with staff on duty and they said this was for security reasons as they felt isolated especially as they only have two

members of staff on duty, at times if one staff member is called away in emergency this meant one staff member was left on their own.

ED environment is a psychiatric Liaison Accredited and meets mental health requirements environmentally. However, during our inspection mental health assessment room, patients potentially have direct and unchallenged access to rooms with fixed ligature points, sharps boxes on display, access to unlocked rooms with boiling water, cables and equipment. Some pin lock doors with access codes had written codes on door frames for example the store room, including unlocked doors to children's emergency department.

All staff we spoke with said that they had access to the equipment they needed but if equipment broke then the trust does not replace. Staff told us that the response they always had was "we will replace equipment when the new hospital is built". Management informed us that there was an equipment replacement programme and a capital investment programme for the trust. Recent investment in ED have included ECG machines, mattresses for trollies and chairs.

We saw ED had CCTV cameras on corridors and most areas were monitored by security staff. The CCTV camera did not work in resus and the doors could not be locked for lockdown. The two doors for resus were accessible from the corridor where members of the public could access.

Toilets were accessed through majors ED, with disabled access to toilets. All toilets had a fixed ligature points. One toilet had a large window that opens to outside area, windows are not alarmed, this could be a potential absconding point or for passing substances.

We saw there was no service operation procedures for managing children and their families in adult waiting room when children emergency service was closed or when violence occurs.

During the inspection we observed members of the public walking into the main nurses' station unattended at city ED, computers were not locked and patients' confidentiality was breached. We witnessed a member of the public walking straight through the automated doors without speaking to any staff member. Staff we spoke with said security around the automated doors and safety of staff is concerning, alert cameras are in place and security staff do visit on regular basis, and if any incident occurs security staff are there immediately. We were given an example of when the trust had to go into 'locked down' due to an incident, staff on duty were impressed with how quickly the security staff, police officers and management team reacted to this incident.

BMEC had an emergency entrance, the reception desk provided a 'pre-triage' desk with two triage nurses and a registration desk with two receptionists. Patients were required to queue and present themselves to the 'registration' desk upon arrival, this resulted in patients having to queue to then be seen by the 'pre-triage' nurse. Since the 2017 inspection, BMEC have implemented a dedicated advice phone line to allow patients to call whether they need to be seen as an emergency or by an urgent appointment, staff told us this helped with patient queuing. There are now two 'pre-triage' nurses who can determine whether a patient is urgent care or emergency care, as a result there are now two separate waiting areas for urgent care and emergency care with additional clinics.

Since the 2017 inspection, BMEC reception has been given a 'dedicated red line' for patient to stand behind when reception staff are booking patients to allow privacy for staff and patients along with a dedicated glass window partition to improve staff safety. When we spoke with staff they said they did not have an emergency alarm in the triage room or in the reception desk and gave us an example where an incident occurred in the main waiting area between patients arguing over waiting in the queue, staff had to drawer the reception shutter blinds until the patients had agreed to not argue anymore.

Security staff do visit on regular basis but in emergency there is no alarm call bell-we asked about what would they do if patient deteriorated in main waiting area staff said they would have to shout to get attention.

Across both ED sites at City, resuscitation equipment and trolleys were checked daily as required by trust policy. Equipment was tamper proofed and in date. All trolleys were visibly clean and organised. Staff we spoke with understood the arrangements if a major incident occurred, aware of the trust policy and arrangements. Equipment were stored safely and were easily accessible in an emergency. Staff in charge regularly checked equipment, pathways, action cards, and specific information was available to staff on the trust intranet. We reviewed the trust major incident plan and found it to be up to date, renewal date due March 2019.

## Assessing and responding to patient risk

**The service had effective systems in place to recognise and respond to deteriorating patients' needs and clinical risks. Observations of the patients were recorded using the national early warning scoring (NEWS) system, staff demonstrated good understanding of how and when to escalate when a patient deteriorates.**

We observed triage nurses across both ED sites and we were assured that all staff were aware of the triage system and all staff knew what system were in use. Staff told us they carried out a 12-month training programme and once completed they would 'shadow' other triage nurses before they could carry out their triage duties. We spoke with three junior nurses who confirmed this, who were currently working towards becoming a triage nurse. We saw on display in the department latest audit for appropriate triage for August 2018 98.48% of staff were compliant.

We saw all staff in triage were all trained on the system, we found the system used for triage were able to give staff support to categorise and prioritise patients waiting to be seen. Staff worked closely with reception staff, for example we observed reception staff who had concerns about a patient who flagged on their system who then followed this up by a telephone call or walk to the triage room to discuss their concerns with the triage nurse.

There were two-triage nurses at reception in main ED, one worked directly for the trust and the other worked for a separate provider. This streaming process took place to determine if patients require urgent care, GP referral, minors or emergency service. Patients are seen in order of clinical priority not attendance.

At BMEC there was a clear triage system in place. Management told us that all nurses working in triage are ophthalmic trained, who can carry out pre- triages, assess patients and are able to assign patient to one, two or three pathways: urgent care pathway, emergency pathway and nurse led pathway. Senior staff told us that BMEC will only treat patients of those with ophthalmic diseases, however if a patient did present themselves into ED and deteriorated on site, staff would seek medical advice and patient would be transferred to main city hospital if stable to do so.

We observed eight patients being assessed using a national recognised triage system. Observations, pain score and analgesia was offered and given appropriately, all triage scores and NEWS scores were recorded electronically. Staff monitored and recorded early warning scores (EWS) in line with national clinical care pathways. Paediatric early warning scores (PEWS) was used same way but specifically for children. We saw clinical observations were consistent and in line with the trust internal policy.

Staff at BMEC told us they only used NEWS/PEWS during theatre and post-operative care. We saw on display outside ED NEWS/PEWS audit for July 2018, 100% staff were compliant and in August 2018, 98% of staff were compliant.

There were clear pathways for staff to manage deteriorating patients at main ED, we saw examples of patients on the sepsis pathway and we observed staff escalating to the appropriate clinician. The

management and recognition of sepsis was well managed. We found that sepsis pathway was in place and staff were aware and actively using this pathway. Patients received prompt and safe care in response to this in most cases. ED at main site had a sepsis bleep holder who was contacted as soon as a patient was triggering sepsis.

Staff on duty had a good understanding on recognising signs and symptoms for sepsis and what to do if they had a patient with pyrexia and tachycardia. On display outside ED we saw between July 2018 and August 2018, 18 patients were identified within one hour as “red flag” sepsis (94% Average time seen under one hour was 22 minutes) with one patient over one hour.

Patients bought into hospital by ambulance crew were handed over promptly, ambulance crew told us they did not have to wait a long to offload patients and handover to the triage nurse. At BMEC we did not see a patient arriving with ambulance and we were unable to determine ambulance crews had any delays to offload patients.

Ambulatory patients who presented themselves in ED at main hospital site received a robust assessment of their clinical presentation and condition; We reviewed 10 Initial assessments and saw patients were seen within the 15 minutes. At BMEC some patient was waiting over 30 minutes to be seen at ‘pre-triaged’ but soon as they were referred to the emergency triage, patients were seen within 15 minutes.

We spoke with the capacity lead who showed us how they monitored patient flow and how issues were escalated through regular capacity meetings, which were held up to five times a day.

We spoke with staff in the children emergency department who told us that all trauma inpatients for children were transferred to Sandwell General hospital or another local hospital. Staff told us that sedation and manipulation of limbs were done by an adult anaesthetist with paediatric experience.

Emergency nurse practitioners (ENP) we spoke with told us they will see children with minor injuries and tend to work majority of their day in minors.

Staff told us children triage stop at 9pm in order to discharge and transfer those children in the department before 10am. Out of hours staff try to bring children straight through to cubicles rather than make them wait in the main waiting area, but during busy times they may not have capacity to do this.

Planned staffing levels and actual numbers were on display throughout the department across BMEC and main ED, staffing numbers were at planned level during our inspection.

## Emergency Department Survey 2016

The trust scored about the same as other trusts for the five Emergency Department Survey questions relevant to safety.

| Question | Score | RAG |
|---|---|---|
| Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff? | 7.6 | About the same as other trusts |
| Q8. How long did you wait before you first spoke to a nurse or doctor? | 5.7 | About the same as other trusts |
| Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse? | 6.1 | About the same as other trusts |
| Q33. In your opinion, how clean was the emergency department? | 8.0 | About the same as other trusts |

| | | |
|---|---|---|
| Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? | 9.6 | About the same as other trusts |

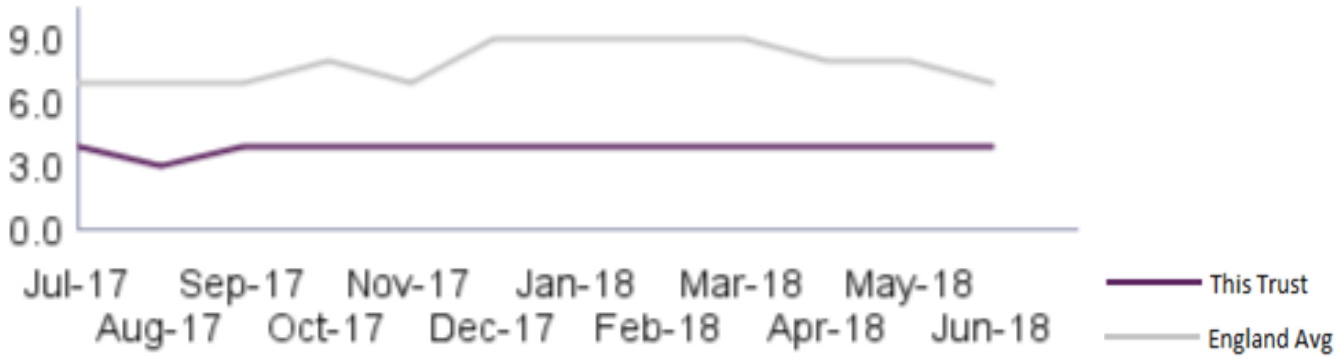
*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

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

**The median time from arrival to initial assessment was consistently better than the overall England median in all 12 months over the period from July 2017 to June 2018.**

In the most recent month, June 2018, the median time to initial assessment was four minutes at the trust compared to the England average of seven minutes.

**Ambulance – Time to initial assessment from July 2017 to June 2018 at Sandwell and West Birmingham Hospitals NHS Trust**




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

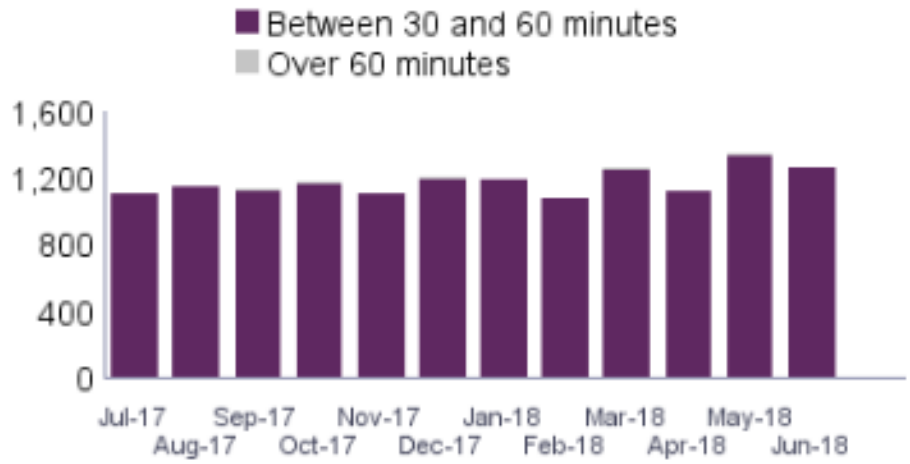
## Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

### City Hospital

The chart below shows the monthly percentage of ambulance journeys with turnaround times over 30 minutes at City Hospital from July 2017 to June 2018.

In the most recent month, June 2018, 55% of ambulance journeys had turnaround times over 30 minutes compared with 46% in July 2017.

## Ambulance: Number of journeys with turnaround times over 30 minutes - City (Birmingham)



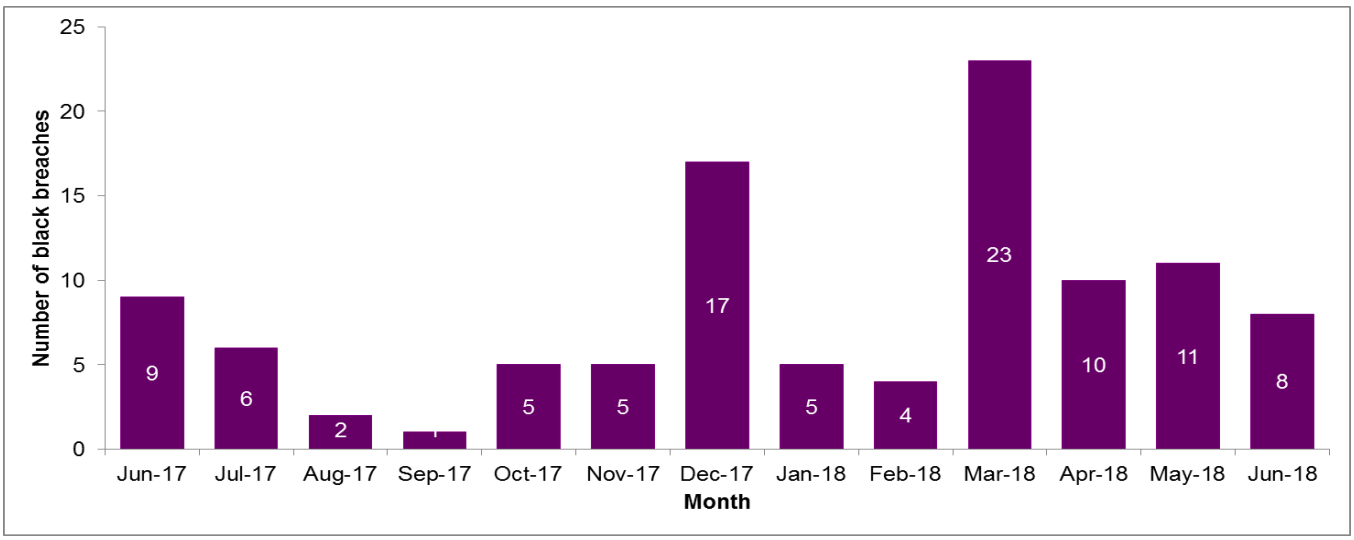

## Ambulance: Percentage of journeys with turnaround times over 30 minutes - City (Birmingham)


*(Source: National Ambulance Information Group)*

## Number of 'black breaches' for this trust

A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From June 2017 to June 2018 the trust reported 106 "black breaches", with peaks in December 2017 (17) and March 2018 (23). The majority of the "black breaches" were attributed to gaps in the registrar rota and a lack of patient flow.



*(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)*

## Nurse staffing

**The service employed nursing staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

Nurses we spoke with felt they were under staffed especially within the paediatric emergency department. The trust has employed more paediatric nurses at children's emergency department, this is an improvement since 2017 inspection, where ED on occasion had no paediatric nurses cover, the trust have five paediatric nurses. At BMEC they have one paediatric nurse who works at ED three days a week, in addition senior nurse told us they had a 24-hour access to paediatric nurses based at city hospital on ward D19.

BMEC staff had three Band 7 nurses all three were whole time equivalent (WTE), eight Band 6 nurses of which five were WTE and three were part time, 10 Band 5 nurses, five were part time and five were full time and three Band 2 healthcare assistant who were full time.

The trust reported the following nurse staffing numbers in urgent and emergency care both for April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| City Hospital and Sandwell General Hospital | 241.4 | 299.0 | 80.8% | 220.6 | 277.5 | 79.5% |

The nursing staffing levels were similar in both time periods.
The trust was unable to provide this data broken down by site, indicating that the nursing staff worked at both City Hospital and Sandwell General Hospital.

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

## Vacancy rates

**Vacancy rates were low within the service with active recruitment and minimal temporary staffing usage. There was a high vacancy rate among staff assigned to 'other' sites, which included nursing staff in the emergency care management team and the resuscitation team**.

From July 2017 to June 2018, the trust reported a vacancy rate of 2.8% for nursing staff in urgent and emergency care at trust level, which was similar to the trust's target of 3%. A breakdown of vacancies at site level is provided below.

- City Hospital emergency department: 0.8% (including a rate of -5.2% at BMEC indicating the service was over-established)
- Staff assigned to 'other' sites within urgent and emergency care: 21.8%

There was a high vacancy rate among staff assigned to 'other' sites, which included nursing staff in the emergency care management team and the resuscitation team. However, this analysis is based on a small number of nursing staff which has inflated the rate and so should be interpreted with care.

The trust noted that the discrepancy between their planned versus actual staffing data and their data for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

**The turnover rate within the service appears to be high; however, there is no overall trust-wide turnover target, staff told us that there was a stable base of staff working within the main emergency department at city and BMEC and this did not affect patient care. However, staff at the children's emergency department felt they were not fully staffed.**

From June 2017 to May 2018, the trust reported a turnover rate of 19.2% for nursing staff in urgent and emergency care at trust level. There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses. A breakdown of turnover at site level is provided below.

- City Hospital emergency department: 21.2% (including a rate of 11.3% at BMEC based on 1.6 WTE staff leaving over the 12 months)
- Staff assigned to 'other' sites within urgent and emergency care: 28.8%

None of the sites met the target of 10.5% for band 5 nurses.

The highest turnover rate was among staff assigned to 'other' sites, which included nursing staff in the emergency care management team and the resuscitation team. However, this analysis is based on only two WTE staff leaving over the 12-month time period.

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

## Sickness rates

**The sickness rate was higher than the trusts target. Any episodes of sickness were managed and appropriate backfill was arranged for any long-term sickness episodes.**

From June 2017 to May 2018, the trust reported an annual sickness rate of 6.1% in urgent and emergency care at trust level, which was higher than the trust target of 3%. A breakdown of sickness rates by site is found below:

- City Hospital emergency department: 4.1% (including a rate of 4.2% at BMEC)
- Staff assigned to 'other' sites within urgent and emergency care: 3.2%

The sickness rate at each site was also worse than the trust target.

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

## Bank and agency staff usage

**The trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts. The trust rate appears to be high, some staff we spoke with had mixed thoughts around the management of sickness and backfill for long-term sickness.**

**Trust level**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in urgent and emergency care at the trust from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 1,938 shifts were filled by bank staff and 379 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 1,184 shifts were filled by bank staff and 28 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 1,938 | 1,184 | 3,122 |
| Agency | 379 | 28 | 407 |

**City Hospital (including BMEC)**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in urgent and emergency care at City Hospital (including BMEC) from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 1,276 shifts were filled by bank staff and 149 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 712 shifts were filled by bank staff and one shift was covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 1,276 | 712 | 1,988 |
| Agency | 149 | 1 | 150 |

**‘Other’ urgent and emergency care department**

The alcohol team consists of one band 7, two band 6, one band 5 and two alcohol practitioners. This service is led by a consultant.

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The trust provided some bank and agency data for nursing staff for which the site was assigned to ‘other’. These are staff working across multiple sites.

The table below shows the numbers of shifts in urgent and emergency care where the site was not specified from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 563 shifts were filled by bank staff and 45 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 355 shifts were filled by bank staff and 23 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 563 | 355 | 918 |
| Agency | 45 | 23 | 68 |
| Not filled | 104 | 40 | 144 |

*(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)*

## Medical staffing

**The service had medical staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was sufficient medical cover to provide consultant presence in the departments for 16 hours a day, as recommended by the Royal College of Emergency Medicine.**

Consultants worked across City hospital and Sandwell general. We saw that acute physician covered ED from 8am to midnight, consultants for both paediatric and adult 8am to 10pm, registrar cover 9pm to midnight with additional support from other practitioners, seven days a week with on call service from 10pm onwards.

Medical staff we spoke with told us that consultant rota is not always filled and at time there are gaps, the rota we reviewed is carrying a current vacancy of 6.3 whole time equivalent across city and Sandwell hospital sites. The rota gaps are impacting by lack of ED consultants available for employment. Staff told us this was on the risk register. We reviewed the weekend rota for consultants for number of Saturday and Sunday shifts, where a second Consultant has not been on shift (3pm-9pm) in September 2017 there were three unfilled cover, November 2017 there were four unfilled cover, three unfilled cover in December 2017 and one unfilled cover for both March and April 2018.

Medical handovers took place three times a day, we observed the 4pm handover and patients' details were discussed in full along with discharges status.

The children's ED had a paediatric emergency medicine consultant that worked different shift patterns every week, during other times a consultant was on call and available at main ED.

ED consultants at BMEC provided an on-call cover 24 hour a day, seven days a week. Staff told us they could contact the consultant any time and support was always there.

The trust reported the following medical and dental staffing numbers both for April 2017 to March 2018 and, more recently, in April/May 2018.

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |

| | | | | | | |
|---|---|---|---|---|---|---|
| City Hospital and Sandwell General Hospital | 110.4 | 125.6 | 87.9% | 112.5 | 130.2 | 86.4% |

The medical and dental staffing levels were similar in both time periods.

The trust was unable to provide this data broken down by site, indicating that the medical and dental staff worked at both City Hospital and Sandwell General Hospital.

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

## Vacancy rates

**Vacancy rates were low within the service with active recruitment and minimal temporary staffing usage.**

From July 2017 to June 2018, the trust reported that medical and dental staff in urgent and emergency care at trust level were over-established by 17.3%, which was lower than the trust's target of 3%. A breakdown of vacancies at site level is provided below.

- City Hospital emergency department: 9.1% over-established

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them. BMEC matron told us they are currently actively recruiting for two ophthalmology consultants.

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

## Turnover rates

**The turnover rate within the service was high although there is no overall trust-wide turnover target. Staff told us that there was a stable base of staff working within the department and this did not affect patient care.**

From June 2017 to May 2018, the trust reported a turnover rate of 32.5% for medical and dental staff in urgent and emergency care at trust level. There is no overall trust-wide turnover target. A breakdown of turnover at site level is provided below.

- City Hospital emergency department: 31.2%

It should be noted that trainee grades may have been included in the turnover data which would have impacted on the rate.

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

## Sickness rates

**There was a low rate of sickness within the department, the rate was lower than the trusts target. Any episodes of sickness were well managed and appropriate backfill was arranged for any long-term sickness episodes.**

From June 2017 to May 2018, the trust reported an annual sickness rate of 1.2% in urgent and emergency care at trust level, which was lower than the trust target of 3%. A breakdown of sickness rates by site is found below:

- City Hospital emergency department: 0.6%

The sickness rate at each site was also better than the trust target.

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

## Bank and locum staff usage

**The service used both agency and bank medical staff to cover any shortfalls in medical cover. There were no shifts not filled by either bank or locum staff.**

**Trust Level**

From June 2017 to May 2018, the trust reported that 2,731 shifts within urgent and emergency care trust-wide were filled by bank staff and 6,562 shifts were filled by locum staff. There were no shifts not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

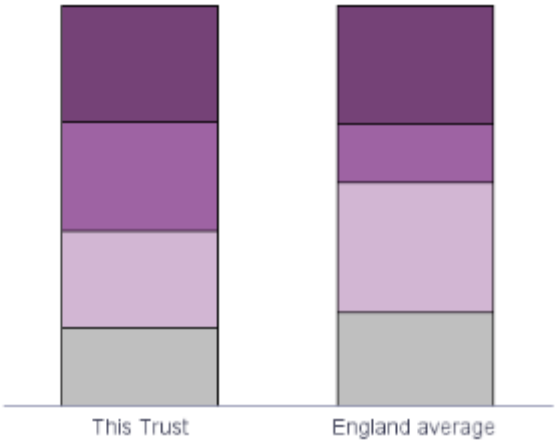
| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank, locum and unfilled) |
|---|---|---|---|---|
| Consultant | 0 | 7 | 0 | 7 |
| Middle Grade | 1,642 | 1,880 | 0 | 3,522 |
| Doctor in Training | 1,089 | 4,675 | 0 | 5,764 |
| **Total** | **2,731** | **6,562** | **0** | **9,293** |

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

## Staffing skill mix

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

**Staffing skill mix for the 46-whole time equivalent staff working in urgent and emergency care at Sandwell and West Birmingham Hospitals NHS Trust**




| | This Trust | England average |
|---|---|---|
| Consultant | 29% | 30% |
| Middle career^ | 27% | 15% |
| Registrar group~ | 24% | 33% |
| Junior* | 20% | 23% |

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

*(Source: NHS Digital Workforce Statistics)*

## Records

**Some records were clear and up to date but some lacked key information, staff did not always keep up to date records of patients' care and treatment.**

Although records were generally of an appropriate standard, there were some gaps noted. We Looked at 41 records including eight children records across city and BMEC ED, and found them all to be inconsistent; We found missing information around Mental Capacity Act proforma, some records we're missing domestic violence proforma, some were missing dates, signatures and inconsistencies around analgesia documentation despite observing staff asking patients about pain and analgesia. However, individual care records were stored safely and managed appropriately.

We saw BMEC ED documentation audit for February 2018 and March 2018, this audit was a sample over one-week period at different times of the day that resulted in:
Clinical exam = 95%
Clinical info = 100%
Prescription chart = 90%
Treatment = 90%
Follow up plan = 95%

We saw audit spot checks for city ED that covered areas such as NEWS, pain scores, care rounds, sepsis box ticked, appropriate triage this was for both adults and children, we reviewed three months of audits and found them all to be 95% and above each month.

At BMEC ED, staff recorded patients notes on an electronic system that held all clinical and health interventions and another for medical records and diagnosis specifically for ophthalmology. BMEC had a slightly different electronic record keeping system to the main hospital. At the main ED site, staff used both electronic and paper recording system, this is also slightly different to the rest of the hospital who use a mobile device Vital Pac to specifically record patient's

observation. Soon as patients were discharge or transferred, documentation was then scanned and securely stored electronically.

When we spoke with staff they told us that the trust are currently carrying out training for a new electronic system that is due to go live in October 2018, but according to management this all depends if staff are all trained and ensuring patients are not at risk.

Doctors, and therapists were provided with a stamp by the trust with their name and personal identification number. This enabled other staff to easily track who had completed the record when required.

Staff in children's' emergency department told us during triage they can review a summary care record where they can access people who live in Birmingham who have used primary or secondary care and see any safety alert on individuals, any concerns or alerts are shared with the hospital paediatric liaison nurse who will triage those individuals.

## Medicines

**The service prescribed and stored medicines in line with local and national guidelines. Documentation around medications was consistent across both ED sites, documents and temperatures for the storage of medicines were recorded appropriately.**

Across both ED site, we saw controlled medicines in the paediatric and adult resus area were stored safely and were checked regularly.

ED staff was able to demonstrate how they used the automated medicine control system in the department, nurses could control, dispense, and manage medicines using a finger print identification. Nurses said it was easy to use, and that the system could identify who and which medicines were taken out with recorded times.

We saw throughout ED a charging socket for keys specifically for entering the control medicine room, the nurse in charge held this key. Staff audited controlled drugs and checks were completed and documented twice daily.

All triage nurses and nurse in charge we spoke with at BMEC ED were all registered nurse prescribers who had completed the prescribing practice and formulary for non-medical prescribers.

BMEC had a pharmacy department on site. The pharmacy department was located on the ground floor next to the main pre-triage reception within ED. The waiting area for pharmacy did not have a seating area for those patients waiting for prescription, and there was no area for staff and patient to discuss prescription. BMEC pharmacy dispensed medication specifically for BMEC, patients were required to either wait for prescription on site or use a known retail pharmacy recommended by BMEC who stock specific prescription similar of those at BMEC.

Pharmacy was open 9.30am to 4.30pm Monday to Friday-during the inspection in 2017, patients were required to go to the main city hospital for prescription during the hours of 1pm-2pm due to lunch breaks, since then improvements have been made and patients are now able to have their prescription at BMEC any time between the hours of 9.30am and 4:30pm.

In 2017, BMEC prescription pads were left open unattended and were easily accessible to the public, this was a breach of NHS security of prescription forms guidance (August 2015) that states "prescribers are responsible for the security of prescription forms once issued to them, and should ensure they are securely locked away when not in use". During 2018 inspection, we saw all prescription pads were locked away, two signatures were required to sign them in and out including the identification code on each pad used and date. We saw four months' worth of audits (May 2018

to August 2018) and saw that 100% of staff were compliant.

## Incidents

**Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team and the wider service. Staff were 'open' and 'honest' and apologised to their patients when things went wrong.**

Staff understood their responsibilities to raise concerns, reports incidents and near misses and were fully supported when they did so. Staff gave examples of when something went wrong, investigations were conducted and lessons learnt.

Staff were aware of their responsibility around Duty of Candour (DoC). DoC is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person.

Staff told us that they were encouraged to report incidents, learning from incidents was shared at team meetings, one staff member told us that "incidents is always a topic for discussions in team meetings", "It's never a blaming culture when we discuss incidents". Staff went on to tell us that any incidents that appear to have trends and themes may result in some additional training to support staff and any immediate concerns would be escalated.

Matron told us that Mortality and Morbidity meetings took place monthly during their clinical governance meeting, where they would discuss deaths that had occurred within emergency department. Investigation reports and further information were reviewed to identify any areas to improve. Mortality and Morbidity review meeting was not a routine meeting that BMEC attended this was because any deteriorating patients were always transferred to the main ED and never had a death at the department.

## Never Events

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

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

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

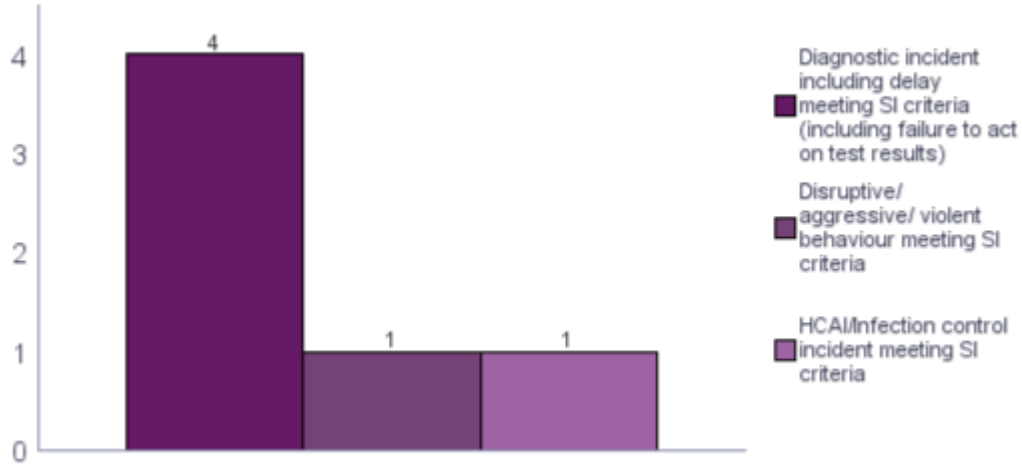
## Breakdown of serious incidents reported to STEIS

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

Of these, the most common type of incident reported was:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): four incidents.

**Serious Incidents (SIs) reported in Urgent and Emergency Care from July 2017 to June 2018**




Site specific information can be found below:

- City Hospital: Three serious incidents

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

**Safety Thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer (which occurred in June 2018), three falls with harm and three new urinary tract infections in patients with a catheter from June 2017 to June 2018 within urgent and emergency care.

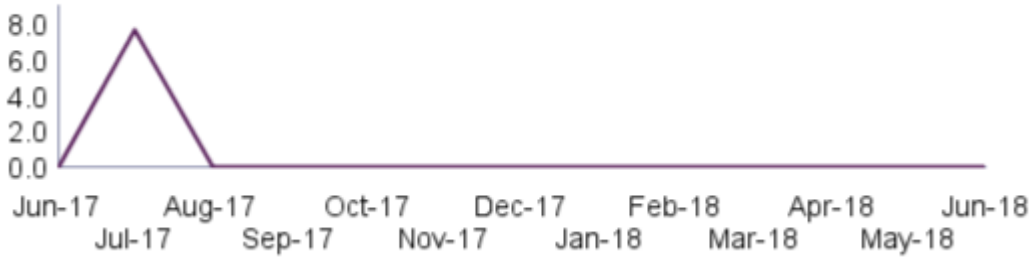
The three new falls all occurred in June 2017 and the three urinary tract infections in July 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Sandwell and West Birmingham Hospitals NHS Trust**

[1]
**Total pressure ulcers (1)**


[2]
**Total falls (3)**

**Total CUTIs (3)** [3]




1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital - Safety Thermometer)*

## Is the service effective?

### Evidence-based care and treatment

**The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment. Local and national audits were completed, and actions were taken to improve care and treatment when indicated.**

Staff were able to show us how they accessed clinical guidelines and local policies on ED intranet page this included staff at BMEC, they included paediatric, AMA and ophthalmic pathways. BMEC in particular followed the Royal College of Ophthalmology guidelines example we saw was causality giant cell arteritis (GCA) and Glaucoma.

We saw patients were placed on suitable pathways throughout our inspection. We saw pathways used followed national guidance and best practice. City hospital speciality was cardiac, we saw a good example of a patient who presented to ED with a ST-Elevation Myocardial Infarction (STEMI) patient was placed on the pathway, seen promptly and received a quick access to effective treatments.

The service participated in many national and local audits. National audits included Royal College of Emergency Medicine audits and ongoing local audits included record keeping, neutropenic sepsis and six bundle screening for sepsis. Senior staff told us the trust participated in the TARN audit (Trauma audit and research network), although City site was not a trauma department all staff worked across both sites, audits and data were shared.

Doctors had access to best practice guidelines from external websites operated by organisations such as National Institute for Health and Care Excellence (NICE guidelines) and the Royal College of Emergency Medicine (RCEM) and Royal College of Ophthalmology (RCoO).

BMEC did not participate in the RCEM audits as many of these audits were not appropriate for BMEC ED environment and setting. The ED lead consultant at BMEC was part of the British Emergency Eye Care Society, which supports and recognises emergency eye care in ophthalmology services.

Majority of staff we spoke with, complained about the IT system, how this did not support or improve patient care. Some staff went on to say, “some days I can’t even see what intervention my patient has had” another said, “I can’t access scans to see results and diagnosis” another went to say, “soon as I log on, the system is slow and takes a lot of time to load”.

### Nutrition and hydration

**Staff monitored patients’ nutrition and hydration needs, patients had access to dieticians.**

During 2017 inspection at BMEC patients were unable to access water unless they purchased it from the restaurant, that was open for few hours of the day. Since then, improvements have been made, patients now have access to a water dispenser free of charge at main waiting area.

We saw one water drink station in the majors area, which had two bottles of fruit cordial (sugar free)

on top.

The restaurant based at BMEC remain to be open for few hours of the day and on the ground floor there are vending machines selling various drinks and snacks available.

We observed staff offering drinks to patients on regular basis throughout the day, patients said staff were very attentive. However, relatives were not offered food or drinks, relatives had access to vending machines in ED waiting room.

Patients who required additional specialist input received a referral, which could be made electronically to the dietician, and this would follow the patient to their admitted ward.

We saw one example where a patient was unable to swallow solid food and could only tolerate soft diet, staff were not able to accommodate as they only had sandwiches which was not suitable for this patient, patient relative had to leave the department to find suitable food.

## Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.9 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.

| Question – Effective | Score | RAG |
|---|---|---|
| Q35. Were you able to get suitable food or drinks when you were in the emergency department? | 5.9 | About the same as other trusts |

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

## Pain relief

**Staff assessed and managed pain on an individual basis and regularly monitored throughout patient care.**

We observed eight patients being assessed using a national recognised triage system, triage nurse specifically asked patient questions around pain using a numerical score scale from one to 10, 10 being highest score for severe pain, this was to enable staff to determine the severity of pain. Staff assessed pain relief in children using "face pain rating scale", the scale of faces ranged from smiling (no pain) to crying (hurts).

We saw analgesia was offered and given appropriately using the Five Rights of Medication Administration, one of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time.

Patients we spoke with were positive around pain relief. One patient said, "staff are very busy, but I've not had to wait long for my pain relief".

On display outside ED we saw compliance rates for pain reviewed audits for July 2018, 100% and August 2018, 96.49%. Along with pain score audit for August 2018, 100% compliant.

## Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust did not provide data in relation to the question "How many minutes after you requested pain relief medication did it take before you got it?"

The trust scored 7.4 out of 10 for the question "Do you think the hospital staff did everything they

could to help control your pain?" This was about the same as other trusts.

| Question – Effective | Score | RAG |
|---|---|---|
| Q31. How many minutes after you requested pain relief medication did it take before you got it? | - | Not applicable |
| Q32. Do you think the hospital staff did everything they could to help control your pain? | 7.4 | About the same as other trusts |

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

## Patient outcomes

**The service monitored the effectiveness of care and treatment and used the findings to improve them. The audits results showed variable results with actions plans in place to address areas that required improvements.**

The trust measured patient outcomes and took part in national and local audits. Where patient outcomes did not meet national targets, the trust introduced action plans to improve.

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

We saw the action plan for RCEM – moderate and acute severe asthma clinical audit action plan that included:

- Educate all nursing and medical staff through induction / training programmes regarding prescribing oxygen for administration.
- A summary of the findings to be shared indicating the areas of improvement with nursing and medical staff.
- Educate nursing and medical staff regarding the RCEM Asthma guidelines.
- A reminder to be sent to all nursing & medical staff (email and induction/teaching programmes) to document the psychosocial factors discussed and the advice provide to patient regarding smoking cessation, inhaler use.
- A written management plan is already available for ED use. A reminder to be sent to all nursing & medical staff for appropriate use of written management plan proforma. A patient information leaflet to be developed / designed.

## City Hospital

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, City Hospital's emergency department met one of the national standards.

The department was in the upper UK quartile for six metrics:

- Standard 1a (fundamental): $O_2$ should be given on arrival to maintain sats 94-98%. This department: 56.0%; UK: 19%.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 56.0%; UK: 26%.

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 90.9%; UK: 77%.

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV

- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

    - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 71.4%; UK: 19%.
    - Standard 5b (fundamental): within 4 hours (moderate). This department: 66.7%; UK: 28%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
    - Adults 16 years and over: 40-50mg prednisolone for 5 days
    - Children 6-15 years: 30-40mg prednisolone for 3 days
    - Children 2-5 years: 20mg prednisolone for 3 days

    - This department: 100%; UK: 52%.

The department was in the lower UK quartile for the remaining metric:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 12.0%; UK: 25%.

*(Source: Royal College of Emergency Medicine)*

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

We saw the action plan for RCEM-consultant sign off audit that included:

- To introduce department flyers
- Weekly email reminders
- Induction training
- To include all information in emergency CAS card

**City Hospital**

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

The department was in the lower UK quartile for one metric:

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 0.0%; UK: 10%.

The department did not submit any data for standards 2 and 3. The hospital's result for the remaining standard was between the upper and lower UK quartiles:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 10.2%; England: 11%.

*(Source: Royal College of Emergency Medicine)*

## RCEM Audit: Severe sepsis and septic shock 2016/17

We saw the action plan for RCEM for severe sepsis and septic shock audit that included:

- Monthly neutropenic Sepsis reports which are showing improved results. We saw number of patients with potential neutropenic sepsis treated within one hour of arrival compared to the total

number of patients who should have been treated for potential neutropenic sepsis within one hour, and the compliance of individual departments and the trust each month, latest audit we saw was July 2017 to June 2018, 188 patients with potential neutropenic sepsis treated within one hour and 210 patients who should have been treated for potential neutropenic sepsis with average of 90% compliance rate.

- To ensure ED has 24 hours seven days a week senior doctor cover so that all Sepsis patients can be reviewed appropriately. Action complete – Emergency Department is currently covered by a senior doctor 24 hour a day seven day a week including registrar cover 24 hours a day seven day a week and consultant cover – 08:00 to 22:00, weekdays and 09:00 to 21:00 at weekends. Assigned Sepsis bleep with 24 hours a day seven day a week in both ED's to attend Sepsis calls.
- To design a new Sepsis pathway for ED to address RCEM guidelines. Action completed – A new Sepsis pathway has been designed as per RCEM guidelines and has been launched within both ED's in February 2018 which prompts staff for appropriate use of oxygen, serum lactate measurement, obtaining blood cultures, fluid administration, and antibiotics administration as part of the treatment for sepsis.
- Spot Sepsis audit checks to be completed within both ED.
- New ED Sepsis pathway prompts urine output monitoring.
- To design a Sepsis patient information leaflet for patients, and/or relatives, admitted with sepsis to City ED.
- Ongoing education and training on Sepsis.

**City Hospital**

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

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

- Standard 1: Respiratory rate, oxygen saturations ($SaO_2$), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 96.0%; UK: 69.1%.

- Standard 3: $O_2$ was initiated to maintain $SaO_2$>94% (unless there is a documented reason not to) within one hour of arrival. This department: 70.0%; UK: 30.4%.

The department was in the lower UK quartile for three metrics:

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 6.3%; UK: 44.9%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 22.5%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 22.5%; UK: 44.4%.

The department's results for the remaining three metrics were all between the upper and lower UK quartiles:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 54.0%; UK: 64.6%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 51.0%; UK:

60.0%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 8.2%; UK: 18.4%.

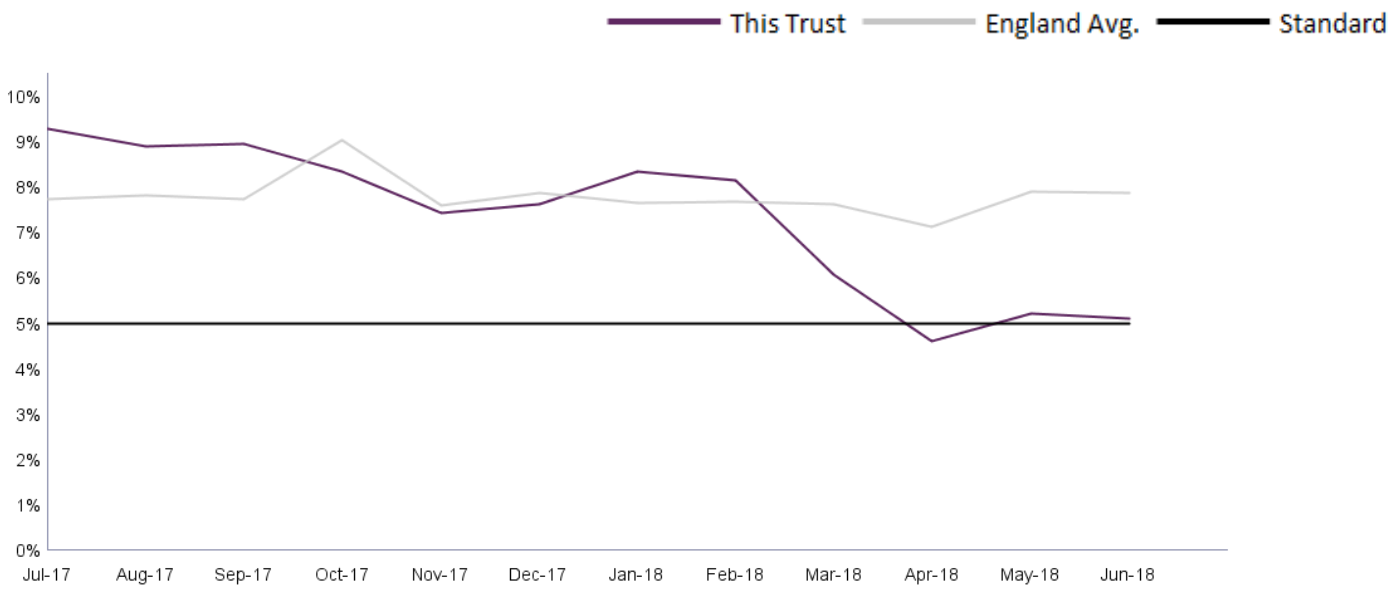
*(Source: Royal College of Emergency Medicine)*

## Unplanned re-attendance rate within seven days

From July 2017 to March 2017, the trust's unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. The trust performed most poorly in July 2017, when they had a 9.3% unplanned re-attendance rate compared to an England average of 7.7%.

In April 2018, the rate at the trust was 4.6% compared to an England average of 7.1%, therefore meeting the national standard of 5%. In the most recent month, June 2018, the trust had an unplanned re-attendance rate of 5.1% compared to an England average of 7.9% which was just higher than the national standard.

**Unplanned re-attendance rate within seven days - Sandwell and West Birmingham Hospitals NHS Trust**




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

Since July 2017, ED has monitored and reviewed all re-attenders, this consists of all patients who re-attend the emergency department within 72 hours and are admitted or deceased on the second attendance.

This information is shared with the department daily through email from the information of previous days in re-attendance; the information is also shared with the senior nurse. If there are any concerns from the first discharge this is also highlighted, then the attendances are discussed with an ED consultant and escalated appropriately to either discussions with the discharging doctor or if more significant concerns are highlighted an incident report is submitted. A summary of the re-attenders is discussed monthly and highlights any significant trends.

## Competent staff

**Staff had the skills, knowledge, and experience to deliver safe care and treatment. Staff were appraised annually, staff told us they found appraisals to be useful and they were encouraged to identify any learning needs they had.**

Newly qualified nurses completed a yearlong development programme before being signed off as competent in emergency nursing. Nurses' progress was reviewed at regular intervals throughout their first year, and any specific training needs were addressed as they were identified. Newly qualified nurses were also provided with a mentor for additional support, and their progress was regularly reviewed throughout their first year.

Staff were required to have a minimum requirement of skills and competency, this was achieved through statutory and mandatory training as well as additional training specific for staff working in the emergency department.

Nurses told us that they were supported with the revalidation process. Revalidation was introduced by Nursing and Midwifery Council (NMC) in 2016. All nurses are required to follow this process every three years to maintain their nurses' registration.

We saw during ED safety huddles, consultants were asking doctors and nurses questions around patients' conditions, illnesses, medicines and vital signs and what steps do they think they should take. We spoke with staff about this and they felt this was a good way to keep them alert, learning and improve their skills when making decisions.

We observed a young adult female admitted to resus by ambulance who had a high heart rate. The senior doctor did the initial assessment of the patient and then delegated it to the junior doctor and student doctor so they could observe their practice and answer any questions and give prompts i.e. 'what would you do next?'. This was a safe controlled manner with full support from the senior doctor.

We observed senior doctors taking the time to explain procedures to year five student doctors and allowing them to undertake safe care and treatment of patients. The senior doctor showed great leadership to the junior team. Senior doctors had the skills and experience to lead their team and allow questions and explanations. The senior team in resus were visible, approachable and we felt there was a good learning culture within the team.

Within the paediatric emergency department, staff told us they have two main senior staff with others being juniors. Some staff felt they were not able to support junior staff as much as they wanted to due to staffing levels. Junior staff felt supported by seniors but felt they were putting additional stress on their seniors by having to support them. Some junior staff were in the process of completing their first 12 months working at ED and some were in the process of completing their triage nurse training, some staff told us once they have completed the triage training they will be able to help more during busy times.

Staff in BMEC worked to a specific competencies and protocols within ophthalmology that enabled them to manage triage system and stream patients with a wide range of ophthalmology conditions.

Junior doctors we spoke with, spoke highly of consultant support and the opportunities for training on a weekly basis, one doctor said "the training is relevant specifically to ED, and a lot of staff attend".

## Appraisal rates

**Trust Level**

From April 2017 to December 2017, 64.8% of staff within urgent and emergency care at trust level received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Public Health & Community Health Services | 6 | 6 | 100.0% |
| Other Non-Medical staff | 3 | 3 | 100.0% |
| Support to doctors and nursing staff | 59 | 85 | 69.4% |
| Qualified nursing & health visiting staff | 121 | 185 | 65.4% |
| NHS infrastructure support | 6 | 11 | 54.5% |
| Medical & Dental staff - Hospital | 24 | 47 | 51.1% |
| Qualified ambulance service staff | 2 | 4 | 50.0% |
| **Total** | **221** | **341** | 64.8% |

## City Hospital

From April 2017 to December 2017, 70.3% of staff within urgent and emergency care at City Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Qualified ambulance service staff | 2 | 2 | 100.0% |
| Public Health & Community Health Services | 3 | 3 | 100.0% |
| Support to doctors and nursing staff | 24 | 28 | 85.7% |
| Qualified nursing & health visiting staff | 44 | 65 | 67.7% |
| Medical & Dental staff - Hospital | 16 | 27 | 59.3% |
| NHS infrastructure support | 1 | 3 | 33.3% |
| **Total** | **90** | **128** | **70.3%** |

## BMEC

We saw evidence from the senior nurse at BMEC ED that showed 100% of staff had their appraisals and were up to date.

## ‘Other’ urgent and emergency care department

Please note that the trust provided a small amount of data for staff for which the site was assigned to ‘other’. These are staff working across multiple sites.

From April 2017 to December 2017, 68.8% of staff within urgent and emergency care at sites classified as ‘other’ by the trust received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Qualified nursing & health visiting staff | 7 | 9 | 77.8% |
| NHS infrastructure support | 4 | 7 | 57.1% |
| **Total** | **11** | **16** | **68.8%** |

*(Source: Routine Provider Information Request (RPIR) - Appraisal tab*

Staff told us notification of non- compliance areas were to be circulated to all team leaders to prompt completion.

## Multidisciplinary working

**The multidisciplinary team worked well together to support patients holistically; doctors, nurses and other healthcare professionals supported one another to provide good care.**

Staff worked effectively as a multidisciplinary team (MDT). All health professionals worked as one team to ensure patient's needs were met. Specialist services were requested when required such as social services, psychological support and learning disability teams to promote a holistic approach to condition management. Staff also told us they had access to additional support from pharmacy, occupational therapists, radiographers and other specialist services. Other services provided support on an on-call basis.

Patient safety huddles were held each day up to three times, so that information could be shared with all relevant staff involved in the care and treatment of the patient. We saw one of these huddles where each patient was discussed and decisions were made about further care and treatment.

We observed good working relationship between ED and GP services, patients were being streamed between the two services with minimal impact on patient.

We spoke with paramedics who were very complimentary towards the trust, who said they had "no concerns" with transferring patients to this hospital. "Staff work with us and we rarely have delays". City ED, also have support from local ambulance services from the HALO (hospital ambulance liaison officer) who works during peak times to support the hospital with patient flow.

BMEC staff said they worked closely with main ED staff, they felt despite different speciality they worked well together if ever needed support especially if some patients became unwell. Patients were able to self-refer to BMEC ED and were seen through appropriate pathways.

We saw examples of effective MDT working with ED and alcohol liaison team, Rapid Assessment Interface Discharge (RAID) service and the psychiatric liaison team: advising when patients are fit to engage in mental health assessment.

## Seven-day services

**The emergency department provided care for the local population 24 hours a day, seven day a week.**

Main ED was open 24 hours day- seven days a week, children's emergency department was open seven days a week from 10am 10pm, any child presenting to ED outside these hours were seen at main ED.

BMEC ED was open Monday to Friday 8:30am to 7pm, Saturdays 8:30am-7pm and Sundays including bank holidays 9:am-6pm.

BMEC pharmacy was open between the hours of 9am and 4:45pm. Pharmacy support was available at main hospital between 8am and 10pm with additional on call pharmacy support available.

Consultants including paediatrician was available Monday to Friday with on call facilities, with additional support from advance clinical practitioners (ACP) who worked 8am to midnight.
The children's and adults safeguarding lead in the trust worked Monday to Friday 9am until 5pm and out of hours advice on safeguarding issues could be sought from senior managers on call.

The trust has an alcohol Liaison Service: pilot is across both sites until October 2018 there is a plan to extend this service, Monday to Friday 8am-4pm plan if extended is to have a seven days service.

RAID team are based on site at city hospital and operates a 24 hour, seven days a week service with one stop psychiatric services, from the age of 16 years and above. The service aims to respond within one hour, mostly see patients within 30 minutes, at times the team will attend triage in emergency if patients are identified with a primary presentation of mental health.

There is not a substance team but staff in the alcohol team told us that they have a good skill mix that can cover substance misuse. Staff told us they have patients elective detox on the toxicology department. There are monthly attendance meetings for patients in need, next meeting is booked for 14 September 2018.

## Health Promotion

**Health promotion materials were available in the ED and staff knew which services to signpost patients to.**

We saw ED had link roles for nurses within Learning Disability (LD), Dementia, Mental Health, safeguarding and sepsis. All staff we spoke with during our inspection were very positive towards having "to go to" person to give staff additional support.

Patients who presented themselves to ED with intentional or accidental overdose were referred directly to the toxicologist based at city site.

Staff alerted relevant mental health assessment teams who would respond within set timescales. Staff had easy access to security staff and police officers during an emergency incident.

Staff throughout ED told us patients had access to the trust bereavement service, chaplaincy service, PALS, psychiatric services, social workers, safeguarding services, and alcohol / drug liaison service.

Alcohol liaison service is a team of mental health nurses, acute nurses and alcohol practitioners. Service checks with ED if any referrals and the team assists with managing alcohol presentations and preventing admission to hospital as of August 2018: the team prevented 85 bed days. Service invites patients presenting to return to clinics, supporting with controlled reductions in community and can arrange inpatient detox.

We saw leaflets on display for members of the public to pick up and read if they required additional contact numbers for support. We saw throughout the hospital a "purple phone" that was easy accessible for patients and members of the public to share their views about the service this could be a form of complaint, compliment or ideas to share.

## Consent, Mental Capacity Act and Deprivation of Liberty safeguards

**Staff awareness of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was variable.**

The trust has a reported Mental Capacity Act and Deprivation of Liberty Safeguards training within their safeguarding training.

Before any interactions were undertaken, we observed staff gaining consent throughout our inspection. We saw examples in patients notes across both ED sites of consent documented in patient records.

Staff we spoke with were aware of the Gillick competence, which is a term, used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

Staff sought support from dementia lead nurse for patients who presented to ED with dementia type illness. Staff on the hospital's dementia ward liaised closely with ED staff regarding patients who presented to ED. ED staff alerted relevant wards in a timely manner when patients arrived.

Staff understanding around MCA and DoLS was variable across ED city site, trust was working to improve the awareness of MCA and DoLS and was being monitored at service and trust level.

Staff at BMEC told us that patients who presented themselves to ED who lacked capacity always had a relative or carer with them, we were not assured staff fully understood the Act and what it meant for the care and treatment of patients.

**City Hospital (including BMEC)**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 76 | 76 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 76 | 76 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 12 | 13 | 92.3% | 95% | No |
| Safeguarding Children Level 3 | 48 | 57 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 16 | 19 | 84.2% | 95% | No |

At City Hospital's urgent and emergency care department, the 95% completion target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible, with both courses achieving a 100% completion rate. The safeguarding children levels 2 and 3 courses both had completion rates of 84.2%.

**Medical staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at City Hospital (including BMEC) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 29 | 29 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 29 | 29 | 100.0% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Safeguarding Adults Level 2 | 10 | 14 | 71.4% | 95% | No |
| Safeguarding Children Level 2 | 16 | 27 | 59.3% | 95% | No |
| Safeguarding Children Level 3 | 1 | 2 | 50.0% | 95% | No |

At City Hospital's urgent and emergency care department, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both courses achieving a 100% completion rate. The safeguarding children level 3 course had the lowest completion rate, at 50%; however, this was based on only one of the two eligible staff members not completing the course.

The trust set a target of 95% for the completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 30 | 31 | 96.8% | 95% | Yes |
| Safeguarding Children Level 3 | 101 | 120 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 59 | 73 | 80.8% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with two of these courses achieving a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 80.8%.

**Medical staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 11 | 13 | 84.6% | 95% | No |
| Safeguarding Adults Level 2 | 16 | 20 | 80.0% | 95% | No |
| Safeguarding Children Level 2 | 23 | 37 | 62.2% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both of these courses achieving a 100% completion rate. The safeguarding children level 2 module had the lowest completion rate, at 62.2%.

## Is the service caring?

### Compassionate care

**Staff cared for patients with compassion and respect. Patients feedback and those close to them throughout our inspection was positive. At times staff treated patients with dignity, respect and empathy.**

Staff introduced themselves before any interactions with their patients; we observed staff to be respectful, polite, and friendly.

We saw support staff such as housekeeping staff, porters and administrative staff were friendly and engaging when working with patients. We observed reception staff to be friendly and took their time with patients when they arrived. We found reception to be open and honest when patients asked about waiting times.

We spoke with patients who provided positive comments regarding the care given by all levels of staff. Patients told us that staff spoke kindly and respectfully towards them; and took time with care and treatment.

At city ED we found that nurses call bell was out of reach and away from patients, we saw at least 10 patients who were not able to reach their nurses call bell, some patients were bed bound and dependent on Health care workers and nurses for support. Many relatives said they would go and look for staff if they need support.

We saw an example where a patient was influenced by alcohol who became very angry and wanting to leave the department, we observed a passionate and compassionate health care worker who managed to deescalate the situation by talking and reassuring this patient in a calm manner.

Patients we spoke with at BMEC spoke very positively of the service, some complained about the initial wait at pre-triage, however the care and treatment was “excellent”.

Patients told us drinks and snacks were offered regularly where appropriate to ensure patients were comfortable.

Staff told us that relatives are given a booklet after bereavement explaining next steps and numbers for registering the death, solicitors and funeral directors. Senior nurse told us in majors that she would give relatives her work telephone number for families to contact after breaking bad news.

The viewing area is very close to resus, this allows the deceased to be taken straight there. Families were given as much time they needed with their loved ones before they are transferred to the mortuary.

### Friends and Family test performance

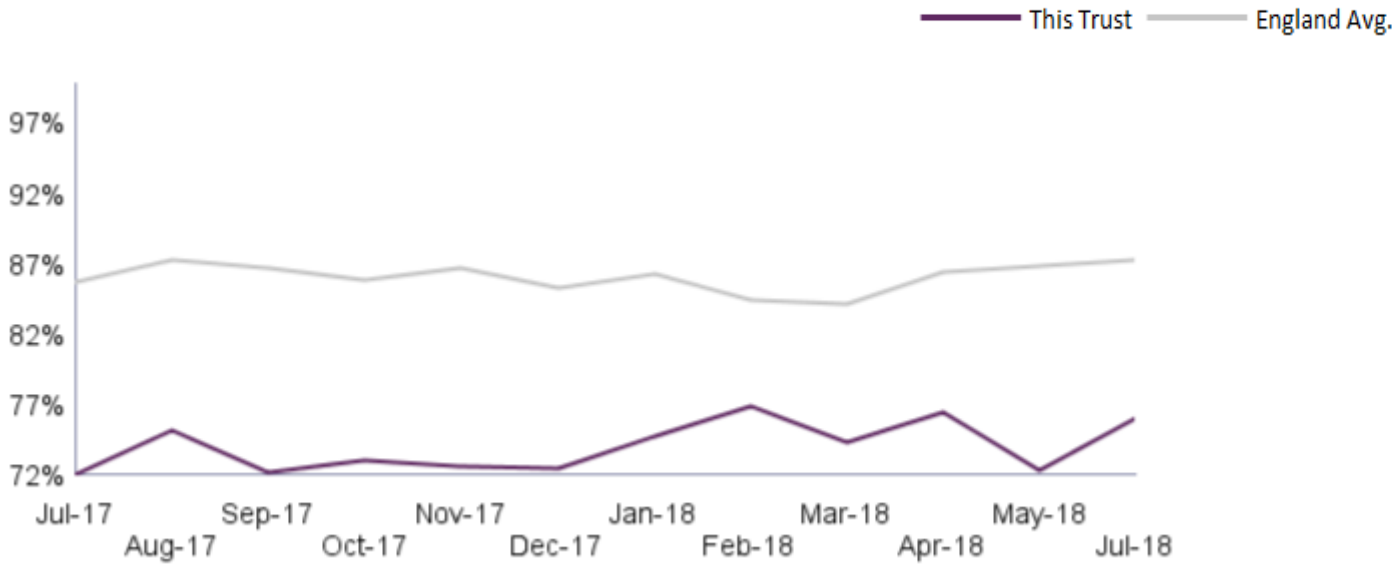
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from July 2017 to July 2018.

In the most recent month, July 2018, 76.3% of patients recommended the trust’s A&E department, compared to the England average of 87.4%.

We saw BMEC ED friends and family test results for August 2018 and September 2018 with

89.80% recommended ED at BMEC, 49 patients responded.

**A&E Friends and Family Test performance - Sandwell and West Birmingham Hospitals NHS Trust**




*(Source: NHS England Friends and Family Test)*

## Emotional support

**Patients' emotional and social needs were seen as being important as their physical well being. Patients had access to the trust bereavement service, chaplaincy service, patient's advice and liaison service (PALS), psychiatric services, social workers, safeguarding services, and alcohol / drug liaison service.**

Patients told us that staff were cheerful and kind, whilst they work at the department; which helped to boost patient morale.

There was access to a multi-faith chaplaincy team to support patient and families, staff knew how to contact the bereavement team and counselling services. Counselling services were available through the ECLO for those patients diagnosed with those losing their sight.

Patients who had support needs were encouraged to follow their normal routine and if patients had their carers with them they were encouraged to stay with patients.

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

**Patients who used the service and those close to them were active in their care and treatment.**

Relatives of patients felt satisfied with the care and felt their loved ones were in safe hands.

Patients and relatives told us they were kept informed of any plans and treatment and told us staff were helpful and approachable.

Patients were encouraged to express themselves and were able to discuss their decisions with staff and loved ones.

During our inspection we witnessed a patient who had deteriorated rapidly later to be transferred

to resus, we observed staff communicating with relatives and keeping them informed, discussions around plan of care and best interest. Staff empathised, kept the situation calm and allowed relatives to ask questions and simply being there. We observed outstanding teamwork, clear direction from the team, MDT working with cardiac consultant, nurses, student nurses, student doctors. The shift co-ordinator cleared the room of staff that didn't need to be in there to ensure smooth running of the situation. All staff had professional respect for the roles undertaken and everyone was seen to have a voice in their part to play.

## Emergency Department Survey 2016

The trust scored worse than other trusts for two questions (questions 42 and 43) and about the same as other trusts for 21 of the 22 remaining Emergency Department Survey questions relevant to the caring domain. The trust did not provide any data relating to the final question, question 39 "Did a member of staff tell you about medication side effects to watch out for?"

| Question | Trust 2016 | 2016 RAG |
|---|---|---|
| Q10. Were you told how long you would have to wait to be examined? | 2.9 | About the same as other trusts |
| Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse? | 8.5 | About the same as other trusts |
| Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand? | 8.5 | About the same as other trusts |
| Q14. Did the doctors and nurses listen to what you had to say? | 8.8 | About the same as other trusts |
| Q16. Did you have confidence and trust in the doctors and nurses examining and treating you? | 8.8 | About the same as other trusts |
| Q17. Did doctors or nurses talk to each other about you as if you weren't there? | 8.6 | About the same as other trusts |
| Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so? | 7.8 | About the same as other trusts |
| Q19. While you were in the emergency department, how much information about your condition or treatment was given to you? | 8.6 | About the same as other trusts |
| Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you? | 7.2 | About the same as other trusts |
| Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department? | 8.8 | About the same as other trusts |
| Q23. Were you involved as much as you wanted to be in decisions about your care and treatment? | 7.8 | About the same as other trusts |
| Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department? | 8.6 | About the same as other trusts |
| Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you? | 6.5 | About the same as other trusts |
| Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you? | 5.4 | About the same as other trusts |
| Q26. Did a member of staff explain why you needed these test(s) in a way you could understand? | 8.7 | About the same as other trusts |
| Q27. Before you left the emergency department, did you get the results of your tests? | 8.0 | About the same as other trusts |
| Q28. Did a member of staff explain the results of the tests in a | 9.1 | About the same as |

| Question | Trust 2016 | 2016 RAG |
|---|---|---|
| way you could understand? | | other trusts |
| Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand? | 9.0 | About the same as other trusts |
| Q39. Did a member of staff tell you about medication side effects to watch out for? | - | Not applicable |
| Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car? | 5.1 | About the same as other trusts |
| Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department? | 4.1 | About the same as other trusts |
| Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 4.4 | Worse than other trusts |
| Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 5.5 | Worse than other trusts |
| Q45. Overall | 7.9 | About the same as other trusts |

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

## Is the service responsive?

### Service delivery to meet the needs of local people

**Patients' needs and their preferences were considered and acted upon to ensure services were delivered and accessible in timely manner. The service planned and delivered services to meet the needs of people using the service.**

We saw ED had one private room; co-located from ED and resus, with en-suite viewing room, that was used only for bereaved relatives. However, we were informed at times this room was used for mental health patients, this was not suitable for patients with mental health problems.

Services was planned to take into account the different needs of patients they responded to, there were facilities for specialist eye treatment, end of life care and for people experiencing significant mental ill health.

Children's ED was adjacent to main ED and separated away from main ED waiting area, this was to ensure children were further away for safety, dignity and privacy. There was one isolation room and one monitor bay with resus area next door in case of an emergency.

GP clinic was situated within main ED area which patients were diverted to if appropriate, patients were able to be diverted back to main ED if GP felt necessary.

In BMEC seating area at times was full, during our inspection we found many patients including young and elderly were having to stand to wait to be seen. Children an elderly were seen as a priority to help reduce the time they had to wait.

Main waiting area for ED was next door to a cafe, patients and relatives were able to use as when needed to.

We saw the trust had access to a translation line; staff we spoke with knew how to access this and said they used this translation line often.

Bariatric commodes, beds, chairs could be ordered from stores and staff would bleep the switchboard for a porter to deliver. If a bariatric patient was being brought in by ambulance then ambulance would notify staff ahead of arrival to order.

### Meeting people's individual needs

**Staff had access to interpreters to aid communication with their patients. Patient's needs were considered when delivering and coordinating services, including those who were vulnerable and had complex needs.**

### Emergency Department Survey 2016

The trust scored about the same as other trusts for the three Emergency Department Survey questions relevant to the responsive domain.

| Question – Responsive | Score | RAG |
|---|---|---|
| Q7. Were you given enough privacy when discussing your condition with the receptionist? | 7.5 | About the same as other trusts |
| Q11. Overall, how long did your visit to the emergency | 7.0 | About the same |

| | | |
|---|---|---|
| department last? | | as other trusts |
| Q20. Were you given enough privacy when being examined or treated? | 9.2 | About the same as other trusts |

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

Staff had access to interpreters to aid communication with patients who could not speak English as their first language or people with hearing difficulties. We saw on display throughout the hospital over 10 different languages, despite this we did not see leaflets on display other than those in English. Staff told us if booked in advance they could access a face to face British sign language support.

During our inspection we found patients privacy during triage was not always adhered to, we observed patients' health being discussed with the door wide open, and in two cases personal information was discussed on corridors. When we spoke with staff they said "environment was not great, and we try to be discreet but when patients are on trolleys we need to ask how they are feeling, while we get a trolley ready in the main area". The triage door was left open for "security reasons" as they did not have an emergency call bell in the triage room. When we spoke to patients about this they had no complaints about this, were happy to be seen and staff kept them informed.

There were vending machines, access to toilets and TV's were mounted throughout the departments And cafés were scattered all over the trust.

At BMEC, for patients with vision impaired, information leaflets and pre-printed consent forms were printed on black on yellow forms.

We saw information on display throughout the trust on domestic violence, including self-referral readily available on website and information boards. We saw a good example of a nurse handing out a compact mirror and lip balm, that was given to those patients who have discreetly spoken up about violence at home, the mirror and lip balm had a helpline telephone number discreetly written in a form of a barcode.

The trust had a learning disability, dementia, domestic violence and safeguarding lead who were visible and staff felt they were easily accessible if advice and support was needed. At BMEC they also had an eye clinic liaison officer, who offered specialist support for patients who were losing their sight and cortical visual impairment.

## Access and flow

**Access to care was managed to take account of patients with urgent needs. Patients had access to the right care at the right time. The trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average. Although trust failed to meet the standard of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.**

## Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 10 months over the 12-month period from July 2017 to June 2018.

The trust performed most poorly in May 2018 when the median time to treatment was 66 minutes compared to the England average of 61 minutes.

In the most recent month, June 2018, the median time to treatment was 60 minutes compared to

the England average of 62 minutes, meeting the standard.

The trust used an electronic system to monitor and analyse the flow of patients throughout ED and the wider hospital. During our inspection we saw this data during our visit to the capacity leads office, this data was accessed by staff throughout the department and in the management, team situated in a different part of the hospital this enabled the trust to see where there were delays.

Since 2017 inspection, BMEC now have advance nurse practitioners running some additional clinics such as the anterior chamber issues and red eye conditions. Triage nurse also now do visual acuity checks, pupils are diluted and pain relief given ready to be investigated further within emergency clinic-this has reduced the wait in emergency clinic.

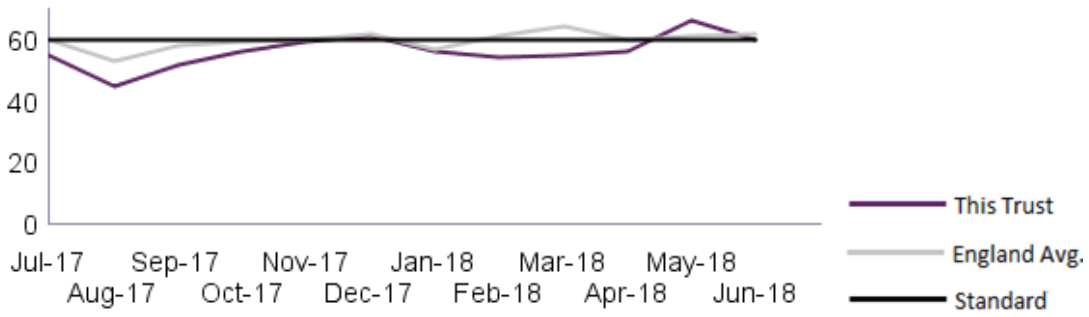
Since the introduction of emergency care clinic in early 2018 run by consultants, registrars or ANP, BMEC have seen a significant reduction in the four breaches by nearly 50%, we saw BMEC four target was at 98.5% in August 2018. We spoke with the matron who told us they have seen significant rise in opticians' referrals on Mondays and Fridays.

BMEC had employed an optometrist in ED who carried out three sessions a week on a Monday morning and Thursday morning and afternoon for Floaters and Flashes clinics and red eye clinic, this was help with access and patient flow to help reduce patient wait.

RAID team told us and we saw that ED receives around 30% of patients under Section 136 presentations. A medical clearance must be completed by a clinician before a patient can be transferred to a local mental health hospital. Staff told us they are in high demands, especially with only one mental health designated room on site at city ED. Staff also said there are longs waits for acute mental health practitioner and social workers to review patients.

We spoke with the alcohol nurse who told us that they can refer patients to community services. Staff provide a 'safe reduction of alcohol' outpatients to clinics to prevent re admissions and work closely with the RAID team.

**Median time from arrival to treatment from July 2017 to June 2018 at Sandwell and West Birmingham Hospitals NHS Trust**



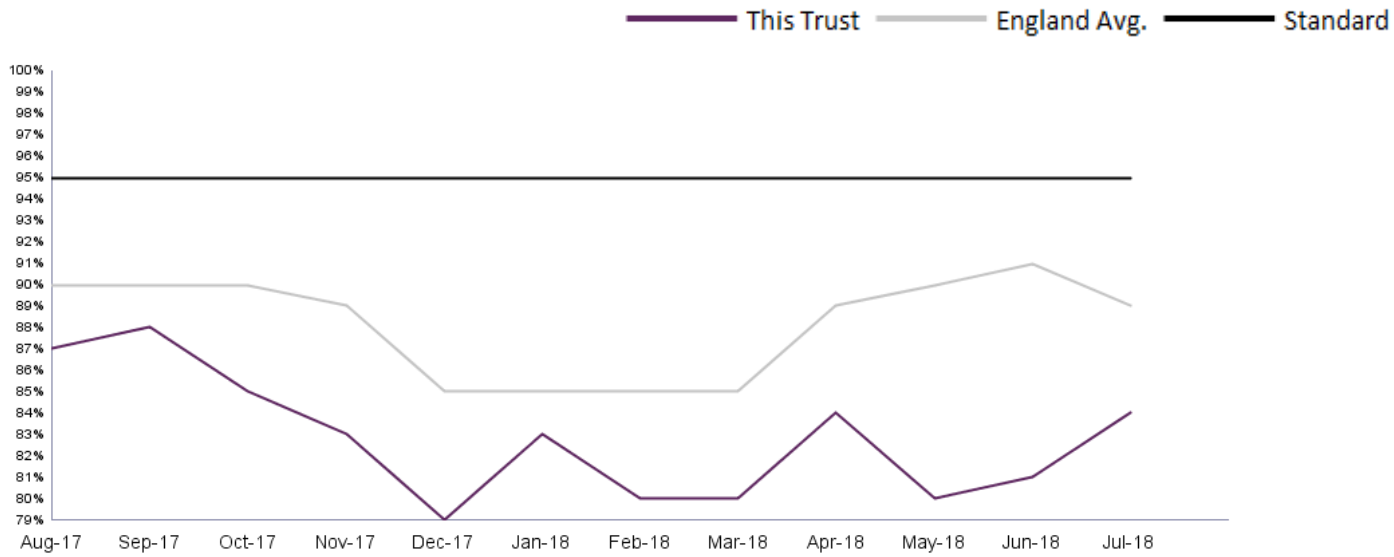

*(Source: NHS Digital - A&E quality indicators)*

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

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

From August 2017 to July 2018 the trust failed to meet the standard in any month and consistently performed worse than the England average.

**Four-hour target performance - Sandwell and West Birmingham Hospitals NHS Trust**




*(Source: NHS England - A&E waiting times)*

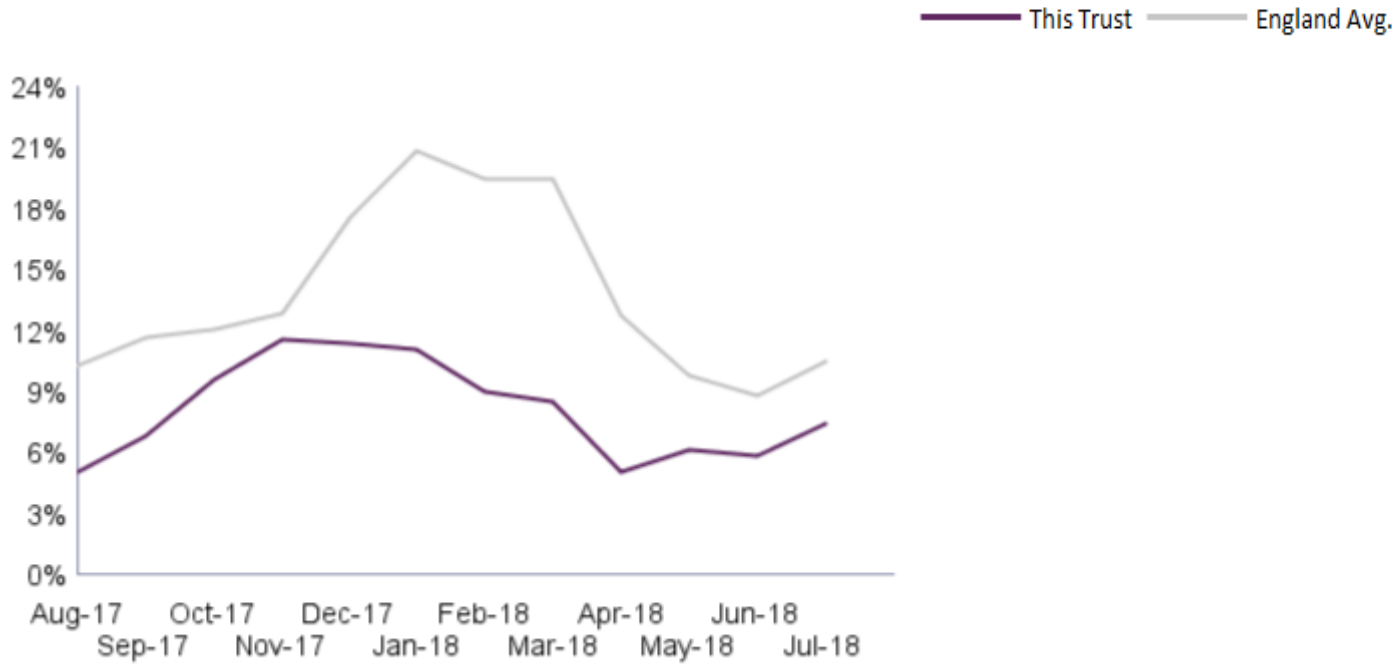
## Percentage of patients waiting more than four hours from the decision to admit until being admitted

From August 2017 to July 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average.

There is evidence of a trend of improvement in performance from November 2017 to April 2018.

In the most recent month, July 2018, 7.4% of patients waited more than four hours from the decision to admit to being admitted compared to the England average of 10.5%.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Sandwell and West Birmingham Hospitals NHS Trust**




The table below shows the number of patients waiting more than four hours to admission from August 2017 to July 2018:

| Month | Number of patients waiting more than four hours to admission |
|---|---|
| August 2017 | 154 |
| September 2017 | 208 |
| October 2017 | 305 |
| November 2017 | 366 |
| December 2017 | 386 |
| January 2018 | 389 |
| February 2018 | 275 |
| March 2018 | 292 |
| April 2018 | 164 |
| May 2018 | 201 |
| June 2018 | 184 |
| July 2018 | 245 |

*(Source: NHS England - A&E waiting times)*

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

Over the 12 months from August 2017 to July 2018, one patient waited more than 12 hours from the decision to admit until being admitted. This instance occurred in December 2017. Management team informed us that this individual patient caused the 12 hour breach due to external waits for mental health support. This had been investigated and reported to the Board level committee.

*(Source: NHS England - A&E waiting times)*

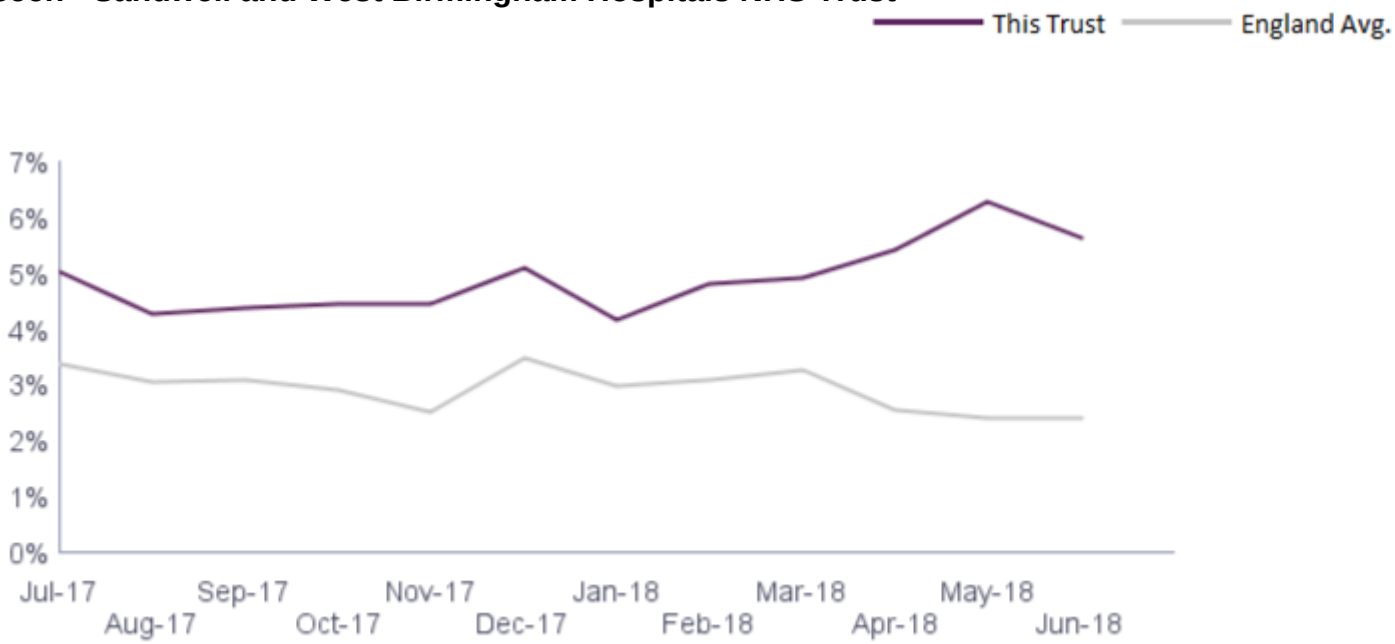
## Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

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

Performance on this metric at the trust was relatively stable from July 2017 to April 2018, at between 4.3% (August 2017) and 5.4% (April 2018), before deteriorating to 6.3% in May 2018, compared to the England average which was 2.4%.

In the most recent month, June 2018, the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 5.6%, compared to the England average of 2.4%.

**Percentage of patient that left the trust's urgent and emergency care services without being seen - Sandwell and West Birmingham Hospitals NHS Trust**



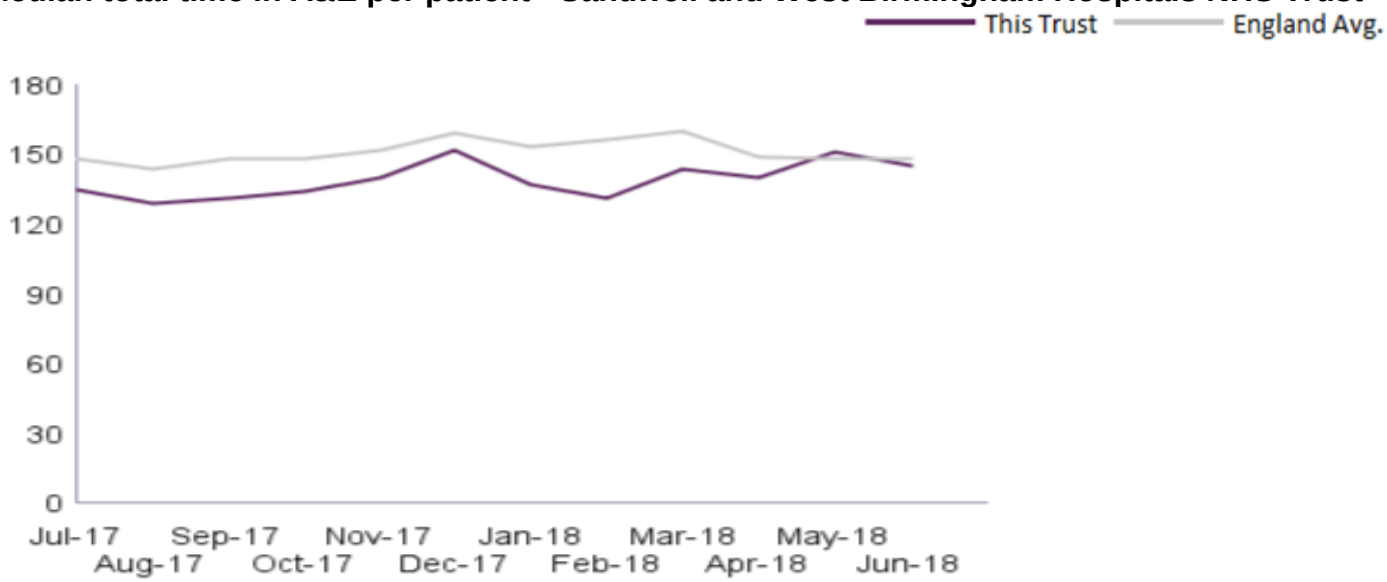

*(Source: NHS Digital - A&E quality indicators)*

## Median total time in A&E per patient (all patients)

From July 2017 to April 2018 the trust's monthly median total time in A&E for all patients was consistently lower than the England average followed by two months, May and June 2018, when performance was similar to the England average.

In the most recent month, June 2018, the trust's monthly median total time in A&E for all patients was 145 minutes which was slightly lower when compared to the England average of 148 minutes.

**Median total time in A&E per patient - Sandwell and West Birmingham Hospitals NHS Trust**




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

## Learning from complaints and concerns

**Patients concerns and complaints were investigated, lessons were learned from complaints and shared with all staff.**

Since the last inspection back in 2017, the trust has implemented a purple phone throughout the hospital with an easy access for patients and members of the public to share their views about the service, this could be a form of complaint, compliment or ideas to share. Any information is then shared with the department. We saw data around the theme and patterns of calls made through purple phone from February 2018 to May 2018 and saw 13 out of the 41 calls to date were made over the weekend (32%). None were made before 9.31am and 9 (22%) were made after hours (after 5pm). Therefore 54% of calls made to date were made of hours calls (after 5pm and at weekends) the latest of which was 8.38pm. 10 of the 41 cases (24%) of cases were compliments.

Staff we spoke with told us that any “Thank you” and compliments to individuals staff member were shred in monthly team meetings, staff handovers and an email would be circulated through the department.

Staff were aware of the action to take if someone wanted to raise a complaint or a concern, and they would seek support from senior staff if they were not able to sort it. We saw leaflets on display at BMEC with telephone numbers to complaint or compliment.

Patients we spoke with knew how to make a complaint and were aware of PALS service, patients were also aware of the purple phones on display through out the hospital.

## Summary of complaints

**Trust level**

From April 2017 to March 2018, there were 187 complaints about urgent and emergency care at trust level. The trust took an average of 38.8 days to investigate and close complaints. This is not in line with their complaints policy, which states all complaints should be investigated and closed

within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 81 | 43.3% |
| Staff values & behaviours | 31 | 16.6% |
| Access to treatment or drugs | 23 | 12.3% |
| Patient care | 18 | 9.6% |
| Waiting times | 9 | 4.8% |
| Communications | 7 | 3.7% |
| Privacy, dignity & well being | 5 | 2.7% |
| No subject specified | 5 | 2.7% |
| Appointments | 3 | 1.6% |
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 2 | 1.1% |
| Administration/policies/procedures (including patient records) | 1 | 0.5% |
| Facilities | 1 | 0.5% |
| Other | 1 | 0.5% |
| Total | 187 | 100% |

## City Hospital (including BMEC)

From April 2017 to March 2018, there were 103 complaints about urgent and emergency care at City Hospital (including BMEC). The hospital took an average of 39.1 days to investigate and close complaints. This is not in line with their complaints policy, which states all complaints should be investigated and closed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 40 | 38.8% |
| Staff values & behaviours | 20 | 19.4% |
| Access to treatment or drugs | 12 | 11.7% |
| Patient care | 9 | 8.7% |
| Communications | 7 | 6.8% |
| Waiting times | 4 | 3.9% |
| No subject specified | 4 | 3.9% |
| Privacy, dignity & well being | 3 | 2.9% |

| | | |
|---|---|---|
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 2 | 1.9% |
| Appointments | 2 | 1.9% |
| Total | 103 | 100% |

### Number of compliments made to the trust

From January to June 2018, there were eight compliments recorded for urgent and emergency care at the trust.
Site specific information can be found below:

- City Hospital: Four compliments (including two relating to BMEC)

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

## Is the service well-led?

### Leadership

**Managers of all levels within the Urgent and Emergency care had the right skills and abilities to run a service providing quality and sustainable care.**

ED was part of the emergency services group, which included an integrated health and social care team. Charge nurse, with senior sisters leading ED daily. Staff told us they were visible and approachable. ED matron had been in post at City site since April 2018 who previously worked at ED Sandwell General hospital.

BMEC is part of the surgical directorate services, A clinical director, matron and general manager lead the directorate. The directorate reported to the surgical services group director, group director of nursing and group director of operations. We reviewed the August 2018 ophthalmology ED leadership meeting minutes, the main discussions were around staffing, concerns were in July 2018, gaps in rota was 115% higher than the norm (of 20 gaps) and August 2018 gaps forecast to be above the norm, recruitment to the 2018 “Production Plan” for Nurse Practitioners is in progress. The meeting also discussed incidents, breaches, modality project and strategy development with BMEC ED.

We reviewed BMEC ED operation meeting minutes July 2018, that discussed areas of concerns within the department. We saw concerns around handwritten information from clinicians and must be clearer, backlog of notes to be scanned and electronically updated and to reduce the post weekend impact of returns to service, the number of days has been increased from three days to seven days.

Junior staff working at ED and BMEC said they felt supported by senior staff and that the senior team were visible and would offer to help if they need support.

ED staff at BMEC felt supported by the rest of the trust, who felt they had a strong local leadership with good professional relationships.

Staff spoke very highly of the senior nurse at BMEC and the matron at city ED. One staff at BMEC

said senior nurse is “always available if you need them”, “she will not allow her staff to struggle and will be hands on if you need her” One staff member at city ED said, “since matron has moved to city things have improved”.

Some staff at BMEC said they rarely see the member of the executive team, but local leadership are their voice if there are concerns.

City ED staff said they do at times see some members of the executive team but mainly if they are extremely busy to review the delays in the department.

Staff felt supported in their roles and felt they had opportunities for training and further develop within their role.

We spoke with three staff who did not know what the trusts strategy was but told us that leadership was good and senior staff were visible.

## Vision and Strategy

**The service had a vision of what it wanted to achieve and plans to turn it to action. Not all staff were able to recite trust values but staff we spoke with were able to demonstrate the values within their role.**

We saw on display the trust values in three staff offices, however we did not see the values on display for member of the public to see in the department.

Staff we spoke with were not able to tell us the exact trust values, however we observed staff to be safe, kind and caring and patients were at the centre of all they did. Staff were committed in improving patient experience.

BMEC continue to focus on improving the children’s services, improving access and flow of the department. Since the 2017 inspection, BMEC have worked on year on year demand of the service, they now have two pre-triage nurses at main reception desk, they have increased running days of some clinics, some clinics are run by advance nurse practitioners with ophthalmology experience with additional support by MECS (minor eye condition service) run by local optometrists.

The trust has been set back due to the delays of the new midland metropolitan hospital, we have been told by staff this is due to be open 2022 but staff aren’t too sure this will happen, the emergency department remain to concentrate on patient safety and experience and electronic patient records and the new infrastructure of new IT system.

## Culture

**Managers across each department in ED promoted a positive culture that supported and valued their staff with shared values on patient care and improving the quality of care within the trust and their own department.**

Multidisciplinary teams worked collaboratively and were focussed on improving patient care and the service provision. During our inspection, we observed positive, respectful interactions, which focussed solely on meeting patients’ needs and providing safe care and treatment.

Managers and staff in ED displayed a positive culture of wanting to provide the best service for their patients and wanted to improve the service in every way.

Staff told us that the matron has ‘an open door’ policy, and they felt able to raise their concerns

anytime.

Staff morale was of high spirit, CQC were made to feel welcome, staff worked well together under pressure and patients care and safety was of high priority.

Staff told us across both ED that they felt confident in raising concerns and felt they were listened to. Staff worked well as team we saw many examples where staff were very caring towards one another especially during busy and challenging times. All staff throughout this inspection spoke positive local working culture in which they felt valued and respected.

## Governance

**The governance arrangements within ED, were clear and operated effectively; staff understood their roles and accountabilities.**

Governance processes were in place, handover meetings, team meetings and managers meetings were fed back into the medicine governance meetings that were held monthly. Matrons from ED across all sites would also meet to discuss local risks and concerns, staff across Sandwell and City ED rotate and work across both sites, at BMEC due to its speciality staff only work at BMEC, however incidents and local risks was shared across departments.

Managers at BMEC held a quarterly governance meeting which linked to the surgical directorate, we saw example of meeting minutes June 2018, July 2018 and August 2018. We saw discussions around complaints, risks, incidents along with access and flow of the department.

Governance systems in use in the department were robust and ensured safe and effective care was being delivered. Senior staff within the department, division and trust were fully aware of key risks and took assurances from processes which were used and exercised by frontline staff.

Senior staff told us they had monthly meetings, they would discuss safeguarding, mandatory training, incidents, complaints/compliments, and learning from legal and root cause analysis updates. Minutes from meetings were shared with staff within the department.

## Management of risk, issues and performance

**The service had an effective operation system in place for identifying risks, planning to eliminate and reduce risks and the ability to cope with expected and unexpected challenges within the emergency services.**

The department had an established risk register in place. The risk register included a description of each risk, with mitigating actions and assurances in place. An assessment of the likelihood of the risk materialising, possible impact and those who responsible for review and monitoring was also included. We saw that risks were reviewed regularly.

Risks featured on the risk register are escalated and reviewed by management through to clinical leadership executive committee and trust board. Trust board takes the decision whether risks featured on the register including approval of requests to be removed.

The risks on the risk register included overcrowding in ED and adversely impact on patient outcomes due to in-substantiated bed open and extended length of stay and delayed transfers of

care-this was reviewed 18 January 2018 and reviewed monthly, the expected completion date is due December 2018. We saw staffing issues as a risk, mainly around consultant rota not always filled and at times there are gaps, the rota we reviewed was carrying current vacancy of 6.3 whole time equivalent (WTE) across city and Sandwell hospital sites. The rota gaps are impacting ED by lack of ED consultants available for employment-this is an on-going review with reliance on locums and ongoing recruitment. We also noted that IT remains on the risk register issues around result being available and delays for certain types of investigation.

Throughout our inspection, we found themes of concerns raised by staff, which were around staffing, security and lack of staffing and tailgating of the main ED doors.

## Information Management

**Management collected, analysed, managed, and used information effectively to support the emergency department activities using secure systems with security to safeguard all processes in use.**

The information technology systems used by the trust did not work well, this was clear from all feedback we received from staff. The combination of paper and electronic records did present many challenges to staff. The patient record system in ED was predominantly paper based.

During our inspection, we found computers were not locked when not in use, this did not prevent unauthorised persons from accessing confidential and patient information. We saw examples throughout the inspection members of the public walking through nurses' station.

Emergency department used an automated medicine control system in the department; nurses could control, dispense, and manage medicines using their finger prints. If there were any medication errors this could identify the person, time, date, and identify the patient.

Staff told us they received a "Friday message" from the chief executive who updated all staff with weekly updates and upcoming events, any staff who had won staff of the week would also be highlighted, staff felt they were kept up to date on the trust through Friday message.

## Engagement

**Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with partners' organisations effectively.**

We observed good staff engagement at all levels throughout the emergency departments.

We saw throughout the trust suggestion boxes to enable patients, staff and members of the public to leave any feedback, trust also had purple phones and trust website allowed feedback using a link online.

Trust provided quality improvement half days staff. Staff were given protected times for teams where non-essential clinical services were stopped one afternoon a month. Training included areas such as lesson learned from incidents and near misses, training, patient experience and latest research updates.

BMEC had a patient involvement group in Uveitis and keratoconus a non-inflammatory eye condition group meeting, that was held quarterly, this group included patients, nurses and doctors who all met to try and improve understanding of these conditions.

Staff had a closed social media group page that enabled staff to communicate, this included discussion around shifts that required covering, staff were able to give their availability to cover shifts, staff we spoke with were positive about this group page as they didn't feel pressured to have to cover shifts if they didn't want to and this was an efficient way for managers to manage staff shortages issues.

The trust carried out local audits and used the outcomes to improve local delivery of services. Outcomes from audits highlighted what was working well, and where there could be improvements.

## Learning, continuous improvement and innovation

**ED was committed as a front house department in improving services by learning from things that have gone well and when things go wrong, promoting training, research, and innovation.**

The service had focussed on addressing the concerns that were raised in October 2017 report. We found many improvements had been made.

In BMEC they have appointed a new band 7 senior nurse and an ED consultant who staff have said and we have seen have made positive changes within ED and processes around patient care, one example given they have increased options for streaming patients to appropriate clinics and have increased running times for clinics.

BMEC had employed an optometrist in ED who carried out three sessions a week on a Monday morning and Thursday morning and afternoon for Floaters and Flashes clinics and red eye clinic, this was help with access and patient flow to help reduce patient wait.

Since last inspection in 2017, BMEC have been working closely with primary eyecare heart of West Midlands Ltd, funded by clinical commissioning group (CCG) that run a minor eye conditioning service (MECS) in the community. Patients have options to be seen in the community for any primary care issues or have their follow up appointment in community rather than travel to BMEC.

ED has an advocacy project, which is an integrated response to domestic abuse and interpersonal violence. This provides crisis response, information sharing and staff training. The domestic violence lead covers domestic abuse, rape and sexual violence, child sexual exploitation, FGM, honour-based violence and historic sexual abuse. The domestic violence lead told us this project was a two-year pilot project (2015-2017) aiming to improve Sandwell and West Birmingham Hospitals Trust identification of and response to domestic abuse and is in partnership with Black Country's Women Aid (BCWA). This project is currently on going.

# Medical care (including older people's care)

## Facts and data about this service

Medical care is delivered over two sites, the City Hospital and Sandwell General Hospital. Both sites provide urgent and planned care. There are total of 383 winter inpatients beds which reduce during the summer months to 355, admitting between 42 and 49 patients a day from assessment units to the main in-patient bed base.

The cardiology service, including the cardiac catheter laboratory (Cath. Lab.), is consolidated on the City site and stroke services are consolidated on the Sandwell site. Respiratory, gastroenterology, clinical haematology and elderly care services are available on both sites.

The trust works closely with primary care, communities and therapies clinical group to facilitate safe discharges for our patients to either their usual place of residence, community bed base or alternative care facility.

Medicine have recently put in place a consultant of the week model across all main admitting specialities which has improved continuity of care and aims to contribute to a reduction in length of stay and increased morning discharge rates.

The trust has a ward based clinical team leadership which ensures a robust multi-disciplinary approach to inpatient care and treatment. They deliver 109,000 outpatient appointments and procedures annually as well as 8,000-day case and elective treatments. Both sites have endoscopy units which are accredited by JAG.

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

The trust had 51,255 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 26,363 (51.4%), 1,328 (2.6%) were elective, and the remaining 23,564 (46.0%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 23,480
- Medical oncology: 7,339
- Clinical Haematology: 5,390

*(Source: Hospital Episode Statistics)*

At the previous inspection, we rated medical care at city hospital as requires improvement overall. We rated it good in the caring domain and requires improvement in the effective, responsive and well-led domains. We rated the safe domain as inadequate. We found a range of concerns in relation to the safe prescribing of medicines, training, learning from incidences, emergency resuscitation trolleys and the management of patients living with dementia. There was inconsistency in the application of the Mental Capacity Act (2005) and a lack of consistency in care processes and which impacted on the effectiveness and responsiveness of care. We found delays occurred at most stages of the patient journey from admission to discharge.

Although there had been improvements across this service since the last inspection we remained concerned with the safe management of emergency resuscitation trolleys. We also found concerns with staffing levels on some wards.

At this inspection we visited ten wards:

- Acute medical unit
- Cardiology Day Unit
- Cardiology Catheter Laboratory
- D5 Cardiology Ward (Male)
- D7 Cardiology Ward (Female)
- D11 Geriatric Ward (Male)
- D15 Gastroenterology / Respiratory Ward (Male)
- D16 Gastroenterology / Respiratory Ward (Female)
- D26 Geriatric Ward (female)
- Sickle Cell and Thalassemia Clinic

We looked at 16 patient records, spoke with 15 patients, three friends and family members and many staff who worked in medical care. Staff interviews included consultants, doctors, nurses, care support workers, pharmacy staff, physiotherapist, fire equipment engineer and catering staff.

## Is the service safe?

### Mandatory training completion rates

**The service had not provided mandatory training in key skills to all staff and made sure everyone completed it.**

Although the trust set a target of 95% for completion of mandatory training the trust had not provided mandatory training in key skills to all staff and made sure everyone completed it.

**Trust level**

**Nursing staff**

A breakdown of trust level compliance for mandatory training courses as at July 2018 for qualified nursing staff in medicine at both sites is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 13 | 13 | 100.0% | 95% | Yes |
| Medical devices competency form | 429 | 431 | 99.5% | 95% | Yes |
| Equality & diversity | 426 | 437 | 97.5% | 95% | Yes |
| Conflict resolution initial training | 425 | 436 | 97.5% | 95% | Yes |
| Fire safety - workplace training | 400 | 412 | 97.1% | 95% | Yes |
| Harassment & bullying level 1 | 424 | 437 | 97.0% | 95% | Yes |
| Health & safety | 420 | 436 | 96.3% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Introduction to information governance | 192 | 204 | 94.1% | 95% | No |
| Blood collection | 58 | 62 | 93.5% | 95% | No |
| Infection control | 385 | 437 | 88.1% | 95% | No |
| Resuscitation: basic life support | 367 | 436 | 84.2% | 95% | No |
| Medicines management | 359 | 430 | 83.5% | 95% | No |
| Medical devices training | 305 | 372 | 82.0% | 95% | No |
| Conflict resolution update | 237 | 290 | 81.7% | 95% | No |
| Moving and handling - patient handling | 329 | 435 | 75.6% | 95% | No |
| Fire response team leader or refresher training | 8 | 11 | 72.7% | 95% | No |
| Transfusion | 256 | 369 | 69.4% | 95% | No |
| Information governance refresher module | 145 | 233 | 62.2% | 95% | No |

Nursing staff in medicine did not meet the trust's completion target for training, with a rate of 88% overall. However, the target of 95% was met for seven of the 18 courses made available to nursing staff. A rate of 100% was achieved for one course, however the number of eligible staff for this course was much lower than for other courses. Therefore, each member of staff accounts for a greater proportion of the total. The course with the lowest completion rate was the information governance refresher module with 62.2%.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 for medical staff at trust level in medicine at both sites is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Harassment & bullying level 1 | 191 | 197 | 97.0% | 95% | Yes |
| Consent - basic consent | 94 | 97 | 96.9% | 95% | Yes |
| Medical devices competency form | 174 | 182 | 95.6% | 95% | Yes |
| Equality & diversity | 175 | 197 | 88.8% | 95% | No |
| Fire safety - workplace training | 161 | 192 | 83.9% | 95% | No |
| Moving and handling - medical staff | 154 | 184 | 83.7% | 95% | No |
| Moving and handling - patient handling | 5 | 6 | 83.3% | 95% | No |
| Resuscitation: basic life support | 150 | 196 | 76.5% | 95% | No |
| Infection control | 148 | 197 | 75.1% | 95% | No |
| Health & safety | 146 | 196 | 74.5% | 95% | No |
| Conflict resolution initial training | 144 | 195 | 73.8% | 95% | No |
| Conflict resolution update | 46 | 66 | 69.7% | 95% | No |
| Medicines management | 126 | 196 | 64.3% | 95% | No |
| Introduction to information governance | 96 | 151 | 63.6% | 95% | No |
| Medical devices training | 88 | 143 | 61.5% | 95% | No |
| Transfusion | 98 | 173 | 56.6% | 95% | No |
| Information governance refresher module | 22 | 46 | 47.8% | 95% | No |

Medical staff in the medical care core service did not meet the trust's target of 95% for training completion, achieving 77.2% overall. However, the completion rate target was met for three of the 17 courses made available to medical staff. As with nursing staff, the course with the lowest completion rate was the information governance refresher module with a rate of 47.8%.

**City Hospital medicine department**

**Nursing staff**

A breakdown of compliance for mandatory training courses, as at July 2018, for qualified nursing staff in the medical care core service at City Hospital is shown below.

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Medical devices competency form | 217 | 217 | 100.0% | 95% | Yes |
| Blood collection | 1 | 1 | 100.0% | 95% | Yes |
| Fire safety warden or refresher training | 6 | 6 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 212 | 217 | 97.7% | 95% | Yes |
| Harassment & bullying level 1 | 211 | 217 | 97.2% | 95% | Yes |
| Equality & diversity | 211 | 217 | 97.2% | 95% | Yes |
| Fire safety - workplace training | 197 | 204 | 96.6% | 95% | Yes |
| Health & safety | 208 | 217 | 95.9% | 95% | Yes |
| Introduction to information governance | 94 | 100 | 94.0% | 95% | No |
| Infection control | 192 | 217 | 88.5% | 95% | No |
| Resuscitation: basic life support | 191 | 217 | 88.0% | 95% | No |
| Medicines management | 183 | 217 | 84.3% | 95% | No |
| Conflict resolution update | 108 | 135 | 80.0% | 95% | No |
| Medical devices training | 160 | 202 | 79.2% | 95% | No |
| Moving and handling - patient handling | 166 | 216 | 76.9% | 95% | No |
| Transfusion | 143 | 199 | 71.9% | 95% | No |
| Fire response team leader or refresher training | 5 | 7 | 71.4% | 95% | No |
| Information governance refresher module | 82 | 117 | 70.1% | 95% | No |

Nursing staff in the medical care core service at City Hospital did not meet the completion rate target, achieving 88.5% completion overall. However, the 95% target was met for eight of the 18 mandatory training modules for which qualified nursing staff were eligible. The course with the lowest completion rate was the information governance refresher module with 70.1%. It should also be noted that two of the three courses with 100% completion had low numbers of eligible staff and therefore, staff represent a higher proportion of the overall total.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 for medical staff in the medical care core service at City Hospital is shown below.

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Introduction to information governance | 3 | 3 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 6 | 6 | 100.0% | 95% | Yes |
| Medical devices training | 2 | 2 | 100.0% | 95% | Yes |
| Health & safety | 6 | 6 | 100.0% | 95% | Yes |
| Equality & diversity | 6 | 6 | 100.0% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Medicines management | 6 | 6 | 100.0% | 95% | Yes |
| Medical devices competency form | 6 | 6 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 6 | 6 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 6 | 6 | 100.0% | 95% | Yes |
| Infection control | 6 | 6 | 100.0% | 95% | Yes |
| Resuscitation: basic life support | 5 | 6 | 83.3% | 95% | No |
| Moving and handling - medical staff | 5 | 6 | 83.3% | 95% | No |
| Information governance refresher | 2 | 3 | 66.7% | 95% | No |
| Transfusion | 1 | 2 | 50.0% | 95% | No |

Overall, medical staff in the medicine department at City Hospital did not meet the 95% training completion target but were close with 94.3%. However, they did meet the trust's target for 10 of the 14 courses made available to them. All of these courses had a completion rate of 100%, although these are based on small numbers of staff having completed the training. The course with the lowest completion rate was the transfusion module with a rate of 50%.

Staff we spoke with said the trust provided regular mandatory training sessions. These sessions could also be completed via the trusts on line training. Although staff said they were encouraged by senior colleagues to undertake training opportunities, several members of staff told us that they had often been unable to attend planned training events because additional staff had not been found to cover their shifts. This meant some staff could not complete all the training identified as necessary for them to have the skills and knowledge they needed to meet people's basic care needs.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to protect people from harm. Staff had training on how to recognise and report abuse.**

## Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 2 | 379 | 433 | 87.5% | 95% | No |
| Safeguarding adults level 2 | 62 | 73 | 84.9% | 95% | No |

In medicine the 95% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff at a trust wide level met the target for safeguarding training overall, with a rate of 95.2%. The course with the lowest completion rate was

the safeguarding adults level 2 module with 84.9%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding children level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding adults level 2 | 73 | 89 | 82.0% | 95% | No |
| Safeguarding children level 2 | 153 | 191 | 80.1% | 95% | No |
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

In medicine the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible. Medical staff at a trust wide level did not meet the target for safeguarding training overall, with a rate of 91.6%. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however, this was based on only one of the two members of eligible staff not completing it.

**City Hospital medicine department**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the medicine department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 217 | 217 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 217 | 217 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 21 | 22 | 95.5% | 95% | Yes |
| Safeguarding children level 2 | 192 | 217 | 88.5% | 95% | No |

At City Hospital, nursing staff in the medical care core service met the 95% training target overall, with a rate of 96.1%. Of the four mandatory safeguarding courses made available to nursing staff, three met the target. The course with the lowest completion rate was the safeguarding children level 2 module with 88.5%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical staff in the medicine department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 5 | 5 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

At City Hospital, medical staff in the medical care core service met the 95% training target overall, with a rate of 95.5%. Of the five mandatory safeguarding courses made available to medical staff, four met the trust's target. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however, this was based on only one of the two members of eligible staff not completing it.

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

The staff we spoke with were able to tell us how they would recognise and report potential abuse in line with local and national safeguarding procedures. We saw staff had involved dedicated safeguarding staff when patients were at risk of or had experienced abuse. Safeguarding information for visitors and staff was display in public areas to support them to identify the signs of abuse and inform the appropriate persons. This information was also available in different languages to prevent harassment and discrimination in relation to protected characteristics under the Equality Act.

There were policies in place for the safeguarding and protection of adults at risk and safeguarding children. The adult safeguarding policy had an approval date of August 2017, and was due to be reviewed in 2020. We reviewed the content of the policy and found it was version controlled. The policy referred to PREVENT (a part of the UK's counter terrorism strategy). It also had information for staff on the different types of abuse such as modern slavery, roles and responsibilities of staff and included a flow chart on what to do if an alleged perpetrator was a staff member; additionally, it contained the contact details of the safeguarding team. The children's safeguarding policy was dated July 2018, was version controlled, contained a flow chart and links to relevant guidance. We asked the trust what was in place around Female Genital Mutilation (FGM). The trust provided us with information, however the information was specific to maternity services and not medical care. There was no information on FGM in the safeguarding adults and children's policies.

## Cleanliness, infection control and hygiene

**The service had improved how it controlled infection risk. Staff kept themselves, equipment and the premises clean. However, some staff were unsure about control measures to prevent the spread of infection.**

When patients had been assessed as being potentially infectious staff did not always take consistent action to minimise the risk of spreading the infection. It was the trust's policy to nurse infected patients in their own rooms with the doors closed. On one occasion signs to alert staff to the risk that a patient was infectious were not displayed. On another ward a side room's door was open despite a sign which said the person in the room had an infection. Staff we spoke with gave contradictor information as to whether the patient had an infection and if their door should be closed. Staff being unclear about which patients were infectious increased the risk of the spread of infection to themselves and others.

The environment was visibly clean and cleaning schedules were in use in all ward areas visited. Records indicated when equipment had been cleaned and when it's next clean was due. Stickers were in use to indicated that equipment was clean and ready for use. There was a dedicated infection control lead who promoted and monitored compliance with the trust's infection prevention and control policy and procedures. There were regular infection prevention control meetings and infection control audits. We saw evidence of regular hand wash audits to identify if staff required further support to ensure compliance with the trust's policy. The outcomes of the audits were

displayed each of the areas we visited. Staff were reminded of their responsibilities and could see how well they were doing or where to make improvements.

Members of staff were vigilant to remind us and other visitors to wash their hands when entering and leaving clinical areas. Staff followed the trust's hand hygiene policy which was regularly displayed around the areas we visited. Staff practised the trust's policy of 'bare below the elbow', to enable effective hand washing and minimise the risk of infections being spread by jewellery and watches. There were supplies of hand washing and sanitizing supplies, and gloves and aprons to prevent the spread of infection. One ward we visited had new refitted toilets/shower areas with automatic hand taps to reduce the risk of spreading infection.

Reusable sharps containers were available on wards to dispose of any sharps. There were processes in place for the collection and disposal of these.

There were practices in place to manage infected linen and curtains This included dedicated linen storage facilities and instructions for staff about how to process infected and soiled linen. The use of disposable curtains was monitored so they would be changed regularly in line with the trust's policy. We looked at three curtains and saw they were still within their use by date. This helped to reduce the risk of cross infection.

## Environment and Equipment

**Systems in place did not ensure equipment for use in an emergency was always well looked after.**

At our last inspection we were concerned that emergency resuscitation trolleys were not tamper proof and appropriate equipment may not have been available when a patient required emergency lifesaving care. We found this had not improved as equipment on the trolleys could still be accessed by people passing by. Trolleys were checked daily however a ward manager told us staff would often use items from their ward's trolley for non-emergency care so the trolley would no longer contain all the equipment necessary to provide lifesaving support. On another ward,16 daily records had not been completed during August to confirm that defibulation equipment and the contents of a hypoglycaemic treatment box would be suitable for use in an emergency. Failure to have the appropriate equipment available during resuscitation could be catastrophic for a patient requiring lifesaving treatment. Staff told us that existing trolleys were due to be replaced by tamper proof trolleys but did not know when.

Emergency equipment in bathrooms was not always effective at ensuring people would receive prompt care if they fell. In the toilet and shower areas of two wards some pull cords intended for patients to summon help when they fell were missing or not always long enough to be reached by patients if they were on the floor. The ward manager accepted that the existing pull cord system was not effective and said they would alert the maintenance department to take corrective action.

All main doors to wards were secured by key pad or staff swipe card access. This allowed staff to protect people on the ward by vetting the suitability of visitors attempting to enter the ward. Staff would unlock doors when required to allow patients and visitors to leave a ward when safe to do so. This protected people who were vulnerable from leaving the ward unnoticed by staff. It also enabled staff to comply with any Deprivation of Liberties Safeguarding (DoLS) authorisations a patient may have which required staff to restrict the patient's freedom of movement to keep them safe.

Staff had access to suitable equipment, which was regularly maintained, to meet people's needs. There was a dedicated department responsible for maintenance of medical equipment. We saw equipment was tagged and monitored so staff would know when it was due for servicing and how to

report faults.  A member of staff responsible for fire detection and protection systems demonstrated how one ward's fire systems met current fire safety regulations. We observed a member of staff effectively install a pressure relieving mattress for one patient. The patient told us the new mattress was comfortable and felt the installation had been done quickly and with minimal disruption. This new mattress would help to protect the patient from the risk of developing pressure ulcers.

## Assessing and responding to patient risk

**Patients were not consistently protected from risks associated with their conditions.**

On several occasions we saw staff were unavailable to support patient's when there was a risk to their own and other peoples' safety. We witnessed one incident when a person, whose care plan required them to be always supported by a member of staff because they were at risk of falling and disorientated, was left on their own and attempted to get out of bed without any support. The person was prevented from falling by the quick intervention of a member of staff who ran across the ward to support them. On another occasion a person became confused and verbally aggressive to other patients and threw a walking frame across the ward. No member of staff approached the person or other patients to offer reassurance or check their welfare. We escalated this to the ward manager who provided reassurance and support to the patient. The manager of another ward told us about a recent incident when there were insufficient staff to support a person with the required individual support and they fell. The person's fall may have been prevented if they had been supported by the required number of staff identified as necessary in their care plans.

Patients across medical care were continuously monitored. We saw patients' observation records were reviewed at daily ward rounds to identify changes in their conditions and review their current care plan. Staff talked to us about the use of national early warning scores (NEWS) and sepsis screening tools. These systems allowed staff to identify early if a patient was experiencing or at risk of deteriorating health. There were systems in place to escalate concerns about a patient's health to other appropriate health care professionals.  We reviewed care records on one ward and saw risk assessments for people's specific conditions were completed on the day of admission. Two ward managers told us they monitored the locations and times of patient falls to identify if there were any trends and action which could be taken to reduce the risk of future falls. After our inspection visit, the provider sent us records of how they monitored falls within the medicine service for trends. We saw that regular checks were completed to identify if there were falls prevention plans in place for patients who needed them. These plans provided guidance for staff about how to reduce the risk of these patients falling.

The risks associated with a patient with mental health issues on one ward had been assessed. The patient's care plan identified how they were to be supported to minimise risks associated with their conditions and staff we spoke with said the records gave them sufficient direction to support the patient in line with their care needs. We noted that upon arrival to the ward the patient was seen by the trust's Dementia, Delirium and Distress (DDD) team and safeguarding team to provide advice to staff advice about how best to support a patient with their specific condition. For several days the patient was agitated and also had a risk of falls. Staff acted to reduce the risk of harm to the patient and others by moving the patient's bed closer to the nursing station so they could provide continued

observation and reassurance to reduce the patient's agitation. Records showed and staff confirmed there was significant improvement in the patient's condition.

The hospital at night team provided support for deteriorating patients during the night. When this service was unavailable support could be sought from the critical care outreach team.

During our inspection visit ward staff regularly challenged members of the inspection team and other visitors for proof of identity and confirmation their presence on the ward was appropriate. This protected patients from being approached by people who may have posed a threat to them or others.

## Nurse Staffing

**The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

The trust reported the following nurse staffing numbers for medical care both from April 2017 to March 2018 and, more recently in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 307.4 | 374.4 | 82.1% | 297.3 | 375.9 | 79.1% |

Staffing numbers for both periods were similar, with the fill rate in April and May 2018 being just three percentage points lower than the fill rate from April 2017 to March 2018.

The trust was unable to provide this data broken down by site, indicating that the staff worked across the City Hospital and Sandwell General Hospital sites.

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

## Vacancy rates

From July 2017 to June 2018, the trust reported an over-establishment in medicine at City Hospital of 2%, compared to the trust's target of 3%.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 18.3% for nursing staff in medical care at City Hospital. This was in excess of the 12.9% rate they reported for medical care

trust-wide. There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses which was not met by City Hospital.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 4.7% in the trust-wide medical care core service, which was worse than the trust target of 3%. City Hospital medical care reported a 4.9 % sickness rate which was worse than the trust target.

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

## Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in medicine at a trust wide level from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff in medical care.

For qualified nurses, 16,277 shifts were filled by bank staff and 5,514 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 10,772 shifts were filled by bank staff and 443 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 16,277 | 10,772 | 27,049 |
| Agency | 5,514 | 443 | 5,957 |

Unfortunately, we are unable to provide a site specific breakdown of nursing bank and agency usage in the medical care core service, due to the format of the data provided by the trust.

Ward staff consistently told us that nurse and healthcare assistant (HCA) staffing levels were regularly below those required to meet patient's specific care needs. This put patients at risk of not receiving the support their care plans identified they needed to support their specific conditions. On one ward a nurse we spoke with cried when they told us they and colleagues were, 'exhausted' because staffing levels were regularly below those necessary to meet patient's specific care needs. They told us that a lack of staff resulted in patients sometimes not receiving their first wash of the day until after lunch. We heard other stories of staff leaving their shifts in tears due to the pressures caused by insufficient staffing levels. We observed one patient, who was not receiving the one to one support they required, nearly fall when they attempted to stand. A member of staff told us there were not enough staff on the ward to provide the patient with the one to one care they needed. We saw a further two patients on different wards, whose care plans identified they required one to one support to remain safe, were also not receiving the staff support needed. Staff told us that HCA's were responsible for escorting patients to other services within the hospital which could result in depleting the ward's staffing levels for significant periods.

We were concerned that staffing levels on two wards were putting patients at risk of harm and escalated our concerns to the matron responsible for these wards. They told us that staffing levels were based on National Institute for Clinical Excellence (NICE) good practice guidelines. They agreed to review staffing levels to ensure the individual care needs of each patient was met. We returned to these wards later in the evening and the next day. Both ward managers and staff we spoke with said they were pleased that staffing levels had improved. One member of staff said, “It’s a relief. Thank you.” Another member of staff told us, “It’s better. I can be behind a curtain and know that other colleagues will be free to watch other patients.” The day after we escalated our concerns a member of staff on one of the wards we were worried about said there were enough staff on duty that day to meet people’s needs and keep them safe. Staff on the other ward however told us that although they had their regular complement of staff, a request for an additional member of staff to support a person who required one to one support had not been fulfilled. This meant they were not being supported in line with their care needs. A member of staff told us, “It’s always difficult, (getting additional staff). Luckily the patient has been asleep for most of the day.”

Two ward managers said low staffing levels meant staff were missing their breaks and becoming exhausted. Staff confirmed they could not always attend planned training events because the lack of availability of additional staff to cover their nursing duties. One ward manager told us these issues had been identified at staff exit interviews as contributing to staff turnover. Ward managers told us that additional staff were often unavailable when required despite them following the local escalation procedures and making advance requests.

After our inspection visit the trust sent us details of three other incidences where the safety of patients on the elderly care wards had been put at risk due to insufficient staffing levels. These incidences had identified some patient had not received their medicines on time and a person who had a DoLS authorisation in place restricting their movements to the ward, could not have been supported from leaving the ward had they wished to do so. The incidences identified that other wards within the hospital had also experienced insufficient staffing levels and bank staff required to support patients with one to one support had not been available.

One consultant we spoke with said staffing levels did not always support the specific needs of male patients who required additional support with delusion and were an increased risk of harm to themselves and others. Ward managers and nurses on the elderly care wards said planned staffing levels did not always reflect the high dependency needs of patients who lived in their beds. These patients required additional support with eating, mobilisation, prevention of pressure ulcers, personal care, reassurance and social inclusion. We observed staff supporting these patients were task orientated and did not spend time interacting with patients to promote social inclusion or prevent them from becoming board.

Senior staff completed regular staffing reviews of medical care which identified the staffing levels required for each ward. We saw that there were regular nurse and HCA recruitment initiatives in place to try to address staffing shortages.

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

## Medical staffing

**The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**

The trust reported the following medical staffing numbers in medical care both from April 2017 to March 2018 and, more recently in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 197.3 | 189.4 | 104.2% | 188.7 | 190.3 | 99.1% |

From April 2017 to March 2018, the trust had a fill rate of 104.2% which equates to 7.9 more members of medical staff than they planned. However, by April/May 2018, the rate was 99.1%.

The trust was unable to provide this data broken down by site, indicating that the staff worked across the City Hospital and Sandwell General Hospital sites.

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

## Vacancy rates

From July 2017 to June 2018, the trust reported an over-establishment of 8.8% overall for medical staff in the medicine core service compared to the trust's target of 3%. They reported City Hospital had an over-establishment of 1.6% which was below the trust's target.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 18.2% for medical staff in medical care. There is no overall trust-wide turnover target. They reported that City Hospital had a turnover of 23.2%.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 0.6% in the medical care core service, which was better than the trust target of 3%. They reported that City Hospital had a sickness rate of 0%.

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

## Bank and locum staff usage

From June 2017 to May 2018, the trust reported that 3,891 shifts within medical care trust-wide were filled by bank staff and 3,293 shifts were filled by locum staff. There were 1,176 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not

provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

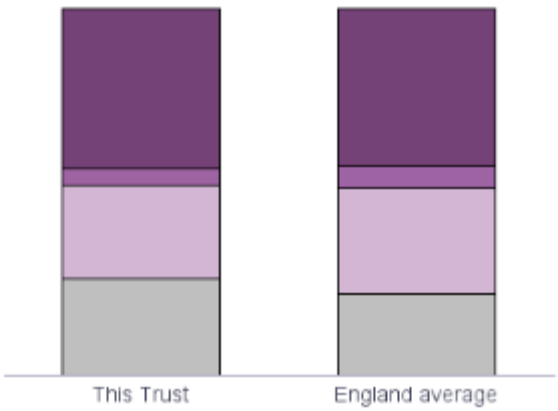
| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank + locum + unfilled) |
|---|---|---|---|---|
| Consultant | 963 | 2,171 | 569 | 3,703 |
| Middle Grade | 1,209 | 306 | 141 | 1,656 |
| Doctor in Training | 1,719 | 816 | 466 | 3,001 |
| **Total** | **3,891** | **3,293** | **1,176** | **8,360** |

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

## Staffing skill mix

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

**Staffing skill mix for the 174-whole time equivalent staff working in medicine at Sandwell and West Birmingham Hospitals NHS Trust**




| | This Trust | England average |
|---|---|---|
| Consultant | 43% | 43% |
| Middle career^ | 5% | 6% |
| Registrar group~ | 26% | 29% |
| Junior* | 26% | 22% |

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

*Source: NHS Digital - Workforce Statistics - Medical (01/03/2018 - 31/03/2018)*

Consultants we spoke with said that recent changes to how medical staff were deployed for ward and board rounds had improved patient care. A respiratory consultant told us that increased respiratory consultant numbers had resulted in an improved consultant presence on wards to provide expert advice, the early identification of deteriorating patients and patients suitable for discharge. There were enough consultants to spent time in AMU to identify patients suitable for transfer to medical wards so they could receive the appropriate care and AMU waiting times reduced.

We observed two medical students ask a senior nurse if they could conduct an ECG on a patient. The nurse asked questions to assess the students experience and supported them to conduct an ECG under their supervision. This protected the patient from the risk of harm by ensuring the ECG was conducted by medical staff who had the appropriate skills and knowledge.

## Records

**Records were largely clear but staff did not always keep them confidential.**

Staff said since our last inspection they continued to experience issues with the trust's IT system. Patient test results were sometimes unavailable electronically due to IT difficulties. A doctor told us that only one of five laptops they had access to on a ward was working which had led to delays in obtaining blood investigations and x-ray results. A paper system was available however this was not as quick as the electronic system when it was operational which put patients at risk of not receiving the support they required. The trust was acting to improve the IT system and a new trust wide electronic patient records system was due to be launched shortly. There was an ongoing training programme in place of the new electronic system for staff. This was to support staff to become familiar with the new system and able to use it when it was launched.

At our last inspection we found some patient records could be accessed by people who were not authorised. At this inspection we found improvements in records management but further action was required. We saw records were stored in communal ward areas and often left unattended. Patients and visitors walking to the ward's bathroom would have had the opportunity to read these records. In one instance we could read personal information about a patient which had been left outside their side room. We observed a member of staff failed to log off a computer after accessing electronic records and a doctor use another person's log in details to access patient records. Practices in place did not protect confidential electronic patient information from being accessed by unauthorised persons.

At our last inspection we identified that nursing care plans were pre-printed documents, most of which had not been personalised. We found this had improved. We looked at 16 patient records and saw these were largely complete, legible, and entries were timed, dated and signed. There was a clear written diagnosis of the patient's condition and a comprehensive management plan. Records contained evidence of consultant-led ward rounds, input from the multidisciplinary team, care plans, and risk assessments. Care records of one patient included information for staff about their preadmission notes, treatment, allergies, potential risks, signed consent forms, test results and a post-operative care and monitoring plan.

There was evidence of referrals to other members of the multidisciplinary team (MDT), for example speech therapists and dieticians. Members of the MDT wrote any relevant information in the medical notes to ensure that information was shared appropriately.

## Medicines

**The service followed best practice when prescribing, giving, recording and storing medicines.**

Patients received the right medication at the right dose at the right time. Members of the pharmacy team reviewed patient's records so their medicines were available and up to date. Where possible this was done within 24 hours of patient admission with prioritisation given to patients with a high clinical need. On a dedicated Parkinson's Disease ward, extra care was taken to ensure patients received their time critical medicines. All information regarding times for medicines was discussed during handover as a reminder to nursing staff. Patients' weights, known allergies and any sensitivities to medicines were recorded on the medicine charts we looked at. This supported staff to prescribe and administer the correct dose of medicine and reduce the risk of it being given in error or

causing harm. A patient on one ward told us staff were knowledgeable about their medication. They said staff had promptly reviewed and changed their medicine when it started to make them feel sick.

Although medication records were usually completed we found records for one patient had not been fully completed. On six occasions over two days staff had not recorded if the patient had been given their medicines. There were not entries in the patient's records to explain why their medicines were not given. Incomplete medicine records meant that it would not be possible to check if patients had received their medicines as prescribed. Patients were counselled and educated about their medicines prior to discharge. This supported patients to continue to receive their medicines as prescribed once they had left the hospital.

Since our last inspection the trust had introduced a secure locking system so medicine storage cupboards could only be opened by authorised staff. The temperatures of medicine storage areas including medicine refrigerators were monitored so staff could check those medicines which would become ineffective if not stored within a specific temperature range remained suitable for administration. Records documented that medicines were stored within the recommended temperature range to remain effective. Staff were aware what action to take if the temperatures were not safe for medicine storage. Controlled Drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses. This prevented medicines being accessed or administered by people who were not authorised to do so.

Medicines stored on resuscitation trolleys were not secured and could have been accessed by patients and visitors passing by. Failure to ensure the trolleys on the medical wards were tamper proof meant it could not be assured emergency medicines, intravenous fluids and equipment would be available or safe to use when needed.

Although daily checks were in place to ensure emergency medicines were available on resuscitation trolleys, there was no consistency between wards on the quantities stored or what medicines should be available on the trolleys. Although this had been highlighted at the previous inspection and was on the medicine management risk register, no further action had been taken to ensure consistent practice. Quarterly audits undertaken by pharmacy staff identified any issues which were fed back directly to each ward for learning and improvement. Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated. Staff we spoke with knew how to report incidents involving medicines. Information including learning from medication incidents was cascaded directly to wards to prevent similar incidences from reoccurring. On one ward we saw 'Drug Alert' information was available and clearly displayed. This notified staff of the latest drug recalls or incorrect information about medicines which could put patients at risk of harm.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned.**

## Never Events

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

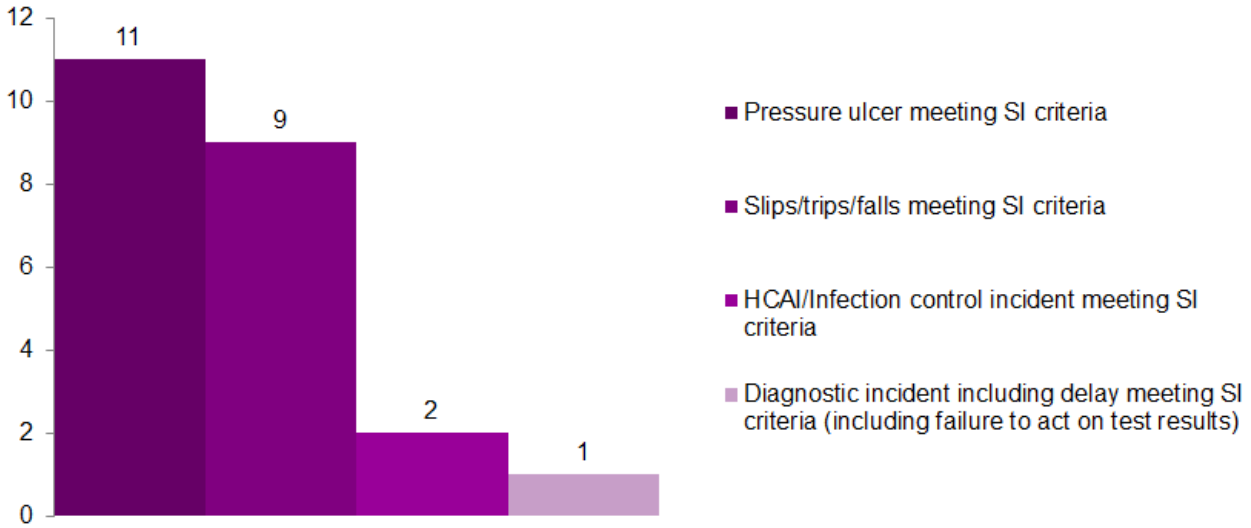
From July 2017 to June 2018, the trust reported no incidents classified as never events for medicine.

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

## Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2017 to June 2018.

**Serious Incidents (SIs) reported in Medical Care from July 2017 to June 2018**




A breakdown of the types of incidents reported is:

- Pressure ulcer meeting SI criteria with 11 (47.8% of total incidents).
- Slips/trips/falls meeting SI criteria with nine (39.1% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (8.7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (4.3% of total incidents).

Of the 23 medicine care serious incidences reported by the trust, six of these were attributed to the City Hospital site.

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

Staff could explain the trust's process for reporting incidents. These included discussing incidents with senior staff and submitting formal incident reports via the trust's electronic incident reporting system. Staff said they felt confident to report incidents and were encouraged to do so without fear of retaliation. One member of staff told us how they reported concerns about a possible breach of confidential information. They felt it had been handled appropriately and were informed of the outcome of the investigation.

Staff received updates on learning from incidences in regular trust communications and staff meetings. Data and outcomes from incidents were shared on the trusts intranet and on quality boards on each ward.  There were also hard copy records displayed in staffing areas. This meant

there was a visual demonstration relating to incidents for all staff daily.

Staff understood their professional duty of candour. They could explain to us when they would tell a patient or their family when something went wrong. They also explained the investigation and review process. This meant they understood their statutory responsibility of openness and honesty when things went wrong.

Records of incidences were not always completed effectively. We asked to look at the records for three incidences which had occurred within the medicines department which had been investigated by senior staff using a common care review technique called 'Root Cause Analysis' (RCA). There was a lack of consistency about how the analysis of each incident had been conducted and reported. One record was not a RCA but an investigation report into an incident that had occurred in another of the trust's core services. The two other records did not consistently review the patients' mental capacity as prompted and the impact this might have on keeping them safe in the future. Although one record identified a patient lacked the mental capacity to operate equipment which had been put in place to help prevent the re-occurrence of a pressure sore, there was no direction for staff about how this could be resolved. One RCA prompted staff to make the patient's family aware of the incident in line with their duty of candour, the other RCA did not. Both records did however identify action staff could take to reduce the risk of the incidences from reoccurring.

## Safety thermometer

**The service used safety monitoring results well.**

Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

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

Data from the Patient Safety Thermometer showed that the trust reported 24 new pressure ulcers, 24 falls with harm and six new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Sandwell and West Birmingham Hospitals NHS Trust**

**Total Falls (24)**


**Total CUTIs[3] (6)**


1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

*Source: NHS Digital - Safety Thermometer*

## Is the service effective?

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance.**

Managers checked to make sure staff followed guidance. Staff in medical care followed National Institute of Health and Care Excellence (NICE) guidelines. These guidelines made evidence-based recommendations to prevent and manage specific conditions and ways to improve health and outcomes.

Patients were monitored using a range of evidenced based and nationally recognised tools, such as the National Early Warning Score tool (NEWS). This promoted a standardised approach to monitoring patients' conditions and triggering an effective care pathway when their condition deteriorated.

An early warning screening tool had identified when a patient was suffering with sepsis. An action plan to manage the condition had been put in place and antibiotics were prescribed in line with good practice. However, records were not clear if antibiotics had been administered promptly within the 'golden hour'. Good practice guidance suggests that antibiotics administered within this time improve the outcome for patients suffering from sepsis. Staff had access to guidance on quality standards on sepsis screening and management which we saw displayed on wards. The use of the sepsis care pathway promoted improved outcomes for patients.

We saw the gastroenterology service followed the national guidance from the European Crohn's and Colitis Organisation and had participated in the royal college of Physicians Inflammatory Bowel Disease (IBD) audit. This meant patients received consistent care and treatment which was in line with best practice and proven to improve outcomes.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their specific needs and preferences.**

Patients received suitable food and drink to meet their nutritional and hydration needs. At our last inspection we were concerned that poor record keeping meant it was not always possible for staff to identify if patients who were at risk of dehydration had consumed enough fluids and found some patients were not consuming adequate fluids. At this inspection visit we found staff had kept records to check patients had received sufficient food and drink to meet their specific needs. Patient's weights and swallowing abilities were monitored and when indicated referrals were made to dieticians and speech and language therapists to ensure people received additional nutritional assessment and support.

Ward staff and a member of the catering staff we spoke with were aware of the needs of patients who required their meals to be prepared in specific ways so they could swallow food easily and safely. The member of the catering staff told us had got to know some of the patients on the ward and their meal preferences. Patients would be offered alternative meals if they did not like items on the day's menu. Patients were provided with hot and cold meals and snacks, tea and coffee and cold drinks throughout the day.

We observed a lunch time service on one ward. Patients were served promptly and told us they enjoyed their meals. There was a choice of meals provided to meet people's cultural and religious needs. The wards operated a protected meal time system and 'red tray service' so patients who needed support to focus on eating and drinking were not distracted by visitors or staff during meal times. Staff knew patients who were given their meals on a red tray may require assistance to eat and drink sufficient quantities. A member of staff who was supporting a person to eat knew they required a specific diet to avoid malnutrition and had checked their meal was fortified with additional calories. Another member of staff told us they would monitor the food and fluid intake of patient's who used red trays so they could identify if they had received enough nutrition to meet their needs.

## Pain relief

**Patients were largely assessed and monitored regularly to see if they were in pain. However, pain relief was not always provided as directed.**

One patient who had been identified as suffering from chest pains did not have a care plan to manage their pain. On the same ward, nursing staff had not documented pain scores for a patient who was admitted overnight. A pain score chart for a patient with a learning disability had been completed which enabled staff to identify if they were experiencing pain and action to take. This supported the person to receive appropriate pain relief when they were unable to verbalise their needs. Two nurses on one ward had completed a prescribing course which meant that they could administer pain medication to patients and promptly ease their discomfort.

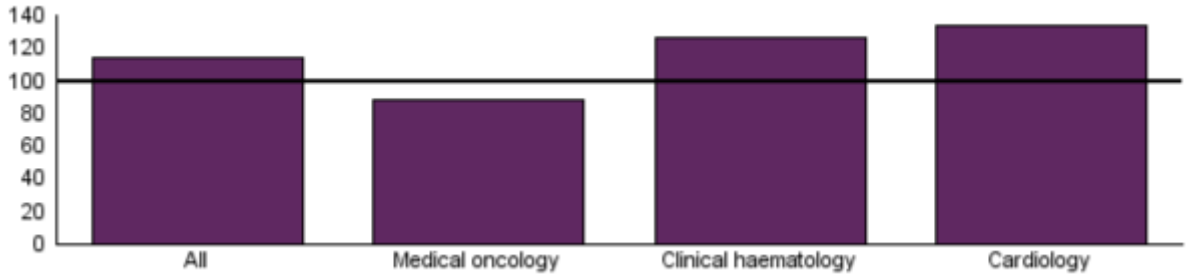
One ward manager told us they had provided pain relief training for staff on other wards in how to support patients who suffered from sickle cell and thalassemia. These had been poorly attended and we could not be assured staff on other wards had sufficient knowledge to meet the pain relief needs of patients with these conditions.

## Patient outcomes

**From March 2017 to February 2018, patients at City Hospital had a higher than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.**

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology and cardiology had a higher than expected risk of readmission for elective admissions

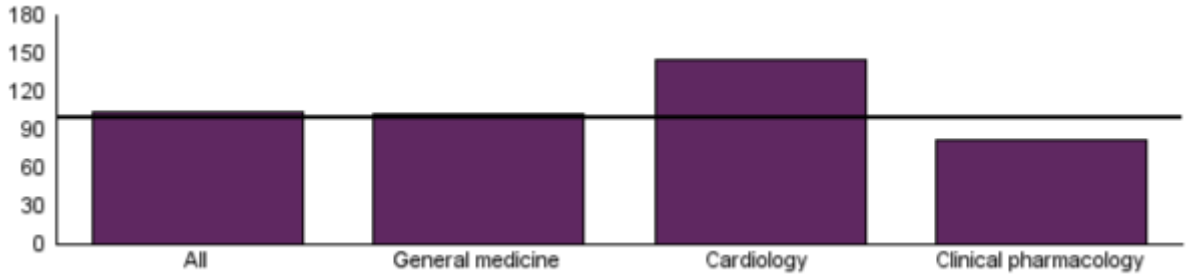
**Elective Admissions - City Hospital**




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

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions
- Patients in clinical pharmacology had a lower than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - City Hospital**




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

## Sentinel Stroke National Audit Programme (SSNAP)

City Hospital did not participate in the Sentinel Stroke National Audit Programme and stroke services were consolidated at Sandwell Hospital. Patients presenting at City Hospital with stroke like symptoms were assessed and transferred to Sandwell Hospital if necessary.

## Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 69.4%, which does not meet the audit aspirational standard of 90%. The 2016 figure was 67.3%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 62%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 68%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2017 was 37%. This is within the expected range. The 2016 figure was not significantly different to the national level.

*(Source: National Lung Cancer Audit)*

## National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 70%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 14%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 73%. This did not meet the national aspirational standard of 100%.

*(Source: Royal College of Physicians)*

## National audit of dementia 2017

City hospital was in the bottom 25% for the ‘percentage of carers rating overall care received by the person cared for in hospital as excellent or good’. The hospital was in the middle 50% of trusts for the remaining metrics.

## Heart Failure Audit April 2015 to March 2016

The results for Sandwell General Hospital were better than the England and Wales average for three of the four of the standards relating to in-hospital care and all of the nine discharge standards. The hospital performed slightly more poorly when compared to the England and Wales average for the proportion of cardiology inpatients.

## National Diabetes Inpatient Audit 2017

94.9% of diabetes patients at City Hospital reported they were satisfied or very satisfied with the overall care of diabetes while in hospital compared to 83.4% nationally. This was an improvement in performance compared with the 2016 report when the hospital's percentage was 88.8%.

## Competent staff

**The service had not ensured all staff had completed the mandatory training identified as necessary to be competent for their roles.**

## Appraisal rates

### Trust level

From April 2017 to December 2017, 70.4% of staff within medical care at the trust received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Public Health & Community Health Services | 5 | 5 | 100.0% |
| Other Qualified Scientific, Therapeutic & Technical staff | 1 | 1 | 100.0% |
| Support to ST&T staff | 48 | 56 | 85.7% |
| Qualified Healthcare Scientists | 60 | 76 | 78.9% |
| Qualified Allied Health Professionals | 22 | 28 | 78.6% |
| Other Non-Medical staff | 7 | 9 | 77.8% |
| NHS infrastructure support | 18 | 24 | 75.0% |
| Qualified nursing & health visiting staff | 326 | 457 | 71.3% |
| Support to doctors and nursing staff | 228 | 339 | 67.3% |
| Medical & Dental staff - Hospital | 131 | 206 | 63.6% |
| **Total** | **846** | **1,201** | **70.4%** |

Two of the staff groups within medical care at the trust met the target of 100% for completion of appraisals. However, it should be noted that both groups had a lower number of required staff than other staff groups, therefore each person accounts for a higher proportion of the total.

### City Hospital

From April 2017 to December 2017, 74.2% of staff within medical care at City Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Other Non-Medical staff | 6 | 6 | 100.0% |
| Support to ST&T staff | 44 | 52 | 84.6% |
| Qualified Allied Health Professionals (Qualified AHPs) | 22 | 27 | 81.5% |
| Qualified Healthcare Scientists | 60 | 76 | 78.9% |
| Qualified nursing & health visiting staff (Qualified nurses) | 181 | 241 | 75.1% |

| | | | |
|---|---|---|---|
| Support to doctors and nursing staff | 110 | 163 | 67.5% |
| NHS infrastructure support | 7 | 11 | 63.6% |
| Medical & Dental staff - Hospital | 2 | 6 | 33.3% |
| **Total** | **432** | **582** | **74.2%** |

One of the staff groups within medical care at the trust met the target of 100% for completion of appraisals. However, it should be noted that this group had a lower number of required staff than other staff groups, therefore each person accounts for a higher proportion of the total.

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

Managers appraised staff's work performance however there was no formal programme of supervision meetings with them to provide support and monitor the effectiveness of the service.

At our last inspection we were concerned that ward managers had not completed their fire orientation and leadership course. At this inspection we found they had undergone training however a ward manager was unable to tell us where fire extinguishers were placed on their ward.

Staff were required to have a minimum requirement of skill and competency. A HCA told us they had to complete mandatory training and were reminded by senior staff when it was overdue. They felt supported by the nurse and other HCA staff they worked with to acquire the skills and knowledge they needed to meet patient's care needs. Staff said senior staff were approachable if they required guidance or worried they might have made a mistake with a patient's care.

Part of a nurse's role on the cardiac catheterisation laboratory (Cath. Lab.) was to support staff to develop their professional skills and knowledge. A cath. lab is an examination room where equipment is used in theatre conditions to view inside a patient's heart and treat any abnormalities. Staff on the unit had completed their mandatory training and local competency assessments. Staff competency assessments had been devised by a consultant to ensure they were up to date and reflected best practice. There was guidance for staff of how to support patients at each stage of their surgical procedures. This included identifying what aspects of the patient's care required discussing at reviews and what action to take if the patient's condition deteriorated. There was a rotation system in place so ward staff would spend time working in the cath. lab to gain knowledge of these patients' care needs. Cardiac catheterisation patients were supported by sufficient numbers of staff with the skills and knowledge required to meet their specific needs.

Staff were aware of the trust's 'freedom to speak up guardian'. This was a senior member of staff who they could raise concerns about patient safety with in confidence. Although not all the staff we spoke with knew about the trust's duty of candour policy they all told us they would inform senior staff immediately of practice or action which could result in poor outcomes for patients. This ensured patients would receive prompt explanations and apologies when something had gone wrong.

## Multidisciplinary working

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

Medical and nursing staff told us that since our last inspection, patients experienced better coordinated care due to improvements in staff multidisciplinary working. Each ward specialised in meeting the needs of patients with specific conditions. Ward staff had access to consultants and range of appropriate medical staff such as psychologists and occupational therapists for expert advice and guidance. When necessary staff interacted with people who were external to the organisation, such as GPs and social workers to meet patient's care needs.

We observed a board round meeting which consisted of a consultant, registrars, pharmacy and nursing staff. It was well structured and inclusive which enabled holistic discussions and active discharge planning. All patients were discussed in detail and estimated discharge dates updated when necessary. A registrar reported that medicines to take out (TTO) had been prepared the previous day so they would not experience a delay when discharged later in the day.

Respiratory and Gastroenterology wards were supported by 'Consultants of the week'. These senior clinicians remained ward based to provide consistent advice and guidance to other medical and nursing staff. These roles had benefited patient care by providing prompt access to advice, guidance, assessments and discharges.

The records of a patient recently admitted to the AMU showed good engagement with the patient's family by the unit's doctor. There was a prompt response from an occupational therapist and DDD team to review the patient when needed. Records showed they provided clear advice and guidance about the person's condition and how to meet their care needs.

## Seven-day services

**The service offered seven-day services to ensure patients would receive consistent care and outcomes, whenever they enter the hospital.**

The head of the rheumatology service told us the service operated a seven day work and medical rota. There were specialist respiratory nurses available at week-ends to ensure consistence of care and advice.

Staff had continual access to a clinical advice due to the trust's 'consultant at night' programme. They told us there was general medical cover at the weekends to review poorly patients and identify patient suitable for discharge. Staff said there was an effective out of hours on call system to access advice and clinical support for patients. Patients in medical care could access full observations including ECG's and MRI scans every day to ensure their needs were met during the week and at weekends.

## Health promotion

**People were provided with information which enabled them to make informed decisions about their life style choices and how they could improve the quality of their lives and outcomes.**

National priorities to improve the population's health were being supported on the wards and in communal areas around the hospital site. Staff documented patients' weight on admission to the medical wards and referred patients who required support with their diet to dieticians. There was healthy eating information in communal areas and information about the role of effective handwashing techniques to prevent and control the spread of infection. Staff had operated information stalls in the local community to support dedicated national health awareness programmes.

There were patient leaflets on the wards relating to specific conditions and the actions patients and their families could take to manage their conditions and reduce the risk of their conditions worsening. This enabled people to make informed decisions about their life style choices and how they could improve the quality of their lives and outcomes.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Although staff understood how and when to assess if a patient had the mental capacity to make decisions about their care, they did not always follow the trust's policy and procedures when a patient could not give consent.**

## Mental Capacity Act and Deprivation of Liberty training completion

The trust has reported that Mental Capacity Act and Deprivation of Liberty Safeguards training is included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 2 | 379 | 433 | 87.5% | 95% | No |
| Safeguarding adults level 2 | 62 | 73 | 84.9% | 95% | No |

In medicine the 95% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff at a trust wide level met the target for safeguarding training overall, with a rate of 95.2%. The course with the lowest completion rate was the safeguarding adults level 2 module with 84.9%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding children level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding adults level 2 | 73 | 89 | 82.0% | 95% | No |
| Safeguarding children level 2 | 153 | 191 | 80.1% | 95% | No |
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

In medicine the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible. Medical staff at a trust wide level did not meet the target for safeguarding training overall, with a rate of 91.6%. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however this was based on only one of the two members of eligible staff not completing it.

**City Hospital medicine department**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the medicine department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 217 | 217 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 217 | 217 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 21 | 22 | 95.5% | 95% | Yes |
| Safeguarding children level 2 | 192 | 217 | 88.5% | 95% | No |

At City Hospital, nursing staff in the medical care core service met the 95% training target overall, with a rate of 96.1%. Of the four mandatory safeguarding courses made available to nursing staff, three met the target. The course with the lowest completion rate was the safeguarding children level 2 module with 88.5%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical staff in the medicine department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 5 | 5 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

At City Hospital, medical staff in the medical care core service met the 95% training target overall, with a rate of 95.5%. Of the five mandatory safeguarding courses made available to medical staff, four met the trust's target. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however this was based on only one of the two members of eligible staff not completing it.

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

We spoke with staff and reviewed the care a patient who was suspected of living with dementia received when they were admitted to the trust's ambulatory admissions unit (*AMU*). The patient's daughter had been involved to agreeing the patient's care plan and had signed to agree that the patient's information could be shared in line with the Data Protection Act 2018. However, there was no record that staff had acted to establish if the patient's daughter had the legal power of attorney to make this decision. Staff had not completed the mental capacity or DoLS safeguarding sections of the patient's assessment record when they had been identified as vulnerable and at risk of neglect due to suffering from Alzheimer's disease. Staff had not highlighted that the patient had dementia in the trust's 'flagging system'. This omission failed to alert other staff who were involved in the patient's care that the patient may be unable to consent to care and that best interest meeting may be required to ensure the person was support in accordance with their legal rights.

A DoLS authorisation for another patient on the AMU had expired. We escalated this to a member of staff. Failure to follow the DoLS authorisation put the patient at risk of having their freedom restricted illegally.

At our last inspection we were concerned that staff did not always have enough knowledge to apply the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS). We found this had improved. Staff had undergone MCA and DoLS training since our last inspection and MCA information sheets were circulated with staff payslips in July.

There were systems in place to support a patient who had a DoLS authorisation to restrict their movement, to leave the ward when they wanted to go outside to have a cigarette. We saw the patient was accompanied when they wanted to leave the ward by staff who were confident in managing the person's specific risks. This meant the patient was supported in the least restrictive way and in line with their wishes. The patient was seen regularly by an Independent Mental Capacity Act Advocate (IMCA) so when they lacked the mental capacity to consent to care, decisions could be made in their best interests.

## Is the service caring?

### Compassionate care

**Staff cared for patients with compassion.**

Feedback from patients confirmed that staff treated them well and with kindness. Patients we spoke with were complementary about the staff who supported them and felt listened to. Two patients on one ward were very complimentary about the quality of the care they received. They both told us staff were attentive and kind. A patient on another ward said, "Staff go above and beyond. You can see the staff feel the pain of the patients."

Staff spoke sensitively and gently with people. On one ward a member of staff supported a patient who was distressed by making them a cup of tea and some toast. They sat with the patient until they felt reassured. On another ward an occupational therapist offer reassurance to one patient about how their house would be adapted for their specific needs and would be ready for when they went home.

We saw staff providing reassurance to a patient and explaining why it was necessary for them to stay in their bed to reduce the risk of them falling. Staff closed the person's curtains so they could discuss their condition in private and supported the person to focus and comprehend the information being discussed. Staff ask the person if they were comfortable with the curtain closed.

Staff acted to protect patient's privacy and dignity. At our last inspection we were concerned that gowns often gaped at the back exposing the patient and compromising their dignity. At this inspection we saw that although this was still a risk, staff acted when they saw a patient required support to maintain their dignity. A member of staff held a person's gown closed when they walked through a ward and another member of staff protected a lady's dignity when the strap of her nightdress slipped off her shoulder. We saw on one occasion however when taking a blood sample from a patient in bed, a doctor did not protect the patient's privacy by closing their curtains or protect other people on the ward from observing a procedure they might have found distressing.

### Friends and Family test performance

**City Hospital (including BMEC)**

The Friends and Family Test response rate for medicine at City Hospital was 31%, which was

better than the England average of 25% from July 2017 to June 2018.

A breakdown of FFT performance by ward for medical wards at this hospital with total responses over 100 for the period from July 2017 to June 2018 is shown below:

| Ward name | Total Resp | Resp. Rate | Percentage recommended | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Ann. Perf. |
| D15 | 839 | 58% | 96% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99% | 98% |
| D26 | 639 | 70% | 72% | 86% | 88% | 94% | 100% | 97% | 100% | 100% | 100% | 100% | 100% | 100% | 95% |
| D11 | 269 | 28% | 64% | 74% | 78% | 79% | 73% | 86% | 71% | 78% | 83% | 100% | 100% | | 77% |

| Key | Highest score to lowest score | | |
|---|---|---|---|
| | 100% | 50% | 0% |

Only three wards received more than 100 responses. Of these, ward D11 had the lowest annual recommendation rate, with 77%, based on 269 responses.

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

*(Source: NHS England Friends and Family Test)*

## Emotional support

**Staff were considerate to provide emotional support and reassurance.**

We saw staff largely respond promptly when patients required reassurance. We saw staff make people drinks when they became agitated and assured them they were safe. Since our last inspection the trust had introduced telephones in public areas which provided a dedicated 'hot line' for patients and visitors to speak with trust staff about any aspect of the service or care which gave them concern. This enable staff to promptly address any concerns which could cause people anxiety or worry.

Patients were involved in agreeing their care plans and offered choices when possible. This supported people to feel in control of their care and what to expect.

Patients admitted to the medical care service were supported by a dedicated psychology service to express their views and any anxieties. Records showed that patients had psychological assessments when necessary which provided guidance for staff about the specific emotional support a patient required. However, patients using the trust's sickle cell and thalassemia service did not have access to this psychological support because they were day patients. The manager for the sickle cell and thalassemia service told us young people transitioning into the adult service often found the change anxious and there was a risk this would make them disengage and not receive the support they required. Patients using the sickle cell and thalassemia service formed longstanding friendships with other patients but there was no support to cope with the trauma and distress when patients they had gotten to know well died.

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

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

Staff explained to patient's how they were to be supported and sought their views about their care plans. We observed a member of staff asking a patient if they were happy with the care they received and asked the patient's relative to translate the question into the patient's preferred language. The person said they were pleased with their care, meals and the staff who supported them. Patients were generally positive about the provision of information which was available in a variety of both written and pictorial formats. For example, two patients we spoke with said staff provide update on their care plans each day, and their 'next steps'. One patient told us they knew when their expected discharge would be. Due to their specific conditions some patients were regularly readmitted and staff had developed a knowledge of how these patients and their relatives wanted to be involved in their care planning. Patients were supported to be involved in their care planning.

There were various processes such as the FFT and formal complaints procedure so patients, friends and family could provide feedback to the trust. Senior ward staff checked that patients who had been identified for discharged had been given the opportunity to feedback their experiences. Feedback was displayed in ward areas and when appropriate, senior staff had also provided a response identifying how the information would be used to improve the service and the experience of other patients.

A consultant told us that patient's GP's were notified when they were admitted to the department so they could share any information to support the patient's care needs and wellbeing in hospital and when they were discharged.

## Is the service responsive?

### Service delivery to meet the needs of local people

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

Information reflected the preferred communication styles of the local population. Signs informing people how to seek further assistance and leaflets about people's specific conditions were available in different languages. There were dedicated telephones in public areas for people to speak to a staff in their chosen language if they preferred. There were interpreting services available to support staff and patients at clinic appointments so patients could be involved in discussing and planning their care. Information boards on wards supported people who may suffer confusion to orientate themselves and health education leaflets to support people to understand and manage common conditions within the local population. This enabled members of the local community to make informed decisions about their life style choices and how to improve their general health and wellbeing.

Staff understood and assessed the diverse needs of the patients they worked with. There was a prayer centre and representatives from religions within the local community to support people of different faiths. Patients were offered a choice of food and drink to meet their religious and cultural needs. One member of staff told us that relatives could bring in food and drink from patients' local community to meet their specific cultural needs. They said this practice had supported people who were at risk of malnutrition.

## Average length of stay

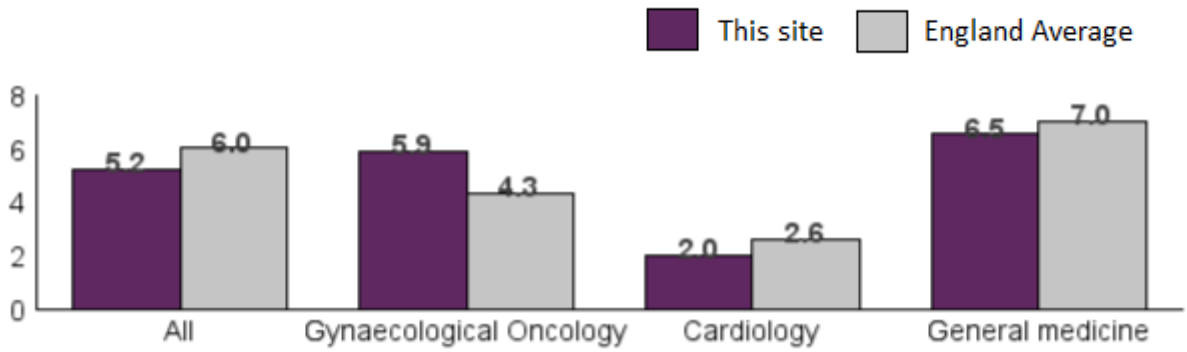
### City Hospital

From April 2017 to March 2018 the average length of stay for medical elective patients at City Hospital was 5.2 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 4.8 days, which is also lower than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology is higher than the England average.
- Average length of stay for elective patients in cardiology and general medicine is lower than the England average.

**Elective Average Length of Stay - City Hospital**

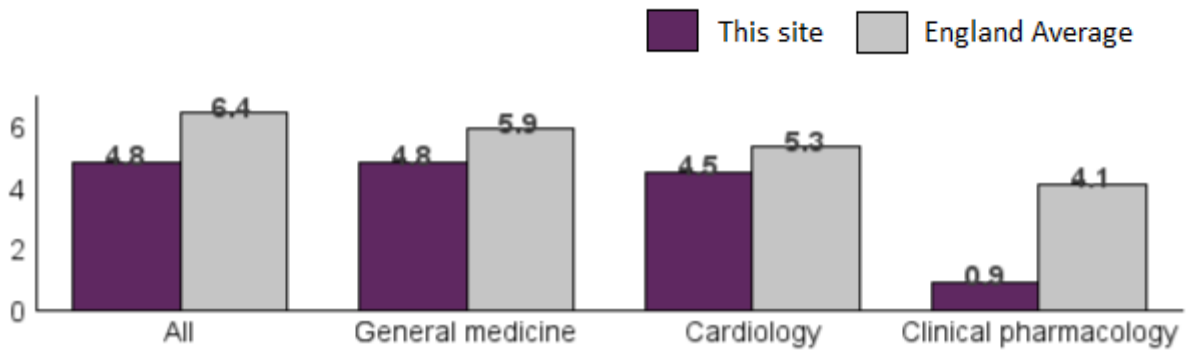



*Note: Top three specialties for specific site based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, cardiology and clinical pharmacology is lower than the England average.

**Non-Elective Average Length of Stay - City Hospital**




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

*(Source: Hospital Episode Statistics)*

## Meeting people's individual needs

**The trust did not plan and provide services in a way that always met people's individual needs.**

Robust processes were not always in place to prevent mixed sex breaches of patients. This happens when patients of different sexes are nursed in the same bed bay, or need to share a bathroom. There is a risk this practice could impact on the privacy and dignity of patients in these areas. Patients of different sex were being supported in the same bed bays on the AMU. Staff told us and records confirmed that this practice had happened most days for several months. We escalated our concern to senior staff who provided assurance they would act to address this. We revisited the AMU on the third day of our inspection visit and found there were no mixed sex breeches. A senior member of staff on the AMU told us, "This is the first time it's been like this [no mixed sex breaches] since December [2017]."

Patients were not always supported in line with their individual needs. The care records for a patient with a learning disability identified they would only drink from a specific cup however a member of staff supporting the patient did not know where the cup was and had not attempted to find it. This increased the risk of the patient refusing drinks and becoming dehydrated. Another patient on the unit who required support with their mental health did not have the one to one support identified as necessary in their care plan. Staff told us and records confirmed that patients were often not supported by the number of staff they required to stay safe. Failure to receive support in line with their care needs put the patient at risk of experiencing poor health outcomes.

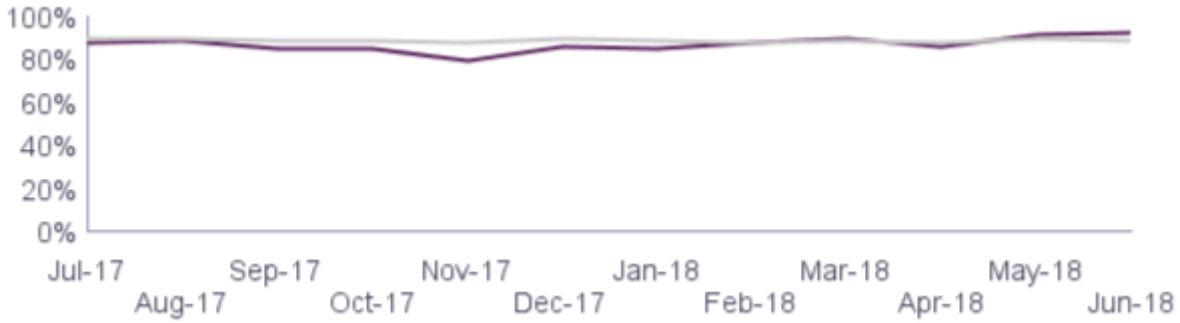
The environment of the sickle cell and thalassemia service did not always meet the needs of the people who used the service. For example, patients were usually required to regularly attend the service for a whole day and had little access to entertainment apart from a communal television and radio. Although Wi-Fi was available, patients had to pay to access this at each visit. During their treatment patients were unable to leave the area to find alternative entertainment or stimulation. One member of staff was concerned the lack of a suitable environment risked younger patients disengaging from the service. If a young person did not receive suitable treatment during their early years it increased the risk of poor outcomes and the need for more complex care in the future. There were plans in place to support younger patients when they transitioned into the sickle cell and thalassemia service from the local children's hospital. There were 'pizza evenings' and the opportunity for new users to meet with and learn about the experiences of patients who already used the service.

## Access and flow

## Referral to treatment (percentage within 18 weeks) - admitted performance

The graph below shows the trust's referral to treatment time (RTT) within 18 weeks for admitted pathways for medicine from July 2017 to June 2018. Over time, the trust has performed similarly to the England average, with a decrease in the number of patients being referred for treatment within 18 weeks in November 2017 (79.5% compared with 88.2% nationally).

The latest data for June 2018 shows that 92.4% of this group of patients were referred to treatment within 18 weeks, compared to the England average of 88.7%.




*(Source: NHS England)*

## Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks). These specialties are shown in the table below.

| Specialty grouping | Result | England average |
|---|---|---|
| Neurology | 93.4% | 91.1% |
| Rheumatology | 98.5% | 94.5% |
| Thoracic medicine | 95.2% | 93.0% |

Geriatric medicine was the only specialty which was below the England average for admitted RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric medicine | 85.7% | 97.0% |

*(Source: NHS England)*

## Patient moving wards per admission

From June 2017 to May 2018, 97.6% of individuals at City Hospital did not move wards during their admission, and 2.4% moved once or more.

*(Source: Routine Provider Information Request – Ward moves tab)*

## Patient moving wards at night

From June 2017 to May 2018, there were 2,830 patient moving wards at night within medicine at City Hospital. The AMU1 accounted for the majority of these (1,768) followed by AMU2 and the West Midlands Poisons Unit, with 841 moves.

**People could access the service when they needed it.**

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. Since our last inspection the trust had acted to address our concerns with delays in patient admittance and discharge from the service. Improved multi-disciplinary team (MDT) working and consultants based on the wards meant patients who required to be admitted or were suitable for discharge from the service were identified earlier. After our inspection visit the trust informed us their delayed transfer of care (DTOC) rate was less than 3.5%. Daily ward rounds were tasked at identifying patients who were expected to suitable for discharge by 10 a.m. the following

day. This enabled ward staff and other services such as pharmacy to prepare for any support a person may require so they would be discharged as planned. Pharmacy staff reviewed people's prescriptions and dispensed medicines directly from the wards to improve and support patient discharge.

Some patients however experienced delayed discharges because placements in the community had not been identified with other agencies. On one ward there was a patient who had been identified as medically fit for discharge but was unable to leave as they had no access to public funds to support their transfer into accommodation which meet their specific needs. The trust was working with the local authority to resolve this issue. The AMU was usually a short stay ward but a patient had been on the unit for 14 days prior to our inspection visit. The patient was suitable for discharge however an appropriate mental health placement had not been identified. Failure to move patients promptly to other placements when needed may place them at risk of not receiving the most appropriate care and risk deteriorating health.

There was a constantly high demand for beds which had led to some patients being be accommodated in mixed sex accommodation. Although this had improved patient flow into the hospital it was contrary to NHS England requirements.

Patients were staying longer on the AMU due to a lack of beds in the hospital to transfer patients to. A member of staff told us, "Patients before [were] three days on the ward, now it's a week or more." There was a 'progress chaser' on the AMU whose role was to chase blood and scan results and prepare discharge papers and medicines so patients identified suitable for discharge left the ward as quickly as possible. This helped to minimise the length of time patients spent on the unit and improved access for other patients who required the unit's support.

There were effective preadmission processes for cardiac day cases to assess patient's specific care needs and identify if there was a risk they might require an overnight stay. This helped to prevent unexpected admissions and cancellations. The cardiac catheterisation laboratory had processes in place to prioritise 'alert calls' so patients who required urgent care would receive prompt and appropriate support.

## Learning from complaints and concerns

## Summary of complaints

### Trust level

From April 2017 to March 2018, there were 229 complaints about medical care at the trust. The trust took an average of 37.4 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (inc delayed discharge due to the absence of a care package) | 84 | 36.7% |
| Patient Care | 44 | 19.2% |
| Values & behaviours (staff) | 22 | 9.6% |
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 19 | 8.3% |
| Access to treatment or drugs | 18 | 7.9% |

| | | |
|---|---|---|
| Communications | 15 | 6.6% |
| Appointments | 9 | 3.9% |
| Waiting times | 6 | 2.6% |
| Privacy, dignity & well being | 5 | 2.2% |
| Facilities | 2 | 0.9% |
| End of life care | 2 | 0.9% |
| Transport (ambulances) | 1 | 0.4% |
| Admin/policies/procedures (inc patient record) | 1 | 0.4% |
| Consent | 1 | 0.4% |
| Total | 229 | 100% |

From April 2017 to March 2018, there were 125 complaints about medical care at City Hospital. The hospital took an average of 35.5 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (inc delayed discharge due to absence of care package) | 46 | 36.8% |
| Patient Care | 19 | 15.2% |
| Values & behaviours (staff) | 13 | 10.4% |
| Access to treatment or drugs | 12 | 9.6% |
| Communications | 9 | 7.2% |
| Appointments | 7 | 5.6% |
| Admissions and discharges (excluding delayed discharge due to absence of care package) | 6 | 4.8% |
| Waiting times | 5 | 4.0% |
| Privacy, dignity & well being | 3 | 2.4% |
| End of life care | 2 | 1.6% |
| Facilities | 1 | 0.8% |
| Admin/policies/procedures (inc patient record) | 1 | 0.8% |
| Consent | 1 | 0.8% |
| Total | 125 | 100% |

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

## Number of compliments made to the trust

From January 2018 to June 2018 there were six compliments within medicine at City Hospital.

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

**Concerns and complaints were investigated and lessons learned shared with staff.**

There were processes in place to support patients and visitors to make formal complaints. There were complaints forms available on the wards and compliments and complaints boxes in ward and communal areas. There were dedicated telephones in communal areas for patients and visitors to speak to staff about their experiences and concerns. Patients said staff were approachable and felt they were supported to raise concerns.

We saw that appropriate action plans were in place to ensure action was taken to address the themes identified through complaints. For example, wards displayed details of complaints received and what action they had taken to prevent them from reoccurring. Examples including improving discharge planning and choice of meals. Staff reviewed complaints during staff meetings and supervision with senior staff. Details of complaints were circulated in regular trust wide communications so staff could learn how to prevent similar incidences from happening again.

## Is the service well-led?

### Leadership

**Action taken by the leadership team had not been effective at providing reassurance to staff that ongoing concerns would be resolved.**

The leadership team consisted of a group of directors, a director of operations and director of nursing. There were also clinical directors, speciality leads, matrons and ward managers.

Senior staff had not been effective at reassuring staff that issue which had been ongoing for some time were being addressed. For example, two members of staff cried when they expressed their frustration that repeated concerns about unsafe staffing levels on some wards remained unresolved. Although senior staff took action when we escalated this concern, staff we spoke with were not confident the actions would be sustained. We also saw that some issues from our last inspection such as low mandatory training rates and unsecured resuscitation trolleys remained unresolved.

Staff said they were encouraged to engage with senior staff and felt comfortable to do so. Staff received regular communication from the trust's executive team and said the Chief Executive was visible around the trust. Staff we spoke with said the Chief Executive was approachable and they referred to him by his first name. One member of staff showed us a recent staff bulletin about trust news which they told us all staff received regularly. This supported staff to understand how the trust was performing, it's plans and the challenges it faced.

Ward managers were visible in the areas we visited and staff knew who they were required to report to, seek advice from or raise concerns with. Staff expressed confidence in their ward mangers' abilities to lead their teams and resolve any local conflicts. In one instance we saw that a ward manager had been nominated for a national nursing award in recognition of their outstanding leadership skills.

Wards had photographs of their medical care teams so other staff and patients could identify who they were and who to approach for support if necessary. Staff on one ward said that they did not have regular contact with senior nursing staff and were unsure who to escalate concerns to when their ward manager was unavailable.

## Vision and strategy

**Staff shared a common vision and strategy, however not all trust policies were understood by staff.**

There were trust polices available on wards and the trust's intranet for staff. These provided guidance for staff about how to comply with the trust's vison and strategies. Ward managers we spoke with however gave us conflicting explanations about their understanding of the trust's policy for the use of agency nurses. Some said they were not allowed to use agency nursing staff if requested bank nurses were unavailable and on several occasions, this had left wards with insufficient staff to meet patients' specific needs. The lack of a clear understanding of the trust's agency nursing staff policy had

Staff we spoke with shared a common desire to provide excellent patient care. Staff behaviours were consistent with trust promises we saw staff being polite, courteous, respectful and keeping patients involved. Displays around the wards and public areas within the medicine directorate promoted this vison. Senior ward staff had referred to the trust's vision when producing their own local promotional material and displays to inform patients and staff of their plan to deliver the trust's values and strategy at a local level. Some staff we spoke with said they did not have regular planned supervisions to discuss and reflect upon their own contribution towards achieving the trust's strategy. This did not allow staff to formally give their views about how the service could be improved. However, staff said senior staff were always available when needed for advice and guidance.

## Culture

**Staff generally enjoyed working at the trust and felt valued.**

Staff told us the trust promoted a 'no blame culture' and felt supported to speak out when patients were at risk of harm or they had concerns about their colleague's behaviour. Staff knew about the trust's whistleblowing policy and said they felt they would be supported by senior managers to express their views about the service without fear of threat or retribution. Freedom to speak up guardians were in place who provided staff with alternative routes to speak out about safety concerns and poor practice. Some staff however told us that a failure of senior staff to effectively respond to ongoing issues such as low staffing levels had left them feeling exhausted and undervalued.

Staff described a culture of good team working on their wards. There were opportunities for staff to pursue their personal developments and goals however low staffing levels sometimes meant staff could not always leave the wards to undertake planned training or breaks. One ward manager told us they were proud that three members of junior staff were soon leaving the ward to take up more senior positions within the trust. There were regular staff meetings with senior staff to review the quality of care patients received and discuss any concerns.

## Governance

**There were structures in place to monitor and review the delivery of the trust's strategy.**

The trust carried out local audits and used the outcomes to identify how services could be improved. Wards had developed local action plans to monitor and improve their delivery of patient care.

Staff were aware of their responsibilities and who they reported to. There were processes at all staff levels, such as ward meetings and heads of speciality meetings to review performance and compliance against set targets. The outcome of quality reviews was also communicated at handovers and by emails, newsletters and staff/public notice boards.

Heads of specialities had regular meetings with the trust's medical director to review the medical department's performance. Senior managers had worked with stakeholders when there was a risk to the quality of care people received such as agreeing breaches of mixed sex accommodation with the local clinical commissioning group. It was standard practice to notify a patient's GPs when they were admitted to the medicines department. This promoted a coordinated and person approach to the patient's care.

Staff were aware of their duty to speak up if they had concerns about any aspect of the service. Staff said senior staff were approachable and would welcome their views as opportunities to improve the service.

## Management of risk, issues and performance

**There were systems in place to identify and report risks however systems were not always effective at promptly reducing or mitigating risks.**

Prompt effective action was not always taken past local level when risks were identified. There was no action plan in place to address regular mixed sex accommodation breaches in AMU and staffing levels were often below those required to meet patients' individual needs. However, we noted the trust had taken action to try and improve in some of these areas such as an ongoing recruitment programme and a process to address the non-completion of training. Staff had failed to take prompt action to mitigate some risks we identified at our last inspection such as unsecured emergency resuscitation trolleys. Although we were informed new emergency resuscitation trolleys were on order, existing trolleys in use were still unsecured and staff on the wards were unable to tell us when the new trolleys would be introduced.

Staff had accessible information displayed on the wards relating to risk management, information governance and how to raise concerns. Staff we spoke with were knowledgeable about the trusts incident reporting process. One member of staff showed us two incidences they had raised through the trust's formal reporting process and the responses received. The responses thanked the member of staff for raising the concerns, details of the investigations and actions taken to prevent the concerns from reoccurring.

Each ward maintained a risk register which was reviewed and discussed at staff meetings. Senior ward staff told us they regularly reviewed their risk registers with more senior staff at the trust to identify actions required to mitigate and reduce the risk of harm to patients and staff.

## Information management

**There were systems in place to collect and share information. However patient information systems were not always accessible and some staff practices risked patient confidentiality.**

Patient information were not always managed effectively. Staff told us the trust's IT infrastructure was sometimes unavailable which caused delays in accessing patients' test results and care records.

There was a risk that confidential information could be accessed by people who were not authorised. On two wards confidential patient records were left unattended in communal areas. On another ward we saw that a member of staff had not logged off a computer after reviewing a patient's details enabling us and others to read confidential information about the patient. On another ward we saw one doctor access a computer using another doctor's log-in details.

Systems were in place to gather, analyse and share data and quality information with trust staff, key stakeholders and the public. The trust had a website where people could access trust board reports, policies and information which would be useful when visiting the hospital. The site also identified where people could obtain additional information if they were anxious or unsure about their treatment and the quality of care they should expect to receive.

Wards displayed information about their performance against the trust's quality monitoring audits. These included their compliance with mandatory training, infection control and the trust's family and friends test. Wards had implemented improvement plans and monitored progress in response to the results of these audits. For example, on ward we saw the action being taken when it was identified some staff had not completed their mandatory training as planned. This gave patients reassurance that data was being used to improve the care they received.

## Engagement

**The trust engaged well with patients and staff.**

Patients were supported to engage in developing their care plans and how the medical services operated. Staff actively sought people's views using the FFT and questionnaires and feedback forms were also available for use by patients and visitors. There was a dedicated telephone line available for people who preferred to speak directly with a member of staff. There was an interpreter service and a range of resources available so people could engage with staff using their preferred communication style. There were specialised staff, such as the DDD team, who had the skills and knowledge to support people who may be confused or required additional support to express their views.

Staff said they felt listen to and had regular contact with senior staff. Ward staff had daily handovers where they could discuss patients care needs and review the latest information from the trust, such as audit outcomes and new polices. When necessary hospital wide learning and consultation events were organised for staff to provide their views about the service. There had been several events arranged so staff could review and provide feedback on the proposed new electronic patient records system.

Two wards had taken innovative action to engage with staff and obtain their views. They had developed their own invitation only group on social media. This was used to inform staff of ward news, training events, links to good practice, success stories and service improvements. Staff could comment on the contents and express their views. All the staff we spoke with said they felt they had good engagement with senior ward staff and their views were welcomed and respected.

## Learning, continuous improvement and innovation

**There were processes in place to promote learning and continuous improvement however the trust did not always learn from external reviews.**

The provider had not responded to all the concerns or issues raised at our last inspection. Although staff were awaiting receipt of new lockable resuscitation trolleys existing trolleys and their contents remained unsecured. We continued to find examples of patient details not being kept confidential and staff continued to tell us the existing IT infrastructure was unreliable. We noted however that the trust was intending to launch a new electronic patient records system to address staff concerns. Staff also told us changes in ward/board rounds in response to our last inspection had resulted in patients being ready for discharge earlier.

There were practices on wards to review performance and identify how their services could be improved. We saw on one ward that incident reports were displayed in the staff room along with an action improvement plan. There was information from different staff groups displayed as learning material for other staff. A gastroenterology consultant said they held half day quality improvement events with staff to review current work practices and identify how they could be improved.

Staff on three wards told us they had regular feedback about incidences reported within the hospital and how they could be prevented from happening again. We saw the cath lab. displayed details about incidences and rated them by severity. Plans to reduce the risk of similar incidences reoccurring were formulated so staff could act to prevent patient's experiencing unsafe or experiences.

# Maternity

## Facts and data about this service

Sandwell and West Birmingham Hospitals NHS Trust delivers maternity services to the Sandwell and West Birmingham population with about 6,000 deliveries annually; approximately 4,500 through the delivery suite (with two co-located obstetric theatres) at City Hospital and 1,400 through the co-located Serenity midwifery-led unit (MLU). There had been 17 births delivered at the stand alone Halcyon MLU, which closed on 14 September 2018. The service aimed to grow the home delivery service.

The delivery suite has:

- 12 delivery rooms
- One induction suite (three bed space)

The trust has two maternity wards, each with 21 beds, located at City Hospital where care for women and babies is delivered providing antenatal, postnatal and transitional care.

City Hospital also hosts:

- The maternity triage unit which is open 24/7.
- The antenatal day assessment unit which operates from 8am to 8pm.
- The obstetric antenatal clinic co-located to the comprehensive sonography services.

The Serenity birth centre has five birthing rooms and one triage room.

The antenatal outpatient department has:

- Six clinical appointment rooms
- One observation room
- One ultrasound room
- Two counselling rooms

The Antenatal Day Assessment Unit has:

- Six couches
- One scan room

Specialist services provided by maternity services at the trust include:

- Antenatal and new born screening team
- Antenatal, obstetric and midwifery led specialist clinics
- Bereavement midwives
- Combined obstetric antenatal clinics for hypertension, haematology and high body mass index
- Community midwifery
- Fetal medicine department
- Infant feeding midwives

- Intrapartum obstetric and midwifery-led care
- Maternal medicine
- Maternity risk management team
- Obstetric theatres
- Postnatal obstetric and midwifery led care
- Professional midwifery advocates
- Recurrent miscarriage counselling
- Sonography
- Teenage pregnancy young person's team

The community midwifery service provides antenatal and postnatal care to approximately 10,000 women in the community from multiple on-site and off-site venues.

Working alongside and in partnership with the obstetric services, is the trust's level 2 neonatal unit hosting five ITU cots, five HDU cots and 19 special care baby unit (SCBU) cots. Occupied cot days for the unit are 1,560, 1,560 and 7,100 respectively.

*(Source: Acute Routine Provider Information Request – Context acute tab)*

The trust also ran some antenatal clinics from Sandwell Hospital. We did not inspect this during our inspection.

During our inspection, we spoke with 24 members of staff including leaders of the service, consultants, matrons, midwives, maternity support workers and domestic staff.

We also spoke with eight patients and three partners present on the maternity unit during our inspection.

We observed safety huddles where staff discussed patients' care and treatment. We reviewed 23 patient records including patient prescription charts and information displayed on huddle boards and noticeboards positioned throughout the department. We also reviewed information regarding the service received from the trust during and following the inspection.

We previously inspected the maternity department at Sandwell and West Birmingham NHS Trust jointly with gynaecology. Therefore, we cannot compare our new ratings for this inspection of maternity services directly with the previous ratings.

We last inspected the maternity and gynaecology services at Sandwell and West Birmingham NHS Trust in 2014. We rated the service as good for each domain of safe, effective, caring, responsive and well-led. The maternity and gynaecology service was rated as good overall.

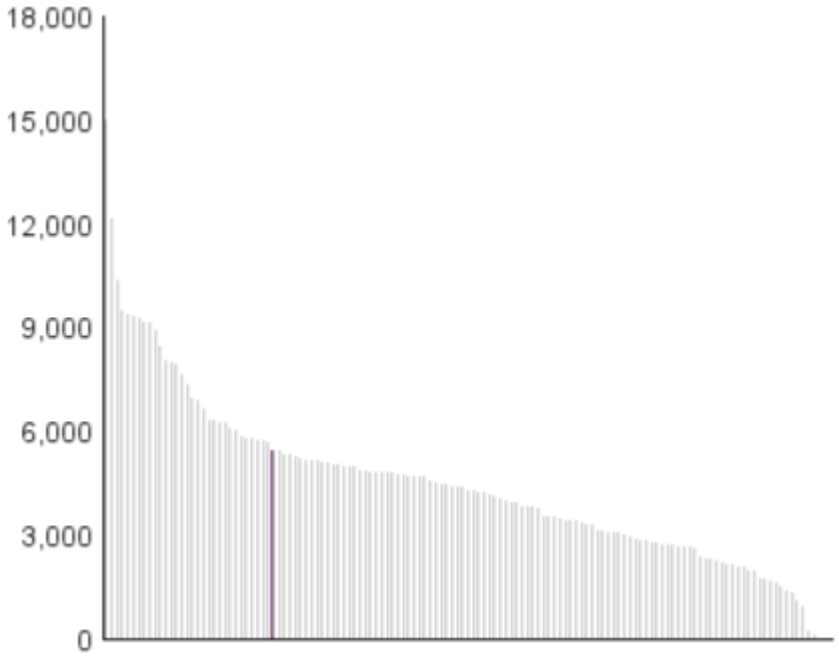
**Deliveries at the trust**

From April 2017 to March 2018, there were 5747 deliveries and 5811 registerable births at the trust.

The maternity dashboard report showed there had been 2,410 births at the trust from April 2018 to August 2018.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below:

**Number of babies delivered at Sandwell and West Birmingham Hospitals NHS Trust – Comparison with other trusts in England**




*(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

**Profile of deliveries**

A profile of all deliveries and gestation periods from January 2017 to December 2017 are provided in the tables below.

The profile of deliveries at the trust in terms of single and multiple births, mother's age and gestation period was similar to the England average over this time-period.

| Profile of all deliveries (January 2017 to December 2017) | | | |
|---|---|---|---|
| | Sandwell and West Birmingham Hospitals NHS Trust | | England |
| | Deliveries (n) | Deliveries (%) | Deliveries (%) |
| **Single or multiple births** | | | |
| Single | 5,521 | 98.8% | 98.5% |
| Multiple | 66 | 1.2% | 1.5% |
| **Mother's age** | | | |
| Under 20 | 202 | 3.6% | 3.0% |
| 20-34 | 4,410 | 78.9% | 74.8% |
| 35-39 | 794 | 14.2% | 18.1% |
| 40+ | 181 | 3.2% | 4.1% |
| **Total number of deliveries** | | | |
| Total | 5,587 | | 592,194 |

*Notes: A single birth includes any delivery where there is no indication of a multiple birth.*
*This table does not include deliveries where delivery method is 'other' or 'unrecorded'.*

| Gestation periods (January 2017 to December 2017) | | | |
|---|---|---|---|
| | Sandwell and West Birmingham Hospitals NHS Trust | | England |
| | Deliveries (n) | Deliveries (%) | Deliveries (%) |
| **Gestation period** | | | |
| Under 24 weeks | * | * | 0.1% |
| Pre- term 24-36 weeks | 362 | 6.5% | 7.8% |
| Term 37-42 weeks | 5,207 | 93.2% | 91.9% |
| Post Term >42 weeks | * | * | 0.2% |
| **Total number of deliveries with a valid gestation period recorded** | | | |
| Total | 5,587 | | 490,944 |

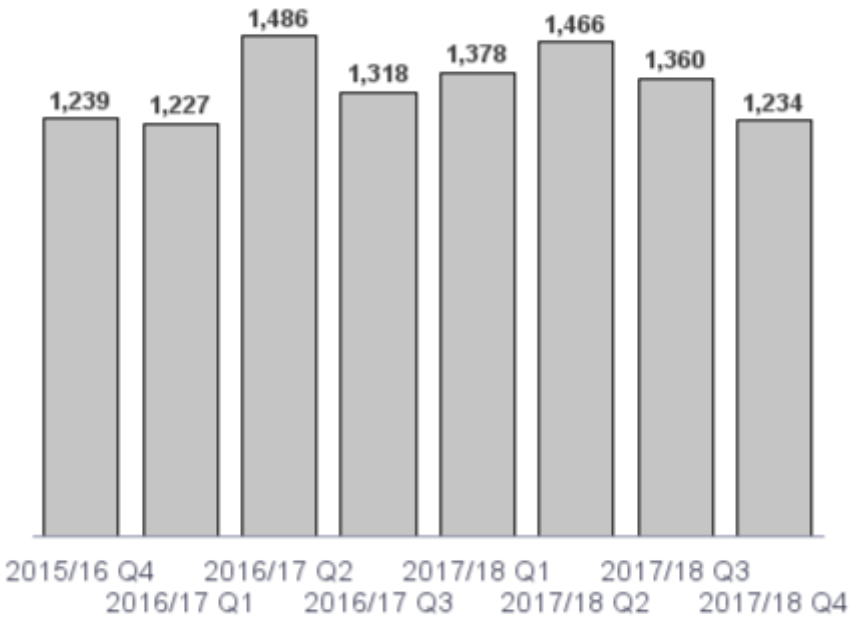
*Note: This table does not include deliveries where delivery method is 'other' or 'unrecorded'. To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.*

*(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

**Number of deliveries**

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below. The number of births at the trust during this period fluctuated between 1,227 and 1,486.

**Number of deliveries at Sandwell and West Birmingham Hospitals NHS Trust by quarter:**




*(Source: Hospital Episode Statistics - HES Deliveries (April 2017 - March 2018))*

## Is the service safe?

**Mandatory training**

**Managers ensured the majority of staff had completed their mandatory training.** The trust's mandatory training compliance target was 95% and the overall compliance rate for maternity staff as at September 2018 was just below the target at 94.17%.

Maternity staff received effective training in safety systems, processes and practices.

The maternity service provided mandatory training figures as at September 2018, split by staff group:

**Overall maternity staff mandatory training compliance rates:**

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 93.35% |
| Mat1 | 96.84% |
| Mat2 | 96.11% |
| Serenity | 95.45% |
| ADAU | 93.96% |
| ANC | 93.79% |
| Community | 91.91% |
| Evolution Admin | 90.32% |
| Obstetrics Speciality | 91.77% |
| Specialist Midwives | 98.18% |
| **Grand Total** | **94.17%** |

The overall compliance rate for the maternity department was just below the trust target at 94.17%

The maternity service's clinical education team co-ordinated staff training according to the training needs of maternity staff by using the electronic staff record (ESR) system. The clinical education team were knowledgeable about how they monitored staff training requirements. However, we saw this system was not streamlined and was time-consuming for clinical education staff to monitor staff training needs.

Staff completed their mandatory training via face-to-face training sessions and online courses. Staff told us staffing levels in the maternity department meant they were sometimes unable to attend training sessions as they needed to prioritise patient care and ensured shifts were covered. In an attempt to increase mandatory training attendance rates, some training was now delivered on the delivery suite and wards to reduce the impact on staffing levels.

Community midwifes attended the acute hospital setting to complete some training however, some training was also delivered in the community hubs.

The maternity clinical education team ran regular multidisciplinary skills drills training. We saw this complied with the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth recommendations. Maternity staff conducted skills drills each year to maintain and gain additional relevant skills needed to manage a range of obstetric emergencies and to remain up-to-date in the management of patient co-morbidities. These included vaginal breech birth, cord prolapse, postpartum haemorrhage, neonatal and maternal resuscitation. The clinical education team conducted unannounced skills drills sessions twice a month across all areas of the maternity department. A debrief which included a video was provided for staff on completion of skills drills to share any learning points or good practice identified. Specific skills drills such as

for water births was also conducted. Staff attendance was multidisciplinary to ensure learning was relevant for all specialities in the maternity department.

The maternity clinical education team had begun delivering 'PRactical Obstetric Multi-professional Training' (PROMPT) training in February 2018 with the aim of including medical staff in this training. This is an evidence based multi- professional training package for obstetric emergencies. As at September 2018, 62% of midwifery staff and 76% of medical staff had completed PROMPT training, which was below the trust target of 90% compliance. Training compliance rates reflected that the newly implemented PROMPT training was in the process of being rolled out to all staff groups. The clinical education team aimed to meet the trust target by March 2019.

## Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

**Trust level**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for qualified nursing staff in maternity is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 3 | 3 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 219 | 221 | 99.1% | 95% | Yes |
| Introduction to information governance | 161 | 163 | 98.8% | 95% | Yes |
| Equality & diversity | 221 | 224 | 98.7% | 95% | Yes |
| Medical devices competency form | 217 | 221 | 98.2% | 95% | Yes |
| Conflict resolution initial training | 219 | 224 | 97.8% | 95% | Yes |
| Harassment & bullying level 1 | 219 | 224 | 97.8% | 95% | Yes |
| Health & safety | 216 | 224 | 96.4% | 95% | Yes |
| Conflict resolution update | 139 | 149 | 93.3% | 95% | No |
| Medicines management | 206 | 224 | 92.0% | 95% | No |
| Resuscitation: basic life support | 205 | 224 | 91.5% | 95% | No |
| Resuscitation: resuscitation of new born | 194 | 217 | 89.4% | 95% | No |
| Infection control | 186 | 224 | 83.0% | 95% | No |
| Medical devices training | 175 | 217 | 80.6% | 95% | No |
| Transfusion | 172 | 217 | 79.3% | 95% | No |
| Moving and handling - patient handling | 146 | 223 | 65.5% | 95% | No |
| Information governance refresher module | 28 | 61 | 45.9% | 95% | No |

Some nursing staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for medical staff at trust level in maternity is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Medical devices training | 6 | 6 | 100.0% | 95% | Yes |
| Medical devices competency form | 15 | 15 | 100.0% | 95% | Yes |
| Consent - basic consent | 3 | 3 | 100.0% | 95% | Yes |
| Health & safety | 14 | 15 | 93.3% | 95% | No |
| Equality & diversity | 14 | 15 | 93.3% | 95% | No |
| Harassment & bullying level 1 | 14 | 15 | 93.3% | 95% | No |
| Conflict resolution initial training | 13 | 15 | 86.7% | 95% | No |
| Fire safety - workplace training | 11 | 13 | 84.6% | 95% | No |
| Resuscitation: basic life support | 11 | 14 | 78.6% | 95% | No |
| Conflict resolution update | 3 | 4 | 75.0% | 95% | No |
| Infection control | 11 | 15 | 73.3% | 95% | No |
| Medicines management | 10 | 15 | 66.7% | 95% | No |
| Information governance refresher module | 6 | 9 | 66.7% | 95% | No |
| Moving and handling - medical staff | 9 | 14 | 64.3% | 95% | No |
| Transfusion | 8 | 14 | 57.1% | 95% | No |
| Introduction to information governance | 3 | 6 | 50.0% | 95% | No |

Medical staff in maternity did not meet the trust's training completion target of 95%, achieving 80.3% overall. The target was met for three of the 16 mandatory training courses for which medical staff were eligible. The course with the lowest completion rate was the introduction to information governance module with 50% (three staff) completion, However, it should be noted that the number of staff eligible for this course was very low (six staff), which resulted in each person accounting for a higher proportion of the total.

The medical staff were not assigned to a specific site but rather to an 'other' site category.

**City Hospital maternity department**

**Nursing staff**

A breakdown of compliance for mandatory training courses, as at July 2018, for qualified nursing staff in the maternity department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 3 | 3 | 100.0% | 95% | Yes |
| Medical devices competency form | 107 | 108 | 99.1% | 95% | Yes |
| Equality & diversity | 106 | 108 | 98.1% | 95% | Yes |
| Fire safety - workplace training | 103 | 105 | 98.1% | 95% | Yes |
| Introduction to information governance | 79 | 81 | 97.5% | 95% | Yes |
| Harassment & bullying level 1 | 105 | 108 | 97.2% | 95% | Yes |
| Conflict resolution initial training | 104 | 108 | 96.3% | 95% | Yes |
| Resuscitation: basic life support | 103 | 108 | 95.4% | 95% | Yes |
| Health & safety | 103 | 108 | 95.4% | 95% | Yes |
| Resuscitation: resuscitation of new born | 99 | 106 | 93.4% | 95% | No |
| Conflict resolution update | 63 | 69 | 91.3% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Medicines management | 97 | 108 | 89.8% | 95% | No |
| Infection control | 93 | 108 | 86.1% | 95% | No |
| Transfusion | 86 | 105 | 81.9% | 95% | No |
| Medical devices training | 88 | 108 | 81.5% | 95% | No |
| Moving and handling - patient handling | 65 | 108 | 60.2% | 95% | No |
| Information governance refresher module | 13 | 27 | 48.1% | 95% | No |

Nursing staff in the maternity core service at City Hospital did not meet the mandatory training completion rate target, achieving 89.9% completion overall. However, the 95% target was met for nine of the 17 mandatory training modules for which qualified nursing staff were eligible. This included resuscitation: basic life support training at 95.4%. However, resuscitation of the new born was just below the trust target at 93.4% compliance. The course with the lowest completion rate was the information governance refresher module with 48.1%. However, it should be noted that the courses with the highest and lowest completion rates both had numbers of eligible staff, which were much lower than for other courses. Therefore, each staff member accounted for a higher proportion of the total.

**Medical and dental staff**

The trust have not provided information for medical staff specifically within the maternity core service at City Hospital. These staff were assigned to an ‘other’ site category. Analysis of this data can be found in the section below.

**Staff assigned to ‘other’ sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to ‘other’. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018, for qualified nursing staff in the maternity department at sites described as ‘other’ by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Introduction to information governance | 82 | 82 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 116 | 116 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 115 | 116 | 99.1% | 95% | Yes |
| Equality & diversity | 115 | 116 | 99.1% | 95% | Yes |
| Harassment & bullying level 1 | 114 | 116 | 98.3% | 95% | Yes |
| Health & safety | 113 | 116 | 97.4% | 95% | Yes |
| Medical devices competency form | 110 | 113 | 97.3% | 95% | Yes |
| Conflict resolution update | 76 | 80 | 95.0% | 95% | No |
| Medicines management | 109 | 116 | 94.0% | 95% | No |
| Resuscitation: basic life support | 102 | 116 | 87.9% | 95% | No |
| Resuscitation: resuscitation of new born | 95 | 111 | 85.6% | 95% | No |
| Infection control | 93 | 116 | 80.2% | 95% | No |
| Medical devices training | 87 | 109 | 79.8% | 95% | No |
| Transfusion | 86 | 112 | 76.8% | 95% | No |
| Moving and handling - patient handling | 81 | 115 | 70.4% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Information governance refresher module | 15 | 34 | 44.1% | 95% | No |

At sites where staff were assigned to the 'other' site, nursing staff in the maternity department did not meet the mandatory training target of 95% for training overall, achieving a rate of 89.6%. However, the target was met for seven of the 16 training modules for which qualified nursing staff were eligible. The course with the lowest completion rate was the information governance refresher module with 44.1%. However, as with other staff groups and locations, the number of staff eligible to undertake this training was much lower than for other courses. As a result, each staff member accounts for a higher proportion of the overall total.

**Medical and dental staff**

Mandatory training data for medical staff in services for children and young people was categorised under the 'other' site category, indicating that the staff worked across multiple sites. The analysis of this data can be found in the trust level analysis section above.

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

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
Following the inspection, the maternity department provided up-to-date safeguarding training compliance rates as at September 2018. Overall, maternity staff safeguarding training compliance rates met or exceeded the trust target of 95% for all adults and children's safeguarding training.

Safeguarding training Children Level 1 compliance rates:

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 100% |
| Mat1 | 100% |
| Mat2 | 100% |
| Serenity | 100% |
| ADAU | 100% |
| ANC | 100% |
| Community | 100% |
| Evolution Admin | 100% |
| Obstetrics Speciality | 100% |
| Specialist Midwives | 100% |
| **Grand Total** | **100%** |

**Safeguarding training Children Level 2:**

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 100% |
| Mat1 | 100% |

| | |
|---|---|
| Mat2 | 100% |
| Serenity | 100% |
| ADAU | 100% |
| ANC | 66.67% |
| Community | 100% |
| Obstetrics Speciality | 100% |
| **Grand Total** | **95.83%** |

**Safeguarding training Children Level 3:**

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 97.83% |
| Mat1 | 100% |
| Mat2 | 100% |
| Serenity | 100% |
| ADAU | 100% |
| ANC | 100% |
| Community | 97.67% |
| Obstetrics Speciality | 55.56% |
| Specialist Midwives | 100% |
| **Grand Total** | 94.56% |

**Safeguarding training Adults Level 1:**

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 98.21% |
| Mat1 | 100% |
| Mat2 | 100% |
| Serenity | 100% |
| ADAU | 100% |
| ANC | 100% |
| Community | 100% |
| Evolution Admin | 100% |
| Obstetrics Speciality | 100% |
| Specialist Midwives | 100% |
| **Grand Total** | 98.82% |

**Safeguarding training Adults Level 2:**

| Staff Group | Maternity & Perinatal Medicine |
|---|---|
| Labour Ward | 100% |
| Mat1 | 100% |
| Mat2 | 100% |
| Serenity | 100% |
| ADAU | 100% |
| ANC | 100% |
| Community | 92.86% |
| Obstetrics Speciality | 88.89% |
| Specialist Midwives | 100% |
| **Grand Total** | 98% |

The Board level Executive Director Lead for safeguarding was the Chief Nurse.

We discussed safeguarding compliance with senior staff during the inspection who told us maternity staff non-attendance at safeguarding training sessions had remained a challenge due to staffing levels. The trust's safeguarding team monitored staff safeguarding training compliance and notified managers when a staff member had not attended a safeguarding training session. Staff attendance was also monitored at the safeguarding children operational group. The clinical education team notified the safeguarding team of new starters and the safeguarding team ensured new staff received safeguarding training as part of their induction programme.

The department did not have a safeguarding midwife in post at the time of our inspection. The recruitment process was in progress and the post was due to be filled by November 2018.
The trust's safeguarding team had covered this role in the interim to ensure joint working with the maternity service in the interim to fill this gap in service provision. The team continued to offer advice and support to midwives during this time. However, this has impacted on the safeguarding team's capacity to provide formal supervision with midwifery staff; although supervision had been provided to the Young Parents Team throughout the year. However, even when this post was filled, the safeguarding team was stretched and felt there was insufficient safeguarding resource for the numbers of safeguarding referrals and the high proportion of vulnerable patients seen in the department.

We discussed safeguarding concerns with all levels of maternity staff. Staff demonstrated how they would recognise safeguarding concerns for adults and children. Staff told us the trust's safeguarding team were accessible and supported them when required to attend court to present their statement. The safeguarding team provided advice, training and quality assurance of the reports. The safeguarding team would also provide court training. This was available to all staff if required. From April 2017 to March 2018, there had been 117 court report requests. Some staff told us they were not given sufficient protected time to complete court reports when required. We saw this risk had been recorded on the directorate's risk register.

Staff accessed safeguarding policies on the trust's intranet and requested further support from the trust's safeguarding team if necessary. Safeguarding vulnerable adults' posters were on display throughout the maternity unit with useful contact numbers for staff to access support.
The trust's safeguarding team had recently begun to produce a safeguarding newsletter to raise safeguarding awareness across the trust.

There had been a 67% increase in Multi Agency Referral Forms (MARF) completed between April 2017 and March 2018 at 325 for maternity services compared to the previous 12 months. The safeguarding team for the trust told us this was due to greater staff awareness following staff

safeguarding training completion, in particular level 3 safeguarding training. In response to an audit the safeguarding team had conducted, the team aimed to check whether staff took the necessary action in relation to safeguarding concerns to ensure the referral system was as robust as possible. Where staff had not taken appropriate action, the safeguarding team liaised with managers of staff to provide re-training and further supervision. The safeguarding team also fed back to staff to recognise good practice where staff had submitted good quality MARF referrals.

We saw the maternity electronic record system had a dedicated section to complete regarding child protection information.

From April 2017 to March 2018, the maternity service had raised 2,373 cause for concern forms. Cause for concern forms were maternity/health visitor liaison forms completed by midwives, often when they completed an antenatal booking appointment. Midwives completed a cause for concern form to share potential concerns they had about the family with other healthcare professionals who were involved in the care of the family. The main themes for reasons for the completion of cause for concerns were mental health concerns, domestic abuse and female genital mutilation (FGM).

The maternity service had a range of specialised midwives to provide personalised care, support and treatment for vulnerable patients. Community midwives completed a mental health assessment at patient's initial booking visit and midwives could complete a mental health assessment at any point during the pregnancy if they had concerns.

The service had a dedicated mental health team to support patients where required. We saw there was a clear mental health referral pathway in place to support patients with mental health concerns during their pregnancy. This also included guidance regarding when to consider completing a cause for concern referral. The mental health midwife updated the patient's GP regarding the outcome of the mental health assessment on the same day as the appointment to ensure they were kept up-to-date.

The mental health midwife requested staff inform them when one of their patients had given birth. If a patient was very distressed with mental health concerns during delivery, staff would contact the mental health midwife or the trust's Rapid Assessment, Interface and Discharge (RAID) team for additional mental health support. The mental health midwife supported patients with mental health concerns postnatally by calling patients or conducting home visits if required.

We reviewed a study of attendance rate, waiting time and diagnosis of patients seen at City Hospital's Mental Health Liaison joint obstetric/psychiatric antenatal clinic over a three-month period. The audit results supported the use of joint psychiatric/obstetric clinics to increase patient attendance. Aspirational waiting standards were not being met and only the unwell patients could be seen. This identified additional funding would be needed to increase the number of clinics across the local region.

The safeguarding team co-ordinated closely with the teenage pregnancy young person's team to ensure safeguarding concerns were appropriately escalated. The maternity dashboard recorded between April 2017 and March 2018 showed staff had offered 100% of teenage patient's additional support for every month, in line with the 100% trust target. The service worked in collaboration with partners in the region to support teenagers as part of the teenage pregnancy midwifery project.

The maternity department had arrangements in place to safeguard patients with, or at risk of female genital mutilation. The service had processes in place to record and report female genital mutilation (FGM). FGM advice was included as part of the trust's safeguarding policy. Staff in maternity services ensured FGM information was shared with midwives, GPs and health visitors.

The FGM midwife monitored the number of FGM referrals. The service had an FGM midwife responsible for referring all suspected cases of FGM or concerns to the police or children's social care service in order to comply with statutory guidance. The FGM midwife or the trust's safeguarding team recorded all FGM cases on a dedicated database and also updated the Department of Health database for all identified cases of FGM.
The trust used the FGM Risk Indicator System (RIS) 2018 for formally recording FGM case. This was an IT system used to assist FGM information sharing. The FGM midwife ensured FGM information was shared with midwives, GPs and health visitors. As part of the maternity pathway, staff offered patients with FGM an appointment at the FGM specialist clinic held once a week at City Hospital.

The trust's safeguarding team attended health forums and had improved links with other external agencies for Birmingham and Sandwell to ensure information and good practice was shared across different agencies. The FGM midwife planned to provide FGM training updates for all midwives to ensure they were all kept up-to-date.

The trust's safeguarding team attended safeguarding children multidisciplinary operational meeting held every six weeks to discuss safeguarding concerns and serious case reviews.

Staff referred patients at risk of domestic abuse to a counselling service managed by an external provider. We saw domestic abuse posters displayed across the department detailing contact details of local charities patients could access for support.

The trust's safeguarding team participated in the Sandwell SCB Child Sexual Exploitation (CSE) Health Group which was chaired by the Sandwell and West Birmingham clinical commissioning group Designated Nurse and co-chaired by the trust's Safeguarding Children's Lead. The trust's safeguarding team also attended the Birmingham CSE Group.

## Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in maternity is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 1 | 224 | 224 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 224 | 224 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 218 | 222 | 98.2% | 95% | Yes |
| Safeguarding adults level 2 | 46 | 51 | 90.2% | 95% | No |

In maternity, the 95% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. Staff met the target for safeguarding training overall, with 98.8% completion achieved.

Some nursing staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

**Medical staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical staff in maternity is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 15 | 15 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 15 | 15 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 8 | 9 | 88.9% | 95% | No |
| Safeguarding children level 3 | 6 | 7 | 85.7% | 95% | No |
| Safeguarding children level 2 | 6 | 8 | 75.0% | 95% | No |

In maternity, the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible. Medical staff at trust level did not meet the target overall for safeguarding training, with 92.6%.

The medical staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

**City Hospital maternity department**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the maternity department at City Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 1 | 108 | 108 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 108 | 108 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 1 | 1 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 106 | 107 | 99.1% | 95% | Yes |
| Safeguarding adults level 2 | 18 | 21 | 85.7% | 95% | No |

At City Hospital maternity department, the 95% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff at City Hospital maternity department met the target overall for safeguarding training completion with a 98.8% completion rate.

**Medical staff**

The trust have not provided information for medical staff within the maternity core service at City Hospital. These members of staff were assigned to an 'other' site category. Analysis of this data can be found below.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff assigned to 'other' within the maternity core service is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 1 | 116 | 116 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 116 | 116 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 1 | 1 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 112 | 115 | 97.4% | 95% | Yes |
| Safeguarding adults level 2 | 28 | 30 | 93.3% | 95% | No |

Nursing staff assigned to 'other' sites within the maternity department met the 95% target for four of the five training courses made available to them. Nursing staff met the target overall for safeguarding courses with a 98.7% completion rate.

**Medical staff**

Safeguarding training data for medical staff in services for children and young people was categorised under the 'other' site category, indicating that the staff worked across multiple sites. The analysis of this data can be found in the trust level analysis section above.

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

PREVENT training was delivered in accordance with the trust's guidance as part of safeguarding level 1 training. PREVENT training aims to safeguard people from becoming terrorists or supporting terrorism. As at August 2018, PREVENT training compliance was 100% for all maternity staff groups as shown in the table below

**PREVENT training :**

| Staff Group | August 2018 compliance |
|---|---|
| Additional Clinical Services | 100% |
| Administrative and Clerical | 100% |
| Estates and Ancillary | 100% |
| Medical and Dental | 100% |
| Nursing and Midwifery Registered | 100% |
| Grand Total | 100% |

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. Control measures were used effectively to prevent the spread of infection.**

There had been no cases of *Clostridium Difficile*, MRSA, or MSSA for the maternity service in the last 12 months. All patients were routinely screened for MRSA before caesarean sections.

Domestic staff and midwives in the Serenity midwifery-led birth unit followed a specific cleaning regime for the birthing pools following each patient use. We saw five months of cleaning schedules documenting when staff had decontaminated and cleaned the birthing pools.

All areas of the maternity department, including the obstetric theatres were visibly clean and clutter free. However, we did not see any methods of monitoring equipment being cleaned such as by the use of 'I am clean' stickers. Staff told us and we saw staff cleaned equipment after each use to ensure it was ready for other staff to use when needed.

Staff adhered to the trust's infection, prevention and control policy. Staff were 'bare below the elbow'. Staff adhered to the maternity service uniform policy. This was an improvement from our last inspection where staff did not consistently follow best practice guidance in relation to hand cleansing and infection control dress code.

The department had sufficiently stocked hand-sanitising gel dispensers available appropriately positioned at the entrances to each area and around the department. We saw staff regularly cleansed their hands using the gel before each patient contact. We saw posters displayed across the department requesting patients and visitors to cleanse their own hands to prevent the spread of infection.

The service undertook monthly infection prevention and control audits in line with the World Health Organisations (WHO) hand hygiene recommendations. The trust target for compliance was set at 95%. The results of hand hygiene audits from 2017 to July 2018 are shown below:

| Ward Name | July 2017 | Aug 2017 | Sept 2017 | Oct 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | March 2018 | April 2018 | May 2018 | June 2018 | July 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Delivery Suite | 100 | 97 | 92 | 92 | 95 | 96 | 90 | 94 | 97 | 95 | 91 | 97 | 90 |
| Maternity 1 | 97 | 97 | 100 | 100 | 100 | 100 | 100 | 100 | | 100 | 100 | 100 | 100 |
| Maternity 2 | 100 | 96 | 100 | 100 | 100 | 100 | 100 | 100 | | 100 | 100 | 100 | 98 |
| Serenity Birth Centre | 99 | 96 | 97 | 97 | 97 | 99 | 100 | 100 | 99 | 99 | 96 | 98 | 99 |

The antenatal ward (maternity 1), postnatal ward (maternity 2) and Serenity Birth Centre achieved above the trust target for all months from 2017 to July 2018. This was with the exception of the antenatal and postnatal wards, which did not submit hand hygiene audit data for March 2018.
The delivery suite met the trust target for seven of the 13 months. For the remaining six months, as hand hygiene compliance scored between 86% and 94%, the department was required to undertake weekly audits to improve compliance. Ward managers and matrons monitored compliance against the trust target. We saw as compliance on the delivery suite had fallen below 95% for a number of months, the delivery suite matron maintained an action plan in an attempt to increase compliance rates.

## Environment and equipment

**The majority of the maternity department's premises and equipment were suitable and well maintained.** The delivery suite was located on the same floor and in close proximity to the obstetric

theatres and neonatal unit in the event of patients requiring transfer. However, the bereavement suite was situated close to rooms where mothers had delivered healthy babies, which was not in line with the National Bereavement Care Pathway guidelines.

The bereavement team were aware of the positioning of the bereavement suite but told us they were currently limited by the building constraints. The bereavement team were researching soundproofing for the bereavement suite in an effort to help address this concern. The bereavement team had been involved in the planning of the maternity department at the Midland Metropolitan Hospital. They had ensured the bereavement suite was positioned in a dedicated area away from the delivery suite in the department plans for the new hospital.

Staff could easily access resuscitation trolleys and had signed to verify they had conducted daily checks of emergency equipment as required. This was to ensure emergency equipment was ready for use in the event of emergencies in the department. This was an improvement from our last inspection where we found staff were not always conducting daily checks.

Breast milk was appropriately labelled with the patient's information and stored in the breast milk fridge on the antenatal ward. Staff were knowledgeable about the timescales for safely storing, using and defrosting breast milk. Staff had checked the temperature of the milk fridge each day for the six weeks we reviewed with the exception of one day (6 September 2018).
However, we found the fridge was unsecured posing a potential safety risk as the fridge could be accessed by unauthorised patients or visitors to the department. We saw evidence the service addressed this in a timely way after we raised this with service leaders as a lock had been fitted to the milk fridge on the antenatal ward.

The environment and equipment in the maternity department was suitable for providing safe care and treatment for patients. The maternity department had medical equipment in place in line with the Royal College of Obstetricians and Gynaecologists Safer Childbirth: 'Minimum Standards for the Organisation and Delivery of Care in Labour' recommendations. Staff confirmed they had no issues with the maintenance or availability of equipment. Equipment was up-to-date with electrical testing.

The department had two dedicated obstetric theatres, one for elective caesareans and one for emergency caesareans. The service monitored the use of the second theatre, which was recorded on the maternity dashboard report, as the department did not have a second dedicated theatre team. The second maternity theatre was used 120 times from March 2018 to August 2018. This included all caesarean section births, perineal repairs, instrumental deliveries and manual removal of placentas.

Patients and visitors felt safe in the maternity department. Staff had access to each area of the department with swipe cards. Visitors gained entry via an intercom system. The maternity unit's two main entrances were locked at night for additional security.

Staff electronically tagged all babies at birth. Regular maintenance checks of the baby tagging system were conducted. The tag remained on babies during their stay in hospital in accordance with the trust's abduction policy. Staff removed babies' tags during the discharge process. Staff told us they had not conducted any recent mock baby abduction drills. However, they were able to easily locate the missing baby in maternity policy on the intranet. This guidance included a clear flow chart for reference and were knowledgeable about the abduction guidance. However, in the absence of regular mock baby abduction drills, we were not assured the staff had adequately checked for any gaps in the process and assessed staff awareness of their role in the event of an abduction.

Staff disposed of waste appropriately. Sluice areas were clean and well maintained. Theatre staff disposed of sharps in the relevant sharps bins.

The service ensured midwives were kept safe in the community. Community staff had lone working safety devices. The service used a security call service with a tracking system to monitor where community midwives were situated and this could be communicated to police if necessary.

## Assessing and responding to patient risk

**The maternity service had systems in place to ensure the safety of patients.** Staff appropriately carried out Cardiotocography (CTG) monitoring in line with local policies and guidance.

As at September 2018, the number of maternity staff who had completed CTG interpretation and escalation training was above the trust target of 90% at 92% for midwives and 98% for medical staff.

The midwifery electronic records system alerted staff when the fresh eyes check was due.
We checked six Cardiotocography (CTG) records; staff had conducted hourly fresh eyes reviews in all six cases. A CTG measures babies' heart rates and monitors the contractions in the uterus. Staff used a CTG before birth and during labour, to monitor the baby for any signs of distress. All maternity staff were required to conduct mandatory cardiotocography (CTG) training each year.

The service conducted monthly audits of a random set of 10 CTG records to monitor staff compliance. We reviewed the results of the audit for April 2018 to August 2018. This showed staff had conducted hourly fresh eyes reviews in all cases where required. Where staff were non-compliant, this was addressed through regular mandatory training, daily CTG case reviews and meetings with individuals to discuss non-compliance.

Staff assessed patient's needs in triage on arrival to the maternity department. Maternity staff staffed the triage area 24 hours a day, seven days a week. Patients could telephone triage staff for advice. Patients could self-refer to the triage unit if they had concerns about their babies' wellbeing or their own condition.

The service monitored the number of term admissions to the neonatal unit (NNU) and recorded this on the maternity dashboard report. Term admissions are babies born at 37+0 weeks gestation. Between April 2018 and August 2018, there had been 162 admissions. Senior leaders monitored transfer rates and held de-briefs to determine learning points. Staff also supported parents and kept them up-to-date with their babies' condition.

Midwives were required to conduct new born resuscitation training every year. Compliance rates for midwives, as at July 2018 was 85.6%, which was below the trust target of 95%.

Maternity staff were knowledgeable about how to monitor and manage patients at risk of sepsis in line with the sepsis policy. We also saw information displayed throughout the maternity department highlighting sepsis triggers.

Maternity staff completed sepsis training as part of their basic life support mandatory training. As at September 2018, overall maternity sepsis training compliance rates were just below the trust target at 94%. Compliance rates per staff group are indicated below:

- Number of midwives compliant: 94%
- Number of obstetricians compliant: 98%
- Overall compliance: 94%
- Trust target: 95%

Staff used the sepsis six pathway along with the modified early obstetric warning score (MEOWS) assessment to detect signs of patient deterioration. The maternity team had developed a regional maternal sepsis toolkit and pathway to support a consistent approach across the region.

The maternity service had an escalation policy for the deteriorating condition of patients, which staff understood. The procedure was tested via the live skills drills sessions conducted in the department. Staff had recorded and took appropriate actions to assess deterioration of patients in maternity. Maternity staff we spoke with about sepsis understood how to escalate in the event of deteriorating maternity patients. The maternity service had a sepsis policy in place for the management of

obstetric patients. Staff were aware of the policy and knew where to locate it. Staff had conducted appropriate sepsis training.

Maternity staff conducted patient risk assessments at their first booking appointments. These included social, medical and maternal mental health assessments. Staff had accurately completed risk assessments in all of the records we reviewed. For example, venous thromboembolism (VTE) and tissue viability assessments were completed.

The service audited compliance against the World Health Organisation surgical checklist as part of the clinical audit programme. Between October 2017 and August 2018, compliance rates for the completion of the WHO surgical safety checklist in obstetric theatres was 100% for each month. We observed staff followed all three steps of the WHO surgical checklist in the maternity theatres.

In response to a maternity service never event involving a retained swab, the service had implemented a change of practice to prevent reoccurrence. All patients with a swab or vaginal pack in situ were now required to wear a fluorescent bracelet to indicate the pack remained in situ. This ensured all staff were aware and appropriate action could be taken to ensure appropriate removal of the swab.

Theatre staff wore coloured hats according to their role to identify staff roles in theatre.

The service undertook monthly theatre audits of staff compliance regarding obstetric theatre equipment and theatre procedures; for example, resuscitation equipment checks and completion of the swab counting board. Senior staff fed back any concerns or good practice to staff.

The department used a '10-point check to safe' checklist to maintain safety. This included for example, staffing and acuity levels and emergency equipment checks.

The service monitored the number of admissions to the neonatal unit (NNU) and recorded this on the maternity dashboard report. Service leaders monitored these numbers each month.

The service monitored the number of babies born before arrival at the hospital. From April 2018 to August 2018, there were a total of 32 babies born before arrival. Staff incident reported when any babies were born before arrival (BBA) via the trust's electronic incident reporting system. The service would conduct an investigation and lessons were learned and shared.

**Midwifery staffing**

**The maternity service did not always have enough nursing staff to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.** Staff in the Serenity Suite told us they sometimes felt staffing levels were not safe which impacted on the levels of patient care staff could provide. Serenity suite staff felt staffing of the delivery suite took priority over the staffing of the Serenity suite. Staff told us this had put a strain on the relationship between Serenity suite and delivery suite staff. However, we did not observe this during our inspection.

Maternity staff mainly worked 12-hour shifts with some staff working shorter days. The department aimed to ensure there was a supernumerary delivery suite co-ordinator on every shift.

We reviewed the maternity staffing rotas for the past 12 months. The delivery suite had the lowest staffing fill rates at below 90% for both day and night shifts for each month from September 2017 to March 2018. The lowest fill rate was in June 2018 where the average fill rate for the night shift was at 75.2%.

Serenity birth centre staffing tended to be above staffing establishment. However, staff were regularly deployed to other areas of the department; the delivery suite in response to increased activity which staff told us left the Serenity suite understaffed.

The community staffing levels were consistently below 90% fill rate for midwives from September 2017 to March 2018.

The directorate's risk register included a risk to the quality of clinical care provided by community midwives to patients because of vacancies and sickness levels amongst community midwifery staff. The trust had a rolling recruitment programme to try to attract experienced midwives and particularly to work in the community setting.

Service leaders told us staffing levels in the maternity department were their main concern. They closely monitored and risk assessed midwifery staffing levels. The service conducted six monthly staffing reviews to ensure they had oversight regarding where the departments staffing pressures existed. The Director of Midwifery also reviewed staffing levels and staff skill mix every two weeks.

The maternity service used the Birthrate Plus acuity tool. This is a midwifery staffing tool used to assess the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. A recent Birthrate Plus table top exercise had calculated the maternity department was below establishment by 27 whole time equivalent midwives. However, this tool was now outdated and the Director of Midwifery had secured funding for another Birthrate Plus assessment to be carried out in October 2018. This would accurately calculate the number of staff required to provide safe care to patients birthing at the trust to ensure leaders of the service had full staffing oversight.

The service struggled to recruit band 6 midwives, which was a national recruitment issue. The service was implementing some measures to retain their student midwives in an attempt to help address this issue. The Director of Midwifery was supported by the trust board to increase the staffing establishment by having an on-going recruitment programme.

Despite the staffing challenges the department was experiencing, patients told us they received one-to-one care whilst in labour and felt well supported by staff. However, the service could not demonstrate that all patients in labour received one-to-one care in line with NICE NG4 guidance: Safe Midwifery Staffing. As at August 2018, 96% of patients received one-to-one care. Senior staff told us the one-to-one figures were not at 100% as when staff were re-deployed to areas of the maternity department this affected the figures. Midwives confirmed they struggled to provide one-to-one care at all times which left them feeling anxious, vulnerable and scared of possible litigation. Staff felt frustrated at being unable to always provide the personalised levels of patient care they wished to give. Midwives told us the constant staffing pressures in the maternity department had affected morale. Serenity staff were often called away to cover shifts on the delivery suite which left the Serenity suite stretched as they were below the planned staffing establishment levels. Senior staff told us they knew Serenity needed a larger core and were had a rolling recruitment process in an attempt to address this.

Staffing incidents were reported by staff using the electronic incident reporting system. From September 2017 to August 2018, maternity staff raised 71 staffing related incidents. Staff told us they were encouraged to incident report staffing levels concerns so leaders were sighted on when and where staffing problems occurred. We discussed this with staff who told us they often did not have time to complete staffing incident reports as they were already stretched to complete their normal duties. In response to this, the risk and governance team had adapted the incident reporting form in an effort to ensure staff reported all incidents

We attended a handover, which we saw followed a Situation Background Assessment Review (SBAR) format and was held away from patient areas. SBAR is a technique that can be used to facilitate prompt and appropriate communication. This was well attended by a range of multidisciplinary staff including consultant obstetricians, consultant anaesthetists, midwives, student midwives and registrars. We saw staff discussed all appropriate patient information.
Staff attending the morning safety huddle were required to complete a daily audit sheet that included staffing levels to maintain safety.

The service had an escalation process where an on-call manager would be available for staff to contact for advice regarding staff deployment and any other concerns 24 hours a day, seven days a week. Staff informed us of a recent serious incident which occurred in the Serenity birth centre. A patient gave birth without a midwife present and a midwifery support worker assisted the patient as they gave birth. The investigation report identified insufficient staffing levels due to short-term sickness across the department as a contributory factor as well as failure to respond effectively to the implementation of the escalation procedure. Staff were unable to deal with the level of unpredictable acuity in the midwifery Serenity birth centre and the maternity unit despite earlier recognition and escalation during the shift. We saw the service implemented actions as outlined in the investigation report action plan to prevent reoccurrence and improve future patient care.

## Planned vs actual

The trust reported the following nurse staffing numbers in maternity at City Hospital both from April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| City Hospital | 251.9 | 293.9 | 85.7% | 245.1 | 285.7 | 85.8% |

Staffing numbers for both periods were similar, with the fill rate in April and May 2018 being just 0.1 percentage point higher that than the fill rate from April 2017 to March 2018.

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

In May 2018, the maternity department reported they had 193 whole time equivalent (WTE) midwives working at the trust.

## Vacancy rates

As at August 2018, the maternity department had 10 midwife vacancies.

Fortnightly senior team meetings were held which included vacancy management. We saw this information fed into the monthly divisional board performance report.

From July 2017 to June 2018, the trust reported an over-establishment of 4.3% for nursing staff in maternity. A site breakdown is provided below:

- City Hospital: an over-establishment of 9.1%
- Staff assigned to ‘other’ sites within the maternity core service: 0.8%

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

We reviewed the reasons documented for the last five staff leaving the department. However, these staff had not received an exit interview and we were not assured senior staff were collecting and assessing information sufficiently regarding staff leaving the department in order to make improvements to improve the retention of staff.

After our inspection the trust provided us with a list of staff who had left with the reason for their leaving. The majority of staff leavers were band 6 midwives. The reasons for leaving were varied.

The service had recently introduced PROMPT training in an attempt to increase staff knowledge, however not all staff yet been trained.

From June 2017 to May 2018, the trust reported a turnover rate of 16.7% for nursing staff in maternity. A breakdown by site is provided below:

- City Hospital: 18%
- Staff assigned to 'other' by the trust: 15.3%

There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses. At both core service and location level, this target was not met.

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

Staff told us staff retention was being affected by the staffing challenges in the department. A number of midwives had recently left the department to work in other local trusts. During the inspection, a number of staff told us they were looking to leave the maternity department as they felt worn out.

## Sickness rates

The Director of Midwiferies' priority was to reduce staff sickness rates in the department to 3%. The maternity service had signed up to the Royal College of Midwives' Caring for You Campaign. This aimed to improve RCM members' health, safety and wellbeing at work so they were able to provide high quality maternity care.

Senior staff monitored themes around sickness to determine how best to address sickness rates. Matrons attended 'confirm and challenge' meetings with senior leaders to discuss sickness rates and ensure structured return to work plans were in place. The directorate had action plans in place to address sickness levels across all levels of the department. These were scrutinised at the group review meeting.

From June 2017 to May 2018, the trust reported a sickness rate of 4.8% for nursing staff in maternity, which was worse than the overall trust target of 3%. A breakdown by site was provided below:

- City Hospital: 4.8%
- Staff assigned to 'other' be the trust: 4.8%

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

## Nursing and midwifery staff bank and agency staff usage

Form April 2018 to August 2018, there were 452 midwifery shifts filled by bank staff.
The trust had increased payments for bank staff in an effort to fill bank shifts. Senior staff told us they monitored the number of hours staff were covering each week to ensure they were not covering too many shifts and become worn out.

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to

be filled.

The table below shows the numbers of shifts in maternity at a trust wide level from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff in maternity.

For qualified nurses, 2,175 shifts were filled by bank staff and 1,069 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 1,653 shifts were filled by bank staff and 12 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 2,175 | 1,653 | 3,828 |
| Agency | 1,069 | 12 | 1,081 |

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in the medical care core service, due to the format of the data provided by the trust.

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

## Midwife to birth ratio

The service recorded the midwife to birth ratio on the maternity dashboard report. From April 2018 to August 2018, the midwife to birth ratio was above the England average at 1:27 for each month. Senior staff told us in reality the midwife to birth ratio was 1:29. This was calculated from the recent midwifery workforce staffing review the Director of Midwifery had conducted.

From January 2017 to December 2017, the trust had a ratio of one midwife to every 25.6 births. This was similar to the England average of one midwife to every 25.2 births.

*(Source: Electronic Staff Records – EST Data Warehouse)*

## Medical staffing

The maternity service met the recommended hours of obstetric consultant presence for the number of deliveries at the trust in accordance with the Safer Childbirth/RCOG: The Future Workforce guidance. The delivery suite had 96 hours of obstetric consultant presence each week, which was above the recommended 60 hours of cover for the number of births at the trust. There was regular consultant presence and consultants conducted regular ward rounds.

Consultant obstetricians were resident on-site for 12 hours each day, Monday to Friday, 8.30am to 8.30pm. Consultants covered an on-call rota from home over the weekend.

Anaesthetic cover was available 24 hours a day, seven days a week on the delivery suite. Obstetric anaesthetists were free from other duties during this time**.**

## Planned vs actual

The trust reported the following medical staffing numbers in maternity at City Hospital both from April 2017 to March 2018 and, more recently in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| City Hospital | 35.9 | 45.4 | 79.1% | 36.2 | 45.4 | 79.7% |

The fill rate and staffing numbers for both periods were very similar.

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

As at May 2018, the maternity department had 19 consultant obstetricians/gynaecologists (WTE).

## Vacancy rates

As of September 2018, the maternity service had two obstetric consultant vacancies. The recruitment process was in progress and these posts were due to be filled by December 2018.

From July 2017 to June 2018, the trust reported a vacancy rate of 24.9% for medical staff in maternity. All medical staff were assigned to 'other' sites within the core service, which indicates staff working across multiple sites.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts, which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 7.7% for medical staff in maternity.

*(Source: Routine Provider Information Request (RPIR) - Turnover tab)*

## Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 1% for medical staff in maternity. This is better than the trust target of 3%. All staff were assigned to 'other' sites within the core service, which indicates staff working across multiple sites.

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

## Medical staff bank and locum staff usage

The maternity service used locums as and when required.

From June 2017 to May 2018, the trust reported that 736 shifts within maternity trust-wide were filled by bank staff and 358 shifts were filled by locum staff. There were no shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank + locum + unfilled) |
|---|---|---|---|---|

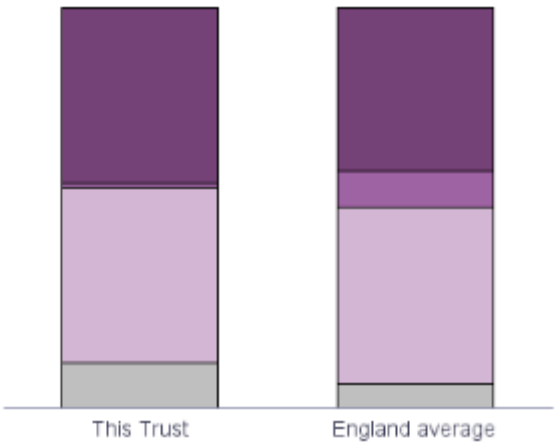
| | | | | |
|---|---|---|---|---|
| Consultant | 0 | 0 | 0 | 0 |
| Middle Grade | 398 | 337 | 0 | 735 |
| Doctor in Training | 338 | 21 | 0 | 359 |
| **Total** | **736** | **358** | **0** | **1,094** |

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

## Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was also higher. This is based on 44.1 whole time equivalent staff.

**Staffing skill mix for the 44.1 whole time equivalent staff working in maternity at Sandwell and West Birmingham Hospitals NHS Trust**




| | This Trust | England average |
|---|---|---|
| Consultant | 44% | 41% |
| Middle career^ | 1% | 9% |
| Registrar group~ | 44% | 44% |
| Junior* | 11% | 6% |

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

*(Source: NHS Digital Workforce Statistics)*

## Records

**Staff kept appropriate records of patients' care and treatment. Records were easy to follow, up-to-date and included all the relevant patient information.**

The department used an electronic maternity records system in conjunction with the paper-based system to record patient care in the department.

We reviewed 23 records during the inspection. We saw records were securely stored and were either supervised or directly held by staff.

We reviewed five caesarean section patient records which were appropriately completed. They included the reason for the caesarean section, which was evidence–based in each case. We saw if patients had previous had caesarean sections, vaginal birth after caesarean (VBAC) was offered to patients.

As at July 2018, 48.1% (13 out of 27) of midwifery/nursing staff and 44.1% of medical staff (15 out of 34) had completed the information governance refresher module which was below the trust target of 95% compliance.

The service planned to introduce an electronic digital key system to monitor staff access to records from the records trolley.

## Medicines

**Maternity staff prescribed, gave and recorded medicines appropriately. However, the storage of some medication needed improvement.** We saw gases were stored in the clean utility area on the delivery suite without the required medical gases warning signage on the door. We raised this with leaders of the service during the inspection and they addressed this in a timely way as signage was added onto the door immediately.

In the delivery suite clean utility room, the ambient room temperature was not recorded to ensure medication was safely stored within their safe storage temperature range. We discussed this with service leaders during the inspection; actions were taken in a timely way to address the high temperatures such as a fan and ordering an air conditioning unit. Staff had checked drugs fridge temperatures daily. We checked the trust's medicines optimisation policy, which did not reference room temperature checks.

We reviewed 10 prescription charts. Staff had clearly documented patients' allergies or sensitivities to medicines on medicine charts in all of the 10 prescription records. Patients wore red identification bracelets to indicate their allergies. All entries were legible and all charts were signed and dated. This information is important to prevent medication being given to patients in error and causing harm. We reviewed five prescription cards in patient's postnatal records.

We saw staff documented medication prescribing well. All mandatory fields were competed in the records we checked and all entries were legible and clear.

We saw staff stored and managed medication and controlled drugs safely in accordance with the trust's medicines optimisation policy. Controlled drugs requiring special storage and recording were stored following good guidance procedures including twice-daily checks. Medication was securely stored in locked drugs trollies. This was an improvement from our last inspection where we identified medication was not securely stored at all times.

However, we found a few items of medication on one drug trolley on the postnatal ward had expired. We raised this with senior staff during the inspection who removed the expired medication immediately.

Electronic prescribing and administration recording was due to be implemented via the new electronic record system the trust was planning to introduce across the trust.

Staff understood how to report a medicine incident in line with the trust's policy. The maternity department had two medication incidents where medication was missing from the department. We reviewed the investigation reports and saw recommendations were made in an attempt to prevent reoccurrence. One of the recommendations included implementing an electronic digital key system to improve medication security. This was now in place in the maternity department and allowed auditing of individual staff access to the drug cupboards.

We saw the trust's pharmacy team had conducted medicine management audits in the maternity department. We reviewed the audits and associated action plans. These identified areas for improvement; maternity staff members were responsible for monitoring the improvement and the action required to prevent reoccurrence.

We saw midwives checked the full medication history of patients during a mental health assessment and fully explained possible side effects on the patient's pregnancy.

Community midwives did not carry home birth medication. Each hospital site had a drug cupboard specific for home birth drugs.

## Incidents

**The maternity service managed patient safety incidents well. Staff recognised incidents and knew how to report them. Managers investigated incidents quickly and shared lessons**

**learned and changes in practice with staff. When things went wrong, staff apologised and provided patients with honest information and gave them suitable support.**

We saw there was a positive incident reporting in the department from all staff levels. Staff were knowledgeable about how to raise incidents on the trust's electronic incident reporting system. Staff received feedback from incidents they had reported.

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from July 2017 to June 2018. We reviewed root cause analysis investigation reports for two of these incidents.
The remaining four serious incident root cause analysis reports were still in progress. We saw some guidelines were amended in response to these two incidents, which were shared with staff. The service leaders shared outcomes of these investigations with staff involved through shared learning events and educational sessions to ensure lessons were learned and to prevent reoccurrence. Learning from one of these incidents was also shared with
We reviewed the root cause analysis (RCA) investigations from two of the six serious maternity the Regional Neonatal Network.

Managers of the service investigated incidents quickly and shared lessons learned and changes in practice with staff. When things went wrong, staff apologised and provided patients with suitable support and information. Staff were able to provide examples of maternity incidents and evidence of change of practice implemented in a timely way in response. We saw senior staff offered family involvement in each investigation and were invited to meet with the trust to discuss outcomes and ask any outstanding questions.

Learning from incidents was discussed with staff via a number of different meetings including Quality Improvement Half Day training sessions. This was to ensure staff remained up-to-date and were aware of changes to practice in response to incidents. However, we did not see evidence of incidents being discussed at ward or department meetings.

We saw senior staff provided feedback regarding incidents at handovers. The risk and governance team communicated learning from incidents via a monthly risk newsletter. Incidents were also discussed at monthly perinatal risk mortality groups. For example, an incident where there was a shoulder dystocia, there was evidence of a multidisciplinary discussion to determine if there were any learning points from reviewing this incident.

The risk and governance team worked collaboratively with other risk teams in the region as a part of the local maternity system risk work stream.

Staff at all levels demonstrated a good knowledge of the Duty of Candour and understood the main principles of the Duty. The service demonstrated how they met the Duty of Candour regulation. The Duty requires health service bodies to act in an open and transparent manner when things go wrong. The maternity service monitored how many occasions the Duty of Candour had been applied in the department. Between September 2017 and August 2018, there had been 55 occasions. The service also recorded in what way the Duty had been applied, whether verbal or written or both. We saw the Duty of Candour had been appropriately applied in a number of cases such as a maternal death and a shoulder dystocia case. We reviewed letters from the department to families following incidents in maternity, which complied with the regulation.

Daily multi-disciplinary patient safety huddles including representatives from neonates, anaesthetist, obstetrics and midwives were held to provide an opportunity for staff to review incidents from the previous day and safety issues for the day ahead.

We saw examples of personal and team learning from adverse outcomes. Staff held multidisciplinary 24 and 72-hour reviews of adverse events at daily handovers to ensure learning took place. For example, in response to a recent incident, the reduced fetal movement guideline

was reviewed and updated.

The service demonstrated lessons had been learned from previous never events in maternity and across the trust. For example, patients with a vaginal pack in situ now wore a bracelet to identify this.

The department was considering implementing an 'IR2' incident reporting process to report positive feedback to staff and commend good practice.

## Never Events

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

From July 2017 to June 2018, the trust reported no incidents which were classified as never events for maternity.

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

## Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with three (50% of total incidents)
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (33.3% of total incidents)
- Maternity/Obstetric incident meeting SI criteria: mother only with one (16.7% of total incidents)

All six incidents took place at City Hospital.

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

There had been three maternal deaths in the maternity service over the last 12 months. We discussed these with senior staff during the inspection. We reviewed two of the investigation reports, which were thorough and showed evidence of learning to prevent reoccurrence. However, we requested the third maternal death investigation report from the trust on a number of occasions, which they did not provide.

We saw there had been some learning in response to these incidents. For example, the maternal death guideline had been amended to reflect when parents were unmarried.

In response to feedback from relatives regarding another maternal death, visitors could now stay on the ward and on the delivery suite to ensure patients had the support of loved ones.

## Safety thermometer/Maternity Dashboard

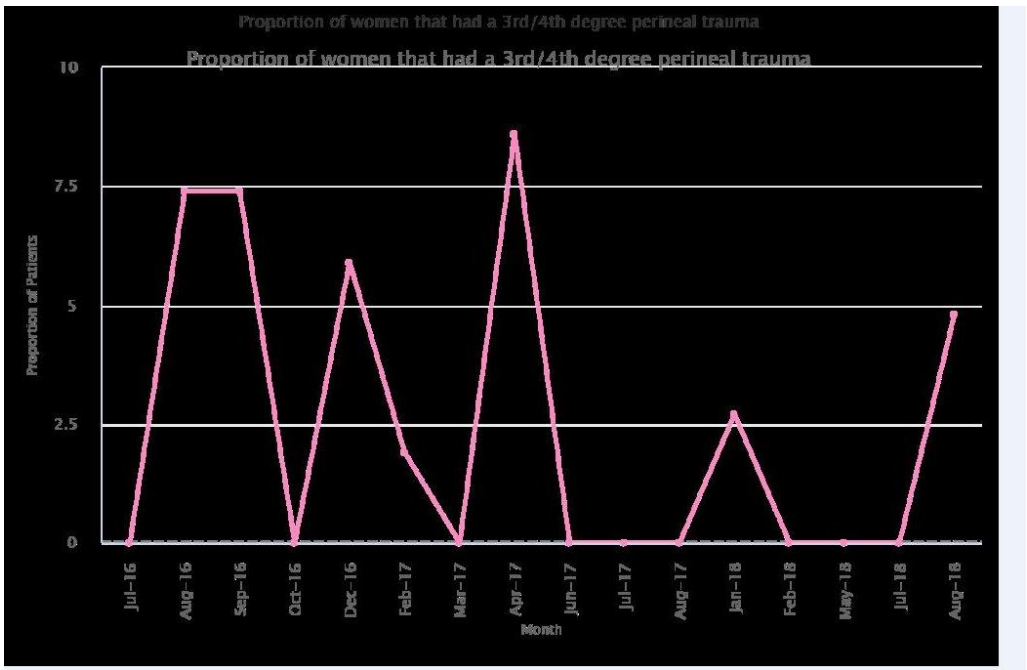
The trust had implemented the Maternity Safety Thermometer August 2016.The service used the maternity safety thermometer to monitor the safety performance of the service over time. This recorded harm and the proportion of patients who have experienced harm free. The Maternity Safety Thermometer measures harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. The safety thermometer supported

improvements in patient care and experience, prompted immediate actions by healthcare staff and integrated improvement measurement into the service's daily routines. The department recorded this data on a single day every month (every first Wednesday of the month) for all postnatal patients and their babies. The results were uploaded to the website by the Maternity Risk & Governance team using the data collection tool.

The data collated from the safety thermometer was reported into the Maternity and Neonatal Governance and Governance Board. Learning from feedback was highlighted through the patient experience QIHD presentations or immediately if patients raised concerns. If maternity staff identified trends from the data, these would be fully investigated.

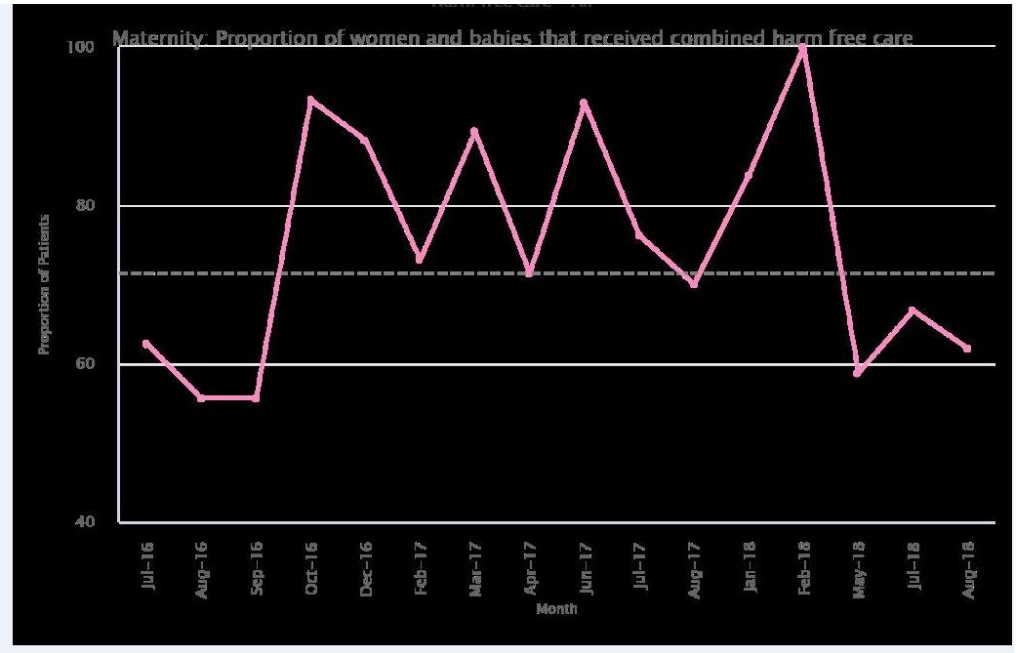
**The Maternity Safety Thermometer information below refers to data collated from July 2016 to August 2018:**

Proportion of women that had a 3rd/4th degree perineal trauma



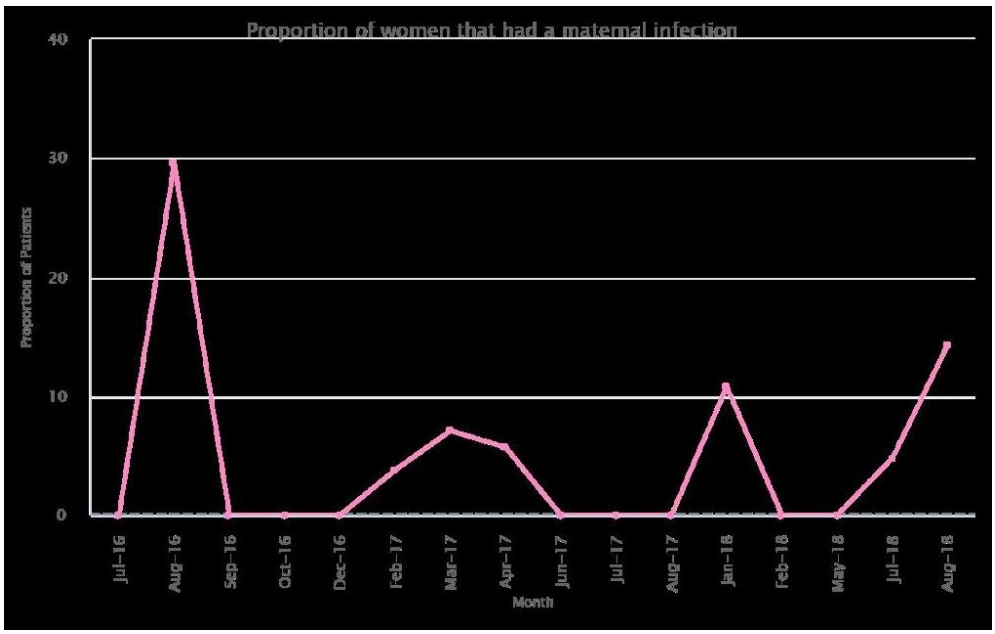

This shows the proportion of patients with a 3rd/4th degree perineal tear peaked in April 2017.

Proportion of women and babies that received combined harm free care:



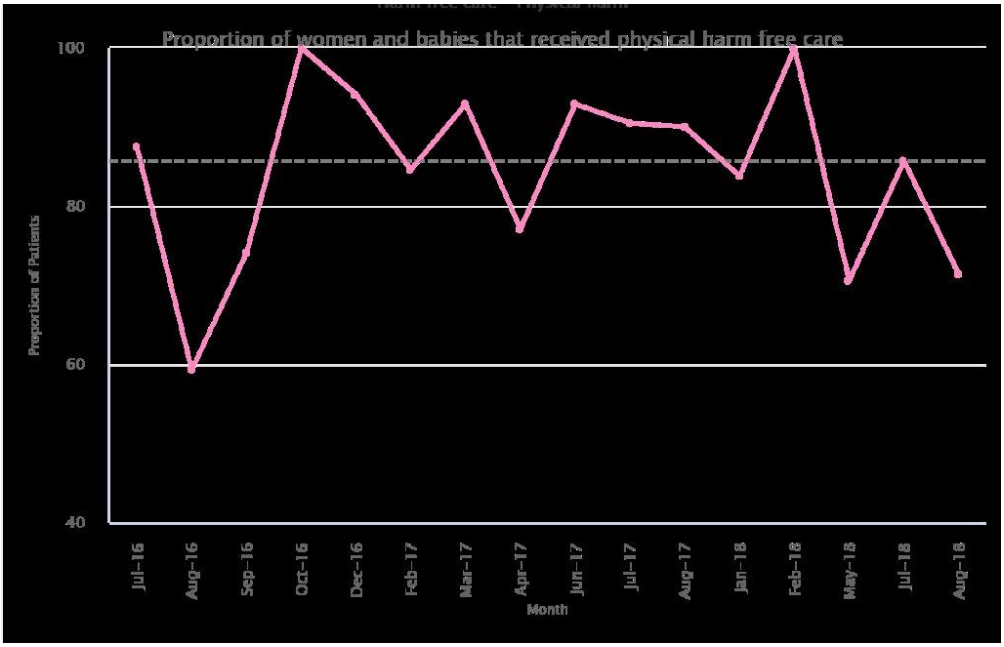

This shows an improving trend from September 2016 to February 2018. However, from February 2018 to May 2018 the proportion of patients that received combined harm free care declined to 60%.

Proportion of women that had a maternal infection:



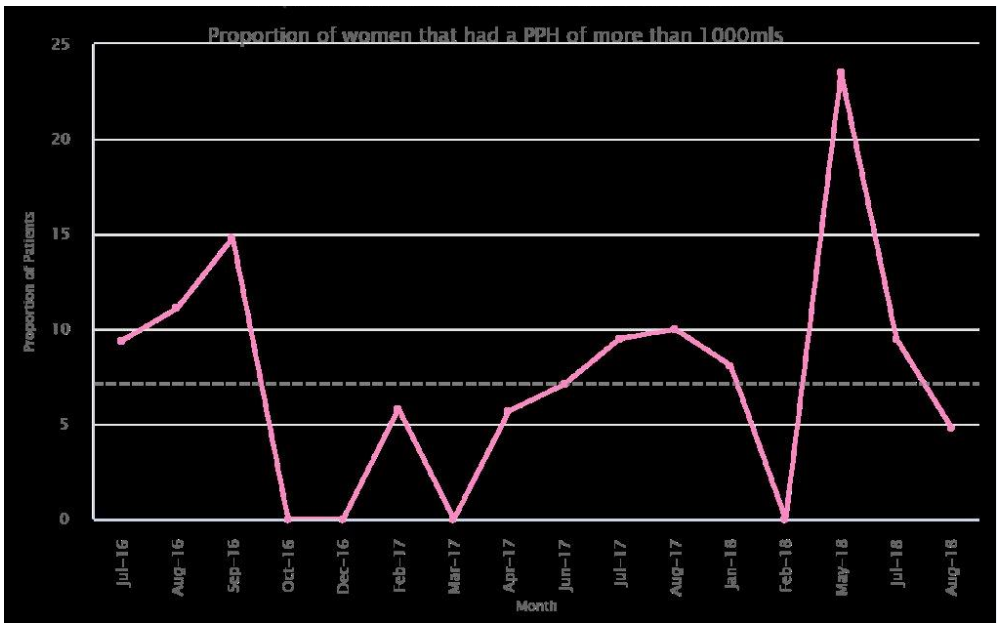

This shows the proportion of patients that had a maternal infection peaked in August 2016 to 30%. From September 2016 to May 2018, the maternal infection rate remained at 10% and below. However, maternal infection rates were on an upward trend from May 2018 to August 2018, as rates increased from 0% in May 2018 to above 10% in August 2018.

Proportion of women and babies that received physical harm free care:



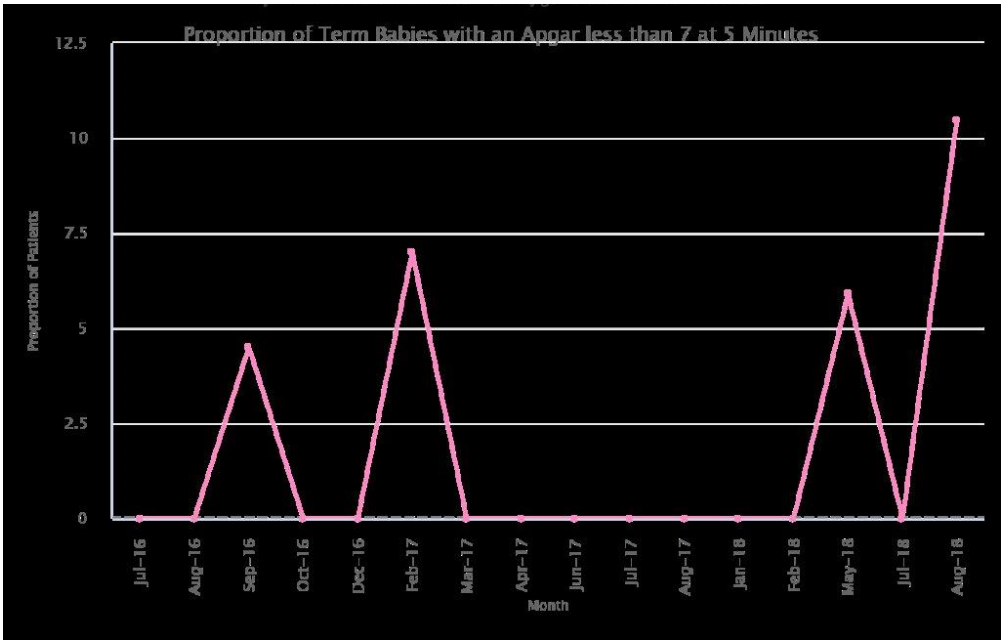

The number of patients that had harm free physical care was variable. The highest number of patients stating they did not experience harm free care was in August 2016 at 60%. However, 100% of patients stated they had harm free physical care in October 2016 and February 2018.

Proportion of women that had a PPH of more than 1000mls:



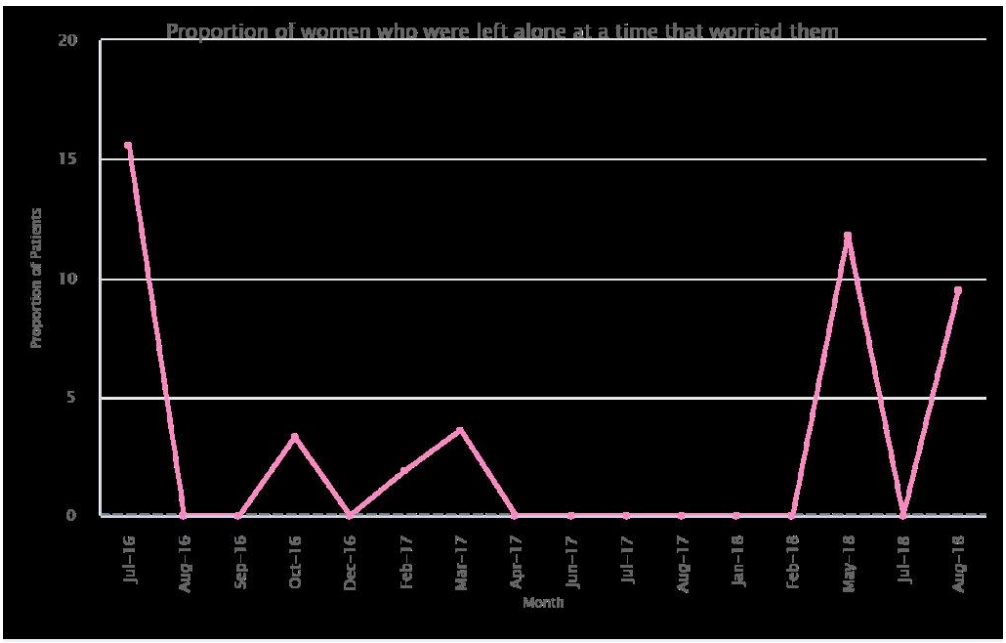

This shows that no patients had a PPH of more than 1000mls from October 2016 to December 2016. The number of patients that had a PPH of more than 1000mls peaked in May 2018. However, there was a declining trend from May 2018 to August 2018.

Proportion of term babies with an apgar score of less than 7 at 5 minutes:




This shows the proportion of term babies with an Apgar score of less than seven at five minutes peaked in August 2018.

Proportion of women who were left alone at a time that worried them:

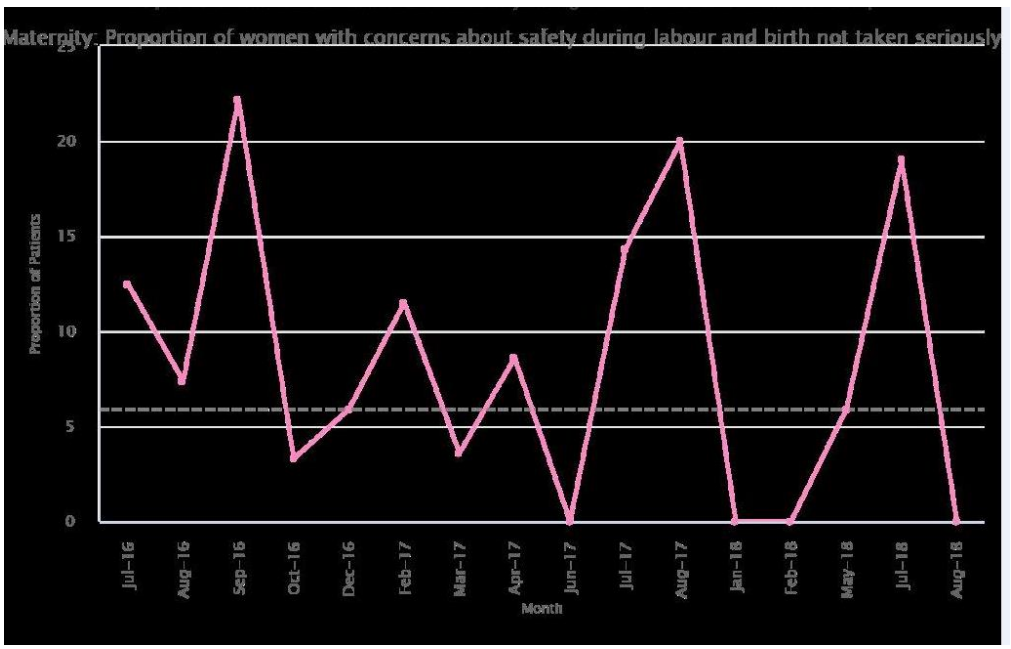



This shows no patients had concerns about being left alone at a time that worried them from August 2017 to February 2018.

Women's perception of safety composite measure:


This shows the number of patients stating they experienced no concerns regarding their safety increased from July 2016 to June 2017. However, this was variable from July 2017 to August 2018.

Proportion of women with concerns about safety during labour and birth not taken seriously:




This shows the proportion of patients with concerns declined from September 2016 to June 2017. However, the proportion increased from June 2017 to its peak in August 2017 at 20%.

**The maternity service maintained a local maternity dashboard report to document activity and clinical outcomes across the department.** However, some performance indicators on the maternity dashboard report did not include local or national targets. Where targets were present, it was unclear where the thresholds originated from to allow the service to sufficiently benchmark the maternity service's performance.

We discussed this with the Director of Midwifery who outlined the dashboard was in the process of being updated to include national key performance indicators to ensure the service was able to benchmark their performance more effectively locally and nationally.

## Is the service effective?

**The maternity service provided care and treatment based on national guidance.** Managers checked to make sure staff followed the most up-to-date guidance to ensure patients' outcomes were the best possible.

### Evidence-based care and treatment

The maternity service was managed in accordance with NICE guidelines and quality standards. Staff could access the most up-to-date maternity guidelines and procedures via the trust's intranet. Guidelines were audited and review dates monitored. Draft policies were shared across all maternity teams to ensure input from a variety of maternity disciplines. There was a policy and guidelines group held bi-monthly. Staff from this group updated policies and shared them with staff via email and highlighted where changes had been made to ensure staff remained up-to-date.

Handovers were well structured, consistent, concise, and effective. The review of the patient board followed the well-established Situation Background Assessment Recommendation (SBAR) method. This format was used to improve communication, ensure effective escalation and increase patient safety. Handovers included reference to the psychological and emotional needs of patients and those close to them. We observed handovers were held away from patient areas to ensure patient confidentiality was protected.

The service had started an enhanced recovery process for patients following caesarean sections to enable quicker patient recovery. This enabled patients to spend more time with their babies as soon as possible after the procedure.

Midwives and obstetricians emphasised the importance of fetal movements to patients at each antenatal contact as highlighted by MBRRACE-UK (2015).

The service had a clear bereavement care plan pathway in place for patients and relatives, which covered all required areas in line with the guidance.

Staff referred patients suspected to be experiencing depression for a mental health assessment. We saw pregnancy and delivery plans routinely addressed the mental health and wellbeing of patients.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health.** Maternity staff supported patients to feed their babies using their chosen feeding method.

The maternity service had recently achieved UNICEF Baby Friendly level three re-accreditation. Maternity staff with support from the infant feeding team and volunteers provided specialist feeding support to patients to ensure they could feed their baby using their preferred feeding method. The infant feeding team provided all new staff in the maternity department with breastfeeding training, which included an assessment for providing infant feeding support.

Patients reported high levels of feeding support and felt supported in their feeding method choices. Midwives provided individualised feeding advice throughout patient's antenatal period.

The service recorded breastfeeding initiation rates on the maternity dashboard report. From April 2018 to August 2018, the service exceeded the local trust target of 63% for each month (76% in April and June 77% in July and 78% in May and August 2018)

The infant feeding team had produced breast milk production guidance for patients who had suffered pregnancy loss to provide information about how to reduce their milk supply.

The maternity service had eight breast pumps in total to assist patients to breastfeed their babies during their stay in the department. The department also loaned small breast pumps for patients to use at home, particularly for feeding babies who had difficulty feeding due to conditions such as tongue-tie.

Patients and visitors had access to refreshments during their stay in the maternity department. In response to patient feedback, hot meals were now available to patients who were having an induction as they were in the maternity department for a number of hours.

A dietitian attended clinics for patients with high body mass indexes to provide dietary and nutritional advice.

Antenatal staff provided Muslim patients with information regarding fasting health risks during pregnancy.

## Pain relief

**Staff assessed and managed patient's pain regularly and effectively.** Patients had a number of different pain relief methods available such as epidurals and natural pain relief options including labouring in birthing pools.

A patient we spoke with on the delivery suite told us they did not have to wait for pain relief which alleviated her concerns as she was anxious about the pain she would experience. Patient group directions (PGD) were in place in the Serenity birth centre to allow for an increased choice of pain relief in a timely way.

Natural pain relief methods such as reflexology and aromatherapy were available to patients in the Serenity birth centre.

Patients should receive an epidural within 30 minutes of requesting one in accordance with NICE guidance, CG70, July 2008. The service audited delays of more than 30 minutes for all types of pain relief and delays of over two hours for patients requesting an epidural to receiving one. We were assured the senior leadership team were able to monitor epidural administration sufficiently in order to be certain patients were receiving epidurals in a timely way and to make improvements if required.

Between March 2018 and August 2018, there were no delays in patients receiving pain relief as shown below:

| Delivery Suite (NB ALL Pain relief types) | | | | | | |
|---|---|---|---|---|---|---|
| | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
| Delay in providing pain relief of more than 30 minutes to any patient in the last week | No | No | No | No | No | No |

From September 2017 to August 2018, there were 15 delays of induction of over two hours.
We saw the service planned to provide low risk English speaking patients with an option to have their inductions of labour at home.
From March 2018 to August 2018, the service monitored the length of time from patients receiving one to receiving one:

| Anaesthesia Type | Number of notes | Time of arrival missing (or before time called) | Less than 15 minutes | 15 - 29 minutes | 30 - 44 minutes | 45 - 60 minutes | more than 60 minutes |
|---|---|---|---|---|---|---|---|
| Epidural | 431 | 277 | 139 | 7 | 5 | 1 | 2 |

However, the patient time of arrival was missing or the epidural was administered before time was called in 277 (64%) of cases audited during this time period. Patients had received their epidural in under 30 minutes for 146 of cases and over 30 minutes for eight cases.

## Patient outcomes

**The maternity service regularly reviewed the effectiveness of patient care and treatment and used the findings to improve patient outcomes.**

The service participated in national audits to benchmark the maternity service provision against national standards and key performance indicators, such as the National Neonatal Audit Programme, Each Baby Counts, annual MBRRACE – UK audit, the Twins and Multiple Births Association (TAMBA) audit, with a Gap analysis and action plan monitored each year at TAMBA site visits. This was to enable senior leaders to benchmark the maternity service provision and performance against national standards and key performance indicators.

The service participated in the wave one of the national Maternity and Perinatal Safety Collaborative to work collaboratively with other maternity services to provide a safe, reliable, and quality healthcare experience to all patients. This forum prioritised quality improvement and provided a supportive structure for maternity services to develop plans for measurable improvements in the service.

We reviewed the service's clinical audit programme which was well embedded and ad-hoc audits could be added if required. For example, the service undertook monthly audits for: hand hygiene, baby resuscitation equipment daily checks and the safety thermometer audit, cleaning audits, and a sepsis audit had just commenced. The infant feeding team conducted monthly baby readmission audits within 28 days of birth to determine themes in particular linked to infant feeding. The infant feeding team shared themes and learning from this audit with staff at Quality Improvement Half Days. The infant feeding team also conducted 10 audits of breastfeeding records each month to review if staff provided patients with appropriate levels of infant feeding support. The infant feeding team fed back to relevant staff where improvements were needed or to commend good practice. Action plans were produced in response to audit results and were regularly reviewed to monitor progress and improvements made.

In the 2017, National Neonatal Audit, Sandwell and West Birmingham Hospitals NHS Trust's performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 135 eligible cases identified for inclusion. Of these, 85.9% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

**There were 35 eligible cases identified for inclusion. Of these, none of the mothers were given magnesium sulphate in the 24 hours prior to delivery.**

**This was lower than the national aggregate of 43.5%, and put the hospital in the bottom 25%of all units.**

*(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

## Standardised Caesarean section rates and modes of delivery

During the last 12 months, there had been 13 home births. Senior leaders told us they needed to improve the number of home births and wanted to promote this service.

From January 2017 to December 2017, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections were lower than expected and rates for emergency sections were as expected. A comparison between the trust and the England average caesarean rates is shown in the following table:

| Standardised caesarean section rate (January 2017 to December 2017) | | | | | |
|---|---|---|---|---|---|
| **Type of caesarean** | **England** | **Sandwell and West Birmingham Hospitals NHS Trust** | | | |
| | **Caesarean rate** | **Caesareans (n)** | **Caesarean rate** | **Standardised Ratio** | **RAG** |
| Elective caesareans | 12.4% | 488 | 8.7% | 75.4 (z=-2.2) | Lower than expected |
| Emergency caesareans | 15.7% | 921 | 16.5% | 106.6 (z=0.5) | Similar to expected |
| Total caesareans | 28.1% | 1,409 | 25.2% | 93.2 (z=-1.0) | Similar to expected |

*Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.*
*Delivery methods are derived from the primary procedure code within a delivery episode.*

In relation to other modes of delivery from January 2017 to December 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England averages:

| Proportions of deliveries by recorded delivery method (January 2017 to December 2017) | | | |
|---|---|---|---|
| **Delivery method** | **Sandwell and West Birmingham Hospitals NHS Trust** | | **England** |
| | **Deliveries (n)** | **Deliveries (%)** | **Deliveries (%)** |
| Total caesarean sections[1] | 1,409 | 25.2% | 28.1% |
| Instrumental deliveries[2] | 475 | 8.5% | 12.5% |
| Non-interventional deliveries[3] | 3,703 | 66.3% | 59.4% |
| Total deliveries | 5,587 | 100% | 100% (n=592,194) |

*Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.*
[1]*Includes elective and emergency caesareans*
[2]*Includes forceps and ventouse (vacuum) deliveries*
[3]*Includes breech and normal (non-assisted) deliveries*

The total percentages of caesarean sections and instrumental deliveries at the trust was lower than the England averages, with the percentage of non-instrumental deliveries being higher.

*(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)*

## Maternity active outlier alerts

As of 14 August 2018, the trust had one active maternity outlier. This alert, for puerperal sepsis (not including other puerperal infections) within 42 days of delivery was passed to the inspection team in October 2017 to follow up on the action plan resulting from the trust's review of the alert.

*(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)*

Puerperal sepsis is an infection of a woman, which occurs within six weeks of giving birth. We discussed this outlier with senior staff during the inspection. In addition, we reviewed the services' investigation response and associated action plan. The main finding of the investigation outlined diagnostic coding errors onto the maternity electronic records system which resulted in the over-reporting of puerperal sepsis where a diagnosis had not been made. The investigation identified if puerperal sepsis rates had been correctly coded, the number of cases where puerperal sepsis was recorded would have been within expected levels and in line with the national average. Training and guidance had been produced for coders to prevent reoccurrence and actions were in place to address and improve the accuracy of this information at the within the service. The service were continuing to monitor and report puerperal sepsis rates as standing agenda at directorate governance meetings and was discussed at the group governance board.

## Maternal, New born and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.97.

This is up to 10% higher than the average for the comparator group rate of 4.95.

*(Source: MBRRACE UK)*

We discussed the perinatal mortality rate with senior staff during the inspection who described how the perinatal mortality rate was decreasing from the previous year.
In 2017, there had been 33 stillbirth or neonatal deaths compared to 2018, where there had been 25. This was a reduction of 24%.
A multidisciplinary perinatal review board had been set up in April 2018 created in line with the Better Births guidance. Sandwell and West Birmingham NHS Trust was one of the pilot sites to use a national standardised Perinatal Mortality Review Tool (PMRT) to review each stillbirth and neonatal death and the deaths of babies who died in the post-neonatal period having received neonatal care. This was a multidisciplinary board led by a consultant obstetrician with an external representative from a local trust.

## Competent staff

**The service ensured staff were competent for their roles. Staff at all levels received training to support their role and personal development needs.**

The service had a clinical education team who coordinated staff training and monitored staff training compliance. They led a comprehensive local induction programme for staff when they began working in the maternity department.

As at September 2018, 22 Midwives had completed the trust's HDU course and been signed off as having achieved the associated competencies. The course provided midwives with the core skills and knowledge to support their ability for care for women requiring enhanced levels of maternity care. The course and competency process was supported by the enhanced care (named HDU) lead midwife, ITU outreach team, ITU team and consultant anaesthetists. An additional nine midwives were currently working towards completing their competencies. The service was also developing a 'care of the critically ill woman in obstetrics' course which followed the same structure as the PROMPT training to further enhance midwives' skills and offer specific critical care skills drills training. The service monitored staff HDU competence on an annual basis.

All maternity staff were required to conduct mandatory cardiotocography (CTG) training each year. The clinical education team monitored compliance and staff competency was also monitored throughout the year.

Student midwives confirmed they felt supported in their role stating there was a "very good learning culture" and told us they enjoyed their placements at Sandwell and West Birmingham NHS Trust. The maternity department collated student feedback and had a good relationship with their local universities. Student midwives who had been working in the antenatal day assessment unit completed evaluation forms. We saw positive comments regarding the department such as: "the department is friendly." Leaders of the department audited responses every six months to identify any themes or concerns or areas of good practice. The department arranged where possible for student midwives to remain working at the trust once they had completed their training.

The maternity service had four Professional Midwifery Advocates (PMA), each allocated four hours per week to support staff. The PMA role was in line with the employer led model of midwifery supervision: Advocating for Education and Quality ImProvement (A-EQUIP) and set. Supervisors or midwives have been replaced with a Professional Midwifery Advocates (PMA). This role replaced the previous midwives' supervisor role and provided midwives with the necessary practical and theoretical support. Midwives felt PMAs provided them with an additional support network where they could raise any concerns if they wished. The PMAs discussed any concerns as a group and identified any themes which they could help address for staff.

Community Midwives reported the occasions where they were on call and were called in to work within the acute maternity unit on the trust's incident reporting system which meant the community midwifery team workload increased as a result. Where there was an impact on the community midwifery workload, it was the responsibility of the community midwifery team to report this via the trust's incident reporting system. However, this relied on community staff incident reporting occurrences. During the daily morning handover and case review held on the delivery suite, this was also reported and reviewed. However, these incidences were not captured separately to the formal incident reporting system and we were therefore not assured senior leaders had full oversight of these incidents. The maternity leadership team were aware these figures were not accurately recorded and had changed the reporting process as a result.

Staff attended Quality Improvement Half Days (QIH) which was protected learning time for staff one afternoon every month aimed at improving cross-organisational learning. This included for example, research updates and training and development.

The midwifery bereavement team led an annual bereavement study days training to all maternity staff in conjunction with a bereavement charity. Staff conducted 'breaking bad news' training to ensure they could give distressing news to patients and relatives in an appropriate way.

## Appraisal rates

Senior staff had appraisal monitoring systems in place to determine when staff appraisals were due. Staff told us they had annual appraisals with their managers which were useful and they felt able to

raise any concerns. Senior staff had completed an accredited managers course, which included monitoring appraisals.

We received maternity service appraisal rates split per staff group as outlined in the table below.

Appraisal rates up to 12 September 2018:

| Staff Group | Completed | % | Not Scheduled | % | Review not completed or not recorded on ESR | % | Total |
|---|---|---|---|---|---|---|---|
| Additional Clinical Services | 54 | 92% | 2 | 3% | 3 | 5% | 59 |
| Admin & Clerical | 40 | 100% | 0 | 0% | 0 | 0% | 40 |
| Estates | 1 | 100% | 0 | 0% | 0 | 0% | 1 |
| Medical | 14 | 67% | 0 | 0% | 7 | 33% | 21 |
| Nursing and Midwifery | 227 | 88% | 11 | 4% | 20 | 8% | 259 |
| Total | 336 | 88% | 13 | 3% | 30 | 8% | 380 |

As at September 2018, the overall maternity service appraisal compliance was 88%. This was lower than the trust appraisal target rate of 100%. However, the overall appraisal compliance rates had improved on the overall rates from April 2017 to December 2017 at 61.1%. Medical staff had the lowest appraisal rate at 67% which affected the overall maternity compliance figures. Nursing and midwifery staff appraisal compliance was 88%. Senior staff told us there had been a drive across the trust to ensure managers conducted as many staff appraisals as possible between April 2018 and June 2018 in an attempt to increase appraisal rates.

From April 2017 to December 2017, 61.1% of staff within the maternity core service at the trust received an appraisal compared to a trust target of 100%. A breakdown by staff group is provided below:

Trust level:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Support to doctors and nursing staff | 39 | 56 | 69.6% |
| Qualified nursing, health visiting and midwifery staff | 146 | 243 | 60.1% |
| Medical & dental staff | 7 | 14 | 50.0% |
| NHS infrastructure support | 0 | 1 | 0.0% |
| **Total** | **192** | **314** | **61.1%** |

Of the four staff groups within the maternity core service, no groups met the trust's 100% appraisal target. The two groups with the lowest appraisal rates had fewer members of staff than those with higher rates. As a result, staff in these groups accounted for a higher proportion of the overall total.

**City Hospital**

From April 2017 to December 2017, 79.6% of staff within maternity at City Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Support to doctors and nursing staff | 29 | 34 | 85.3% |
| Qualified nursing, health visiting and midwifery staff | 92 | 118 | 78.0% |
| **Total** | **121** | **152** | **79.6%** |

Of the staff groups within maternity at City Hospital, neither met the trust's target of 100% for completion of appraisals.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

From April 2017 to December 2017, 43.8% of staff assigned to other sites by the trust within maternity received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Medical & Dental staff - Hospital | 7 | 14 | 50.0% |
| Support to doctors and nursing staff | 10 | 22 | 45.5% |
| Qualified nursing, health visiting and midwifery staff | 54 | 125 | 43.2% |
| NHS infrastructure support | 0 | 1 | 0.0% |
| **Total** | **71** | **162** | **43.8%** |

Of the four staff groups assigned to 'other' sites by the trust, none met the trusts 100% target for completion of appraisals. All staff groups had a rate of 50% or less with one staff group having a rate of 0%. However, this group consisted of only one member of staff.

*(Source: Routine Provider Information Request – Appraisals tab)*

## Multidisciplinary working

**Staff from a variety of maternity disciplines worked together as a team to benefit patients.** Consultants, midwives and other healthcare professionals supported each other to provide good patient care.

Staff respected their colleagues' opinions. We saw all levels of maternity staff could contribute to patient discussions at the safety huddle and felt able to challenge each other.

We saw midwives and consultants communicated effectively. All staff told us consultants were approachable and they were able to ask them questions and raise concerns with them.

During a caesarean section in theatre, we observed staff provided multidisciplinary care to the patient and baby during the procedure and on discharge to the ward.

The service had arrangements in place to care for patients with a high body mass index (BMI). Patients would be referred to the high BMI antenatal clinic.

Community staff co-ordinated with GPs and health visitors to ensure patients had continuity of care throughout their pregnancy care pathway. Community teams worked closely with the breastfeeding support team to ensure patients received feeding advice.

The bereavement team had strong links with the fetal medicine team and the wider multidisciplinary maternity team to ensure they supported patients and staff when needed.

## Seven-day services

The maternity service at Sandwell and West Birmingham NHS Trust provided patient care and treatment 24 hours a day, seven days a week.

The triage unit provided patients with 24 hours, seven days a week access to a midwives and obstetricians.

Anaesthetists were available on the delivery suite to provide patient's pain relief and to attend to emergencies 24 hours a day, seven days a week.

The scanning department was situated as part of the antenatal clinic. Scanning staff conducted patient's fetal growth assessments from Monday to Friday from 8am to 5pm.

The antenatal day assessment unit was open from 8am to 8pm, Monday to Friday. The service had extended the working hours in response to patient feedback to ensure patients could attend more easily.

The antenatal clinic held a specialist clinic at weekends for parents whose pregnancy was at 30-32 weeks gestation which were not completely low risk. Sessions included pre-term birth, diabetes in pregnancy and transfer of a baby into the neonatal unit.

## Health promotion

The maternity service had strong links with local partners, stakeholders and charities to promote health initiatives for patients in the local region.

Patients were not currently offered the influenza and pertussis (whooping cough) vaccine at the antenatal clinic due to the vaccine midwife being a vacant post. This post was due to be filled and the midwife would work across both City and Sandwell Hospital sites. Local arrangements were in place for patients to receive vaccinations. Maternity staff signposted patients to their GP surgeries to obtain vaccinations during this interim period to ensure patients still received the required vaccinations.

Staff documented patients' smoking status at the initial booking appointment and each antenatal appointment thereafter. The numbers of patients who were smoking during their pregnancy was recorded for each quarter on the maternity dashboard report. From May 2018 to July 2018, this was above the target of 11.5% for each month at 15.8%, 14.0% and 17.0% respectively.
Staff signposted patients to smoking cessation services and workshops to gain support to stop smoking.

Patients were routinely screened for MRSA.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Maternity staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They understood how to support patients experiencing mental ill health to make decisions about their own care.

Maternity staff understood the Mental Capacity Act and Deprivation of Liberty Safeguards and knew they could access the specialist mental health midwife or perinatal mental health team for support if necessary. Staff could also obtain further mental health support for patients from the trust's Rapid Assessment Interface and Discharge (RAID) team based at City Hospital and mental health liaison nurses based at Sandwell hospital. Serenity birth centre staff told us the perinatal mental support team were a "great support for the birth centre."

The service had a dedicated midwife-led mental health antenatal clinic ran by the mental health midwife.

Maternity staff confirmed the trust's safeguarding team based at Sandwell Hospital were accessible throughout the trust to provide advice and support to staff on MCA/DoLS and to

lead specialist training.

The service used paper consent forms to record patient consent. We saw some good practice as the electronic midwifery records system required staff to identify and confirm consent had been received and then documentation was required regarding the method of consent; either verbal or written. We saw staff had appropriately recorded patients' consent to caesarean sections in the records we checked.

### Mental Capacity Act and Deprivation of Liberty training completion

Mental Capacity Act and Deprivation of Liberty Safeguards training at the trust was included in safeguarding training outlined in the safe section of the appendix above.

As at September 2018, maternity staff safeguarding training compliance rates met or exceeded the trust target of 95% for all adults and children's safeguarding training.

## Is the service caring?

**Maternity staff cared for patients with compassion. Patient feedback confirmed that staff treated them well and with kindness.**

### Compassionate care

Without exception, we observed all maternity staff interactions with patients and relatives were reassuring, caring and supportive. All patients we spoke with highlighted the "caring nature" of maternity staff. A patient described the care received from staff on the delivery suite: "you could tell they cared and it wasn't just a job."

Staff told us they were concerned the staffing challenges impacted on staff being able to interact with patients and provide patients and relatives with the level of kind and compassionate care they wanted to. However, we saw staff were courteous and helpful to patients and treated them with dignity and respect. We observed staff understood and respected patients' social, cultural, and religious needs and how these related to their care requirements. Staff introduced themselves and interacted with patients and relatives in a considerate, respectful and sensitive way.

Patients who had previously given birth at the trust had chosen to have subsequent children at Sandwell and West Birmingham Hospitals NHS Trust due to the positive and compassionate care they had previously experienced.

Staff treated patients with dignity and respect. Staff knocked before entering patients' rooms on the delivery suite. Staff also held confidential discussions regarding patients away from patient and public areas. The eight patients and three partners we spoke with told without exception, maternity staff maintained patients' privacy and dignity. Staff pulled around curtains particularly for any intimate examinations.

We saw staff displayed an understanding and non-judgemental attitude towards patients with mental health needs.

Staff in the maternity outpatient's department told us they had a dedicated room set aside which they could use should they need to deliver bad news. We saw this room was in use during our inspection.

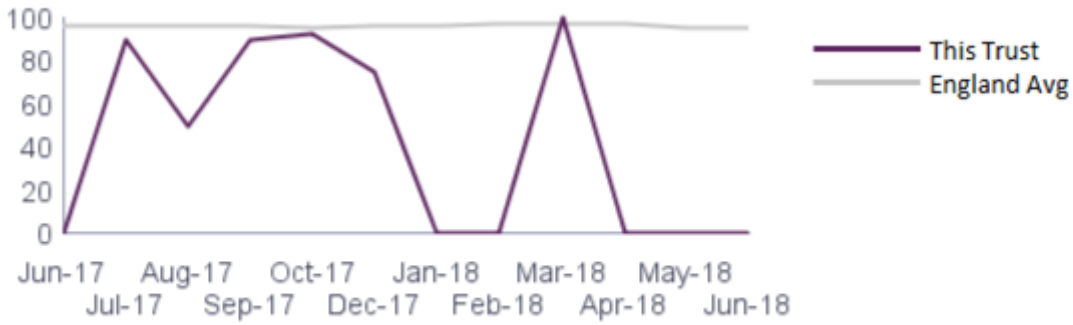
The service's bereavement team closely supported patients who had previously experienced pregnancy loss by attending appointments with them for support if requested.

The friends and family test was circulated each day across all areas of the maternity service. Leaders of the service collated results each month and circulated a list of themes to each area of

the department. We discussed the low response rate with senior leaders who told us due to the demographics of the local region, the test was needed in a number of different languages to be able to gain feedback from more patients.

## Friends and Family test performance

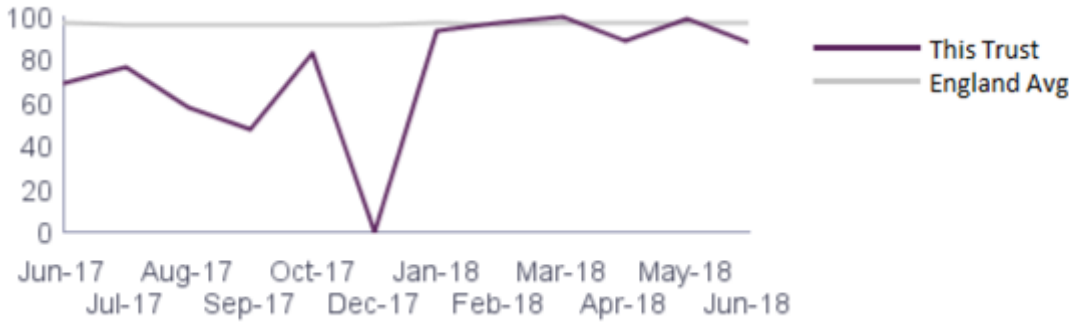
**Friends and family test performance (antenatal), Sandwell and West Birmingham Hospitals NHS Trust**




From June 2017 to June 2018, the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally worse than the England average, with only one month (March 2018) showing better performance with a score of 100% compared to the England score of 97%.

January 2018 and the final three months have a score of zero. This is because there were no eligible responses for some months and too few responses in others.

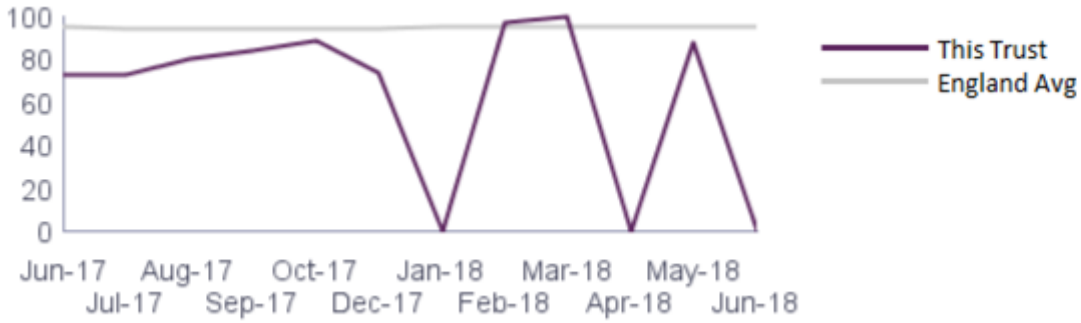
**Friends and family test performance (birth), Sandwell and West Birmingham Hospitals NHS Trust**




From June to October 2017, the trust's maternity Friends and Family Test (birth) performance (% recommended) was worse than the England average before performing similarly to the England average from January to June 2018.

December 2017 has a score of zero. This is because there were too few responses to analyse.

**Friends and family test performance (postnatal ward), Sandwell and West Birmingham Hospitals NHS Trust**




From June 2017 to June 2018, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse than the England average, with the exception of February and March 2018. March 2018 saw the trust's performance reach 100%.

January, April and June 2018 have a score of zero. This is because there were no eligible responses for some months and too few responses in others

Throughout the entire reporting period from June 2017 to June 2018, the trust's maternity Friends and Family Test (postnatal community) showed performance to be zero. This was because there were no eligible responses for some months and too few responses in others.

*(Source: NHS England Friends and Family Test)*

We discussed the Friends and Family results with the Director of Midwifery. They were aware the results needed to be improved and had a clear plan of how to make improvements to improve these results.

**The trust performed about the same as other trusts in the CQC maternity survey 2017. However, the maternity service performed worse than other trusts for 10 out of 16 questions and about the same for six of the 16 questions.**

The maternity service participated in the Care Quality Commission maternity survey each year. Senior staff shared the results of this survey as part of a presentation with staff to drive improvement in patient experience. The service had an action plan to monitor improvements. We discussed the response rate with senior staff who confirmed staff did encourage patients to complete the feedback. Maternity staff told us that due to the high number of patients attending the service whose first language was not English this affected the completion rate. Staff told us test needed to be available in a number of different languages to be able to gain feedback from more patients.

| Area | Question | Score | RAG |
|---|---|---|---|
| **Labour and birth** | At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital? | 7.25 | Worst performing trusts |
| | During your labour, were you able to move around and choose the position that made you most comfortable? | 6.53 | Worst performing trusts |
| | If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? | 9.48 | About the same |
| | Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth? | 9.30 | About the same |
| **Staff** | Did the staff treating and examining you introduce | 8.48 | Worst |

| | | | |
|---|---|---|---|
| **during labour and birth** | themselves? | | performing trusts |
| | Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you? | 6.22 | Worst performing trusts |
| | If you raised a concern during labour and birth, did you feel that it was taken seriously? | 6.36 | Worst performing trusts |
| | Thinking about your care during labour and birth, were you spoken to in a way you could understand? | 8.87 | Worst performing trusts |
| | If you used the call button how long did it usually take before you got the help you needed? | 7.53 | Worst performing trusts |
| | Thinking about your care during labour and birth, were you involved enough in decisions about your care? | 7.54 | Worst performing trusts |
| | Thinking about your care during labour and birth, were you treated with respect and dignity? | 8.87 | About the same |
| | Did you have confidence and trust in the staff caring for you during your labour and birth? | 8.13 | Worst performing trusts |
| **Care in hospital after the birth** | Looking back, do you feel that the length of your stay in hospital after the birth was appropriate? | 5.80 | Worst performing trusts |
| | Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? | 7.41 | About the same |
| | Thinking about your stay in hospital, how clean was the hospital room or ward you were in? | 8.45 | About the same |
| | Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? | 8.05 | About the same |

*(Source: CQC Survey of Women's Experiences of Maternity Services 2017)*

## Emotional support

**Staff provided patients and relatives with appropriate information and timely emotional support to minimise their distress.**

Staff showed determination to provide patients and those close to them with emotional support despite the staffing challenges in the department.

The department had a well-embedded culture to put patients' care at the centre of they did. During our inspection, we saw a number of occasions where staff had put this into practice.

For example, a patient who had an emergency caesarean told us staff had supported them through an emotionally challenging time. Staff had kept them up-to-date with what was happening which they told us helped reduce their anxiety.

We observed staff provided emotional support to a patient in the maternity outpatient department who had previously experienced domestic violence. Staff were sensitive and caring and ensured they took the time to listen to the patient.

The maternity service had two bereavement midwives in post. They provided patients and those close to them with specialist bereavement support during and following a pregnancy loss or neonatal death.

The bereavement midwifery team co-ordinated with the trust's chaplaincy team to support patients and those close to them with funeral or burial arrangements in accordance with their religious and personal beliefs. Funerals could take place at the trust if relatives wished as the trust funded support from a local funeral director. The chaplaincy team had representatives from a number of faiths: Christian, Muslim, Sikh and Hindu and close links with other faiths. Staff supported parents

of certain faiths to have their babies released as soon as possible to allow for the funeral to be held as soon as possible.

The bereavement team held an annual Memorial Day in conjunction with the trust's chaplaincy service. This was an opportunity for families and staff to remember babies they had lost.

The midwifery bereavement team provided annual bereavement study days training to all maternity staff in conjunction with a bereavement charity. Staff conducted 'breaking bad news' training for maternity staff to ensure they knew how to give distressing news to patients and relatives in an appropriate way.

The maternity service ensured families could spend as much time as possible with their babies if they were stillborn. There were two cold cots available and policies and procedures were in place if families wished to take their baby home. The bereavement midwife told us there had only been one occasion where parents had taken their baby home. The bereavement team had produced a 'taking your baby home' leaflet to ensure parents knew this was an option.

The bereavement team provided memory boxes to all families who had experienced a pregnancy loss. Clothing was also provided to parents to give them the opportunity to dress their baby and maintain their baby's dignity.

The maternity service had a variety of sizes of transportation boxes to transport babies from the maternity department to the mortuary in a dignified and sensitive way.

Maternity staff supported patients and those close to them to cope emotionally with their treatment and condition. The maternity service ensured all planned appointments including scans were cancelled when a patient had experienced pregnancy loss. GPs and community midwives were updated to ensure they were aware of the patient's pregnancy outcome. The discharge letter the service sent to GPs also had a logo of a stillbirth and neonatal death charity present to further highlight the pregnancy loss to GPs.

The trust was not currently part of the National Bereavement Care Pathway (NBCP). However, the bereavement team ensured they remained up-to-date with the pathway updates.

The maternity service produced birth and blessing certificates for parents that wished to receive them. This was a way to recognise babies without being able to formally register babies. UK law currently states babies born before 24 weeks cannot be legally registered.

Staff held debriefs and supported each other following bereavements in the maternity department. The bereavement team provided 24 hour a day, seven days a week support to patients and staff via face-to-face support, phone calls or texts. Staff highlighted how the bereavement midwife, Director of Midwifery and Chief Nurse had closely supported maternity staff following a maternal death. Senior staff led a de-brief immediately following this incident and a Schwartz round was conducted. Counselling was provided to staff via their Professional Midwifery Advocates and staff were released from their shift.

The consultant midwife was a trained counsellor and psychotherapist to provide additional emotional support particularly to vulnerable patients, including patients affected by sexual abuse and trafficked patients.

The fetal medicine unit had interchanging rooms to enable staff to hold private consultations with patients to discuss screening and investigation results in a sensitive way.

During a morning handover, staff discussed emotional support they had provided to a patient who had received a life-changing diagnosis for their baby.

We saw numerous thank you cards displayed across the department from patients praising staff for supporting them during their pregnancy and in particular during distressing times.

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

**Staff involved patients and those close to them in decisions about their care and treatment.** Staff provided patients and relatives with information and advice regarding different birthing settings available to them appropriate to their clinical needs and risks.

Patients were empowered to have individualised care plans for the birth of their child. The service had strong links with a doula service to provide additional support to patients throughout their pregnancy pathway.

A patient with complex needs told us they had been well supported by the diabetic team throughout their pregnancy.

We spoke with three partners during the inspection who felt involved and well supported by staff in the acute hospital setting and in the community. However, new fathers felt it would be beneficial to have more specific information available for them.

We observed in theatre, staff ensured a partner was involved in the photo opportunity with their new born.

Home births were not always promoted as a birthing option due to staffing challenges in the department. Senior staff told us this was an area they wished to promote via the community midwifery team, particularly following the closure of the Halycon birth centre.

Senior staff told us they would like to promote transitional care to provide additional support for babies who did not require admission to the neonatal unit, but may have been born prematurely or required extra care or monitoring before being discharged home. This would allow parents to stay with their baby during this extra support provision. A dedicated transitional care area was planned at the Midland Metropolitan Hospital.

Families were kept well informed following a pregnancy loss, stillbirth or maternal death. The bereavement midwives and senior staff explained the processes and what to expect. Staff supported families whilst still in the maternity department and on their return home.

## Is the service responsive?

### Service delivery to meet the needs of local people

**The trust planned and provided specialist services in a way that met the needs of local people.** Specialist antenatal clinics were held in maternity and support was individualised to meet the diverse requirements of the local population.

The maternity service held a range of specialist clinics for patients with complex needs during their pregnancy. For example: female genital mutilation (FGM) clinic, mental health, vaginal birth after caesarean (VBAC) and hypertension in pregnancy clinics. The majority of clinics were held at City Hospital however, some clinics were also conducted at Sandwell Hospital.

The maternity department had a range of specialist midwives in post to provide individualised specialist support to patients. These roles included midwives involved in the teenage pregnancy team, asylum seeker midwife, infant feeding midwifes, bereavement midwives, research midwifes and midwives responsible for the maternity records system.

The Halcyon midwifery birth centre had been available to patients living nearer to Sandwell Hospital since 2010. This had opened to provide choice to patients following the closure of facilities for patients to birth at Sandwell Hospital a number of years ago. The centre closed on 14 September 2018 and patients who would have chosen to birth there were re-directed to the Serenity midwife led

unit at City Hospital. There had been 17 births at the Halcyon Birth Centre during the last 12 months. Senior leaders told us there needed to be 440 births at the unit to make it a viable birthing option.

The fetal medicine unit provided specialist care to patients if fetal problems had been identified usually after 26 weeks of pregnancy. This unit provided more frequent patient monitoring and observations. Patients could self-refer to the unit if they had concerns about reduced baby movements.

Pregnancy related leaflets were readily available in the maternity department. The trust's website also had a number of leaflets available to print. However, we saw some leaflets on the trust's website were past their review date and the information may be out-of-date. For example, 'Pregnancy Advice Information and the advice for Gypsy, Roma and Travellers' leaflet was due for review in July 2014, 'Expressing your milk antenatally' was due for review in September 2016 and 'A guide to feeding your baby' was due for review in February 2018. Some leaflets were available in the most frequently spoken languages: Bengali, Polish, Punjabi and Urdu in the department and on the trust's website.

The maternity service had strong links with a local health centre where refugees and asylum seekers attended. These patients' needs would be prioritised and they were provided with antenatal appointments straight away to ensure they had a personalised birth plan in place as soon as possible.

Staff were aware of the pathways available to vulnerable patients and knew how to signpost patients to the relevant services if they faced problems with housing or money for example.

The department was accessible to wheelchair users and patients with limited mobility. Bariatric equipment (for heavier patients) was available for patients who needed it.

The department was in the early stages of implementing a maternity voices partnership. This linked in with individual support groups which were already held, such as the Somalian women's support group.

Visiting times for relatives were flexible and arrangements could be made for partners to stay. Visiting times had been extended in response to patient feedback.

## Meeting people's individual needs

**The service took account of patients' individual needs.**

The continuity of care model was being implemented in the maternity department in line with 'Better Births' guidance to ensure continuity of care for patients. For example, community staff were trained to conduct neonatal examinations (NIPE) at patient's homes to reduce the numbers of patients attending the hospital for these checks.

Patients were allocated a named midwife at their initial booking appointment. The service aimed for patients to be cared for by the same midwife or same community team throughout their pregnancy to ensure continuity of care. Patients told us they usually saw the same community midwife during their pregnancy or a midwife from the same regional team.

The department had a consultant midwife who had been in post for a number of years. They had ensured providing bespoke and individualised care particularly to vulnerable patients was a priority for the service.

The community midwifery team had strong links with local doula (birth companion) services for patients if requested. Doulas could accompany patients to appointments. Staff documented this in-patient notes if a doula had supported patients.

We saw the maternity service provided patients with 'Your concise, easy-read mother's and others guide' at their first booking appointment. This described all parts of the pregnancy journey for patients and partners.

The service had improved communication for patients whose first language was not English since our last inspection. During this inspection, overall, we saw translation services were accessible for patients when required. Staff were no longer used to translate which is in line with good practice.

Staff arranged for face-to-face interpreters to attend appointments where possible. A telephone translation service was also available 24 hours a day which staff told us was usually easy to access. We observed an antenatal appointment where a face-to-face interpreter attended to translate for the patient. This ensured the patient fully understood their condition and could ask the midwife any questions they wanted to.

However, a serious incident report referenced where there had been no interpreter available for a number of a patient's appointments whose first language was not English. Staff had not documented what efforts were made to find an interpreter or whether any consideration was given to the use of language line. In order to prevent reoccurrence, staff were reminded efforts must be made to either source an interpreter or to use language line. Where this was not possible, staff were required to document why they have not been used.

During a mental health antenatal appointment, we saw a midwife went the extra mile to assist a patient whose first language was not English by helping them to make a GP appointment.

The service had a dedicated mental health team to support patients where required. We saw there was a clear mental health referral pathway in place to support patients with mental health concerns during their pregnancy. This also included guidance regarding when to consider completing a cause for concern referral. The mental health midwife updated the patient's GP regarding the outcome of the mental health assessment on the same day as the appointment to ensure they were kept up-to-date.

The mental health midwife requested staff inform them when one of their patients had given birth. If a patient was very distressed with mental health concerns during delivery, staff would contact the mental health midwife or the trust's Rapid Assessment, Interface and Discharge (RAID) team for additional mental health support. The mental health midwife supported patients with mental health concerns postnatally by calling patients or conducting home visits if required.

In the antenatal day assessment unit, cue cards (fans) were available in five different languages were used to help describe certain conditions.

We saw some patient information and posters was tailored specifically for patients such as information on feeding methods for Asian women's families directed at grandmothers. The department had evidence-based information linking pressure from, or lack of support from family members to low breastfeeding rates for certain ethnic groups.

The infant feeding team had developed conversation prompt cards to provide infant feeding information to patients in an easily understandable format. Other trusts had purchased these cards for use in their own maternity departments.

Parent craft classes were offered to women in the community and from the Halcyon Birth Centre. Following the closure of the Halcyon Birth centre, parent craft classes were planned to be held from the Sandwell Hospital site.

The service offered a post-mortem examination to families who had experienced a stillbirth or neonatal death from 16-week gestation in order to improve future pregnancy outcomes for parents. In addition, all patients' placentas were sent for histology testing. These procedures were carried out at another local trust. As soon as the histology results were received, the bereavement midwife and an obstetric consultant would conduct a follow-up appointment with the patient to discuss results and

put an appropriate plan in place for any future pregnancies. The bereavement team would also send the patient a detailed letter outlining the histology findings.

## Access and flow

**Patients could access the maternity service when they needed it.** However, it could take a number of hours for patients to complete their antenatal appointments. This ensured all appointments were conducted on the same day rather than having to return on a number of different days.

Patients we spoke with in the antenatal clinic told us they could make appointments at a convenient time to suit them and they found it easy to make an appointment. was to ensure patients had all procedures on one day rather than over a number of separate days.
The service recorded the number of women booked within 12 weeks on the maternity dashboard report. From April 2018 to August 2018, this ranged from 90% to 94, which met the trust target of 90%.

We discussed waiting times in the antenatal clinics with senior staff. Maternity staff kept patients up-to-date regarding waiting times by displaying current waiting times on a board positioned by the entrance to the antenatal clinic. The service did not currently audit the times patients had to wait for appointments in the antenatal clinic so we were not assured senior staff had full oversight of where the main delays occurred in order to address delays.

The service monitored when patients did not attend antenatal appointments and made new appointments for them to attend. Appointment letters were sent to patients to inform them of their appointment details, however reminders were not sent to patients. The mental health midwife would contact patients to assess their wellbeing and conduct home visits if required.

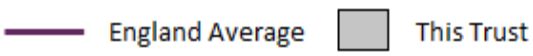
Patients could access community growth scanning (COGS) at the antenatal day assessment unit. Patients were able to self-refer or maternity staff would refer them.

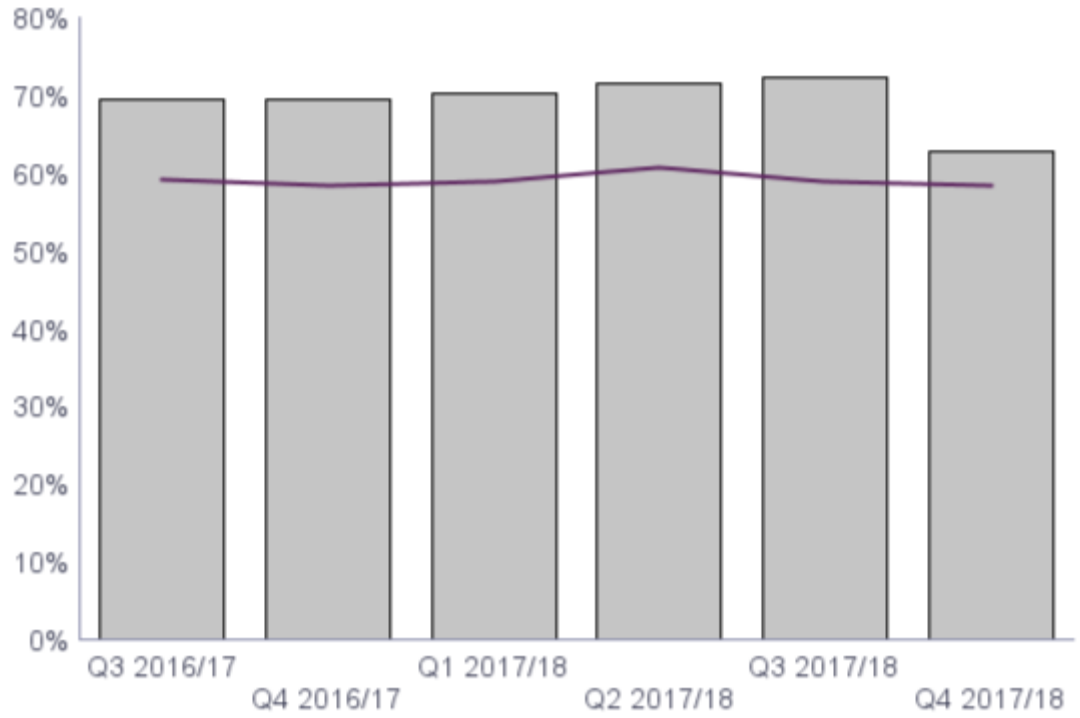
## Bed Occupancy

Service leaders were aware the department needed additional maternity beds which would be available when moving to the new Midland Metropolitan Hospital site planned for 2022.
We discussed bed occupancy levels with senior managers during the inspection. They stated bed occupancy levels were higher due to the number of high-risk patients they saw in the maternity department. Bed occupancy levels also increased due to some patients declaring themselves homeless when giving birth in the department as it would usually take a number of days to coordinate with other agencies for alternative accommodation to be arranged. This increased the number of days patients stayed in the department.

From October 2016 to March 2018, the bed occupancy levels for maternity were consistently higher than the England average. Bed occupancy during the reporting period remained steady at around 70%, with the exception of the final quarter when this dropped to 62.6%. This was still higher than the England average of 58.5%.

The chart below shows the occupancy levels compared to the England average over the period.






*(Source: NHS England)*

**Closure of the maternity unit**

The midwifery led unit (MLU) had closed on one occasion during the last 12 months. The unit was closed for 12 hours between 31 August 2018 and 1 September 2018. This was due to severe adverse weather conditions affecting the ability of staff to attend work. This was a management decision in accordance with the escalation policy to ensure the safety of the unit. During this time period when the unit was closed, the service told us no patients attended the MLU and therefore there was no impact on patient care or experience.

The home birth service was suspended once during the last 12 months due to inclement weather.

## Learning from complaints and concerns

**The maternity service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.** Staff aimed to alleviate patient concerns at the earliest opportunity before they became formal complaints.

Leaders of the service reviewed all complaints and contacted all complainants to determine how they preferred their complaints to be dealt with. A new process had been implemented where ward managers were responsible for reviewing complaints specific to their area in order to implement changes at ward level in response.

We saw the service learned from complaints and changed practice accordingly if required. For example, in response to complaints regarding delayed discharges, the service had implemented a process to prescribe take home medications to allow patients to be discharged in a more timely way. In addition, the department now had open visiting times for partners, which had been a key theme from complaints received.

We saw the service had made changes in the antenatal department waiting area in response to patient and relative feedback. Patients and relatives had specified they would like baby changing facilities for fathers. In response, the department had acted on this feedback and moved the baby changing facility from the female toilet to the gender-neutral toilet.

No maternity complaints had been referred to the Parliamentary and Health Service Ombudsman over the last 12 months.

The trust had introduced the ‘purple phone points’ across the trust to ensure patients and relatives had someone to raise concerns with or to give compliments. Advisors manned the phones from 9am to 9pm seven days a week. The aim of this service was to help resolve issues in a timely way before patients had gone home and negate the need for formal complaints to be raised as a result.

Complaints and Patient Advice and Liaison Service (PALS) posters and leaflets were displayed throughout the unit. Patients we spoke with confirmed they could easily raise concerns if they needed. If staff received a patient complaint, they would attempt to resolve the concern before it became a formal complaint. They would request senior staff directly discuss the issue with the complainant in the first instance. Staff would then provide patients with PALS leaflets and explain the formal written complaints process if required.

## Summary of complaints

### Trust level

From April 2017 to March 2018, there were 51 complaints about the maternity core service at trust level. The trust took an average of 27.9 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (inc delayed discharge due to absence of care package) | 27 | 52.9% |
| Patient Care | 8 | 15.7% |
| Values & behaviours (staff) | 5 | 9.8% |
| Access to treatment or drugs | 4 | 7.8% |
| Communications | 2 | 3.9% |
| Admissions and discharges (excluding delayed discharge due to absence of care package) | 2 | 3.9% |
| Waiting times | 1 | 2.0% |
| Admin/policies/procedures (inc patient record) | 1 | 2.0% |
| Privacy, dignity & well being | 1 | 2.0% |
| Total | 51 | 100% |

### City Hospital

From April 2017 to March 2018, there were 47 complaints about the maternity core service at the trust. The trust took an average of 27.9 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (inc delayed discharge due to absence of care package) | 26 | 55.3% |
| Patient Care | 7 | 14.9% |

| | | |
|---|---|---|
| Access to treatment or drugs | 4 | 8.5% |
| Values & behaviours (staff) | 3 | 6.4% |
| Communications | 2 | 4.3% |
| Admissions and discharges (excluding delayed discharge due to absence of care package) | 2 | 4.3% |
| Privacy, dignity & well being | 1 | 2.1% |
| Waiting times | 1 | 2.1% |
| Admin/policies/procedures (including patient records) | 1 | 2.1% |
| Total | 47 | 100.0% |

**Complaints at other locations**

From April 2017 to March 2018, there were three complaints about the maternity core service at Sandwell General Hospital. The trust took an average of 20.7 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 days.

Two of the complaints related to staff values and behaviours while the remaining complaint was about integrated care (including delayed discharge due to the absence of a care package).

The remaining complaints related to the maternity core service at Oldbury Health Centre. The trust took 28 days to investigate and close this complaint which is in line with their complaints policy, which states complaints should be completed within 30 days. This complaint related to patient care.

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

### Number of compliments made to the trust

From January 2018 to June 2018, there were two compliments relating to the maternity service at City Hospital.

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

## Is the service well-led?

### Leadership

**Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.**

The maternity service was part of the Women's and Child Health Directorate. The Director of Midwifery (DoM) and the Clinical Director led the maternity department. There was clear accountability at all levels and staff understood who they reported to.

The Director of Midwifery had been in post since April 2018. They had previously held the position of Deputy Director of Midwifery in the maternity department.

The Deputy Director of Midwifery had been in post for one year. Their responsibility included directly line managing matrons and the risk governance lead.

There were mixed views regarding the style of leadership. Some staff told us the maternity service had a ‘bottom up’ approach where they had been able to shape their services themselves so they became midwife-led. For example, the mental health, Female Genital Mutilation and vaginal birth after caesarean antenatal clinics.

However, a number of staff said the maternity service had a ‘top down’ leadership approach as they had little influence on the service provisions offered. Some staff gave the closure of the Halcyon birth centre as an example as they felt staff were given little opportunity to increase the utilisation of the centre prior to its closure on 14 September 2018. Staff felt this decision had been made at a senior level with little consultation with front-line staff. We saw some staff discussions had taken place before the closure of the unit. However, staff told us not all staff had been able to attend. The Director of Midwifery held regular drop in sessions where staff could raise any concerns, including the closure of the Halcyon unit. Discussions had taken place between the trust and stakeholders in the local region, where it was decided not to put the closure of the unit out to public consultation.

The DoM proactively reviewed all aspects of the maternity department to ensure they had a full understanding of the main concerns. The DoM had formed good working relationships with staff at all levels.

Hospital-based staff told us leaders of the service were visible on the unit. Staff spoke highly of their ward managers and felt supported. However, some staff felt senior staff did not always act upon their concerns to ensure they were addressed. Some staff told us they had raised the staffing pressures they were experiencing on a number of occasions and there had been no changes as a result so they discontinued raising their concerns.

## Vision and strategy for this service

**The maternity department had a clear vision for what it wanted to achieve. Service leaders had workable plans to turn it into action which were developed with involvement from staff, patients, and key groups representing the local community.**

Each area of the maternity department had a dedicated vision. For example, the vision for the antenatal clinic was to ‘make you feel welcome’ and ‘keep you involved.’

Leaders of the service had a clear local vision and strategy for the maternity service. The agreed priorities within the maternity strategy included expanding the midwifery workforce in line with the recommendations expected from the Birthrate Plus assessment in October 2018.

The trust’s 2020 vision referenced promotion of breastfeeding, low rates of smoking, high natural delivery rates and reduced teenage and unplanned pregnancy rates were the future priorities for the maternity service.

Staff were knowledgeable about the local strategy plans for the maternity service which linked into the trust vision to become the best integrated care organisation in the NHS. Some staff were anxious about the future of the maternity department regarding how the implementation of the ‘continuity of care’ would affect themselves and the department overall.

Senior leaders felt well supported by the trust’s Chief Executive (CEO) and often received feedback from the CEO. The maternity department was well represented at the clinical executive board. The Director of Midwifery and group manager attended board meetings when maternity was under consideration.

Service leaders worked collaboratively with trusts in the local region as part of the Black Country Local Maternity System (LMS) with the aim of improving maternity services for the local population in accordance with the Better Births guidance.

Staff told us they had been involved with the design and layout of the maternity department at the new Midland Metropolitan Hospital (MMH). Despite the delay in the completion of the building of

MMH, staff told us they were able to have new equipment and did not have to wait until they moved across to MMH. Community staff told us they had sufficient access to equipment.

## Culture within the service

**Managers across the maternity department overall promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** However, some staff reported morale was low particularly in the Serenity birth centre mainly due to the staffing shortages the maternity department was experiencing and the closure of the Halcyon birth centre. This was demoralising for staff and some staff said it made them feel anxious.

The culture in the maternity department was open and transparent. Staff felt able to raise concerns as there was not a blame culture. The trust had freedom to speak up guardians for staff to access if required.

Staff were involved in incident reviews and discussed case studies and incidents at morning handovers.

Staff told us their priority was to ensure they provided personalised patient care. Staff had maintained high levels of care despite the staffing pressures the maternity services was experiencing.

Overall, we saw a positive working culture between staff at all levels, including midwives and consultants. However, some staff reported a strained working relationship between midwives on the delivery suite and midwives from the Serenity birth centre. Serenity staff told us delivery suite staffing was often prioritised over the staffing of the Serenity birth centre often leaving staffing below establishment in Serenity. However, during our inspection we observed positive working relationships between staff from these areas of the maternity department.

**Staff morale was affected by the staffing levels in the department. Some staff told us they felt stressed on a daily basis which meant they were looking for employment elsewhere.**

Some maternity staff said they would not currently recommend working in this maternity department due to the staffing shortages. A number of staff told us they were considering seeking employment with other trusts.

Staff told us they were most proud of the strong and supportive team working across most areas of the maternity department. We saw strong team working in all of the separate areas of the maternity unit. A senior staff member told us the maternity team were a “fantastic team” and they would want their family cared for here.

The infant feeding team were proud of achieving the UNICEF Baby Friendly level three re-accreditation.

Staff in the antenatal outpatient department were most proud of the range of midwifery-led clinics the department held. The mental health and Female Genital Mutilation midwife and vaginal birth after caesarean midwife were able to shape these clinics themselves so they were midwife-led.

## Governance

**The maternity service used a systematic approach to continually improve the quality of its services. All levels of governance and management teams functioned effectively and worked together appropriately.**

The service was supported by the board to ensure the maternity service was sustainable. The board supported the service particularly with the midwifery staffing challenges it was currently facing.

The Director of Midwifery, Clinical Director and area leads shared the same concerns for the service. All staff agreed that staffing issues were the main concern in addition to the maternity service environment in light of the delay moving to the new MMH. These concerns were documented on the directorate risk register.

Some midwives told us they currently did not look forward to coming into work each day as they worried what the staffing levels would be on arrival. They told us the department was currently relying on the good will of staff to ensure patient care was not affected by the staffing levels. However, some staff told us this was to the detriment of staff wellbeing as they often missed their breaks or stayed beyond their shift finishing time.

## Managing risks, issues and performance

Maternity service leaders encouraged staff to report incidents. Learning from incidents was shared with staff. Staff felt able to raise concerns if required however; staff reported they often did not have time to complete incident reports due to lack of time due to the staffing levels in the department. In addition, staff did not always raise incident reports relating to staffing levels as they told us they had raised incidents in the past and had seen no improvements in staffing levels as a response.

We reviewed the Women's and Child Health Directorate directorate's risk register. As at September 2018, there were 23 recorded for maternity services. The risk register accurately recorded the main risks to the service in line with what maternity staff told us were their main concerns. Each risk had an allocated owner and risk and governance leads and senior staff regularly reviewed risks at the group governance board and risk action group meetings.

The maternity service maintained a local maternity dashboard report to record activity and clinical outcomes across the department. However, some performance indicators on the maternity dashboard report did not include local or national targets or it was unclear where the thresholds originated from. We were therefore not fully assured the service could sufficiently benchmark the maternity service's performance. We discussed this with the Director of Midwifery who outlined the dashboard was in the process of being updated to include national key performance indicators to ensure the service was able to benchmark their performance more effectively locally and nationally.

The trust had two maternity champions who represented the service at a board level. The Chief Nurse was the champion for the Baby Friendly Initiative and the Medical Director was the safety champion. They promoted best practice and ensured safety and outcomes were regularly monitored.

## Managing information

**The trust collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards**.

The maternity service used an electronic based records system. The service had effective arrangements in place to ensure records were available when required. The service had two midwives to support staff with using the maternity records system.

In the event of IT problems, the service told us they would resort to paper records and update the electronic records as soon as possible. Community midwives had access to patient notes via the maternity electronic records system. There had been some concerns regarding connectivity in the community, which the trust were addressing by replacing tablet computers with laptops. There had been a problem with the rolling out and connectivity of laptops in the community, which was included on the directorate risk register.

The trust was introducing a new electronic record system. The maternity electronic record system would continue in isolation alongside this system. However, there was currently no interface between the two systems.

The maternity electronic records system had a baby version and an adult version. These two systems did not communicate to one another and information such as social history logged on the adult system may not be linked to the baby system. This may result in babies returning home to an unsafe environment. Leaders of the service were knowledgeable about this concern and discussions were on-going regarding how to address this as soon as possible.

If a patient transferred from another maternity unit out-of-area, it was not possible to access patient information from their maternity record keeping systems.

The service had robust arrangements to ensure the confidentiality of patient records particularly in the community in accordance with data security standards. There had been no recent data security breaches recorded for the acute hospital setting or in the community.

## Public and staff engagement

**Overall the trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.** However, staff told us the communication regarding the closure of the halcyon birth centre was insufficient.

The service participated in the Friends and Family Test (FFT) to gather feedback on patient's experience of using the maternity service. However, the response rate had been low which senior staff told us was due to the test not being available in other languages apart from English.

Maternity staff recognised colleagues' contribution for going the extra mile in their roles. The service was involved in the trust's STAR awards. The infant feeding team had been nominated for a trust 'Star' award for Clinical team of the Year for their development of infant feeding prompt cards.

There was active engagement between the maternity infant feeding team and maternity staff in the department at the trust and externally with local and national groups. Service leaders had arranged a tea party to celebrate achieving UNICEF Baby Friendly level three re-accreditation. This was to be combined with new starters coming into post to welcome them into the department. All of the infant feeding team attended the UNICEF UK Baby Friendly Initiative's Annual Conferences for health professionals each year, which is Europe's largest conference on infant feeding. The infant feeding team had set up a monthly Breast feeding Initiative Strategy Group in 2017, which included maternity service managers, local public health and mothers.

The Director of Midwifery regularly met with other Head of Midwiferies (HoMs) at monthly regional meetings to provide support especially to newer HoMs. The Deputy Director of Midwifery also had close links with Deputy Head of Midwiferies at other trusts to provide support for one another.

The service had strong links with a number of individual support groups in the local area such as a Somalian women's support group and young parent's groups. The service was in the early stages of implementing a Maternity Voices Partnership for the local population to help shape maternity services that meet the needs of local women and families.

The department was well supported by the local community. The Mayor of Sandwell had named the trust's Maternity and Neonatal Appeal as one of their chosen charities for 2018-2019. This would involve holding events and fund-raising for the charity throughout the year. A local primary school had attended the maternity department to help decorate public areas.

The Director of Midwifery ran staff focus groups and produced a monthly maternity newsletter 'team talk' in response to staff feedback regarding how they would like the senior leadership team to communicate with them. This was a way of increasing feedback about working for the department from maternity staff, which we had highlighted at our previous inspection.

The DoM had led a recent focus group to discuss the closure of the Halcyon birth unit. Staff told us two patients were due to give birth at the Halcyon birth unit following the closure and they would be able to give birth at the Serenity birth centre. This had been communicated to the patients directly. However, we discussed the closure of the birth centre with staff during the inspection who felt communication from the senior maternity team regarding the closure of the centre was insufficient. We saw a letter dated 29 August 2018 the Director of Midwifery had written to maternity staff outlining the Halcyon birth centre would be closing on 14 September 2018. This had been displayed in the Serenity birth centre however, some staff told us they were unaware of the closing date for the Halcyon birth centre. Staff told us they were confused about the closure of the Halcyon birth centre considering the department's future strategy included supporting continuity of care for patients.

Staff had been invited to a continuity of carer events to remain up-to-date. This was well attended by a variety of levels and disciplines of staff attended.

Senior staff told us the wellbeing of staff was one of their main priorities. The trust offered staff free Pilates and yoga sessions

The maternity service hosted the March 2018 Black Country 'whose shoes workshops' on behalf of the Black Country Local Maternity System. This provided an opportunity for staff and stakeholders to engage with pregnant women and parents to improve the service in line with the 'Better Births' recommendations.

## Innovation, improvement and sustainability

**Maternity service leaders were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**

Leaders of the maternity service coordinated with local commissioners as part of the Black Country and West Birmingham sustainability and transformation partnership (STP) to plan future services to meet the needs of the local communities.

The service considered and acted upon the MBRRACE annual and perinatal reports. A multidisciplinary perinatal review board was in place in line with the Better Births guidance. Sandwell and West Birmingham NHS Trust was one of the pilot sites to use a national standardised Perinatal Mortality Review Tool (PMRT) to review each stillbirth and neonatal death and the deaths of babies who died in the post-neonatal period having received neonatal care. This was a multidisciplinary board led by a consultant obstetrician with an external representative from a local trust.

The service responded to the findings of serious incident investigations by ensuring recommendations were implemented to prevent reoccurrence of serious incidents. Senior leaders regularly monitored the progress of actions in conjunction with the service's risk team via local and trust-level action plans.

Staff attended Quality Improvement Half Days (QIH) which included patients sharing their birth stories to provide learning for staff.

The maternity department had a dedicated midwifery research team consisting of three research midwives. The team were recruiting into the Pregnancy Trial of E-cigarettes and Patches (PREP) study to test new ways to help pregnant smokers to cease smoking. We saw posters across the maternity department promoting the study to support pregnant smokers.

The role of the consultant midwife was a valuable addition to the maternity department to promote bespoke care particularly for vulnerable women.

The maternity department had been nominated for and received a number of awards. The Serenity birth centre had been awarded the Beacon award from the national maternity unit's forum. This acknowledged the success of the Serenity birth centre in providing individualised patient care in line with Better Births. The young parents team had won a team of the year award at the midlands maternity festival awards. The refugee and asylum seeker team were shortlisted for a Royal College of Nursing award in 2017. The service won a trust 'STAR' award for this service.

The 'Silent Cockpit' principle used in maternity theatres to ensure the patient was the main focus had been nominated for an award. The community growth scanning (COGS) team were also nominated for an award.

The service was proud of the improvement in the Baby Friendly Initiative assessment results in achieving accreditation. The baby friendly team had learned from the previous assessment and implemented changes in order to achieve the accreditation.

The infant feeding team had developed infant feeding conversation prompt cards to provide infant feeding information to which other trusts had purchased to use in their own maternity departments.

The mental health and Female Genital Mutilation midwife and vaginal birth after caesarean midwife had been supported to shape these clinics themselves so they were midwife-led.

# Services for children and young people

## Facts and data about this service

We visited City Hospital and Sandwell Hospital as part of the inspection process and each location has a separate evidence appendix. Services that fell within the Acute and Community Paediatric Directorate were managed by the same team; the neonatal unit was managed by a different team however both fell within the Women & child Health Group. Birmingham and Midland Eye Centre children and young people services were managed within the Surgical Group. For this reason, there may be some duplication contained within the two evidence appendices.

This evidence appendix relates to services for children and young people provided at City Hospital.

During the inspection visit, the inspection team:

- spoke with 10 patients and relatives.
- reviewed 18 patient records;
- observed staff caring for patients within wards and theatres
- reviewed trust policies and procedures
- reviewed performance information and data from, and about the trust;
- spoke with 39 members of staff including nurses, doctors and members of the multidisciplinary team
- met with service manager, clinical lead, matrons, Director of midwifery, Head of Service for acute and community paediatrics, Deputy Director of Midwifery and Governance Lead Midwife.

During this inspection we looked at the changes the service had made to improve the service. The paediatric and neonatal service was last inspected in October 2014 and was rated as requires improvement overall including safe and well led. It was rated as good for effective, caring and responsive.

Birmingham and Midland Eye Centre was last inspected in March 2017. At the last inspection it was rated as requires improvement overall including safe, effective and well led. It was rated as good for caring and inadequate for responsive.

Since the 2017 inspection, CQC methodology has been updated and we did not inspect the paediatric ophthalmology accident and emergency service under this core service.

Services for children and younger people at City Hospital were as follows:

Neonates:

- Neonatal unit consisting of 29 beds; five intensive care, five high dependence and 19 special care

Paediatrics:

- Ward D19: Paediatric assessment unit consisting of 11 beds including six side rooms

- Ward D6: Paediatric elective surgical day case unit consisting of eight beds located within side room
- Paediatric outpatients located within the Birmingham treatment centre

Birmingham and Midland Eye Centre (BMEC)

- Paediatric ophthalmology: two operating lists per week for children. All children were admitted through the BMEC day unit. Children requiring an overnight stay following surgery are transferred to D19 Ophthalmology outpatients' department

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

Staff within paediatrics worked at both the City Hospital and Sandwell Hospital sites. One group of staff were required to work as required within:

- Paediatric outpatients at the Birmingham Treatment Centre located at City Hospital
- Medical day unit at the Birmingham Treatment Centre located at City Hospital; opened on a planned basis to accommodate medical day case activity
- Ward D6 at City Hospital: opened on a planned basis to accommodate day surgery activity
- Priory Ground at Sandwell Hospital: opened on a planned basis to accommodate medical and surgical day case activity
- Paediatric outpatients located at Sandwell Hospital

A second group of staff worked as required within:

- Ward D19 located at City Hospital
- Lyndon Ground located at Sandwell Hospital

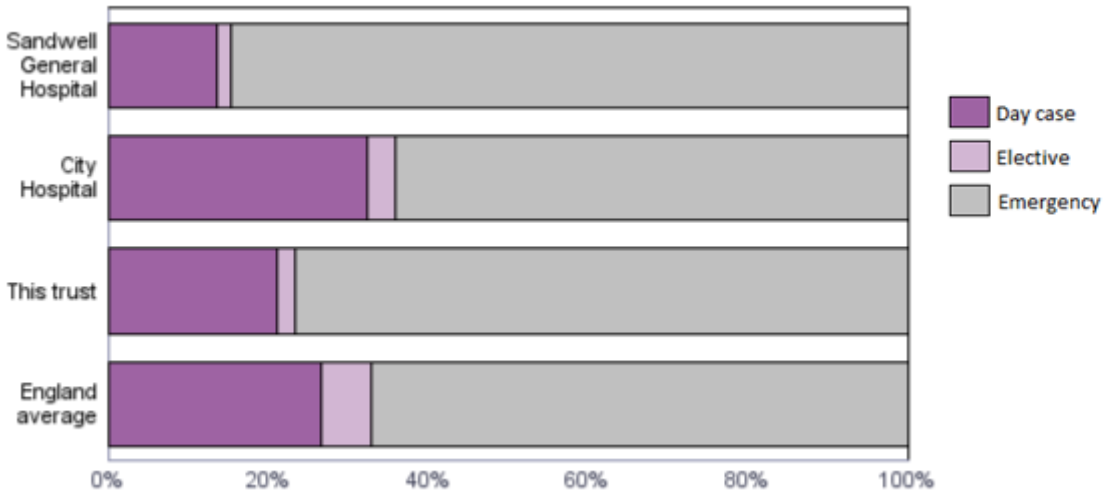
Inpatient acute paediatrics were a 24/7 service accepting 7,500 admissions through the paediatric assessment units on both City and Sandwell sites. Inpatients are admitted to either the inpatient ward (Lyndon 1 at Sandwell hospital) or the 6-bedded adolescent unit on Lyndon Ground (Sandwell hospital).
The paediatric service offered the full range of outpatient paediatric specialties delivering 12,000 outpatient attendances annually.

*(Source: Routine Provider Information Request (RPIR) – Context acute)*

The trust had 10,901 spells from April 2017 to March 2018. A Hospital Provider Spell is the total continuous stay of a patient using a hospital bed on premises controlled by a trust during which medical care is the responsibility of one or more consultants, or the patient is receiving care under one or more nurse within a ward.

Emergency spells accounted for 77% (8,350 spells), 21% (2,282 spells) were day case spells, and the remaining 2% (269 spells) were elective.

**Percentage of spells in children's services by type of appointment and site, from April 2017 to March 2018, Sandwell and West Birmingham Hospitals NHS Trust**




**Total number of children's spells by site, Sandwell and West Birmingham Hospitals NHS Trust**

| Site name | Total spells |
|---|---|
| ndwell General Hospital | 6,595 |
| Hospital | 4,306 |
| **s trust** | **10,901** |
| **gland total** | **1,114,797** |

*(Source: Hospital Episode statistics)*

Trust wide data is included within the surgery core service report for comparison with the core service data. Please refer to the provider level report for further information.

# Is the service safe?

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

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

## Mandatory training

**The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

The service provided mandatory training in key skills to all staff however, staffing shortages meant not all staff could be released to attend the training.

The trust's training completion rates were mixed. The trust set a target of 95% for the completion of mandatory training. A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff and medical staff in services for children and young people is shown below:

Neonatal Unit: Qualified Nursing Staff

In the neonatal unit, the 95% completion target was met for six of the 18 mandatory training modules for which qualified nursing staff were eligible. Three of the modules had a completion rate of 100%. The lowest completion rate was for resuscitation of new-born, which had a rate of 54.2%.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| ood Collection | 1 | 1 | 100% | 95% | Yes |
| e Safety Warden or Refresher Training | 1 | 1 | 100% | 95% | Yes |
| edical Devices Competency Form | 60 | 60 | 100% | 95% | Yes |
| nflict Resolution Initial Training | 58 | 60 | 96.7% | 95% | Yes |
| uality & Diversity | 58 | 60 | 96.7% | 95% | Yes |
| rassment & Bullying Level 1 | 58 | 60 | 96.7% | 95% | Yes |
| ealth & Safety | 57 | 60 | 95.0% | 95% | No |
| roduction to Information Governance | 30 | 32 | 93.8% | 95% | No |
| e Safety - Workplace Training | 55 | 59 | 93.2% | 95% | No |
| edicines Management | 55 | 60 | 91.7% | 95% | No |
| nflict Resolution Update | 33 | 39 | 84.6% | 95% | No |
| ection Control | 50 | 60 | 83.3% | 95% | No |
| ansfusion | 45 | 59 | 76.3% | 95% | No |
| edical Devices Training | 45 | 60 | 75.0% | 95% | No |
| suscitation: Basic Life Support | 45 | 60 | 75.0% | 95% | No |
| ormation Governance Refresher Module | 17 | 28 | 60.7% | 95% | No |
| oving and Handling: Patient Handling | 33 | 60 | 55.0% | 95% | No |
| suscitation of New-born | 32 | 59 | 54.2% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Neonatal Unit: Medical Staff

In the neonatal unit, the 95% completion target was met for one of the 17 mandatory training modules for which medical staff were eligible. The lowest completion rate was for health and safety, which had a rate of 64.7%.

| aining module | Staff trained | ligible staff | ompletion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| roduction to Information Governance | 14 | 14 | 100% | 95% | Yes |
| rassment & Bullying Level 1 | 16 | 17 | 94.1% | 95% | No |
| uality & Diversity | 15 | 17 | 88.2% | 95% | No |
| edical Devices Competency Form | 15 | 17 | 88.2% | 95% | No |
| edical Devices Training | 15 | 17 | 88.2% | 95% | No |
| suscitation: Basic Life Support | 15 | 17 | 88.2% | 95% | No |
| nflict Resolution Update | 6 | 7 | 86% | 95% | No |
| nsent - Basic Consent | 6 | 7 | 86% | 95% | No |
| oving and Handling - Medical Staff | 14 | 17 | 82.4% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| esuscitation of New-born | 11 | 14 | 78.6% | 95% | No |
| ection Control | 13 | 17 | 76.5% | 95% | No |
| nflict Resolution Initial Training | 12 | 17 | 71% | 95% | No |
| e Safety - Workplace Training | 12 | 17 | 70.6% | 95% | No |
| edicines Management | 12 | 17 | 70.6% | 95% | No |
| ansfusion | 12 | 17 | 70.6% | 95% | No |
| ormation Governance Refresher Module | 2 | 3 | 66.7% | 95% | No |
| ealth & Safety | 11 | 17 | 64.7% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Paediatrics: Qualified Nursing Staff

Paediatric staff were required to work across both the City Hospital and Sandwell Hospital sites. The data below consists of staff attributed to Priory Ground and Ward D6 including outpatients, Lyndon Ground and Ward D19, and paediatric management.

For paediatrics, the 95% completion target was met for was met for five of the 17 mandatory training modules for which qualified nursing staff were eligible. One of the modules, medical devices competency form, had a completion rate of 100%. The lowest completion rate was for fire safety warden or refresher training, which had a rate of 66.7%.

| **aining module** | **Staff trained** | **Eligible staff** | **Completion rate** | **Trust Target** | **Met (Yes/No)** |
|---|---|---|---|---|---|
| edical Devices Competency Form | 37 | 37 | 100% | 95% | Yes |
| nflict Resolution Initial Training | 37 | 38 | 97% | 95% | Yes |
| uality & Diversity | 37 | 38 | 97.4% | 95% | Yes |
| ealth & Safety | 37 | 38 | 97.4% | 95% | Yes |
| e Safety - Workplace Training | 34 | 35 | 97.1% | 95% | Yes |
| arassment & Bullying Level 1 | 36 | 38 | 94.7% | 95% | No |
| roduction to Information Governance | 15 | 16 | 93.8% | 95% | No |
| ection Control | 35 | 38 | 92.1% | 95% | No |
| oving and Handling - Patient Handling | 33 | 37 | 89.2% | 95% | No |
| edical Devices Training | 32 | 36 | 88.9% | 95% | No |
| ansfusion | 23 | 26 | 88.5% | 95% | No |
| ood Collection | 7 | 8 | 88% | 95% | No |
| nflict Resolution Update | 21 | 24 | 88% | 95% | No |
| edicines Management | 31 | 38 | 81.6% | 95% | No |
| ormation Governance Refresher Module | 17 | 22 | 77.3% | 95% | No |
| sic Life Support | 29 | 38 | 76.3% | 95% | No |
| e Safety Warden or Refresher Training | 2 | 3 | 66.7% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Paediatrics: Medical staff

Paediatric staff were required to work across both the City Hospital and Sandwell Hospital sites. The data below consists of staff attributed to Priory Ground and Ward D6 including outpatients, Lyndon Ground and Ward D19, and paediatric management.

For paediatrics, the 95% completion target was not met for any of the 17 mandatory training modules for which medical staff were eligible. The lowest completion rate was for resuscitation of new-born training, which had a rate of 0% but only two eligible staff.

| aining module | Staff trained | ligible staff | ompletion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| nsent - Basic Consent | 19 | 21 | 90.5% | 95% | No |
| rassment & Bullying Level 1 | 33 | 37 | 89.2% | 95% | No |
| suscitation: Basic Life Support | 32 | 37 | 86.5% | 95% | No |
| ving and Handling - Medical Staff | 28 | 34 | 82.4% | 95% | No |
| nflict Resolution Update | 6 | 8 | 75% | 95% | No |
| ection Control | 27 | 37 | 73.0% | 95% | No |
| dical Devices Competency Form | 27 | 37 | 73.0% | 95% | No |
| e Safety - Workplace Training | 26 | 37 | 70.3% | 95% | No |
| uality & Diversity | 25 | 37 | 67.6% | 95% | No |
| ormation Governance: Information Governance Refresher Module | 4 | 6 | 66.7% | 95% | No |
| ormation Governance: Introduction to Information Governance | 16 | 31 | 51.6% | 95% | No |
| dical Devices Training | 16 | 32 | 50% | 95% | No |
| nflict Resolution Initial Training | 18 | 37 | 49% | 95% | No |
| dicines Management | 17 | 37 | 46% | 95% | No |
| alth & Safety | 16 | 37 | 43.2% | 95% | No |
| ansfusion | 15 | 37 | 40.5% | 95% | No |
| suscitation: Resuscitation of New-born | 0 | 2 | 0.0% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Birmingham and Midland Eye Centre (BMEC): All staff

BMEC training data could not be split into specific staffing groups and was not specific to services for children and young people.

For BMEC, the 95% completion target was met for two of the 18 mandatory training modules for which staff were eligible. Fire safety warden or refresher training had a completion rate of 100%. The lowest completion rate was for resuscitation of transfusion training, which had a rate of 25%.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| e Safety Warden or Refresher Training | 4 | 4 | 100% | 95% | Yes |
| dical Devices Competency Form | 183 | 188 | 97.3% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| le Safety - Workplace Training | 212 | 224 | 94.6% | 95% | No |
| oving and Handling - Patient Handling | 121 | 129 | 93.8% | 95% | No |
| arassment & Bullying Level 1 | 223 | 240 | 92.9% | 95% | No |
| edical Devices Training | 816 | 891 | 91.6% | 95% | No |
| uality & Diversity | 217 | 240 | 90.4% | 95% | No |
| nflict Resolution Initial Training | 184 | 205 | 89.8% | 95% | No |
| ormation Governance: Introduction to Information Governance | 165 | 185 | 89.2% | 95% | No |
| ection Control | 213 | 240 | 88.8% | 95% | No |
| ealth & Safety | 204 | 230 | 88.7% | 95% | No |
| nflict Resolution Update | 103 | 124 | 83.1% | 95% | No |
| edicines Management | 115 | 142 | 81.0% | 95% | No |
| suscitation: Basic Life Support | 159 | 203 | 78.3% | 95% | No |
| oving and Handling - Medical Staff | 50 | 71 | 70.4% | 95% | No |
| sic consent | 20 | 29 | 69.0% | 195% | No |
| ormation Governance: Information Governance Refresher Module | 23 | 55 | 41.8% | 95% | No |
| ansfusion | 2 | 8 | 25.0% | 95% | No |

*(Source: Trust data: DR643)*

Staff received a structured induction on commencing employment. Staff we spoke with had received this induction and spoke highly of the programme. Mandatory training for all staff was a mixture of face-to-face and online learning with modules such as equality and diversity, information governance, fire training, infection control and manual handling. The trust used an electronic staff record (ESR) system which alerted staff via automatic email when their training was due for renewal to remind them to book a session.

However, staff could not always access training. Staff told us that while trust development opportunities were good they struggled to attend training sessions due to staff shortages. Examples were given where staff members were stopped from attending training sessions to backfill shifts. Staff were then struggling to access the training. This meant that staff had not updated their skills and knowledge, which could affect their responses in an emergency or when performing those tasks related to the training. Managers we spoke with told us that the trust were offering staff the opportunity to attend development sessions on bank shifts. However, none of the staff interviewed were aware of this initiative.

The trust had a monthly half day where all elective activity was cancelled to provide clinical teams with protected learning time. These were known as quality improvement half days (QIHD). Each month there was a shared learning topic which all teams had to view and discuss, with some specific questions posed. However, the paediatric sessions were held predominately at the Sandwell Hospital and as such staff working at City Hospital could not always attend.

The trust was not aware of how many staff were suitably qualified, which could put children and young people at risk. During our previous inspections in October 2014 and March 2017, we found that training data was not available confirming how many trained staff had completed paediatric intermediate life support or advanced paediatric life support (APLS) training. Evidence the trust provided us showed that only one nurse across the paediatric services was trained in APLS. Staff we spoke with said that not all shifts were covered by a APLS trained nurse.

The trust did not provide training on mental health, learning disabilities or autism. Staff we spoke with said there was no specific training. However, the team could contact the relevant therapy service of school children's community nursing team for support.

The trust's sepsis policy did not guide staff to additional information. We requested a copy of the trust's sepsis policy and the trust submitted a physiological observation, monitoring and escalation policy. This could be accessed via the intranet. However, we found that the policy referred staff to the sepsis pathway, sepsis screening tool and sepsis six treatment but could not see any details on how to access these nor any examples of them within the document.

However, we saw information boards detailing how to manage sepsis. Sepsis training was included in the basic life support module including the use of sepsis screening tools and use of sepsis care bundles; care bundles are a group of best evidence based interventions which when instituted together, gives maximum outcome benefit. But when asked about the sepsis training, most staff could not recall the training. Birmingham Midlands Eye Centre (BMEC) had a local safety board which had a list of 10 daily checks that included the sepsis checks.

**BMEC staff had created training and resources to improve the ophthalmology paediatric service.** The paediatric ophthalmology consultant had created specific paediatric training, on a voluntary basis, for new and existing doctors. Each doctor had to complete two sessions for retinopathy of prematurity (ROP); when the retinal blood vessels don't develop normally in babies that are born earlier than their expected date of delivery.

The consultant also ran quality improvement half days for staff to attend which had the aim of reducing the lack of confidence in treating paediatrics within ophthalmology. Positive feedback had been received from the staff and the dean of training. They were also in the process of creating a paediatric ophthalmology handbook with agreed clinical pathways.

*(Source: Trust data DR79 and DR649)*

The General Medical Council (GMC) National Training Survey 2018

Every year the GMC surveyed all doctors in training and trainers for their views. This helped them make sure doctors in training receive high quality training in a safe and effective clinical environment, and trainers are well supported in their role.

Paediatrics generated a red flag in the area of clinical supervision. This meant that the department was substantially below its peer group in this this area. The concerns raised related to large volume of new admissions on ward and inadequate number of registrar's or consultants to review them in a timely manner and inadequate nursing staff.

*(Source: Trust data: DR522)*

## Safeguarding

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

The trust's safeguarding training completion rates were mixed. The trust set a target of 95% for the completion of safeguarding training. A breakdown of compliance for safeguarding training courses as at July 2018 for staff in services for children and young people is shown below:

Neonatal Unit: Qualified Nursing Staff

The 95% completion target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. Both modules achieved a 100% completion rate. The lowest completion was for safeguarding children level 3, with a rate of 86.7%. No data was provided for safeguarding children level 2.

| aining module | Staff trained | ligible staff | ompletion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| feguarding Adults Level 1 | 60 | 60 | 100% | 95% | Yes |
| feguarding Adults Level 2 | 16 | 18 | 89% | 95% | No |
| feguarding Children Level 1 | 60 | 60 | 100% | 95% | Yes |
| feguarding Children Level 3 | 52 | 60 | 86.7% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Neonatal Unit: Medical Staff

The 95% completion target was met for three of the four safeguarding training modules for which medical staff were eligible. All three modules achieved a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 89% which equated to one member of staff being outstanding.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| feguarding Adults Level 1 | 17 | 17 | 100% | 95% | Yes |
| feguarding Children Level 1 | 17 | 17 | 100% | 95% | Yes |
| feguarding Children Level 2 | 8 | 9 | 89% | 95% | No |
| feguarding Children Level 3 | 8 | 8 | 100% | 95% | Yes |

*(Source: Routine Provider Information Request – Training)*

Paediatrics: Qualified Nursing Staff

Paediatric staff were required to work across both the City Hospital and Sandwell Hospital sites. The data below consists of staff attributed to Priory Ground and Ward D6 including outpatients, Lyndon Ground and Ward D19, and paediatric management.

The 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. All three modules achieved a 100% completion rate. The lowest completion was for safeguarding adults level 2, with a rate of 80%.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| feguarding Adults Level 1 | 38 | 38 | 100% | 95% | Yes |
| feguarding Adults Level 2 | 4 | 5 | 80% | 95% | No |
| feguarding Children Level 1 | 38 | 38 | 100% | 95% | Yes |
| feguarding Children Level 2 | 3 | 3 | 100% | 95% | Yes |
| feguarding Children Level 3 | 32 | 35 | 91.4% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Paediatrics: Medical staff

Paediatric staff were required to work across both the City Hospital and Sandwell Hospital sites. The data below consists of staff attributed to Priory Ground and Ward D6 including outpatients, Lyndon Ground and Ward D19, and paediatric management.

The 95% completion target was met for three of the five safeguarding training modules for which medical staff were eligible. All three modules achieved a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 78.3%.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| feguarding Adults Level 1 | 36 | 37 | 97% | 95% | Yes |
| feguarding Adults Level 2 | 2 | 2 | 100% | 95% | Yes |
| feguarding Children Level 1 | 36 | 37 | 97.3% | 95% | Yes |
| feguarding Children Level 2 | 18 | 23 | 78.3% | 95% | No |
| feguarding Children Level 3 | 11 | 14 | 78.6% | 95% | No |

*(Source: Routine Provider Information Request – Training)*

Birmingham and Midland Eye Centre (BMEC): All staff

BMEC training data could not be split into specific staffing groups and was not specific to services for children and young people.

For BMEC, the 95% completion target was met for two of the five safeguarding training modules for which staff were eligible. Safeguarding children level 3 had a completion rate of 100%. The lowest completion rate was for safeguarding children level 2, which had a rate of 86.1%.

| aining module | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| feguarding Adults Level 1 | 228 | 240 | 95.0% | 95% | No |
| feguarding Adults Level 2 | 69 | 78 | 88.5% | 95% | No |
| feguarding Children Level 1 | 229 | 240 | 95.4% | 95% | Yes |
| feguarding Children Level 2 | 167 | 194 | 86.1% | 95% | No |
| feguarding Children Level 3 | 2 | 2 | 100% | 95% | Yes |

*(Source: Trust data: DR643)*

Staff had online access to hospital safeguarding policies and procedures. We reviewed the trust's policy for safeguarding children and young people, which was available on the trust intranet. The policy was implemented in August 2018 and valid until August 2021. The policy detailed roles and responsibilities and the process to follow for reporting and escalation of concerns about child welfare. It also included useful contact details for internal teams and external agencies. Section 9 detailed the procedures available to staff to follow however, the detail of those procedures was held in additional documentation meaning staff would have to read multiple documents. These included child protection, no access and was not bought process, and the domestic advice policy.

The safeguarding policy did not mention child sexual exploitation (CSE) or female genital mutilation (FGM). However, the trust had a child protection policy, also implemented August 2018, which did contain information on CSE and FGM which gave definitions and procedures for them to follow.

The trust was not aware of how many staff were suitably qualified as per the intercollegiate document Safeguarding Children and Young People: Roles and competencies for Health Care Staff published in March 2014. The trust did not provide data in the provider information request not when requested post inspection on the completion rate for safeguarding children level 2 for neonatal nursing staff. Additionally, the data for paediatric nursing staff showed low numbers of eligibility and completion compared to that of the level 3 training. Therefore, the trust could not provide assurance that they met the intercollegiate document recommendation is that 'those requiring competences at levels 1 to 5 should also possess the competency at each of the preceding levels'.

There was an identifiable nursing and medical lead for children's safeguarding both trained to level three. These included a paediatrician with child protection experience and skills. All could be contacted via telephone. The medical lead was in the process of completing safeguarding level four and five. The trust also had a safeguarding team based in Sandwell. Referrals to the children's safeguarding team were via telephone Monday to Friday between 9am to 5pm. The trust safeguarding children policy contained guidance for staff who need to make a referral out of hours.

Staff we spoke with could identify the different types of abuse and knew how to respond to safeguarding concerns and allegations of abuse. They felt confident in identifying potential abuse. Staff knew and understood what steps to take and who to contact when they identified concerns. We saw posters and leaflets detailing CSE, FGM, domestic violence and safeguarding. All of which contained details of different agencies and their contact details. We also saw trust computer screen savers detailing the same information.

Staff gave examples of when safeguarding cases were discussed within meetings where learning was discussed however, this was not minuted. There were monthly paediatric safeguarding meetings and fortnightly neonatal safeguarding meetings. Staff would discuss individual patient safeguarding concerns at handover. Child protection referrals would go to a consultant who was an experienced registrar. There would be a named consultant for the child.

At the time of our inspection staff there had not been any local safeguarding or serious case reviews within services for children and young people.

Staff knew how to refer patients to external agencies. If a patient was assessed to be at risk of suicide or self-harm staff explained that they would complete a risk and a child and adolescent mental health services (CAMHS) assessment. They would also complete a multi-agency referral form (MARF). The child would be placed within a room where there was nothing they could use to hang themselves. Staff within neonates also had access to a consultant midwife who would complete a depression scoring tool and ensure safe monitoring of the parent and baby.

The trust had a policy for restraint, this included specific details for the restraint of children. This policy was in line with national guidelines and suggested de-escalation techniques. No staff on the ward were trained in restraint and said they would have to get security if a child required restraining.

Senior staff had access to an online system which highlighted individual child protection plans or concerns. The trust had a CSE screening tool which gave staff a system to understand what degree of risk the child was at. The electronic system flagged up children who were at risk and senior staff could access interagency information.

The trust met the statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the trust underwent a DBS check prior to employment, and those working with children underwent an enhanced level of assessment.

Staff we spoke with were not able to explain the Mental Health Act S5(2) nurse's holding power nor did they know when and how they can be used.

At the time of our inspection the trust did not have an established peer review process for doctors nor did they have safeguarding supervision in place for nurses. This was a core competency as outlined by the requirements of level three safeguarding training: 'Undertakes regular documented reviews of own (and/or team) safeguarding/child protection practice as appropriate to role (in various ways, such as through audit, case discussion, peer review, and supervision and as a component of refresher training).' The trust's named doctor for safeguarding identified it as a risk and had plans to improve this in the future.

## Cleanliness, infection control and hygiene

**The service did not control infection risk consistently well. Staff did not ensure that equipment were kept clean to prevent the spread of infection.**

Staff followed the trust's infection prevention and control policy and procedures. Hand washing facilities and sanitising gel were available throughout the paediatric and neonatal departments, including in corridors, by ward entrances and in clinical areas. There was prominent signage reminding people of the importance of hand washing. We observed staff washing their hands before attending to patients. All staff we saw were 'arms bare below the elbow' in clinical areas, in line with national guidance.

Staff wore appropriate personal protective equipment. Staff wore aprons and gloves before giving personal care to patients and these were changed in-between patients.

There was an integrated infection prevention and control service. Staff told us that the infection control team nurse visited the wards and gave advice where needed which meant appropriate professional advice was available. The microbiology team visited the neonatal unit daily and attended weekly rounds.

However, the children's and young people service could not assure itself of its cleaning standards. Whilst all wards appeared to be clean, they did not use 'I am clean' stickers; these stickers provided the date the equipment was last cleaned. Staff we spoke with said that if equipment was set up in full it would indicate it had been cleaned and that they would wipe all equipment again to be sure. Staff could not explain how the cleaning was audited. This meant staff were unable to provide assurance that all equipment was fully cleaned and sterilised. We saw lack of understanding around safety of infection and prevention control clinical waste such as sharps bins which were not labelled or dated. In one instance we found a used soup tin in a clinical waste sharp bin including other non-clinical waste.

The neonate's scrubs procedure was inconsistent. Neonatal staff were required to change into their scrubs before entering the unit. The changing facility was located off a main public corridor some distance from the unit. Staff had to use several doors prior to entry to the unit, this then reduced the effectiveness of infection prevention through the mitigation of clean scrubs. On the inspection, inspectors were asked to change into scrubs before entering the intensive care and high dependency units however, parents and relatives were asked to only remove outdoor coats before entering the unit. We also saw children visitors in school uniform who were not confined to the locality of their sibling's incubator and were wandering around the unit. We also saw inconsistent adherence to the trust's process for admittance into the special care unit. With some visitors being allowed access in their street clothing and some being asked to wear protective covers.

Isolation procedures were not fully adhered to. There were two isolation rooms on the neonatal unit. During our inspection both rooms were occupied and we saw that the doors had been propped open with bins. We raised this with staff whilst on-site and were told that due to a lack of staff they were unable to adequately staff the rooms. The doors had been propped open to allow the one staff member overseeing both babies, to hear any alarms. This practice could increase the risk of spread of infection from infectious patients.

The neonatal unit had weekly colonisation screening of all babies to inform potential for infections such as MRSA and E. coli. This practice had led to the early identification of a recent pseudomonas outbreak where four babies had tested colonisation positive. As part of the investigation, pseudomonas contamination was identified in an ITU tap and family room shower which were immediately taken out of service. Of the four colonised babies, one had tested positive for infection however the typing showed this to be unrelated to the other babies. Colonisation described when bacteria grow on body sites exposed to the environment, without causing infection.

Due to the number of babies cared for in the ITU, the room could not be emptied for a full deep clean. Instead the service had enhanced the cleaning of each area and had increased screening for that period. They had also replaced equipment such as the tap mixer valve. They had also increased the housekeeping regime and the microbiology team did additional work with the neonatal team to improve hand hygiene. However, it was noted on inspection that the contaminated sink had a paper towel over the sensor and red and white tape. Which did not appear sufficient to be able to prevent the use of the sinks; therefore, posing a further risk to cross contamination of equipment and risk to patients.

At the follow-up inspection, the service had completed the three tests needed to confirm an all clear for the tap. However, the family room was still undergoing additional tests.

The trust submitted data that showed whilst hand hygiene audit compliance was high, submissions were not always consistent on ward D19.

| Monthly Hand Hygiene Audits (% compliance) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ard | ug-17 | ep-17 | Oct-17 | lov-17 | ec-17 | Jan-18 | eb-18 | Mar-18 | Apr-18 | lay-18 | Jun-18 | Jul-18 |
| NU | 100 | 98 | 98 | 99 | 98 | 99 | 100 | 98 | 100 | 58 | 99 | 98 |
| .9 | 100 | 100 | 100 | | 100 | 100 | | 100 | | 100 | 99 | 100 |

No submission was made for ward D6

*(Source: Trust data DR515)*

Additionally in the Birmingham and Midland Eye Centre we found a single adult bed, which was ready and resus compliant which had bed linen contaminated by dark hair and stains. We raised this with staff on site and brought to their attention the infection risk. This was actioned immediately and fresh linen was placed on the bed.

**CQC Children and Young People's Survey 2016**

In the CQC Children and Young People's Survey 2016 the trust scored 8.59 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

**Patient-Led Assessments of the Care Environment (PLACE) - 2018**

| te level: not specific to children and young people services | Cleanliness Score |
|---|---|
| ty Hospital | 97.91% |
| rmingham and Midland Eye Centre | 97.68% |

## Environment and equipment

**The service did not always have suitable premises and equipment and did not consistently look after them well.**

We saw equipment suitable for babies, children and young people in all clinical areas. We undertook random checks of the clinical equipment throughout the neonatal and children's units and found that equipment had been serviced.

There was an electronic key fob entry system for authorised personnel to gain access to the main entrance each children's ward. We saw the doors remained securely shut and the key fob entry was always used during our inspection.

Staff knew how to locate all emergency equipment, and maintained a register of checks which showed equipment was checked on at least a daily basis and the required equipment was in place and in date.

Appropriate resuscitation equipment was available. On our previous inspection in 2014, we found there was no defibrillator on D19. On this inspection we found a defibrillator to be available and checked daily. Overall the resuscitation trolley was checked daily and signed for and that a sample check of equipment showed it to be in date.

Staff we spoke with expressed concerns that the day-case unit had been relocated from the Birmingham Treatment Centre (BTC) to ward D6 within the main hospital. They were concerned that the move was a backward step due to the unit originally being located with the paediatric outpatients' department and medical day unit; both of which were staffed by the same group of staff. They felt that BTC was more child friendly and the original ward had been designed as a child's ward. The ward was moved overnight to avoid the need for closure however, this had not provided staff with ample time to decorate the ward and make it more appealing to children.

On inspection on more than one occasion, within the outpatient's department we found that the door to the dirty utilities and treatment room were unlocked and propped open. Neither room was within oversight of the staff. Within the dirty utilities room, we found chloral cleaning tabs and scissors within reach, and within the treatment room we found easy access to syringes. This could provide a risk to children if they were unsupervised. The controlled medications were also within the treatment room but were within locked cupboards.

Also within outpatients we found a large quantity of out of date stock such as scissors, feeding tubes and lubricating jelly. Both the stock and the unlocked doors were raised to staff whilst on site. Staff we spoke with said that the stock was not used by them and they were unaware of how the stock was managed and disposed of.

Neonatal staff were required to change into their scrubs before entering the unit. The changing facility was located off a main public corridor some distance from the unit. The female changing facilities were inadequate for the number of staff who worked on the unit. The changing room had no shower and one toilet. On inspection we saw the room was cluttered with dirty discarded scrubs. It did not give the impression of having been cleaned for some time and paint was peeling off the walls in several places.

The neonatal rooms were compact, with minimal space between incubators and for families to move freely round the cot side.

Equipment was stored in corridors. Whilst on inspection, the neonatal unit was visibly cluttered with equipment being stored in corridors including oxygen tanks. This restricted access to the unit. We saw several crates with supplies left in front of the neonate's reception and parent locker area, these contained some formula milk and syringes.

We found open plug sockets within the children's play area and raised this to the attention of staff. Staff we spoke with told us that there were issues with the milk fridge room overheating due to inadequate ventilation. As a temporary measure the service had relocated some fridges and borrowed a kitchen fridge, placing them in a treatment room. We found that audits had been completed. The trust was in the process of approving plans to modify the milk fridge room to aid in its ventilation.

There were limited facilities for children with sensory, behavioural or mental health needs. The hospital did not have a sensory room. Staff we spoke with said there were two play specialist staff who worked cross site who they could contact for assistance. The play specialists could provide sensory equipment to place on ward.

During our previous inspection in March 2017 of Birmingham and Midland Eye Centre (BMEC), we found there were no dedicated children's play areas or separate waiting areas. On this inspection we saw a separate outpatient's waiting room for children which included a television and toys. There was a paediatric bay consisting of five beds which were only used Mondays and Thursdays for children exclusively. The bay was decorated with child friendly murals and had child friendly literature such as the monkey friends and family test. The orthoptic department had sectioned off part of their waiting area to introduce a child's play area and we saw toys and child friendly posters within the treatment rooms.

Although the department's open plan design made it difficult, staff managed patient privacy and dignity well. On our previous inspection, we raised concerns around privacy and dignity in treatment rooms. On this inspection we saw staff staggered appointments to avoid treating patients together. The service showed us architectural designs for it planned new treatment areas, which would provide six individual treatment rooms.

On the previous inspection, it was noted that resuscitation trolleys were overstocked, packed and full and staff told us this could make it difficult to locate equipment. We found on this inspection, that the resuscitation trolleys were adequately stocked and not over full. However,

We found two bottles of solution both dated 04.00 one was labelled water (H2O) and the other bottle was not labelled and smelt of chlorine. This was raised with staff on site as a potential risk.

**Patient Led Assessments of the Care Environment (PLACE) 2018**

Overall, BMEC and City hospital scored high for questions relating to environment and equipment.

| te level: not specific to children and young people services | Cleanliness Score | Privacy, Dignity and Wellbeing | Condition Appearance and Maintenance |
|---|---|---|---|
| ty Hospital | 97.91% | 82.18% | 96.42% |
| rmingham and Midland Eye Centre | 97.68% | 94.97% | 95.26% |

## Assessing and responding to patient risk

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

The children's service used an early warning system called the 'paediatric early warning score' (PEWS) which was a system used to monitor children and to ensure early detection of deterioration. PEWS were used to detect the onset of sepsis. The service used the paediatric sepsis six bundle to respond to deteriorating children within an hour; sepsis six is a bundle of evidence of medical therapies designed to reduce death in patients with sepsis. We saw evidence that the service had achieved 100% in their internal PEWS audit for the last three months.

We reviewed a sample of paediatric early warning score observation charts and found these were completed in detail by members of the nursing team, with exception of one record where we could not find the actions.

As part of our inspection we observed a consultant-led ward round. This was well attended by the medical team, the nurse in charge and specialists appropriate to each patient. The ward round included a full, systematic review of the clinical needs of each patient and addressed their immediate risks and medical status as part of evidence of good, consistent team decision-making and review practices.

We observed a handover for medical staff where there were thorough discussions about each patient admitted on the ward. A briefing printout was available which provided a summary of each patient to be discussed. We also observed a nursing handover, we found the handover to be comprehensive and covered areas of patient risk.

The service was not adhering to national staffing guidance. The Royal College of Nursing recommend at least one member of qualified staff on the children's unit has an advance paediatric life support qualification (APLS). Staff we spoke with said that not every shift was staffed by a member with APLS. Evidence the trust provided us showed that only one nurse across the paediatric services was trained in APLS.

In neonates 58.26% of qualified neonatal nurses had a qualification in neonatal intensive care.

Staff completed the necessary surgical documentation. For children requiring surgery, we observed pre-operative safety checklists were completed. We also observed the World Health Organisation (WHO) '5 steps to safer surgery' checklist was completed which reduce risks associated with surgery.

Children requiring additional mental health support were transferred to Sandwell Hospital which had an adolescent area which was used to care for patients with additional mental health needs. However, concerns were raised on the inspection about the area not being ligature free and staff were unaware if ligature cutters were available.

*(Source: Trust data DR518 and DR519)*

### CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 7.72 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

The trust scored 9.46 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with

food)?' This was also about the same as other trusts.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Nurse staffing

**The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

Nursing staffing levels did not meet the requirements consistently and issues over staffing were longstanding. This had been included in the paediatric risk register and rated as an amber concern.

Neonatal staff we spoke with said that staffing levels were terrible and they felt that patient and staff safety was being compromised. Staffing levels were below the British Association of Perinatal Medicine (BAPM) recommendations. Staff regularly worked over their hours to support their colleagues and often worked without breaks. Staff were visibly distressed as they recollected on the staffing pressures, the risks, and the adverse situations they had been placed under. Staff reported incidents of low staffing via the trust incident reporting system.

Staff we spoke with said they were exhausted and at the end of their tether. That missing breaks was a constant issue and many staff felt ill after shifts. They felt the situation was negatively impacting on retention rates and sickness. The short staffing situation had implications for staff development and for the quality innovations that speciality roles provided as staff could not be released for training, project work, innovations etc.

The trust's staffing data showed that from June to August 2018 only 18 out of 184 shifts met the BAPM recommendations. The data also showed that of those 184 shifts only 70 had the recommended number of qualified in specialty nursing staff.[1]

| BAPM Recommendations | | | |
|---|---|---|---|
| | verall | ay | ght |
| tal number of shifts | 184 | 92 | 92 |
| shifts that met staffing recommendations | 18 | 12 | 6 |
| shifts below toolkit | 9.8% | 13.0% | 6.5% |

The trust had recruited into six out of eight vacancies and had invested funds to increase the funded establishment in May 2018, after a three-month negotiation with NHS England.

*(Source: DR571 Badger Nursing Numbers & Acuity)*

Shifts were being supplemented by bank staff which staff told us were predominantly being filled by the neonatal staff. Staff told us that they felt pressure to cover bank shifts to assist colleagues but that goodwill was running out. Also, a recent initiative to change the pay band for bank staff had upset several of the team and as such many staff were now reluctant to volunteer for the bank. There were also concerns that staff were burning themselves out by covering the bank as well as

their own shifts.

Paediatric staff we spoke with said that the service did not always feel safe and they felt under pressure to make up shortfalls in staffing. Staff were shared between the two hospital sites within two teams and were allocated as required.
One team of staff were split between five wards located at both sites:

- City Hospital: ward D6, paediatric outpatients, medical day unit
- Sandwell Hospital: Priory Ground, paediatric outpatients

The team reported to a band six sister who had stepped up to cover the band seven ward manager role which had been vacated due to retirement. The ward manager role oversaw, with support from matron, all five areas and as such was challenged to provide direct staff support. In addition, due to staffing shortfalls the band 6 sister had to step back into a clinical role as well as complete their managerial duties.

The second team were based at either:

- City Hospital: ward 19
- Sandwell Hospital: Lyndon Ground

This team reported into a band 7 ward manager who worked between the two sites. However, staff we spoke with said that the band 7 ward manager was predominantly based at Sandwell Hospital. Again, this challenged the ability to provide direct staff support.

Examples were given by staff, where high dependency unit (HDU) patients were being admitted to the assessment units despite a lack of sufficient staffing to support them. HDU patients required a higher level of care, requiring staffing ratios to enable one nurse to monitor two HDU patients. Staff we spoke with gave an example of a shift when there were two qualified nurses on duty. The ward then received a HDU admission which led to one nurse providing one to one care to the HDU patient, the remaining qualified nurse then supported nine patients. This did not meet the Royal College of Nursing (RCN) recommendations, which recommends a staffing ratio of one qualified nurse to four patients aged two or over or one qualified nurse to three patients aged under two.

The trust submitted data which detailed dates where HDU patients were admitted to the assessment units. From June to August 2018, there were five occasions where a HDU patient was admitted to D19. Based on their average patient numbers, prior to the HDU admission, D19 had just enough staff to meet a nurse patient ratio of 1:4. However, the addition of a HDU patient may have led to the ward being short staffed.

Other examples were given of the impact of short staffing. Day case units were closed intermittently and staff redeployed to the inpatient areas despite their workloads, with no recognition of the impact. Whilst on inspection, we saw that staff had been redeployed from outpatients to ward D6 which had then meant that no qualified nursing staff from that team were on the Birmingham Treatment Centre within outpatients. This left a healthcare assistant to support consultants within the outpatient department including conducting staff training. However, staff told us that colleagues within other teams were supportive and would aid where required.

Staff told us that staff were leaving with newcomers not staying very long and that staff were not being replaced. They felt that the reason behind this turnover was due to a lack of support from the leadership team.

Staff we spoke with said they followed the trust's escalation guidelines and reported staff shortages via the incident reporting system. We reviewed the escalation guidelines for paediatrics and neonates and found that the paediatric guidelines were currently review, having past their February 2017 review date. We also noted that the appendix relating to ward staffing levels detailed wards comprising of 12 or more beds. The paediatric wards within the City Hospital compromised of 11 or less beds, therefore the guidance was not complete.

We requested data detailing the number of times the escalation policy had been implemented and the number of times wards had closed. The trust response was that this would not be documented on an incident form as the escalation policy was used to ensure a plan is in place to support staff unless the escalation plan had failed to be delivered and or the intended output not achieved. Over the past 12 months, the unit had not closed to admissions.

Leaders we spoke with said that they were aware of the concerns regarding staffing. There had been a continuing active recruitment drive to increase the number of registered staff working in neonates and across paediatrics; the services were in the process of appointing successful candidates. The trust reported the following nurse staffing numbers in services for children and young people both for April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | lanned WTE staff | Fill rate | ctual WTE staff | Planned WTE staff | Fill rate |
| sites | 51.6 | 57.1 | 90.4% | 47.5 | 57.1 | 83.3% |

Services for children and young people had a planned to actual nursing staffing level of 90.4% from April 2017 to March 2018. However, this dropped to 83.3% in April/May 2018 due to a decrease of 4.1 WTE nursing staff in post.

Nursing staff working within services for children and young people worked across both City Hospital and Sandwell Hospital.

*(Source: Routine Provider Information Request – Total staffing tab, trust data DR510 and DR511)*

**Vacancy rates**

The trust had a target vacancy rate of 3% or below. From July 2017 to June 2018, the trust reported a vacancy rate for nursing staff in services for children and young people as below:

| inical area name | Total actual WTE vacancies | Total establishment | Annual vacancy rate |
|---|---|---|---|
| YPAE - Paediatric Speciality | 7.12 | 11.88 | 59.9% |
| YPMA - Paediatric Mgt & Senior Medics | 7 | 12 | 58.3% |
| YNEO - Neo Natal Unit | 83.09 | 662.4 | 12.5% |
| YLYG – D19 / Lyndon Ground | -1.55 | 303.84 | -0.5% |
| YGPR – D6 / Priory Ground | -4.38 | 101.64 | -4.3% |

The vacancy rates highlighted exceeded the trust target.

The trust noted that the discrepancy between their planned versus actual staffing data and their data for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

Management staff told us that there had been six out of eight vacancies recruited into and that the trust had invested funds to lead to an addition of incremental shifts.

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 20.8% for nursing staff in services for children and young people at trust level, based on 17.7 WTE members of nursing staff leaving over the 12-month period, compared with an average substantive level of 85.1 WTE staff. There was no overall trust-wide turnover target, however there was a target of 10.5% for band 5 nurses.

| inical area name | tal # of substantive staff leavers | Total # of substantive staff | nnual turnover rate |
|---|---|---|---|
| YLYG – D19 / Lyndon Ground | 6 | 22 | 26.3% |
| YGPR – D6 / Priory Ground | 2 | 8 | 21.5% |
| YNEO - Neo Natal Unit | 10 | 53 | 19.3% |
| YPAE - Paediatric Speciality | 0 | 1 | 0.0% |
| YPMA - Paediatric Mgt & Senior Medics | 0 | 1 | 0.0% |

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

**Sickness rates**

From June 2017 to May 2018, the trust reported an annual sickness rate of 6.2% for nursing staff in services for children and young people, which was higher than the trust target of 3%.

| inical area name | Total permanent staff sick day | tal available permanent staff days | Annual sickness rate |
|---|---|---|---|
| SYLYG – D19 / Lyndon Ground | 547.1 | 8061.2 | 6.8% |
| NYNEO - Neo Natal Unit | 1283.5 | 19612.4 | 6.5% |
| SYGPR – D6 / Priory Ground | 112.6 | 2893.1 | 3.9% |

| | | | |
|---|---|---|---|
| NYPMA - Paediatric Mgt & Senior Medics | 16.0 | 617.0 | 2.6% |
| NYPAE - Paediatric Speciality | 3.0 | 306.0 | 1.0% |

Three of the eligible clinical areas had sickness rates higher than the trust target.

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

**Bank and agency staff usage**

Trust level

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we were unable to analysis bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in services for children and young people at trust level from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 1,830 shifts were filled by bank staff and 1,535 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 2,573 shifts were filled by bank staff and 52 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 1,830 | 2,573 | 4,403 |
| Agency | 1,535 | 52 | 1,587 |

We were unable to provide a site-specific breakdown of nursing bank and agency usage in services for children and young people, due to the format of the data provided by the trust.

*(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)*

## Medical staffing

**The service did not have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

The trust had 11.75 whole time equivalents who worked across the two hospital sites. Consultants told us that they were having to ‘act down’ to cover junior shifts. At the time of the inspection clinics were still being maintained however, there was no capacity if there was an unexpected absence. This had been included as a risk on the paediatric risk register.

The trust did not provide onsite paediatric consultant cover out of hours but did cover on call based from home. Consultants worked at City Hospital from 8.30am to 4.30pm. This did not meet the Royal College of Paediatrics and Child Health Facing the Future standards. Staff we spoke with said that

consultant staff would arrive within 20 minutes of being called were available over the telephone for advice. This was also raised as a concern at the previous 2014 inspection.

There was work in progress to address the chronic middle grade rota gap by recruiting resident on-call consultants and increase provision of rapid access clinics to help avoid presentation to the emergency department and improve patient flow. This would also allow the trust to support the objective of improving coverage of 14-hour target for consultant review.

At the last inspection we found that within Birmingham Midlands Eye Centre (BMEC) there was only one paediatric ophthalmology consultant available in the centre, with no plans to increase this headcount. This was not in line with the Royal College of Paediatrics and Child Health guidelines which stated there should be a consultant paediatrician available in the hospital during times of peak activity, seven days a week. There was a daily on-call rota which included out of hours for both, Consultant ophthalmologists and Consultant paediatricians.

Since the last inspection, the trust had approved the recruitment of a second paediatric ophthalmology consultant. However, no suitable candidates had applied which the trust felt was in due to a national shortage of ophthalmology consultants. This was backed by the Royal College of Ophthalmologists (RCOphth) Workforce Census 2016 found that 51% of responding units in the UK have unfilled full-time consultant posts.

Due to the inability to recruit a consultant the trust created a fellowship post and was in the process of finalising recruitment into that post. The on-call rota had been altered to include paediatric ophthalmology Consultant cover and the centre had developed links with a neighbouring Trust to provide additional paediatric ophthalmology support. BMEC had also begun to engage with other external organisations with a view to creating a shared paediatric care network.

The trust reported the following medical and dental staffing numbers in services for children and young people both for April 2017 to March 2018 and, more recently, in April/May 2018.

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| sites | 45.2 | 48.0 | 94.2% | 46.1 | 48.0 | 96.1% |

The medical and dental staffing levels were similar in both time periods.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab, Trust Data DR636 and DR637)*

**Vacancy rates**

From July 2017 to June 2018, the trust reported that medical and dental staff in services for children and young people at trust level were over-established by 2.0%, which was better than the trust's target of 3%.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were

recruited via their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them.

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

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 42.2% for medical and dental staff in services for children and young people at trust level. There is no overall trust-wide turnover target.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

It should be noted that trainee grades may have been included in the turnover data which would have impacted on the rate. This should be confirmed on inspection.

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

**Sickness rates**

From June 2017 to May 2018, the trust reported an annual sickness rate of 0.5% in services for children and young people at trust level, which was lower than the trust target of 3%. There is no overall trust-wide turnover target.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

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

**Bank and locum staff usage**

Neonates vacancy – trying to incentivise the bank, using the vacancy pot to increase the bank pot. Finding new starters are coming to the unit to do training but going back to their old level 3 trust after their 12 months. Struggling to source neonatal,

**Trust wide**

From June 2017 to May 2018, the trust reported that 681 shifts within services for children and young people trust-wide were filled by bank staff and 946 shifts were filled by locum staff. There were no shifts not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

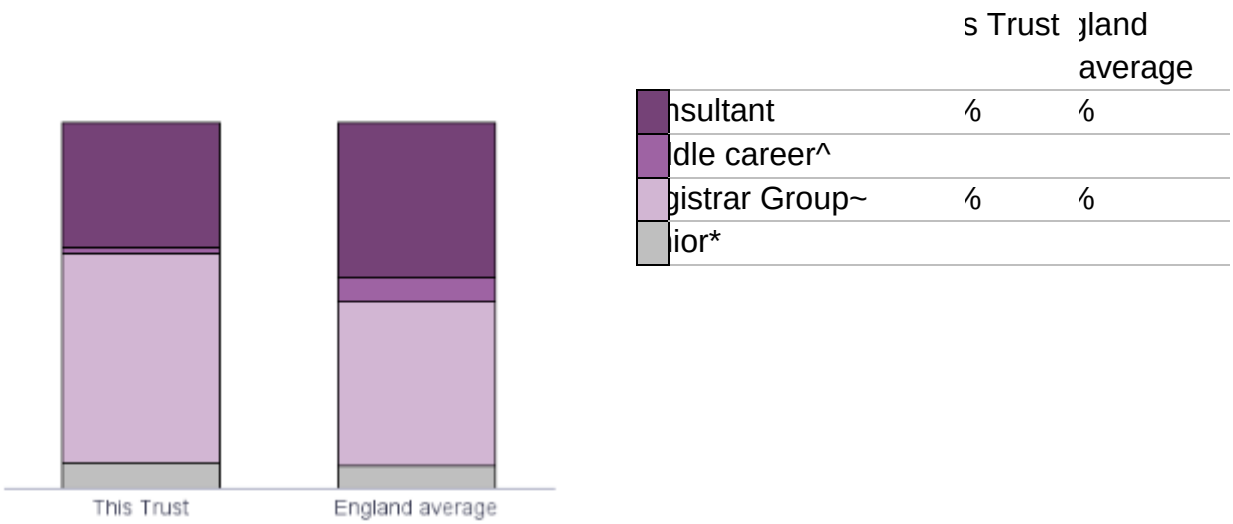
| **affing type** | **Bank shifts** | **Locum shifts** | **Unfilled shifts** | **Total shifts bank, locum and unfilled)** |
|---|---|---|---|---|
| onsultant | 302 | 608 | 0 | 910 |
| ddle Grade | 303 | 281 | 0 | 584 |
| octor in Training | 76 | 57 | 0 | 133 |
| **otal** | **681** | **946** | **0** | **1,627** |

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

**Staffing skill mix**

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

**Staffing skill mix for the 56 whole time equivalent staff working in children's services at Sandwell and West Birmingham Hospitals NHS Trust**




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

*(Source: NHS Digital Workforce Statistics)*

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found records within the neonatal unit to be of mixed quality and to not always be fully completed.**

Patient records across the neonate's unit, paediatric wards and in the outpatients' department were paper records. The trust was in the process of implementing an electronic record system. We observed records being stored securely in a locked notes trolley. In NNU medical staff wrote in separate records to the nurses but both were reviewed on ward rounds. All disciplines had access to current information on each patient.

Paper documentation included a range of risk assessments, pain scores, paediatric early warning scores (PEWS), allergies and care plans for patients. We saw that staff consistently recorded PEWS scores.

Within paediatrics, we saw patient records were multidisciplinary and had entries made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech

and language therapists and dietetic staff. We reviewed 12 sets of notes and found them to be legible and appropriately signed and dated.

We reviewed four sets of notes at BMEC and found the sample to be of a good standard. Relevant paperwork was evident and where needed, was clearly signed and dated. We saw pre and post care plans in place including any falls and safeguarding checks. Since the last inspection in 2017, BMEC had introduced an induction for all new doctors to complete that introduced them to the electronic medical record system. There was also a one-month buddy system which enabled each new intake of junior doctors to have a mentor to assist with familiarising them with the system. The lead nurse then reviewed all the data entries to ensure full compliance and included the findings in an independent report as assurance.

We found that there were issues with the quality of documentation in the neonatal unit. We reviewed four sets of records and found that sepsis pathway documentation was not always evident, nasogastric tube stickers were not always fully completed and in one instance, documentation to a reference to bruising was not robust.

From May to July 2018, 13 paediatric records were audited for completeness. Paediatrics scored 100% for physical quality and completing the basics of records.

| Compliance | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physical quality | | | | Basics of records | | | | Documentation for the current or last episode | | | |
| Folders in satisfactory | | First 7 indicators | | Entries contemporaneous | | Daily entry made (Inpatient only) | | Self inking stamp used | | Allergies recorded | |
| 13 | 100% | 13 | 100% | 13 | 100% | 8 | 100% | 6 | 46% | 7 | 88% |

The trust reported there had been no records audits for the neonate's unit. This meant the trust could not assure itself that records were being completed in full and to a good standard.

*(Source: Trust data DR507 and DR509)*

## Medicines

**People received their medicines as prescribed. However, the service did not always follow relevant national guidelines around storing medicines.**

There was an electronic key system to enable the security of medicines across the trust. Only authorised staff had access to medicine cupboards, and the electronic system had the ability to track who had accessed medicine cupboards.

Prescription medicines were stored safely in locked cupboards which staff accessed using their keys. There was also a locked controlled drugs cupboard that staff only accessed when two staff were present. Medicines were stored in locked cupboards and fridges where necessary

During this inspection we found out of date medication including controlled drugs within outpatients, the inspector alerted the staff in that clinical area. This meant that these drugs were removed immediately to reduce the likelihood of a future medication incident from occurring.

On ward D19, the resuscitation trolley was not secured and contained intravenous fluids. This was not safe practice and patients and relatives could access the drugs.

Temperature sensitive drugs were stored in fridges and staff recorded temperature levels daily. We saw daily audits that showed the temperature remained within an acceptable range. Staff on ward D6 only recorded fridge temperatures for the days when the ward was open. This could mean that medicines could be stored at a higher temperature on days when the ward was closed which would make the medication ineffective and the staff would not be aware.

The trust conducted 13 records audits between May and July 2018. It found 100% of entries contemporaneous and that daily entries were made. However, it also found that only 88% of allergies were recorded, the trust highlighted this as an area for improvement and put actions in place to improve this.

The trust audited antimicrobial prescribing and had implemented an action plan to address any shortfalls such as incomplete allergy status. The results of the audit in July 2018 are show below:

| **dicator** | **ty** | **CG target** |
|---|---|---|
| ımber of patients | | |
| with allergy status documented* | .7% | 7% |
| on antibiotics | .9% | |
| on IV antibiotics | .3% | |
| on IV antibiotics for more than 48 hours | % | aintain at baseline level |
| on antibiotics for >7 days | % | |
| with stop/review date documented on drug chart | .3% | 5% |
| with indication documented on drug chart | .7% | 5% |
| with antibiotics in line with guidelines | 0% | 0% |

*Excludes NNU

*(Source: Trust data DR509)*

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents however, they were inconsistent in how they shared lessons learned with the whole team and the wider service. When things went wrong, staff were inconsistent in their approach to apologise and give patients honest information and suitable support.**

Staff we spoke with knew how to report incidents and were encouraged by leaders to do so. Incidents were logged via the trust-wide electronic reporting system. Staff told us that there were instances where time constraints due to staffing led to a delay in the record being logged. Doctors said they reported incidents and received feedback including lessons learnt.

All incidents were reviewed by the ward manager and escalated where necessary to senior staff. Serious incidents were reviewed by the service triumvirate and a 72-hour report, with initial investigation findings, completed.

The service had monthly risk meetings where any identified risks were discussed and appropriate actions and timelines put in place. These were then fed into the wider paediatric clinical governance group.

Neonatal staff told us that lessons learnt from incidents were communicated to staff at handover sessions. The paediatrics team received feedback from the paediatric lead for risk who led investigation review meetings. However, there was no evidence of a formal process to ensure that staff who were not in attendance received the updates.

The trust had a monthly newsletter 'Heartbeat' which was delivered monthly with payslips, which included a section on patient safety issues and we saw screen savers used to share messages.

The neonatal service held joint mortality and morbidity meetings with the maternity units. We reviewed two sets of perinatal mortality review board outcomes summary which gave a brief overview of actions and investigation points with additional detail being held on a separate document. However, no minutes were available due to the board decision to use the outcome summary in conjunction with the perinatal mortality review tool and therefore we could not judge the effectiveness of this discussions. We also reviewed two set of minutes from the learning from deaths committee. These documents confirmed that discussions relating to morbidity and mortality had also taken place at service and at trust level.

There were no formal mortality and morbidity meetings held by the paediatric service.

We reviewed the business continuity plan for neonates which included actions for ward staff in the event of loss of power, loss of IT, staffing shortages and major incidence guidance and found this to be robust. Staff knew about the plan and were able to express knowledge of the actions. No business continuity plan was submitted for the paediatric service.

**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 to provide reasonable support to that person.

Not all staff we spoke with were not aware of the duty of candour policy and could not provide examples of when it had been discharged.

We requested copies of the duty of candour and we received screen shots of the case files. The examples explained that parents had been informed by the medical team in two cases but we saw no evidence of any formal letter detailing duty of candour.

**Never Events**

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

From July 2017 to June 2018, the trust reported no incidents classified as never events for children’s’ services.

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

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in children's services at City Hospital which met the reporting criteria set by NHS England from July 2017 to June 2018.

Two of these serious incidents were classified as HCAI/Infection control incidents meeting SI criteria and both occurred in the neonatal unit:

- 2018/10337/RXK: Three babies were identified on the neonatal unit as having MRSA but were colonised not infected. Colonisation describes when bacteria grow on body sites exposed to the environment, without causing any infection.
- 2017/28970/RXK: Microbiology received typing results for four Ecoli isolates taken from neonatal unit. The results confirmed that they were identical. The root cause was suspected cross contamination and hand hygiene practices were reviewed and reinforced.

The remaining incident was classified as a maternity/obstetric incident relating to the baby only (this includes a foetus, neonate or infant).

- 2017/27628/RXK sudden unexplained death of an infant (SUDI)

We reviewed the root cause analysis for each incident and found them to include lessons learned complete with actions, timelines and evidence of completion.

*(Source: Routine Provider Information Request – Incident Overview and Trust data DR506 , DR512 DR568)*

## Safety thermometer

**The service did not consistently use safety monitoring results well. Staff did not consistently collect safety information and share it with staff, patients and visitors. Managers did not use this to improve the service.**

**There were no visible patient safety thermometer results on the wards. Staff were not aware of the safety thermometer or its results.**

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and no new urinary tract infections in patients with a catheter from June 2017 to June 2018 for children's services. The pressure ulcer occurred in June 2018.

**valence rate (number of patients per 100 surveyed) of pressure ulcers at Sandwell and West Birmingham Hospitals NHS Trust**

1

**al**

**Pressure ulcers**


1 Pressure ulcers levels 2, 3 and 4

*(Source: NHS Digital and Trust data DR638)*

# Is the service effective?

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence of its effectiveness.**

Policies and guidelines were kept on the intranet for staff to access. We reviewed a sample of trust policies and found they appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges.

We saw guidelines on physiological observation monitoring and escalation policy, which detailed the steps to take when patient observations flagged different risk areas. This policy was due for review in July 2018 and did not reference up to date NICE guidelines (sepsis: recognition, diagnosis and early management (NG51). However, we saw a sepsis flow chart was clearly displayed on the walls in the wards.

We saw that staff handovers referred to the psychological and emotional needs of patients. However, staff we spoke with said they did not receive any training in mental health conditions, learning disability or autism. There was no formal service level agreements with the child and adolescent mental health service (CAMHs). However, CAMHs contacted the wards daily to ask whether there were any children admitted to the ward that fit the clinical criteria for CAMHs.

We saw that the World Health Organisation (WHO) surgery safety checklist used was age specific in line with Guidelines for the Provision of Paediatric Anaesthesia Services.

The neonatal unit participated in Baby Friendly (Unicef) and BLISS baby charter initiatives and national audits were used to monitor the effectiveness of the standard of care provided.

The service promoted the use of an externally designed mobile application to assist children and young people in managing their diabetes.

The trust completed the national audits for Paediatric diabetes audit 2015/16. The trust also completed monthly local audits on infection control, paediatric asthma audit and paediatric indicator audit.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.**

Patients' nutrition and hydration needs were met on the ward. Patients had all meals provided and drinks and snacks were available throughout the day. We saw that wards catered for vegetarian, vegans and patients with specific dietary requirements.

We saw nutritional assessments and management plans in patient records and the service had access to five paediatric dieticians to review patients.

The day case wards encouraged parents to bring a packed lunch for children to eat post-surgery and were able to provide some basic facilities such as a microwave.

On the neonatal unit, breastfeeding was promoted to new parents. An infant feeding nurse worked with new mothers on the unit. An infant feeding support group was run at the hospital that was well attended. We saw posters promoting breast feeding and skin-to-skin contact on the neonatal ward and within public areas of the hospital. Supporting information was also provided on the intranet.

The unit had achieved UNICEF Baby Friendly accreditation. This meant the unit was committed to supporting mothers to initiate breastfeeding and encouraged them to exclusively breastfeed for the first six months, while at the same time also supporting parents who chose to bottle-feed.

We checked the fridge where the breast milk was kept. We found that temperature logs were recorded on a daily basis and that these were in range. Bottles containing breast milk were named and dated appropriately.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Children and young people had access to a range of pain relief, including topical, oral and intravenous analgesics (painkillers) when needed. We saw that pain assessments were completed in the records we reviewed. The service used the smiley faces universal pain assessment tool, where children were asked to point to the faces to help indicate their level of pain.

There were regular meetings that included appropriate members of the multi-disciplinary team to address pain management, for example, following paediatric surgery. We saw pain management processes which were documented in patient records.

The trust had a dedicated pain management team who would attend the wards when requested to give specialist support.

## Patient outcomes

**The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them**.

The service had a ward dashboard, known as the quality management framework, which was updated monthly by ward managers. This was completed for ward D19 and covered areas such as infection control, the paediatric asthma audit and paediatric indicator audit. The latest results are shown below and show that the ward had achieved 100% compliance in 11 out of the 26 indicators. The lowest scoring indicators were height and weight recorded on the growth chart at 23.08%.

At the time of our inspection the children and young people's service was not involved in any peer review programmes or research programmes.

The trust submitted sepsis audit data for the period May to July 2018. Ward D19 only appeared within the audit in June 2018, where four out of nine patients were screened for sepsis and none were diagnosed with sepsis. This suggested that the ward was not being regularly audited.

**Quality Management Framework: Ward D19**

| | | Jun | Jul | Aug 2018 |
|---|---|---|---|---|
| **tient Safety** | | | | |
| **ection Control** | | | | |
| RSA bacteraemia (post 48 hours) | No | | | |
| Difficile Cases (post 48 hours) | No | | | |
| ving Lives Audits | No | 0■ | 0■ | 0■ |
| nd Hygiene | % | 99.31%▼ | 100.00%▲ | 100.00%■ |
| **ediatric Asthma Audit** | | | | |
| haler technique checked | % | 100.00%■ | 100.00%■ | 100.00%■ |
| thma/wheeze written action plan given | % | 100.00%■ | 100.00%■ | 100.00%■ |
| oking cessation advice given | % | 100.00%▼ | 100.00%■ | 100.00%■ |
| me of school documented | % | 0.00%■ | 0.00%■ | 0.00%■ |
| iggers explained Reliever and preventer inhalers explained | % | 100.00%▼ | 100.00%■ | 100.00%■ |
| haler instruction leaflet given | % | 0.00%■ | 0.00%■ | 0.00%■ |
| ns and symptoms of worsening asthma explained | % | 100.00%▼ | 100.00%■ | 100.00%■ |
| me medication supplied for week 1 | % | 100.00%■ | 100.00%■ | 100.00%■ |
| ect access arranged if needed | % | 100.00%▼ | 0.00%▲ | 100.00%▼ |
| **ediatric Indicator Audit** | | | | |
| eight recorded on admission | % | 100.00%▼ | 100.00%■ | 84.62%▲ |
| eight recorded on the growth chart | % | 16.67%▼ | 27.27%▼ | 23.08%▲ |
| ight measured on admission | % | 41.67%▲ | 81.82%▼ | 38.46%▲ |
| ight recorded on the growth chart | % | 0.00%■ | 9.09%▼ | 23.08%▼ |
| ad circumference measured on admission for under 2s | % | 33.33%▲ | 14.29%▲ | 50.00%▼ |
| iage recorded on arrival to the ward | % | 91.67%▼ | 90.91%▲ | 92.31%▼ |
| iage acted upon appropriately | % | 100.00%■ | 90.00%▲ | 92.31%▼ |
| in score recorded on admission | % | 83.33%▼ | 63.64%▲ | 76.92%▼ |
| WS chart commenced on admission | % | 100.00%▼ | 100.00%■ | 92.31%▲ |
| WS chart completed adequately | % | 0.00%▲ | 0.00%■ | 100.00%▼ |
| WS score acted upon appropriately | % | 100.00%■ | 100.00%■ | 100.00%■ |
| ergies documented | % | 91.67%▲ | 81.82%▲ | 100.00%▼ |
| tial Depression assessment completed on admission by nursing staff (for 12+ only) | % | 66.67%▼ | 100.00%▼ | 0.00%▲ |
| pression screening assessment escalated appropriately | % | 0.00%▲ | 100.00%▼ | 0.00%▲ |
| sclaimer form completed | % | 41.67%▼ | 30.00%▲ | 30.77%▼ |

| | | | | |
|---|---|---|---|---|
| ild reviewed by registrar within 4 hours of admission | % | 58.33%▲ | 100.00%▼ | 92.31%▲ |

*(Source: Trust data DR646)*

Birmingham and Midland Eye Centre had a dashboard which compared their results that of their peers. The dashboard showed that the service was performing better than their peers for two metrics; new to follow up ratio and the risk adjusted length of stay.

| Description | Site Numerator | Site Denominator | Jul 17 - Jun 18 | Jul 16 - Jun 17 | Change | Peer Value | Performance | Alert |
|---|---|---|---|---|---|---|---|---|
| Average Length of Stay (Spell Trimmed 1-49 days) | 186 | 71 | 2.62 | 2.75 | -4.7% | 1.38 | | Red |
| Risk Adjusted Length of Stay Index 2017 | 183 | 293 | 62.36 | 82.28 | -24.217% | 6.517 | | Red |
| Average Pre-Op Length of Stay | 28 | 394 | 0.071 | 0.0254 | 180% | 0.00197 | | Red |
| Elective IP - procedure not carried out - other than patient reason | 0 | 7 | 0% | 0% | -% | 0% | | - |
| Weekend discharge rate for emergencies as percentage of weekdays | 7 | 11 | 63.64% | 109.09% | -41.67% | 13.158% | | - |
| Day Case Rate | 338 | 367 | 92.10% | 92.06% | 0.03758% | 98.62% | | Amber |
| BADS Day Case Rate (Case Mix adjusted) | 237 | 237 | 99.90 | 102.59 | -2.6269% | 106.76 | | Amber |
| Readmissions within 28 days | 11 | 455 | 2.4176% | 2.0173% | 19.843% | 0.4699% | | - |
| Outpatient DNA Rate | 2253 | 17189 | 13.107% | 12.696% | 3.240% | 12.342% | | - |
| Outpatient New to follow-up ratio | 9652 | 5284 | 1 : 1.83 | 1 : 2.91 | -37% | 1 : 3.3 | | - |
| Data Quality Index | 443 | 459 | 96.44 | 95.47 | 1.0137% | 96.93 | | - |
| Complication rate - attributed | 1 | 455 | 0.21978% | 0% | -% | 0.8459% | | - |
| Misadventure rate | 0 | 455 | 0% | 0% | -% | 0.3759% | | - |
| Decubitus ulcer | 0 | 0 | -% | -% | -% | -% | | - |
| Post operative pulmonary embolism or deep vein thrombosis | 0 | 143 | -% | -% | -% | -% | | - |
| Post operative wound infection | 0 | 2 | -% | -% | -% | -% | | - |

*(Source: Trust data DR642)*

The service fed into the Getting It Right First Time (GIRFT) programme which reported on several metrics for paediatric surgery. The service scored within the lowest 25% of trusts for the metrics pertaining to:

- friends and family response rate
- staff survey response rate
- staff survey; staff recommending the trust as a place to work or receive treatment
- % of patients requiring ICU and uplift where the team attends patients within 3.5 hours of referring call

The service scored in the top 25% of all trust's for:

- staff survey; staff motivation
- % of time critical patients departs base within 60 minutes

*(Source: Trust data DR523*

**Paediatric diabetes audit 2015/16**

**City Hospital**

In the 2015/16 Paediatric diabetes audit, the proportion of patients receiving all key care processes annually at City Hospital was 51.4%, which was within the expected range. The national aggregate was 35.5%, while the hospital's score in the 2014/15 report was 73.2%.

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".

The mean average HbA1c value (adjusted by case-mix) for this hospital was 62.8 mmol/mol which was better than expected. The national aggregate was 68.3 mmol/mol. The hospital was a positive outlier for this metric in the previous year's audit.

The median HbA1c value recorded amongst the 2015/16 sample for this hospital was 64.0 mmol/mol, which did not indicate a clinically significant change from the previous year's median of 63.5 mmol/mol. The national aggregate was 65.0 mmol/mol.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

From February 2017 to January 2018, there were no specialties with six or more readmissions following an elective admission recorded for the under one or 1-17 age groups.

The tables below show the percentages of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that, from February 2017 to January 2018, a lower percentage of patients aged under one were readmitted following an emergency admission in paediatrics, compared to the England average.

| nergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2017 to January 2018) | | | | |
|---|---|---|---|---|
| Specialty | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| ıediatrics | 2.2% | 2,240 | 50 | 3.3% |
| No other speciality at this trust had six or more readmissions. | | | | |

In addition, a lower proportion of the trust's patients aged 1-17 years old were readmitted following an emergency admission in paediatrics compared to the England average.

In contrast, a higher proportion of the trust's patients in this age group were readmitted following an

emergency admission in paediatric surgery compared to the England average.

| ıergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2017 to January 2018) | | | | |
|---|---|---|---|---|
| ıecialty | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| ıediatrics | 1.5% | 4,961 | 74 | 2.8% |
| ıediatric Surgery | 3.1% | 227 | 7 | 1.9% |
| No other speciality at this trust had six or more readmissions. | | | | |

*(Source: Hospital Episode Statistics, provided by CQC Outliers team)*

**Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes**

From March 2017 to February 2018, a similar proportion of the trust's patients aged from one to 17 years of age had two or more admissions for asthma. However, please note that this analysis was based on a small number of multiple admissions.

In contrast, higher proportions of the trust's patients aged from one to 17 years of age had two or more admissions for diabetes and epilepsy in comparison to the England rates.

| ıte of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under one year and from one to 17 years) (March 2017 to February 2018) | | | | |
|---|---|---|---|---|
| Long term condition | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | ıltiple admission rate | At least one admission (n) | Two or more admissions (n) | Multiple admission rate |
| **sthma** | | | | |
| ıder 1 | - | - | - | 14.5% |
| o 17 | 16.0% | 250 | 40 | 16.1% |
| **abetes** | | | | |
| ıder 1 | - | - | - | 20.0% |
| o 17 | 21.2% | 33 | 7 | 13.1% |
| **ilepsy** | | | | |
| ıder 1 | * | * | * | 34.0% |
| o 17 | 36.4% | 55 | 20 | 27.0% |

Note: For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'. Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

*(Source: Hospital Episode Statistics, provided by CQC Outliers team)*

**National Neonatal Audit Programme**

**City Hospital**

In the 2017 National Neonatal Audit, City Hospital's performance in the four measures relevant to services for children and young people was as follows:

**Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc**

Out of 62 eligible cases identified for inclusion, 50.8% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºC and 37.5ºC. This was within the expected range when compared to the national aggregate of 61.0%.

The hospital did not meet the audit's recommended standard of 90% for this measure.

**Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission**

Out of 451 eligible cases identified for inclusion, 89.2% of babies had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This was within the expected range when compared to the national aggregate of 90.5%.

The hospital did not meet the audit's recommended standard of 100% for this measure.

**Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity**

Out of the 86 eligible cases identified for inclusion, 93.9% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit's recommended standard of 100% for this measure.

**Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age**

Out of the 45 eligible cases identified for inclusion, 82.2% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This placed the hospital within the top 25% of hospitals in England for this measure. The national aggregate was 61.2%.

The hospital did not meet the audit's recommended standard of 100% for this measure.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

## Competent staff

**The service did not make sure staff were competent for their roles. Managers did not consistently appraise staff's work performance and did not hold supervision meetings with them to provide support and monitor the effectiveness of the service.**

The trust reported that 58% of paediatric staff and 60.2% of neonatal staff had received an annual appraisal. Staff we spoke with told us that they found the appraisals to be effective at highlighting areas for development over the coming 12-months.

Staff we spoke with said they were encouraged to develop and attend training but that staff shortages on wards had meant this was difficult and protected time was often used to work clinical shifts. Staff working at City Hospital did not have regular contact with leaders, who were predominantly based at Sandwell Hospital, in the service and as such were not getting regular one to one performance supervision.

Staff were not receiving regular one to one meetings and staff raised concerns that junior staff were feeling pressure to perform duties before they were signed off as competent, due to low staffing.

The trust had a performance development review (PDR) programme known as Aspiring to Excellence PDR. Section D of the PDR contained the Future Aspirations and Personal Development Plan and encouraged individuals to discuss the aspirations and plans for next three years. This serves two purposes; purpose one to identify anyone who was looking to retire or leave their role in the next three years and purpose two to identify those employees who demonstrated high performance and potential.

To support the succession planning, those high performing and high potential employees would have access to a programme of talent management with opportunities including shadowing, exposure to meetings and forums that they previously would not have attended, coaching and mentoring and for appropriate posts, recruiting firstly within the organisation to enable employees to grow and have opportunities to stay working within the organisation. However, staff were not aware of this initiative but praised the trust's approach to development.

A consultant paediatrician was available for immediate telephone advice for acute problems for all specialties. This was in line with the Royal College of Paediatrics and Child Health Facing the Future standards 2015. The paediatric inpatient units adopted an attending consultant or 'consultant of the week' system.

Anaesthetists, theatre and recovery staff had up-to-date competencies. At September 2018, all 10 of the consultants covering paediatric surgical lists had received paediatric training and nine had completed advance paediatric life support. Three consultants had been trained in managing emergencies in paediatric anaesthesia.

However, the service could not provide assurance that there were sufficient nursing staff trained in advanced life support on every shift.

Only 58.26% of the nurses in the neonatal unit were qualified in speciality (QIS), this was less than the 70% recommended by the British Association of Perinatal Medicine (BAPM) guidelines. Regular experienced bank and agency nurses were used to make up the numbers however, the neonatal still had shifts that were regularly unfilled. The matron confirmed most of the permanent staff also worked as bank staff.

At the time of this inspection staff did not receive any training in mental health conditions, learning disability or autism. Staff had mixed understanding of the procedure of who would provide told us that if a patient required observations from a specialist mental health nurse then they would use an

agency who specialised in mental health nurses, with some staff saying they would use a colleague to assist without MH knowledge.

The trust had a nurse apprenticeship scheme which was a trial programme. This was a yearlong course leading to the student becoming a band two healthcare assistant at the end of the programme. The apprentice was supported by a mentor and a sister who had a responsibility for education. The programme involved 20% off the job training where the apprentice could shadow shifts for example, with medics, midwives and for example spend time on labour ward. The aim being provide background experience and insight. Staff we spoke with said that the apprenticeship was very good and they were enjoying their placement. They felt well supported by their colleagues.

Neonatal Unit:

From April 2017 to December 2017, 60.2% of staff within services for children and young people within neonates received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| edical & Dental staff - Hospital | 11 | 20 | 55.0% |
| ualified nursing & health visiting staff | 39 | 63 | 61.9% |

Paediatrics:

Paediatric staff were required to work across both the City Hospital and Sandwell Hospital sites. The data below consists of staff attributed to Priory Ground and Ward D6 including outpatients, Lyndon Ground and Ward D19, and paediatric management.

From April 2017 to December 2017, 58.0% of staff within services for children and young people within paediatrics received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| edical & Dental staff - Hospital | 13 | 39 | 33.3% |
| ualified nursing & health visiting staff | 34 | 42 | 81.0% |

*(Source: Routine Provider Information Request – Succession Planning, Trust data DR519, DR521)*

## Multidisciplinary working

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

Ward rounds were multidisciplinary with a consultant, trainee doctors and nurse attending to review each patient and consider any investigations and plans necessary. A thorough assessment was undertaken within a calm environment. We saw a consultant use an assessment as an opportunity for teaching the trainee staff.

We reviewed 18 records and saw evidence of multidisciplinary discussions and that staff planned discharges in advance.

Staff we spoke with described good multidisciplinary working between teams. Staff told us that they liaised with social services regularly but acknowledged that there were sometimes delays within social services to respond and that they would chase them when required.

There was a psychologist available to see children on the wards and we were told of good links with child and adolescent mental health services (CAMHs). The local CAMHs were used within the children's ward as necessary; and were provided by the local mental health trust. CAMHs staff would call the children's ward on a daily basis for verbal referrals of overnight admissions; they would then visit the ward if required. This service was available seven days per week.

There were two play specialists who covered both the City Hospital and Sandwell Hospital. Staff could request assistance from the play specialists, who could also supply sensory equipment when needed. However, the play specialists were not available seven days a week and only one worked full time. This meant that the wards were often unable to access them when they needed them.

The trust had a policy which covered the transition of young people from paediatric to adult's services. The policy included staff safeguarding responsibilities and outlines a transition pathway for patients aged 14 and above for patients transitioning from within the service and from an external service.

When children and young people were discharged or transferred from the service, there were clear mechanisms for sharing appropriate information. Information was shared with families, and external professionals including GPs. This was to ensure that the child and family fully understood what next steps were.

**CQC Children and Young People's Survey 2016 – Q23**

In the CQC Children and Young People's Survey 2016 the trust scored 8.69 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts."

*(Source: CQC Children and Young People's Survey 2016, RCPCH, trust data DR648)*

## Seven-day services

**Most services were available seven days a week.**

Neonates and ward D19 were open 24 hours a day, seven days a week. Ward D6 and paediatric outpatients were opened on a planned basis to accommodate outpatient activity.

A consultant was available seven days a week with cover out of hours provided by an on-call consultant. All children and young people were reviewed by a consultant everyday

Staff could access diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) seven days a week.

Occupational therapists including physiotherapists were available to visit wards seven days a week. Community therapy services visit the ward after a patient has been referred. Respiratory physiotherapists were available to visit the wards and provide a 24 hour, 7 day a week service as required.

The trust employed two play specialists who worked across the sites. They were not available seven days a week and staff told us that they were not always available when needed due to the number of different areas they covered.

## Health promotion

**The service encouraged patients to manage their own health and national priorities to improve the populations health were supported.**

Information leaflets were available throughout the service providing details on how to manage conditions including diabetes. Information was provided about the children's respiratory service and advice for children with disabilities.

On the neonatal unit we saw supporting literature in relation to breastfeeding premature babies and the benefits of skin-to-skin contact. The neonatal unit promoted breast feeding. The unit had achieved UNICEF Baby Friendly accreditation. This meant the unit was committed to supporting mothers to initiate breastfeeding and encouraged them to exclusively breastfeed for the first six months, while at the same time also supporting parents who chose to bottle-feed.

Staff told us the ward-based dietician was involved in health promotion.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They did not know how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.**

Staff we spoke with were unclear about mental capacity act (MCA) and deprivation of liberties. However, this only applied to children and young people aged 16 and above. Staff told us they would refer patients to the trust safeguarding team if they required a MCA referral. The trust had a mental capacity act policy which included information on assessing capacity in children and young people and when staff can or cannot use the act.

On request we saw a completed parental consent form. Nursing staff we spoke with were not clear on the relevant consent and decision making and could not describe how Gillick competencies or Fraser guidelines were used within the trust.

Clinical staff we spoke with had varying knowledge about the Fraser and Gillick competencies to help assess whether a child had the maturity to make their own decisions without consent of a parent or guardian. Some staff having a comprehensive understanding and others having very limited knowledge.

Staff explained that the consent process was completed by surgeons for children requiring surgery and were reliant on competency and consent being gained at the pre-assessment checks. Prior to treatment staff would print off the relevant forms and agree the contents with the parents, and where relevant the patient. Staff said that without the completed form the patient would not receive their surgery.

There were no examples given of instances where the parents or patient lacked capacity to consent.

Staff we spoke with said that there was no training in restraint techniques and that they would call security if restraint was required. The trust had a restraint policy which was written in line with national guidance.

The trust reported that Mental Capacity Act and Deprivation of Liberty Safeguards training was included within safeguarding training.

# Is the service caring?

## Compassionate care

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

We observed kind and compassionate care being provided by nursing and medical staff within all areas of the children's and young people's service within the hospital. Staff treated individuals with dignity and respect and were calm and polite when talking to children and their parent or carer. All children that we spoke with said that staff were friendly and kind.

We saw staff interacting with children in a kind and considerate manner, and providing privacy and dignity to patients. There were many cards displayed within the ward area thanking staff and the hospital for the care they had provided.

Comments we received from children about their care at the hospital included, "the nurses are really friendly" and "the nurses are nice and they care".

Parents and carers all gave positive feedback about the care their child was receiving. Comments received from parents included, "staff are hardworking and caring.", "staff were all compassionate, supportive and understanding".

Parents praised staff for their hard work and caring but said they were aware that staff were under pressure.

**CQC Children and Young People's Survey 2016**

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

| uestion Number | Question | ge group | rust score | RAG |
|---|---|---|---|---|
| 10 | new members of staff treating your child introduce themselves? | -7 adults | 8.26 | bout the same as other trusts |
| 14 | you have confidence and trust in the members of staff treating your child? | 15 adults | 8.51 | bout the same as other trusts |
| 22 | re members of staff available when your child needed attention? | 15 adults | 8.02 | bout the same as other trusts |
| 42 | you feel that the people looking after your child were friendly? | -7 adults | 8.91 | bout the same as other trusts |
| 43 | you feel that your child was well looked after by the hospital staff? | -7 adults | 8.90 | bout the same as other trusts |
| 44 | you feel that you (the parent/carer) were well looked after by hospital staff? | 15 adults | 7.68 | bout the same as other trusts |
| 58 | s it quiet enough for you to sleep when needed in the hospital? | 8-15 children | 7.15 | bout the same as other trusts |
| 64 | ou had any worries, did a member of staff talk with you about them? | 8-15 children | 8.14 | bout the same as other trusts |
| 74 | you feel that the people looking after you were | 8-15 | 9.26 | bout the same as |

| | | | | |
|---|---|---|---|---|
| | friendly? | children | | other trusts |
| 75 | erall, how well do you think you were looked after in hospital? | 8-15 children | 8.60 | bout the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Emotional support

**Staff provided emotional support to patients to minimise their distress.**

Staff we spoke with were aware of the emotional challenges to children and young people using the service. We saw staff discussing patient's emotional wellbeing during meetings and observed staff providing reassurance and answering children's questions as they arose.

Parents we spoke with said staff gave them emotional support and worked at the families' pace. They told us they felt confident leaving the ward and their child's care with the staff on the ward.

Mothers on the neonates were encouraged to have skin-to-skin contact to promote bonding with their babies. We saw information boards detailing a neonate's parental support group which offered opportunities for parents to meet and opportunities for parents to learn basic life support.

Psychological services were involved with supporting children and young people on the wards. They were used to support children and young people with long term conditions and visited the wards as requested.

**CQC Children and Young People's Survey 2016**

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People's Survey 2016.

**CQC Children and Young People's Survey 2016 questions, emotional support, Sandwell and West Birmingham Hospitals NHS Trust**

| uestion Number | Question | e group | Trust score | RAG |
|---|---|---|---|---|
| 7 | s your child given enough privacy when receiving care and treatment? | 7 adults | 9.09 | bout the same as other trusts |
| 29 | our child felt pain while they were at the hospital, do you think staff did everything they could to help them? | 5 adults | 7.92 | bout the same as other trusts |
| 45 | re you treated with dignity and respect by the people looking after your child? | 7 adults | 9.00 | bout the same as other trusts |
| 65 | re you given enough privacy when you were receiving care and treatment? | 8-15 children | 9.04 | bout the same as other trusts |
| 67 | ou felt pain while you were at the hospital, do you think staff did everything they could to help you? | 8-15 children | 8.40 | bout the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.

0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

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

**Staff did not always involve those close to patients in decisions about their care and treatment.**

Children being cared for within the children and young people's service they were kept informed about their care and treatment at the hospital. Children told us that nurses and doctors took time to fully explain any procedures to them and ensured they understood what was happening. During ward rounds we saw consultants and doctors talking to children in a calm and relaxing manner.

Language was used that was age appropriate and would be easily understood by the child. Medical plans for the patient were fully discussed with parents and carers, and time was provided for children to ask questions. Parents said staff listened to them, and did what they could to give comprehensive answers to any questions.

We were told that access to interpreters or a language line could be arranged and wherever possible staff would assist.

We saw parental involvement was encouraged in the anaesthetic and recovery areas of the operating theatre department. We observed staff explain surgical procedures to children and their parents. A named nurse was allocated to each child or young person and they and their parents knew which nurse was looking after them.

There were pre-assessment consultations which provided the opportunity for information to be given to children and young people and their parents about planned procedures. It also offered the chance for children and young people and parents to visit the environment where they would be cared for.

At Birmingham and Midland Eye Centre we saw a young person visit the service in preparation for their transition from children's services to adult's services. We saw staff talk to the patient in an open and transparent way, explaining the differences between the services.

Mothers and children said they felt included in the decision-making process and noted that they were sensitive to their family requirements. However, a few fathers said they had felt excluded from some aspects of the patients care. We were told that they "often felt left out" and were asked to leave the wards after visiting hours as only one parent could stay. There was an automatic assumption that the mother would be the one staying. We were given an example of a mother being given detailed information on her child's condition whilst the father received a brief and conflicting overview. The mother was also asked to decide on treatment options whilst the father had not been afforded the same opportunity. We were also given examples of mother's being given food and drink but the fathers were not.

**CQC Children and Young People's Survey 2016**

The trust performed worse than other trusts for one question and about the same as other trusts for 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016. No score was available in relation to question 66 'If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?'

**CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Sandwell and West Birmingham Hospitals NHS Trust**

| uestion Number | Question | e group | Trust score | RAG |
|---|---|---|---|---|
| 11 | members of staff treating your child give you information about their care and treatment in a way that you could understand? | 5 adults | 9.06 | bout the same as other trusts |
| 12 | members of staff treating your child communicate with them in a way that your child could understand? | 7 adults | 7.06 | Vorse than other trusts |
| 13 | a member of staff agree a plan for your child's care with you? | 5 adults | 9.10 | bout the same as other trusts |
| 15 | staff involve you in decisions about your child's care and treatment? | 5 adults | 8.51 | bout the same as other trusts |
| 16 | re you given enough information to be involved in decisions about your child's care and treatment? | 5 adults | 8.60 | bout the same as other trusts |
| 17 | hospital staff keep you informed about what was happening whilst your child was in hospital? | 5 adults | 8.37 | bout the same as other trusts |
| 18 | re you able to ask staff any questions you had about your child's care? | 5 adults | 8.77 | bout the same as other trusts |
| 31 | ore your child had any operations or procedures did a member of staff explain to you what would be done? | 5 adults | 9.34 | bout the same as other trusts |
| 32 | ore the operations or procedures, did a member of staff answer your questions in a way you could understand? | 5 adults | 9.28 | bout the same as other trusts |
| 34 | erwards, did staff explain to you how the operations or procedures had gone? | 5 adults | 9.12 | bout the same as other trusts |
| 39 | en you left hospital, did you know what was going to happen next with your child's care? | 5 adults | 8.23 | bout the same as other trusts |
| 41 | you feel that the people looking after your child listened to you? | 7 adults | 8.58 | bout the same as other trusts |
| 59 | hospital staff talk with you about how they were going to care for you? | 8-15 children | 8.91 | bout the same as other trusts |
| 60 | en the hospital staff spoke with you, did you understand what they said? | 8-15 children | 8.78 | bout the same as other trusts |
| 61 | you feel able to ask staff questions? | 8-15 children | 9.03 | bout the same as other trusts |
| 62 | the hospital staff answer your questions? | 8-15 children | 9.79 | bout the same as other trusts |
| 63 | re you involved in decisions about your care and treatment? | 8-15 children | 6.55 | bout the same as other trusts |
| 66 | ou wanted, were you able to talk to a doctor or nurse without your parent or carer being | 12-15 children | o Score | No Score |

| | | | | |
|---|---|---|---|---|
| | there? | | | |
| 69 | ore the operations or procedures, did hospital staff explain to you what would be done? | 8-15 children | 9.75 | bout the same as other trusts |
| 70 | erwards, did staff explain to you how the operations or procedures had gone? | 8-15 children | 8.81 | bout the same as other trusts |
| 72 | en you left hospital, did you know what was going to happen next with your care? | 8-15 children | 7.77 | bout the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12-15 children = asked of children aged from 12 to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Is the service responsive?

### Service delivery to meet the needs of local people

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

Each paediatric area had a child friendly play area. Ward D19 was decorated with murals on the ceiling and had child friendly posters on the ward. Ward D6 had recently been relocated from the Birmingham Treatment Centre and as such was still decorated as an adult ward. Staff had added posters and children's pictures to the walls. There was no adolescent area in City Hospital however, both wards had single rooms available which could accommodate teenagers or a child or young person who started to display behaviour that is challenging.

The neonatal unit had a separate waiting area for children visiting the unit. However, the play area was located at the end of the corridor and had limited toys and equipment. We also saw that plug sockets did not have child protection covers. There were plans by the trust to remove this area to allow the milk fridge room to be extended. Discussions were underway as to where the child area would be relocated.

On ward D19 and the neonatal unit, we saw parent kitchens which provided the basic amenities such as sink, kettle and microwave. We also saw that family rooms were available for parents to use overnight. However, two of the rooms were currently out of use due to an infection outbreak. One parent was permitted to remain on the ward with the child overnight and large reclining chairs were available at the bed side.

Each bed had a white board on which magnetic stickers were used to identify patients requiring additional care such as nil by mouth or risk of falls. We also saw the use of curtains to aid patient's privacy and dignity.

Staff we spoke with said that Wi-Fi was not available at City Hospital which meant that children and young people could not access the intranet during their stay.

On our 2017 inspection we noted that there were no separate waiting areas for children and young people. designated play areas within Birmingham and Midland Eye Centre (BMEC) and that privacy and dignity was not protected in orthoptics. We noted on this inspection that BMEC had introduced child play areas into each of their waiting rooms; these contained age appropriate toys and equipment. The surgical recovery area had a five-bedded bay sectioned off for children. The bay had

murals of cartoon characters and we saw child friendly posters. The bay had sectioning so children could be separated from adults.

Staff we spoke with in orthoptics told us that every effort had been made to ensure that the treatment rooms were booked to accommodate patient's privacy and dignity. They ensured that patients were not seen in an area directly opposite one another and wherever possible used the single treatment room. We saw architectural plans to renovate the treatment rooms into six single use rooms. However, staff were not aware of the timelines for this to take place.

**CQC Children and Young People's Survey 2016**

The trust performed about the same as other trusts for all 17 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

**CQC Children and Young People's Survey 2016 questions, responsive domain, Sandwell and West Birmingham Hospitals NHS Trust**

| Question Number | Question | e group | Trust score | RAG |
|---|---|---|---|---|
| 4 | most of their stay in hospital what type of ward did your child stay on? | 5 adults | 9.83 | bout the same as other trusts |
| 5 | the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs? | 5 adults | 8.45 | bout the same as other trusts |
| 25 | you have access to hot drinks facilities in the hospital? | 5 adults | 8.08 | bout the same as other trusts |
| 26 | re you able to prepare food in the hospital if you wanted to? | 5 adults | 3.68 | bout the same as other trusts |
| 28 | w would you rate the facilities for parents or carers staying overnight? | 5 adults | 7.22 | bout the same as other trusts |
| 55 | s the ward suitable for someone of your age? | 12-15 children | 7.65 | bout the same as other trusts |
| 8 | re there enough things for your child to do in the hospital? | 7 adults | 7.02 | bout the same as other trusts |
| 24 | your child like the hospital food provided? | 7 adults | 5.98 | bout the same as other trusts |
| 37 | a staff member give you advice about caring for your child after you went home? | 5 adults | 8.38 | bout the same as other trusts |
| 38 | a member of staff tell you who to talk to if you were worried about your child when you got home? | 7 adults | 8.06 | bout the same as other trusts |
| 40 | re you given any written information (such as leaflets) about your child's condition or treatment to take home with you? | 5 adults | 7.79 | bout the same as other trusts |
| 56 | re there enough things for you to do in the hospital? | 8-15 children | 6.14 | bout the same as other trusts |
| 57 | you like the hospital food? | 8-15 | 7.76 | bout the same as |

| | | | | |
|---|---|---|---|---|
| | | children | | other trusts |
| 71 | a member of staff tell you who to talk to if you were worried about anything when you got home? | 8-15 children | 7.76 | bout the same as other trusts |
| 73 | a member of staff give you advice on how to look after yourself after you went home? | 8-15 children | 8.13 | bout the same as other trusts |
| 2 | the hospital give you a choice of admission dates? | 7 adults | 3.10 | bout the same as other trusts |
| 3 | the hospital change your child's admission date at all? | 7 adults | 9.54 | bout the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12 to 15 children = asked of children aged from 12 to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Meeting people's individual needs

**The service did not always take account of patients' individual needs.**

Patient care plans were not always person centred and staff were not trained to support children or young people with mental health needs. However, staff were responsive to the individual needs of the patient and their families

Patients care plans were completed, however, they were often generic and were not always person centred. There was scope to introduce aspects of personalised care planning in the care plans, however, this was not always done.

Staff we spoke with could not explain how the service would record information regarding communication needs of people with a disability or sensory loss. It was expected that any communication or accessibility needs would be recorded at pre-admission and recorded on the care plan. However, staff could not provide examples of when this had occurred.

There was no formal agreement with the child and adolescent mental health service (CAMHs). However, CAMHs contacted D19 daily to ask whether there were any children admitted to the ward that fit the clinical criteria for CAMHs. If there were children in the hospital then CAMHs would attend to review. The ward also had access to the trust psychiatrist who could attend ward when required.

Staff were not experienced to support children or young people with mental health needs if their mental health deteriorated. Staff told us that if a child requires extra observations from staff then this would be delivered by a healthcare assistant or nurse on the ward or from elsewhere in the hospital. This could put the child at extra risk by not having someone who is suitably experienced or trained to conduct their observations.

Transitional arrangements were in place for adolescents. Staff told us they were especially proud of their young people's diabetes service, allergy management and the way acutely ill children were cared for. We saw a young person visit Birmingham and Midland Eye Centre for a one to one tour of the environment in preparation for their transition into adult services. We saw staff talk to the young person about expectations and answered any questions a caring and open manner.

Play specialists were available five days a week from 8am to 4pm. They supported children undergoing procedures on the ward by offering therapeutic play. These activities were best suited to younger children. Older children on the ward had access to age appropriate activities, for example, a games console and portable televisions.

Interpreting services could be arranged to support patients' families whose first language was not English and staff knew how to access the services.

## Access and flow

**People could access the service when they needed it. However, waiting times from treatment were and arrangements to admit, treat and discharge patients were not always in line with good practice.**

Children and young people could be referred into the service via their GP, accident and emergency or via an outpatient clinic. If children required admitting overnight they were transferred into ward D19 or transferred to Lyndon 1 at Sandwell Hospital. For elective admissions, children and young people were seen by pre- admissions within Birmingham Treatment Centre who would complete all necessary paperwork.

Royal College of Paediatrics and Child Health Facing the Future standards 2015 stated every child who was admitted to a paediatric department with an acute medical problem should be seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission. Trust data showed that in June 2018 78.26% of patients were seen within four hours, 95% in July 2018 and 95.45% in July 2018. This showed an improving picture but was below the standard of 100%.

Staff we spoke with said that not every child admitted to a paediatric department with an acute medical problem was seen by a consultant paediatrician within 14 hours of admission. The earliest a child admitted after 6pm would be seen was at 9.30am the following morning, i.e. 15.5 hours after admission. This was not in line with Facing the Future standards 2015. However. the trust was drafting a proposal to enable consultant cover until 8pm so that the 14-hour target could be met.

The service reported that surgery and outpatient clinics were rarely cancelled with less than 24 hours' notice. From June to September 2018, surgery had been cancelled twice with less than 24 hours' notice at the City Hospital and twice at Birmingham Treatment Centre. Within the same period, four clinics had been cancelled across the two sites with less than 24 hours' notice.

Children and young people undergoing emergency eye surgery were admitted ward D19 and transferred to and from the Birmingham and Midland Eye Centre operating theatre department. During the last 12 months, 14,936 children and young people visited the Birmingham and Midlands Eye Treatment outpatient's department and 455 received surgery. There were twice daily consultant-led ward rounds to ensure effective and timely discharges and transfers of children within 23 hours.

On our previous inspection in 2017, we found that 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. The service had since tried to recruit additional paediatric ophthalmologists and had been unsuccessful and were in the process of creating a fellowship role. As such the surgery lists remained the same as they were in 2017.

**Referral to treatment times**

Detailed below are the referral to treatments times for August 2017 to July 2018. The data included completed pathways (inpatient and outpatient) under the minimum wait, maximum wait and average wait for patients aged under 18 years at treatment. The standard for consultant led referral to treatment waiting times was to be seen in 18 weeks. The average maximum wait was 24.5 weeks.

| pecialty | Minimum RTT | Maximum RTT | Average RTT |
|---|---|---|---|
| al surgery | 0 | 52 | 18.99 |
| eneral Surgery | 0 | 36 | 18.11 |
| ology - Paediatric | 8 | 22 | 17.75 |
| ediatric cardiology | 1 | 31 | 15.55 |
| ology | 0 | 42 | 12.89 |
| r nose throat | 0 | 51 | 12.83 |
| ediatric ophthalmology | 0 | 34 | 12.81 |
| stroenterology | 0 | 43 | 12.27 |
| ediatric surgery | 0 | 33 | 11.54 |
| ediatrics | 0 | 48 | 10.1 |
| ematology (clinical) | 0 | 49 | 9.78 |
| rmatology | 0 | 44 | 9.24 |
| munopathology | 0 | 30 | 9.24 |
| in Management | 5 | 14 | 8.75 |
| docrinology | 2 | 20 | 8.68 |
| ediatric neurology | 1 | 30 | 8.28 |
| spiratory medicine | 1 | 16 | 7.22 |
| eneral Medicine | 0 | 28 | 7.0 |
| rdiology | 6 | 6 | 6.0 |
| phrology | 1 | 10 | 5.5 |
| eumatology | 0 | 14 | 5.03 |
| erventional Radiology | 5 | 5 | 5.0 |
| naecology | 0 | 23 | 4.86 |
| in Management - follow up | 0 | 7 | 3.5 |
| hthalmology | 0 | 49 | 2.71 |
| nae-oncology | 0 | 5 | 2.5 |
| nical genetics | 1 | 5 | 2.11 |
| auma & orthopaedics | 0 | 42 | 1.99 |
| east surgery | 0 | 13 | 1.85 |
| aesthetics | 1 | 1 | 1.0 |
| lorectal | 1 | 1 | 1.0 |
| ute internal medicine | 0 | 4 | 0.08 |
| nae-colposcopy | 0 | 0 | 0 |

**Did not attend**

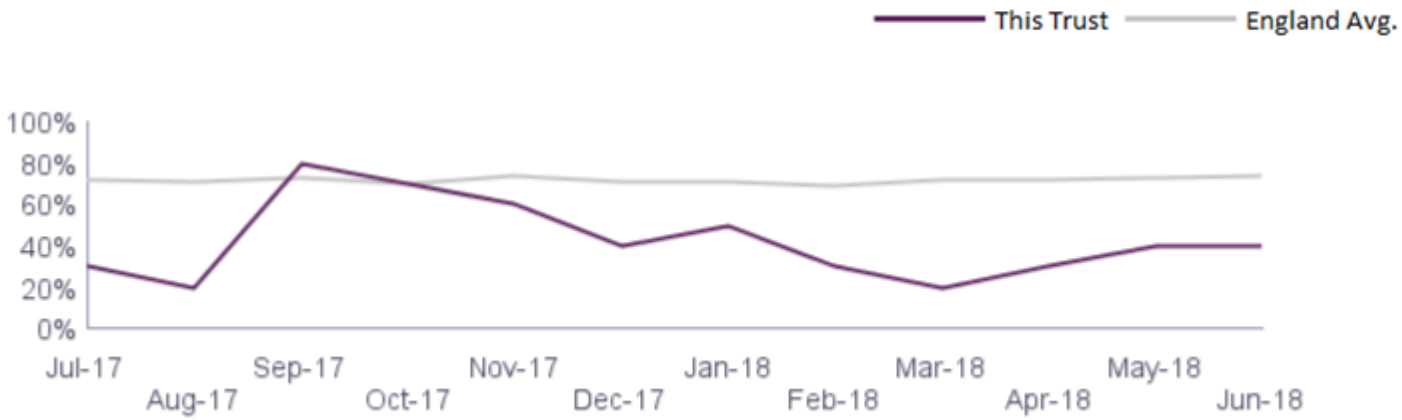
The trust collected data relating to patients who did not attend their appointment under three outcomes; discharged, another appointment given or appointment to be made at a later date. The number of did not attend figures for June to September can be found below:

| | Site | | |
|---|---|---|---|
| onth | City | BMEC | BTC |
| n-18 | 147 | 173 | 162 |
| l-18 | 148 | 171 | 152 |
| g-18 | 134 | 156 | 144 |
| p-18 | 71 | 86 | 71 |
| **tal** | **500** | **586** | **529** |

The trust had an access policy which stated that adults who did not attend were discharged back to their GP but children who did not attend were reviewed on a case by case basis.

**Neonatal Critical Care Bed Occupancy**

From June 2017 to May 2018, the trust had 10 open neonatal intensive care and high dependency cots in every month. The neonatal bed occupancy rate at the trust fluctuated but was lower than the national average in 10 of the 12 months over this time period. The exceptions were in September 2017 (80.0% at the trust compared with an England average of 72.5%) and October 2017 (70.0% at the trust compared with an England average of 69.7%).




Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England, Trust Data DR528, DR629, DR630, DR631, DR636, DR637)*

## Learning from complaints and concerns

**The service treated concerns and complaints seriously, investigated them. However, learned lessons from the results were not routinely shared with all staff.**

The trust had a patient advice and liaison service (PALs) and several purple point telephones for patients to access staff to make a complaint or a compliment. The purple point phones were located in corridors and provided details on the numbers to call in multiple languages. However, the purpose

of the purple point was only described in English. We could not locate any leaflets not signage promoting PALs within the City Hospital.

Staff we spoke with understood how to manage complaints made by patients and visitors and would initially work with the complainant to resolve the concern. However, staff did not routinely receive feedback about lessons learned from complaints in part due to the lack of formal team meetings.

The service used child friendly inpatient survey to gather feedback, this consisted of a smiley face scale with tick boxes. We saw these were available on all of the wards.

We reviewed the trust's response to eight complaints relating to services for children and young people at City Hospital. We found that they communicated in an open, honest and sensitive manner. The feedback letters explained how the complaint had been investigated, the outcome and the learning that had been implemented as a result.

**City Hospital**

From April 2017 to March 2018, there were 15 complaints about services for children and young people at City Hospital. The hospital took an average of 32.3 days to investigate and close complaints. This was not in line with their complaints policy, which stated all complaints should be investigated and closed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 7 | 46.7% |
| Patient care | 3 | 20.0% |
| Appointments | 2 | 13.3% |
| Privacy, dignity & well being | 1 | 6.7% |
| Access to treatment or drugs | 1 | 6.7% |
| Communications | 1 | 6.7% |
| Total | 15 | 100% |

**Number of compliments made to the trust**

The trust submitted data that showed from January to June 2018, there were no compliments recorded for services for children and young people at the trust. However, we saw posters on ward walls which showed the teams had received a number of compliments in the form of thank you cards, chocolates and flowers.

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

## Is the service well-led?

### Leadership

**Managers at all levels in the trust did not always have the right skills and abilities to run a service providing high-quality sustainable care. There was little or no attention to succession planning and development of leaders. Staff felt unable to access their leaders.**

Senior managers were not visible and staff felt unsupported. Staff we spoke with said that leaders from matron to more senior managers including executive level were rarely visible at City Hospital and they felt unsupported. Staff described managers as being critical of people and unwilling to consider the day-to-day workings of the wards. However, staff across the service said they felt supported by their immediate colleagues and that the ward managers worked hard to support all staff in difficult circumstances.

Staff shortages led to ward managers stepping back into clinical roles. On our previous inspection in 2014, ward managers told us they rarely had the opportunity to take their protected non-clinical hours. This had not improved and staff we spoke with on this inspection said they were still regularly having to step back into clinical roles despite having protected non-clinical time. This meant that managers were struggling to complete managerial tasks and were having to complete their work outside of their working hours.

Ward leaders said that they did not always have the experience or knowledge that they needed to carry out their roles. We saw a ward being managed by a Band 6 sister who was also fulfilling clinical shifts; it was shared that there was no on-site access to the service leaders at this time however we were advised that service leaders could be accessed at any time by phone. This was during the interim period after the ward manager had retired pending the appointment of the new ward manager.

On the previous 2014 inspection, staff told us there had been a lack of recognition of the neonatal service by the trust's senior management and executive teams, which had resulted in a lack of support. This had been echoed on this inspection, with staff expressing concern of the lack of neonatal experience within the leadership team.

## Vision and strategy

**The trust did not have a strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**

During our previous inspection in March 2017 we found there was no separate strategy for the children and young people service. During this inspection we asked staff if there was a strategy and what it entailed. Only staff within Birmingham Midlands Eye Centre (BMEC) were aware of a strategy. None of the interviewed staff located within paediatrics or neonates were aware of a strategy. Leaders, when interviewed, could not provide an overview of the strategy.

Following the inspection, we requested a copy of the specific vision and strategy for children and young people, and for neonates. The trust provided us with the local strategy for children and young people at BMEC. However, the document consisted of two pages with six strategic objectives including infrastructure, use of resources and auditing. There were no actions, benchmarks or timelines to accompany these objectives other than a statement that the strategy covered a ten-year period. The document was not dated so no start date could be ascertained.

We observed staff displaying the values of the trust. The trust had nine values they described as care standard promises to; "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".

*(Source: Trust data return DR527)*

## Culture

**Managers across the trust did not promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff did not feel respected, valued, supported or appreciated by senior leaders.**

There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated by senior leaders**.**

Staff did not feel supported and felt unsafe. Staff were visibly distressed as they recollected on the staffing pressures, the risks, and the adverse situations they had been placed under. Staff we spoke with said that morale was low and that the service was currently running on goodwill, but that was running low.

Due to a shortage of staff there were staff wellbeing concerns and the team culture was to cope and be resilient. However, it was strongly felt that the situation was not sustainable. Staff were asked to change shifts at short notice and called at home, feeling pressure to cover deficits.

Staff we spoke with said the ward managers and shift leaders were very supportive, but the matron level and above was regarded as being less so. Managers including executive level were not visible. Staff gave examples of the culture being top-down and directive. Not one of fairness, openness, transparency, honesty, challenge and candour. Staff were not always taken seriously, appropriately supported, or treated with respect when they raised concerns.

Consultants had written a letter to management last winter which addressed concerns about the lack of nurses and how they felt unsupported. Consultants we spoke with said they felt unsafe on the ground and were not working in line with national guidelines. Inspectors were shown the management team's response to this letter which included an action plan, 'you said – we did' presentation and were informed of the engagement of the senior management team with the consultants at Consultant meetings and QIHD.

However, we saw that staff worked well together and there were positive working relationships between the multidisciplinary team. It was evident that all grades of staff within the children and young people's service were passionate about their work and with improving the health outcomes for the patients that they cared for.

Senior leaders of the service said that although it was a constantly busy and challenging environment, they were proud of their teams and commitment staff showed in pulling together to get the work done.

Staff we spoke with within BMEC said they felt that morale had improved and that the service provided was of a high quality. They were proud of the changes they had made to the service since the previous inspection. However, staff said that morale had been low after the last report and had felt that leaders had blamed them for the rating.

## Governance

**The service did not use a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

Staff we spoke with were unclear of the governance structure within the service. Staff within the service told us that team meetings did not happen and as such they felt they were not given opportunity to feed into improvements to the service.

Governance meetings were held bi-monthly to discuss risks, with senior managers, clinical managers and directors attending these meetings. Departmental risk and safety meetings were held every two weeks. Specialty leads attended a monthly paediatric risk meeting and clinical effectiveness meeting. The outcomes from both meetings fed into the trust governance structure, reporting into the executive board. However, we were unable to evidence how effective these meetings were.

The service had monthly safeguarding meetings which had standing agenda items such as maternity service, health visiting service, paediatric service, serious case reviews, domestic violence update, safeguarding children training, prevent, quality assurance and performance and audits. We reviewed three sets of minutes and found no updates from the paediatric service documented.

The medical director had oversight and lead on the implementation of the quality plan which had sepsis as one focal area. A consultant anaesthetist acted as the trust sepsis lead with support from a consultant paediatrician and neonatal consultant in the women and child health directorate

The paediatric service did not hold separate mortality and morbidity meetings to discuss patient deaths. However, we saw a trust wide learning from deaths committee was in place. This committee discussed deaths across the trust and had action points to be completed with clear review dates documented. In addition, paediatric and neonatal deaths were clearly discussed and documented within clinical governance meetings. The service had a child death lead paediatric consultant who convened learning investigation meetings in the event of a child death or incidence of morbidity.

BMEC held quarterly paediatric ophthalmology governance and oversight meetings to demonstrate achievement against targets, learning from each other and development of the service to children and young people. Staff within BMEC had attended team meetings and felt empowered to feed into the service improvements.

*(Source: Trusts data DR505, DR506 and DR640)*

## Management of risk, issues and performance

**The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

There were 32 live risks on the paediatric risk register of which 12 related to ward D19, paediatric outpatients and paediatrics. The risk register did not contain dates for when the risks were added and there were dates missing for the target date and next review date. This meant that the trust would not be aware of how long risks had been on the risk register or when the risks would need to be reviewed.

The risk register was not always completed in full, an example being below and had been added to the register twice:

| | | | | |
|---|---|---|---|---|
| omen & Child Health | ediatrics | ediatric OPD (S) | 94 | w ways of working may lead to Paediatric OPD departments at Sandwell and Birmingham treatment centre children opd. |

There were 21 risks on the neonate's risk register. Whilst more complete than the paediatric register, the risk register also did not contain dates for when the risks were added.

We saw risk assessments had been completed for risks such as the milk fridge room being unfit for purpose. However, we saw that some risk assessments had been completed after the risk was raised on inspection. This meant that leaders were not always sighted on the risks as they occurred.

Staff we spoke with were unaware of the main risks on each register and said they had not received information relating to the risks.

Neonatal mortality and morbidity meetings were held every month where serious incidents were presented. These were a multidisciplinary forum attended by consultants, doctors, nurses, anaesthetists and members of the resuscitation team. The paediatric service did not have a standalone mortality and morbidity meeting but did employ a child death lead Paediatric Consultant who was also the risk lead, who convened learning investigation meetings in the event of a child death or incidence of morbidity.

*(Source: Trust data DR 504, DR573, DR574, DR575)*

## Information management

**The service did not consistently collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards**

Staff were unaware of what information was used in reporting or performance management. Leaders and staff did not always receive information to enable them to challenge and improve performance**.**

Paediatric staff including some leaders we spoke with were unaware of what information was available to aid improvement in the service. They were unable to explain how they measured or collected patient outcomes and how improvements were made to the service. Staff were not regularly having team meetings and as such had little opportunity to feed into any development streams.

Computer stations were available so that staff could access the intranet and internet on the children and young people's wards. Staff we spoke with said there were issues with the information technology (IT) policies blocking their access to the internet. This meant they could not always access work-related tools such as the child sexual exploitation screening tool. They had raised this with the IT department but it had yet to be resolved.

There were long standing concerns with the trust's internet facility. Staff told us that there was little assurance that the newly anticipated electronic patient system would be supported by the trust's current network infrastructure.

The service used paper-based records. This meant that medical and nursing staff were unable to electronically access patient information documented within the community, although discharge letters were accessible. Senior managers told us that a move to electronic records was a priority for the trust although no timescale was given

There were quality information boards outside each ward and, except for neonates, we found these to be empty or out of date. When compared to other wards, not within the service, we saw information such as staffing figures, hand hygiene audit results and friends and family test result. These provided patients and visitors with an overview of the ward.

There were paediatric sepsis awareness posters throughout the children's and young people's clinical areas.

## Engagement

**The trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively**

There was minimal engagement with people who use services, staff, the public or external partners. Feedback was not always reported or acted on in a timely way.

Leaders could not identify any formal engagement methods with patients or their families and carers. They identified this as an area that they needed to focus on in the future. We were told that in the past there had been a session with matron and clinical director in the play areas on the ward but this was not taking place at the time of our inspection.

There was a children and young people paper-based feedback survey was used to ask parents and children about the service. Staff told us how they had tried various initiatives to improve response rates but that it remained a challenge.

Staff told us they did not feel actively involved in change in the organisation. Team meetings were not occurring regularly or at all and staff did not have access to minutes.

## Learning, continuous improvement and innovation

**There was knowledge of improvement methods and the skills to use them at all levels of the organisation. There were organisational systems to support improvement and innovation work.**

Post our inspection in 2017, Birmingham and Midland Eye Centre had worked together to redesign their waiting and clinical areas to make them more appealing to children. We saw child play areas within each waiting room, stocked with age appropriate toys and books. We also saw posters and toys within the clinical areas.

The trust had an infant feeding team whose local role was to support midwives, and families particularly those whose infants have been identified as having medical risk with impact on breastfeeding. There had been small improvements which had made a difference. Charity monies meant that pumps could be supplied to mums so that they could pump at home. This was important as the supply of milk can run out if not measured and accounted for requiring the unavoidable use of formula. The team had also seen an improvement in breastfeeding outcomes.

The trust had a nurse apprenticeship scheme with apprentices in training across the services as part of an NHS wide programme. This was a yearlong course leading to the student becoming a band two healthcare assistant at the end of the programme.

# Community inpatient services

Facts and data about this service

**Wards and departments**

The trust has reported a provision of 131 adult community beds on six nurse led wards, split across three sites at Rowley Regis Hospital, Leasowes Intermediate Care Centre and the Sheldon block on the City Hospital site. We inspected Rowley Regis Hospital and Leasowes Intermediate Care centre only.

There are three medically fit for discharge (MFFD) wards which account for 69 inpatient beds. These are located on the McCarthy and Eliza Tinsley wards at Rowley Regis Hospital, as well as D43 in Sheldon block at City Hospital. MFFD wards receive patients transferred from the acute wards that are deemed well enough for discharge but require ongoing nursing care and cannot be discharged to their normal place of residence. Reasons for this might include awaiting a package of care or placement to a residential or nursing home. The majority of these patients do not require therapeutic rehabilitation although maintenance therapy continues. Referrals to these MFFD wards are co-ordinated by the capacity team in liaison with the senior ward staff.

The trust's 62 intermediate care (IMC) beds are on Henderson ward at Rowley Regis Hospital, Leasowes Intermediate Care Centre and ward D47 in the Sheldon block at City Hospital. These patients no longer require acute medical care but have a continued requirement for intensive rehabilitation. Physiotherapists, occupational therapists and rehabilitation support workers, in liaison with the patient and their family/carers, design rehabilitation programmes based on individual needs. Referrals to IMC beds are conducted through a trusted therapy model with clearly documented rehabilitation goals, accepting patients as a step down from the acute bed base and a step up from the trust's community team, on recognition of specific patient need.

Medical cover on these nurse-led wards is delivered by two local GP practices attending daily. In liaison with the multi-disciplinary team (MDT), they adopt a flexible approach in their attendance and are readily available by phone to respond to any additional issues.

The wider MDT includes social workers and pharmacists available daily and speech and language therapists and dieticians on request. These wards adopt a collective trust approach to consistency of care, reporting safety checks daily through the matron and group director of nursing.

*(Source: Routine Provider Information Request – Context CHS tab)*

A breakdown of community inpatient wards with number of beds is provided in the table below:

| Site | Ward name | Patient group | Number of beds | Services provided |
|---|---|---|---|---|
| City Hospital | D43 ward | Mixed | 27 | Medically fit for discharge (MFFD) ward |
| City Hospital | D47 ward | Mixed | 20 | Intermediate care (IMC) |
| Rowley Regis Hospital | Henderson ward | Not specified | 24 | Intermediate care (IMC) |
| Rowley Regis Hospital | Eliza Tinsley Ward | Mixed | 24 | Medically fit for discharge (MFFD) ward |
| Rowley Regis Hospital | McCarthy ward | Mixed | 16 | Medically fit for discharge (MFFD) ward |
| Leasowes Intermediate Care Centre | Leasowes | Mixed | 18 plus 2 palliative care beds | Intermediate care (IMC) |

*(Source: Routine Provider Information Request (RPIR) – P2 Sites tab)*

**Percentage of patients that are children**

From April 2017 to March 2018, no patients attending community inpatient services were identified as being a child aged 17 years or under.

*(Source: Routine Provider Information Request – Children tab)*

## Is the service safe?

**Mandatory training**

**The service provided mandatory training in key skills to all staff and took steps to make sure everyone completed it. However, compliance was low in some areas such as information governance.**

This meant the trust could not assure itself that staff had completed all aspects of mandatory training deemed essential for safe and efficient service delivery and personal safety.

**Mandatory training completion rates**

The trust set a target of 95% for the completion of mandatory training.

**Trust level**

**Nursing staff**

A breakdown of trust level compliance for mandatory training courses as at July 2018 for qualified nursing staff in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Equality & diversity | 64 | 64 | 100.0% | 95% | Yes |
| Medical devices competency form | 64 | 64 | 100.0% | 95% | Yes |
| Introduction to information governance | 37 | 37 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 64 | 64 | 100.0% | 95% | Yes |
| Transfusion | 1 | 1 | 100.0% | 95% | Yes |
| Fire response team leader or refresher training | 2 | 2 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 63 | 64 | 98.4% | 95% | Yes |
| Fire safety - workplace training | 61 | 62 | 98.4% | 95% | Yes |
| Health & safety | 62 | 64 | 96.9% | 95% | Yes |
| Conflict resolution update | 29 | 30 | 96.7% | 95% | Yes |
| Resuscitation: basic life support | 61 | 64 | 95.3% | 95% | Yes |
| Infection control | 61 | 64 | 95.3% | 95% | Yes |
| Medicines management | 59 | 64 | 92.2% | 95% | No |
| Moving and handling - patient handling | 55 | 64 | 85.9% | 95% | No |
| Medical devices training | 26 | 31 | 83.9% | 95% | No |
| Information governance refresher module | 19 | 27 | 70.4% | 95% | No |

Nursing staff in the community inpatient core service met the trust's target of 95% overall, with a completion rate of 95%. The target was met for 12 of the 16 mandatory training courses made available to staff, six of these attaining a score of 100%. However, it should be noted that, for two of the training courses where a 100% completion rate was observed, the number of eligible staff was very low. As a result, these staff accounted for a higher proportion of the total than for other training courses in the same group.

The course with the lowest completion rate was the information governance refresher module with 70.4%.

**Healthcare assistants**

A breakdown of trust level compliance for mandatory training courses as at July 2018 for healthcare assistants in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Harassment & bullying level 1 | 75 | 75 | 100.0% | 95% | Yes |
| Equality & diversity | 75 | 75 | 100.0% | 95% | Yes |
| Fire safety warden or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Conflict resolution update | 22 | 22 | 100.0% | 95% | Yes |
| Introduction to information governance | 43 | 43 | 100.0% | 95% | Yes |
| Moving and handling - non- patient limited load handling | 1 | 1 | 100.0% | 95% | Yes |
| Medical devices competency form | 61 | 61 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 74 | 75 | 98.7% | 95% | Yes |
| Health & safety | 74 | 75 | 98.7% | 95% | Yes |
| Fire safety - workplace training | 73 | 74 | 98.6% | 95% | Yes |
| Infection control | 72 | 75 | 96.0% | 95% | Yes |
| Resuscitation: basic life support | 68 | 74 | 91.9% | 95% | No |
| Moving and handling - patient handling | 65 | 74 | 87.8% | 95% | No |
| Medical devices training | 23 | 32 | 71.9% | 95% | No |
| Information governance refresher module | 22 | 32 | 68.8% | 95% | No |

Healthcare assistants in the community inpatient core service almost met the trust's target of 95% overall, with a completion rate of 94.9%. The target was met for 11 of the 15 mandatory training courses made available to staff, seven of these attaining a score of 100%. However, it should be noted that, for two of the training courses where a 100% completion rate was observed, there was only one number of eligible staff.

The course with the lowest completion rate was the information governance refresher module with 68.8%.

**Medical and dental staff**

The trust did not provide mandatory training data for medical staff within the community inpatient core service. They informed us their community inpatients service was predominantly a nurse-led therapy service with medical provision provided by local General Practitioners (GPs).

**Leasowes Intermediate Care Centre**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Medical devices competency form | 14 | 14 | 100.0% | 95% | Yes |
| Infection control | 14 | 14 | 100.0% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Equality & diversity | 14 | 14 | 100.0% | 95% | Yes |
| Medicines management | 14 | 14 | 100.0% | 95% | Yes |
| Introduction to information governance | 9 | 9 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 14 | 14 | 100.0% | 95% | Yes |
| Medical devices training | 14 | 14 | 100.0% | 95% | Yes |
| Conflict resolution update | 7 | 7 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Health & safety | 13 | 14 | 92.9% | 95% | No |
| Resuscitation: basic life support | 13 | 14 | 92.9% | 95% | No |
| Fire safety - workplace training | 13 | 14 | 92.9% | 95% | No |
| Moving and handling - patient handling | 12 | 14 | 85.7% | 95% | No |
| Information governance refresher module | 4 | 5 | 80.0% | 95% | No |

Nursing staff in the community inpatient core service at Leasowes Intermediate Care Centre met the trust's target of 95% overall, with a completion rate of 96.6%. The target was met for nine of the 14 mandatory training courses made available to staff, nine of these attaining a score of 100%. However, it should be noted that, for two of the training courses where a 100% completion rate was observed, the number of eligible staff was lower. As a result, these staff accounted for a higher proportion of the total than for other training courses in the same group.

The course with the lowest completion rate was the information governance refresher module with 80%.

**Healthcare assistants**

A breakdown of compliance for mandatory training courses as at July 2018 for healthcare assistants in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Medical devices competency form | 14 | 14 | 100.0% | 95% | Yes |
| Equality & diversity | 14 | 14 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 14 | 14 | 100.0% | 95% | Yes |
| Health & safety | 14 | 14 | 100.0% | 95% | Yes |
| Introduction to information governance | 4 | 4 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 14 | 14 | 100.0% | 95% | Yes |
| Conflict resolution update | 10 | 10 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Resuscitation: basic life support | 13 | 14 | 92.9% | 95% | No |
| Moving and handling - patient handling | 12 | 14 | 85.7% | 95% | No |
| Information governance refresher module | 8 | 10 | 80.0% | 95% | No |
| Infection control | 11 | 14 | 78.6% | 95% | No |

Healthcare assistants in the community inpatient core service at Leasowes Intermediate Care Centre almost met the trust's target of 95% overall, with a completion rate of 94.7%. The target was met for eight of the 12 mandatory training courses made available to staff, eight of these attaining a score of 100%. However, it should be noted that, for one of the training courses where a 100% completion rate was observed, there were only four eligible staff.

The course with the lowest completion rate was the infection control module with 78.6%.

**Rowley Regis Hospital**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire response team leader or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Introduction to information governance | 12 | 12 | 100.0% | 95% | Yes |
| Equality & diversity | 24 | 24 | 100.0% | 95% | Yes |
| Health & safety | 24 | 24 | 100.0% | 95% | Yes |
| Medical devices competency form | 24 | 24 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 24 | 24 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 23 | 23 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 23 | 24 | 95.8% | 95% | Yes |
| Conflict resolution update | 12 | 13 | 92.3% | 95% | No |
| Resuscitation: basic life support | 22 | 24 | 91.7% | 95% | No |
| Infection control | 22 | 24 | 91.7% | 95% | No |
| Medical devices training | 11 | 13 | 84.6% | 95% | No |
| Moving and handling - patient handling | 20 | 24 | 83.3% | 95% | No |
| Medicines management | 20 | 24 | 83.3% | 95% | No |
| Information governance refresher module | 7 | 12 | 58.3% | 95% | No |

Nursing staff in the community inpatient core service at Rowley Regis Hospital did not meet the trust's target of 95% overall, with a completion rate of 92.8%. The target was met for eight of the 15 mandatory training courses made available to staff, seven of these attaining a score of 100%. However, it should be noted that, for one of the training courses where a 100% completion rate was observed, the number of eligible staff was very low. As a result, these staff accounted for a higher proportion of the total than for other training courses in the same group.

The course with the lowest completion rate was the information governance refresher module with 58.3%.

**Healthcare assistants**

A breakdown of compliance for mandatory training courses as at July 2018 for healthcare assistants in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Introduction to information governance | 17 | 17 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 32 | 32 | 100.0% | 95% | Yes |
| Medical devices competency form | 31 | 31 | 100.0% | 95% | Yes |
| Health & safety | 32 | 32 | 100.0% | 95% | Yes |
| Equality & diversity | 32 | 32 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 32 | 32 | 100.0% | 95% | Yes |
| Moving and handling - non- patient limited load handling | 1 | 1 | 100.0% | 95% | Yes |
| Conflict resolution update | 2 | 2 | 100.0% | 95% | Yes |
| Fire safety - workplace training | 32 | 32 | 100.0% | 95% | Yes |
| Infection control | 32 | 32 | 100.0% | 95% | Yes |
| Moving and handling - patient handling | 30 | 31 | 96.8% | 95% | Yes |
| Resuscitation: basic life support | 29 | 31 | 93.5% | 95% | No |
| Information governance refresher module | 9 | 15 | 60.0% | 95% | No |
| Medical devices training | 7 | 16 | 43.8% | 95% | No |

Healthcare assistants in the community inpatient core service at Rowley Regis Hospital almost met the trust's target of 95% overall, with a completion rate of 94.6%. The target was met for 11 of the 14 mandatory training courses made available to staff, 10 of these attaining a score of 100%. However, it should be noted that, for two of the training courses where a 100% completion rate was observed, the number of eligible staff was very low. As a result, these staff accounted for a higher proportion of the total than for other training courses in the same group.

The course with the lowest completion rate was the medical devices module with 43.8%. This meant not all staff had the training, competency and skills needed safe and appropriate use of all medical devices.

The low compliance rate for information governance refresher module training meant the trust could not assure itself that all staff were aware of the right processes to protect patients and service users and their information.

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

The different modes of mandatory training offered flexibility for staff, helped to improve completion rates and ensured staff completed the training deemed essential for safe and efficient service delivery and personal safety. This helped reduce organisational risks and complied with local policies and/or government guidelines.

Mandatory training consisted of face to face training and 'reading' and 'eLearning modules. Link nurses provided staff with support around mandatory training and cascade trainers on the ward provided training in areas such as basic life support (BLS) and moving and handling.

Managers had oversight of mandatory training compliance and identified actions to improve compliance. Managers discussed mandatory training in governance meetings. For example, in a governance meeting in September 2018 it was identified there were issues with compliance with BLS training. Managers recorded that a BLS trainer was now in place and managers needed to get staff booked onto training sessions as soon as possible. At the time of our inspection compliance ranged from 92% to 95% (full compliance).

**Safeguarding**

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

**Safeguarding Training completion**

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of trust level compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 64 | 64 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 64 | 64 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 63 | 64 | 98.4% | 95% | Yes |

Nursing staff in the community inpatient core service met the trust's target of 95% overall, with a completion rate of 99.5%. The target was met for all four safeguarding training courses made available to them, three of these attaining a score of 100%.

**Healthcare assistants**

A breakdown of trust level compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 75 | 75 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 75 | 75 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 73 | 74 | 98.6% | 95% | Yes |

Healthcare assistants in the community inpatient core service met the trust's target of 95% overall, with a completion rate of 99.6%. The target was met for all three safeguarding training courses made available to them, two of these attaining a score of 100%.

**Medical and dental staff**

The trust did not provide safeguarding training data for medical staff as part of the community inpatient core service. They informed us their community inpatients service was predominantly a nurse-led therapy service with medical provision provided by local GPs.

**Leasowes Intermediate Care Centre**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 14 | 14 | 100.0% | 95% | Yes |

Nursing staff in the community inpatient core service at Leasowes Intermediate Care Centre met the trust's target of 95% overall, with a completion rate of 100%.

**Healthcare assistants**

A breakdown of compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 14 | 14 | 100.0% | 95% | Yes |

Healthcare assistants in the community inpatient core service at Leasowes Intermediate Care Centre met the trust's target of 95% overall, with a completion rate of 100%.

**Rowley Regis Hospital**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 24 | 24 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 24 | 24 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 24 | 24 | 100.0% | 95% | Yes |

Nursing staff in the community inpatient core service at Rowley Regis Hospital met the trust's target of 95% overall, with a completion rate of 100%.

**Healthcare assistants**

A breakdown of compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 32 | 32 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 31 | 31 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 32 | 32 | 100.0% | 95% | Yes |

Healthcare assistants in the community inpatient core service at Rowley Regis Hospital met the trust's target of 95% overall, with a completion rate of 100%.

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

Staff we spoke with understood how to protect patients from abuse. All eligible nursing and healthcare assistant staff had completed training on how to recognise and report abuse. Safeguarding training compliance meant staff had the knowledge and skills to confidently deal with safeguarding issues.

**Safeguarding referrals**

Staff knew how to protect the health, well-being and human rights of individuals, which allowed people to live free from abuse, harm and neglect.

All staff we spoke with had a good understanding of the principles of safeguarding, including warning signs of abuse such as unexplained bruising and suspicious behaviour. All staff knew how to contact the trust's safeguarding team and could give examples of the kind of safeguarding referrals they had or might make.

The adult and children safeguarding policy was up to date and set out the statutory requirements for staff to safeguard its patients. Policies reflected the safeguarding Intercollegiate guidance (2014). The trust had updated policies against national and local guidance, including female genital mutilation; paediatric liaison service policy, child death policy and the PREVENT agenda.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust only provided safeguarding referrals information at a trust-wide level as they informed us that they were unable to break the data down by core service. Therefore, we are unable to provide any commentary of referrals made solely within the community inpatient core service.

**Trust-wide referrals**

There were 319 adults and 659 child safeguarding referrals trust-wide from April 2017 to March 2018. In relation to the adult referrals, the trust stated that this number included advice given by the safeguarding team, with referrals being accepted by email and telephone. The data included vulnerable adult protection sharing forms; however, inappropriate flags raised were excluded.

Over the 12-month period, the trust noted there were 48 concerns raised with the local authority by the trust and 25 concerns raised about care at the trust with the local authority. None of these concerns led to a section 42 enquiry. An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

*(Source: Routine Provider Information Request – Safeguarding refs tab)*

**Cleanliness, infection control and hygiene**

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

We found high levels of cleanliness across the wards we visited.

Staff followed the trust's infection prevention control policy and prevented the spread of infections such as MRSA. Staff used infection prevention control techniques to prevent spread of infection including hand-washing, use of antibacterial hand gel and use of personal protective equipment such as gloves and aprons. All staff looked well presented in clean and smart uniforms and were bare below the elbows.

Staff protected themselves and others from infection. Hand sanitising gel was available at the entrances of each ward and we observed staff using this on entering and leaving clinical areas. We observed staff reminding visitors and inspectors to the ward to use hand gel before entering and leaving.

Staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the sharps bins were dated and were not filled more than halfway.

Managers had an overview of the infections surveillance data. We reviewed the clinical group infection prevention and control compliance report for April to June 2018. This reported on alert organism surveillance (previous three months), compliance against key infection prevention and control markets, period of increase incidence outbreaks and summary of infection incident review meetings, post infection reviews and summary of infection incident review meetings, compliance against environmental standards and infection prevention and control risks and other infection control initiatives or issues identified by clinical group. Appropriate learning points and actions were

documented to address areas of noncompliance. For example, one patient who was transferred to the trust from an outside trust tested positive for carbapenem-resistant organisms. These are bacteria that have become resistant to treatment by powerful antibiotics. Actions documented were 'The patient was isolated and the room was decontaminated when discharged. The infection control nurse was made aware and advice was taken'.

Managers audited staff compliance with handwashing. This reduced the risk of patients acquiring hospital acquired infections such as MRSA.

Staff generally complied with good basic infection control standards. Hand hygiene results displayed on Leasowes Ward for 9 August 2018 showed full compliance for both staff and visitors. We reviewed the hand hygiene compliance for August 2017 to August 2018. Staff on the Eliza Tinsley Ward achieved 95 % to full compliance. Staff on the Henderson Ward achieved 93% to full compliance. Staff on Leasowes Ward achieved full compliance in 10 out of the 12 months (two months did not display results) and McCarthy Ward staff achieved 91% to full compliance in 11 months, (one month was not recorded).

Staff ensured standards of cleanliness were high to support all the successful efforts to reduce the incidence of healthcare associated infections such as MRSA. Staff completed cleaning audits, identified areas of noncompliance and implemented actions to achieve compliance.

Staff compliance with keeping commodes clean was varied. We reviewed the commode cleanliness audits. The April 2018 audit showed staff fully complied with keeping patients commodes clean. Audit results for July to September 2018 showed staff fully complied on Leasowes and Eliza Tinsley Ward, however staff on the McCarthy Ward demonstrated 66% and Henderson 50% compliance. The March 2018 audit results showed full compliance for Leasowes and Eliza Tinsley Ward staff, 67% for McCarthy ward staff and 0% for Henderson. The trust did not provide us with action plans put in place to address areas on non-compliance.

Staff safely inserted and maintained catheters which showed high standards of infection prevention and *patient* comfort and experience. We reviewed the catheter associated urinary tract infection audits for May to August 2018 and found full staff compliance.

**PLACE (Patient Led Assessments of the Care Environment) Assessments**

Teams of NHS and private/independent health care providers undertake PLACE self-assessments, and these include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration; the extent to which the provision of care with privacy and dignity is supported; and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The PLACE score for cleanliness of the environment at the trust was 99.7% from March to June 2018, based on data for the Leasowes Intermediate Care Centre alone, compared to the national average of 98.8%. The trust scored better than the England average for all four of the aspects overall.

Please note that PLACE scores relate to the whole site and are not specific to inpatient settings.

| Site Name | Cleanliness | Condition Appearance and maintenance | Dementia Friendly | Disability |
|---|---|---|---|---|
| Leasowes Intermediate Care Centre | 99.7% | 97.2% | 90.6% | 95.4% |
| **England average (NHS community only)** | **98.8%** | **93.0%** | **81.0%** | **86.6%** |

*(Source: NHS Digital)*

The above PLACE audit results supported the high levels of cleanliness we found during our inspection.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

The service had systems for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. During our previous inspection, we found clinical and domestic waste storage rooms unlocked and accessible. On this inspection we found staff had took steps to ensure waste management was safe.

Staff stored equipment appropriately and safely. During our previous inspection we found clinical areas and surrounding corridors cluttered due to a lack of storage space for large equipment, such as wheelchairs, beds and mattresses. On this inspection we found staff made the appropriate adjustments to ensure patients and staff were kept safe from environmental hazards. This minimised the risk of healthcare associated infections.

Staff used a mattress audit tool which aimed to identify mattresses and mattress covers in poor condition.

Resuscitation trolleys and defibrillators were now accessible to all staff. This was in line with Resuscitation (UK) guidance which states ‘All clinical service providers must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of the patient in cardiorespiratory arrest’.

Although resuscitation equipment and drugs were always available for use in a cardiac arrest or emergency, they were not always securely stored in tamper-evident containers, in line with resuscitation (UK) guidance. Documentation checks were completed and up to date in all cases.

Therapy staff told us they would participate in trials for new pieces of therapeutic equipment through external companies. Therapy staff would be required to record patient's outcomes for the company and staff could then use this data when requesting funding for the equipment from the trust.

The trust supplied staff with the appropriate amount of apparatus and equipment to facilitate the use of physical therapy and to re-build their patient's strength and endurance. We saw therapists working with patients with grab rails, frames and chairs.

Therapy staff told us of pioneering therapeutic equipment such as a partial body weight support system to offer patients a supported standing harness. This was a piece of equipment therapy staff had on loan to work with physically dependent patients with fear of falls.

Staff ensured and audited the effective and efficient maintenance and repair of medical equipment, and allocated sufficient resources for service and maintenance contracts by external agencies when necessary.

Staff completed environmental audits to ensure patients were cared for with compassion and dignity in a clean, safe environment. We reviewed a sample of these. These audited the overall ward area, sluice, kitchen toilets, patient records and medicine and security. These included aspects to be reviewed, for example, cleanliness and state of repair of re-usable items and specific details such as bed pans and commodes. Actions were taken where compliance was breached. For example, it was found that the clinical room 'door closed but didn't lock'. Staff were reminded to ensure the door was closed when exiting the room until the door was fixed.

The service gathered feedback, directly from patients, about how the environment or services might be enhanced. Leasowes received a PLACE assessment of the environment in September 2018. The report recorded issues and comments and associated actions. For example, assessors identified a dent in the bathroom wall and paintwork flaking and an action to address this was 'wall to be made good and repainted'. We found Leasowes to be in a good state of repair.

**Assessing and Responding to Patient Risk**

Staff we spoke with were clear about the process of dealing with a patient whose condition had deteriorated. The procedure for escalation depended on the level of the problem but varied from seeking advice from the patients GP or facilitating immediate admission to hospital.

Nurses took a holistic approach to their patients and acknowledged and addressed the physiological, psychological, sociological, developmental, and cultural needs of the patient.

Staff completed comprehensive risk assessments for patents and developed risk management plans in line with national guidance such as National Institute for Care and Excellence (NICE). The patient's assessment included a discharge planning, carers information, lifestyle assessment, the Malnutrition Universal Screening Tool (MUST) screening tool, infection control checklist, skin assessment, waterlow risk assessment falls risk assessment tool, moving and handing assessment, activities of daily living and vulnerable persons checklist

Staff had the opportunity to share key information in a systematic and safe way. Effective handovers took place.

Staff reassessed patient's conditions such as pressure ulcers so that they could detect changes in the patient's condition and care needed. During our previous inspection, we found staff undertook initial risk assessments for pressure ulcers on all patients; however, staff did not reassess in accordance with the care plan.

Staff prioritised keeping their patients safe. A safety initiative introduced in 2017 saw staff completing a series of safety checks, also known as always events, when assessing a patient. This happened within the first 24 hours of admission. A system was in place to ensure that any of those missed were then completed within 48 hours. This meant potentially dangerous conditions, like Venous Thromboembolisms (VTE) were more likely to be picked up and treated in a timely manner. Once the condition of the patient was assessed a treatment plan was devised which included looking at their medical history, as well as looking at their current prescriptions and an expected date of discharge.

Staff followed a safety plan which set out 10 clear promises for patients. Safety check compliance was reviewed on a shift by shift basis. These were:

1. Because we complete our Ten out of Ten safety checklist for every patient within 24 hours, all patients will receive expert care. all patients will receive expert care.
2. Because we assess and monitor every patient, and learn from every incident, we will protect patients from harm so that they do not experience pressure ulcers or falls that could be avoided.
3. Because we have outstanding infection control practices, we will prevent avoidable infections in our care.
4. Because we always monitor patients' vital signs at the right time we can and will quickly take action if their condition worsens.
5. Because we involve patients in their care plans, and sign personalised plans, our patients and their carers will be best placed to understand their condition and have an agreed care plan.
6. Because we are committed to providing dementia care in the best possible manner, we will work with carers to always meet the commitments in our focused care plan and John's Campaign.
7. Because we review all patients with antibiotics every 72 hours, patients will only be given

antibiotics when they are needed.
8. Because we always give patients their medication at the right time, no patient will miss out on a dose of medication.
9. Because we give patients clear information about any invasive procedures, patients are able to give informed consent that we will always record.
10. Because we involve patients in their discharge planning, we will usually meet the expected date of discharge and will always follow up home care packages to make sure they are in place. Staff were committed to carrying out these checks within the first 24 hours of admission and correcting them immediately when a check had been missed. Staff reported safety check compliance on a shift by shift basis.

Staff used audits to assure themselves they were offering patients safe and effective care. We reviewed the daily assurance audit for 'Leasowes completed in September 2018. This audited general safety, nutrition, mobility/falls, skin integrity, personalised care, discharge planning.

Staff acted on patient falls by causing change and not only reacting to change when it happened and put action points into practice. All staff received 'prevention of falls' training on induction and annual mandatory training. Staff completed a proactive falls audit at Leasowes in May 2018. The report highlighted common themes such as six out of eight falls were unwitnessed and in three out of the eight cases the patients had been assessed to have full capacity. Key finding and actions were identified. For example, it was found that all the falls occurred in single rooms (for example bedroom or en suite bathroom), patients in isolated areas were at higher risk of falls because of reduced supervision potential and most falls occurred between 9am and midday when it was assumed that patients were involved in group rehabilitation activities in communal areas. Anecdotal data from leadership team walk arounds also noted that there was a lack of communal rehabilitation activities. The action plan was for the ward manager to work in collaboration with the lead therapist to devise a weekly rehabilitation schedule for patients to occur in communal areas with increased supervision, all patients to agree to a rehabilitation contract, and a meeting with the matron and therapy lead to agree joint staffing model to ensure adequate patient supervision. We saw that all patients at risk of falls were cohorted in the activity room with supervision from a healthcare assistant to reduce the number of patient falls. Staff also used mechanisms to reduce patient falls such as motion sensors, non-slip socks and low-rise beds. We saw these actions had been implemented and senior staff told us the number of falls had decreased since implementing the action plan.

Staff had strategies to help identify and resolve any waits or delays in the patient's hospital stay. This enhanced patient experience and reduced the risk factors associated with a prolonged hospital stay.

The daily board round was attended by nursing, healthcare assistant and therapy staff. Areas discussed included length of stay, risk of falls and whether patients had a 'Do not attempt

cardiopulmonary resuscitation'- (DNACPR) in place. Board rounds are a summary discussion of the patient journey and what is required that day for it to progress.

The occurrence of adverse events such as cardiac arrests had not always been minimised. This put the patient's safety at risk. Nurses monitored vital signs as clinically required, and were required to take time appropriate action(s) to prevent an avoidable deterioration in a patient. Managers completed a daily assurance audit to check whether staff had complied with these requirements. However, we reviewed the patient's files for the two current patients who had their vital signs monitored. We found staff had not activated the specific escalation according to the score. We raised this with the ward sister. She reviewed the documentation, agreed with our findings and assured us she would address this.

Staff ensured records were always up to date and staff could access patients integrated care plan daily. Nursing staff used daily care records. These forms recorded the responsible registered nurse for each shift, daily goals patient observations such as oral input and urine output, eating and drinking and repositioning charts.

The trust had equipped staff with the knowledge and skills to assess and respond to patients with suspected or confirmed sepsis. We reviewed the services' sepsis pathway and found this to be in line with The UK Sepsis Trust current guidance. The trust had implemented the national sepsis screening tool from The UK Sepsis Trust. Staff told us they would call 999 if they suspected a patient had sepsis.

Staff told us sepsis had been a big drive within the trust. For example, a quality improvement half day (QIHD) in 2018 included a presentation on key points for sepsis and a case study discussion as part of it being the trusts top priority.

Staff called 111 for out of hours medical advice and support. Nurses told us they had recently been allocated a dedicated line. Staff told us this was a satisfactory arrangement and patients received timely medical attention.

Therapy staff helped reduce unnecessary transfers into both accident and emergency (A&E) departments and admissions, but also eased the patient's journey and ensured timely, appropriate and safe discharge home. The service lead for therapies attended the medically fit for discharge board meetings twice weekly to identify potentially deteriorating patients.

Patients could raise concerns and staff were present within each bay to support patients. Staff had an overview of all patients by way of the board round so all staff were aware of patients with 'do not attempt resuscitation' orders in place, those at risk of falling and patients at risk of deterioration. Staff then undertook bedside handovers for each patient.

**Staffing**

**Safer staffing levels**

**The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

The trust staffed community inpatient services with the appropriate number and mix of clinical professionals vital to the delivery of quality and safe care.

Staff fill rates compared the proportion of planned hours worked by staff (nursing, midwifery and care staff) to actual hours worked by staff (day and night). Community trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; in January 70% of the planned working hours for daytime nursing staff were actually 'filled'.

Details of staff fill rates within community inpatient services for registered nurses and care staff for June 2018, for each community inpatients site was published on the trust's website.

For community inpatient services, there is information for two locations. These are:

- Leasowes Intermediate Care Centre
- Rowley Regis Hospital: Eliza Tinsley, Henderson and McCarthy wards

Fill rates for day and night shifts (%) by location and ward for June 2018 are shown in the tables below:

**Leasowes Intermediate Care Centre**

| Month | Day | | Night | |
|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff |
| Leasowes | 98.9% | 99.0% | 100.0% | 100.0% |

**Rowley Regis Hospital**

| Month | Day | | Night | |
|---|---|---|---|---|
| | Nurses | Care staff | Nurses | Care staff |
| Eliza Tinsley Ward | 92.8% | 96.7% | 100.0% | 103.3% |
| Henderson Ward | 96.6% | 93.1% | 101.6% | 100.0% |
| McCarthy Ward | 100.0% | 95.0% | 100.0% | 100.0% |

**Key**

| > 125% | < 90% |
|---|---|

Please note that safer staffing information available on the trust website for the months before June 2018 did not provide enough detail to extract information for community inpatient services.

*(Source: Safer Staffing Data – Trust website)*

**Nursing staffing**

**Planned versus actual establishment**

The trust reported the following nurse staffing numbers both from April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 99.7 | 122.8 | 81.2% | 95.7 | 117.9 | 81.2% |

Staffing numbers for both periods were similar, with the fill rate in April/May 2018 being the same as the fill rate from April 2017 to March 2018.

Please note, all nursing staff were assigned to the site 'other' as they work at multiple locations. As a result, we were unable to provide a breakdown of this data by site.

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

**Vacancies**

From July 2017 to June 2018, the trust reported an over-establishment of 5.7% for nursing staff in community inpatients trust-wide, compared to the trust's target vacancy rate of 3%. A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: an over-establishment of 17.0%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): 17.2%

The trust noted the discrepancy between their planned versus actual staffing data and for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

**Turnover**

From June 2017 to May 2018, the trust reported an annual turnover rate of 17.8% for nursing staff in community inpatients trust-wide. There was no overall trust-wide turnover target; however, there was a target of 10.5% for band 5 nurses. A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: 19.6%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): 21.3%

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

**Sickness**

From June 2017 to May 2018, the trust reported an annual sickness rate of 6.3% for nursing staff in community inpatients trust-wide which is worse than the overall trust target of 3%. A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: 1.7%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): 8.2%

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

Managers had oversight of sickness rates, discussed sickness in governance meetings and identified actions to improve compliance. For example, in a meeting in August 2018 it was identified there was a delay with closing sickness on the electronic staff record. Actions identified were for all to continue to update the sickness tracker and ensure sickness episodes were closed on ESR.

Managers took the necessary steps to support their staff and manage sickness absence. Managers discussed sickness percentages during ward meetings. We reviewed the ward meeting from June 2018. Managers identified McCarthy had high sickness levels. Action points were the human resources department (HR) would have a regular meeting with the manager to set some action plans, managers asked staff to be aware of the standard operating procedure for sickness and it was shared that managers would do the necessary referral to occupational health/HR if needed and therefore they needed to review staff details such as who's been on long term sickness.

**Nursing – Bank and agency qualified**

Please note the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

**Trust wide**

In community inpatients at a trust wide level from June 2017 to May 2018, 3201 shifts were filled by bank staff and 1,346 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

**Leasowes Intermediate Care Centre**

In community inpatients at Leasowes Intermediate Care Centre from June 2017 to May 2018, 775 shifts were filled by bank staff and 123 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurse's shifts.

**Rowley Regis Hospital**

In community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) from June 2017 to May 2018,1425 shift were covered by bank staff and 454 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

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

**Healthcare assistants**

**Planned versus actual establishment**

The trust reported the following staffing numbers for healthcare assistants both from April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All Sites | 91.2 | 105.6 | 86.4% | 87.5 | 103.2 | 84.8% |

Healthcare assistant staffing numbers for both periods were very similar with a fill rate of 86.4% from April 2017 to March 2018, decreasing slightly to 84.8% in April/May 2018.

Please note, all healthcare assistants were assigned to the site 'other' as they work at multiple locations. As a result, we were unable to provide a breakdown of this data by site.

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

**Vacancies**

From July 2017 to June 2018, the trust reported an over-establishment of 2.6% for healthcare assistants in community inpatients trust-wide, compared to the trust's target vacancy rate of 3%. A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: an over-establishment of 5.2%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): an over-establishment of 0.1%

The trust noted the discrepancy between their planned versus actual staffing data and for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

**Turnover**

From June 2017 to May 2018, the trust reported an annual turnover rate of 8.5% for healthcare assistants in community inpatients trust-wide. There was no overall trust-wide turnover target; A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: 0.0%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): 15.4%

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

**Sickness**

From June 2017 to May 2018, the trust reported an annual sickness rate of 6.8% for healthcare assistants in community inpatients trust-wide which was worse than the overall trust target of 3%. A site breakdown can be seen below:

- Leasowes Intermediate Care Centre: 3.3%
- Rowley Regis Hospital (McCarthy and Eliza Tinsley wards): 8.6%

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

**Nursing – Bank and agency non-qualified nurses**

Please note the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

**Trust wide**

In community inpatients at a trust wide level from June 2017 to May 2018, 4,312 shifts were filled by bank staff and 49 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

**Leasowes Intermediate Care Centre**

In community inpatients at Leasowes Intermediate Care Centre from June 2017 to May 2018, 186 shifts were filled by bank staff and two shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

**Rowley Regis Hospital**

In community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) from June 2017 to May 2018, 1,727 shifts were filled by bank staff and 21 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

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

**Medical staffing**

The community inpatient core service was predominantly a nurse-led therapy service, with medical provision being provided by two local GPs. As a result, there was no data for medical staff.

*(Source: Routine Provider Information Request (RPIR) – Context CHS tab)*

**Suspensions and supervisions**

From June 2017 and June 2018, community inpatient services reported that there were no cases where staff had been either suspended or placed under supervision.

(Source: Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Senior staff told us of their recruitment processes to fill vacancies with the right people more quickly including open days and guaranteed jobs for student nurses who passed their relevant competencies and assessments.

**Quality of records**

**Staff kept appropriate records of patients' care and treatment.** Records overall, were clear, up-to-date and available to all staff providing care.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system they could all update.

Patient records were accurate, complete, legible, up to date and stored securely. Overall, the 35 sets of patients notes we reviewed were written and managed in a way that kept people safe.

Whilst we observed staff giving person centred care, we found patient care plans were generic and not person centred. This was not in line with NHS England recommendations that staff should offer everyone with a long-term condition a personalised care plan. A person-centred care plan ensures

that that people's preferences, needs and values guide clinical decisions, and provides care that is respectful of and responsive to them.

Although compliance with information governance training was poor, we found staff had secure processes in place to keep patients personal information safe when it was being used, shared, and when it was being stored to protect it and make sure it was only available to authorised members of staff. For example, we found medical records stored in locked trolleys when not in use and staff locked or logged off computers when not in use to protect patient information. During our previous inspection, we found data protection breaches, however during this inspection staff were committed to protecting patient's information in line with the General Data Protection Regulation (GDPR) 2018.

Ward managers undertook a documentation audit weekly by randomly selecting 10 sets of patients notes and assessing against set criteria. Areas of noncompliance was discussed with the individual staff member. Managers told us repeated non-compliance would result in the line manager undertaking performance management. The group head of nursing met with local GP's to discuss their role in ensuring medical records were contemporaneous and accurate. The ward manager and matron told is they would liaise directly with the GP to apply contract sanctions for any repeated non-compliance. As of May 2018, record keeping audits showed more than 95% adherence to criteria in five out of six wards. The ward manager and matron developed an action plan for the ward which had not achieved full compliance.

Managers told us daily assurance audits were now completed to provide shift by shift review of all notes and to enable proactive action planning and that these audits showed improvements across all areas. Staff only considered "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) forms to protect patients from invasive treatments that had little or no chance of success. This was in line with guidance such as Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (previously known as the "Joint Statement") 2016. However, the DNACPR form contained tick boxes to describe ceilings of treatment and there were no narrative boxes which meant they could easily be ticked after the form was signed. Some aspects were not sufficiently explained, for example antibiotics did not state whether this meant oral or intravenous (IV) antibiotics were not to be given. During our previous inspection two doctors told us that they did not routinely review certain aspects of a patient's care, for example a 'do not attempted resuscitation' order, as the patients they treated were "old and likely to die soon anyway". This was not in line with requirements of the Equality Act 2010 or the Human Rights Act 1998. On our current inspection we found this had changed, showing staff were responsive to our feedback in this area.

**Medicine**

**Overall the service prescribed, gave, recorded and stored medicines well, however patients did not always receive the right medication at the right dose at the right time.**

We found controlled drugs (CD) were stored securely and checked daily. For example, two registered nurses completed the required daily checks. We found all medication was in date and matched the controlled drugs register on each ward. Staff checked controlled drugs were secured appropriately, checked for missed doses and patient identification as part of a daily audit. We checked a sample of controlled drug audits which supported our findings. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include morphine.

Staff we spoke with knew what actions to take if the fridge temperatures were outside of the expected range. We saw evidence that the fridge temperature was checked daily and there were no out-of-date medicines.

We reviewed a sample of medication charts. All medication was prescribed appropriately, with clear legible writing, signed by a prescriber and reviewed by a pharmacist.

The matron identified and shared with staff any areas of risk associated with medicines and any medicine safety alerts. The matron for community and therapies attended the medicine safety group meetings.

We reviewed the trust wide medication incidents summary for July 2017 to August 2019 and found 18 of these related to the Henderson Ward, three to the Rowley Regis Ward and two to the McCarthy Ward. Five of these were related to medication delay/omissions, five related to administration errors ‘such as medication being given to patients but not prescribed, four were dispending errors, four were classed as ‘medication other’, three were prescribing, one was a security issue, one was monitoring and one was relating to a discharge with wrong take home medication.

The missed dose audit for McCarthy Ward from January to August 2018 showed that there were 3 missed doses in January. This represented 0.10% of failed administrations, Eliza Tinsley Ward had between seven and 62 missed doses which equated to 0.3 to 2.3% of failed administrations respectively and Henderson Ward had zero to 23 missed doses which equated to zero to 0.8% of failed administrations respectively.

A missed dose audit completed for September 2017 to August 2018 highlighted there was one missed dose in September 2017 at Leasowes. The action plan to address this included the action points ‘speak to nurse involved with the medicine omission and confirm administration of the medicine by the following shift nurses, ‘If not given, to do an incident report, reflection and assess patient for any adverse effects of not having this medications’.

Managers had introduced robust action plans to reduce the incidents of omitted medicine doses. Acton plans for missed doses included registered nurses would be challenged for omitting medications without documenting an appropriate variance code or no signature on variance chart,

discussion about appropriateness of medication and reason for omission, staff would be supported at ward level, staff encouraged to talk to previous shift about any medication concerns, if substantive staff was identified for omitting medicines on three separate occasions they would be issued with a file note, staff must ensure they are up to date with the mandatory medicine management e-learning module and are encouraged to complete the training module on medication, if missed doses continue then the individuals conduct and capability will be investigated.

Staff took measures to prevent potential errors occurring during the drug round. Staff wore red disposable tabards when undertaking medication rounds to reduce unnecessarily interruptions.

Staff prioritised and delivered pharmaceutical care at ward level in a way which maximised patient outcomes. The trust told us the pharmacist visited Rowley Regis wards four times a week and Leasowes twice weekly. The visits included checking all the drug charts for clinical accuracy and appropriateness and ordering of any medications. A technician visited Rowley Regis twice weekly to provide extra support.

**Incidents**

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

**Never Events**

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

From July 2017 to June 2018, the trust reported no incidents which were classified as never events for community inpatients.

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

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in community inpatients which met the reporting criteria set by NHS England from July 2017 to June 2018.

A breakdown of the types of incidents reported is:

Pressure ulcer meeting SI criteria with five (55.6% of total incidents)

Slips/trips/falls meeting SI criteria with four (44.4% of total incidents)

Six of the serious incidents took place at City Hospital, two at Rowley Regis Hospital and one at Leasowes Intermediate Care Centre.

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

There was a standard of information required which was shared with managers for review and next steps. Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally, where appropriate. They recorded incidents using a recognised electronic system. Incidents would then either be investigated or signed off as complete. Relevant staff, services, partner organisations and people who used services were involved in reviews and investigations.

There were good systems and processes in place to ensure incidents were reviewed and investigated safely and duty of candour was embedded in the services patient culture.

There was evidence of investigation followed by action planning and staff told us duty of candour was followed to keep patients and those involved in their care informed with how incidents are managed. Duty of candour was integrated into the electronic reporting system. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Senior and ward staff demonstrated an understanding of the duty of candour regulation and what kinds of incidents would trigger this regulation. Senior staff told us the service had not raised an incident requiring duty of candour in the previous 12 months. All staff we spoke with demonstrated the importance of being open, honest and transparent with their patients.

Staff shared examples of learning and improving following many themes relating to incidents. For example, a programme to reduce falls which was highlighted as the most common type of incident resulting in serious harm.

The trust had effective mechanisms in place for learning both within the community inpatient service and the trust wide. For example, we saw shared learning point in a 2018 QIHD was ‘Learning from Serious Incidents’. Learning identified from this session was all departments to review head injury pathway and clarification on anticoagulant therapy needed.

Staff conducting investigations found out what happened, got beyond 'the obvious' to the bottom of why the incident happened and identified underlying system and process issues that caused or contributed to the incident. We reviewed the root cause analysis (RCA) for a fall resulting in a fracture. The investigation documented the events and contained reflective comments, root causes and contributory factors were identified and an action plan was produced. Actions included 'Incident to be discussed in Band 7 meetings and Ward meetings for reflection' and 'learning and nursing staff to have a clear understanding of focus care plan and assessments for patients who needs one-to-one, tag system, behaviour charts'. We reviewed the previous three RCA's related to pressure ulcers. All staff had completed a table top reviews, identified whether the pressure ulcer was avoidable or unavoidable and identified learning such as to ensure daily heel/foot check monitoring was done, nurses used a small mirror to easily check heels and ensure that advise and instructions to patient with full mental capacity was documented.

**Prevention of Future Death Reports (Remove before publication)**

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, two prevention of future death reports were sent to the trust. Neither of these related to the community inpatient core service.

*(Source: Routine Provider Information Request (RPIR) – P86 Prevention of future death reports)*

**Safety performance**

**The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.**

**Safety Thermometer**

Staff were committed to providing a care environment free of harm for their patients.

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

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

From June 2017 to June 2018 the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter within all community inpatients wards.

(Source: NHS Safety Thermometer)

The team focussed on timely solutions that were within their sphere of influence and encouraged team participation in data collection, discussions and providing solutions, increasing the chances of success. Ward staff used a safety cross system to monitor the prevalence of pressure ulcers, falls and medication incidents. This was a one-month colour-coded calendar that notes daily safety measure incidents. Each number on the cross represented the day and date for that month to enable staff to differentiate safety incidents – coloured in red, from incident-free days – coloured in green.

## Is the service effective?

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance. For example, policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and professional bodies.

Therapy staff used an Initial physical therapy assessment. This was in line with NICE guidelines (Falls in older People: assessing risk and prevention (NICE CG161, 2013), which recommends that older people should be assessed for their ability to benefit from interventions to improve strength and balance to prevent falls, using a multifactorial assessment.

Therapists used a range of evidence based assessment tools such as the Modified Barthel Activities of Daily Living index (MBI). The MBI is a measure of physical disability used widely to assess behaviour relating to activities of daily living for stroke patients or patients with other disabling conditions.

We saw therapists working with other assessment tools to measure mobility, balance and gait. Therapists we spoke with explained the rationale behind the assessment used and the outcome measures they used in line with best practice.

Staff told us there was a marked emphasis on rehabilitation and therapy at Leasowes, and on multidisciplinary team working in the interests of patients.

Although we observed patient centred care, we found patient care plans were generic and not person centred. This was not in line with NHS England recommendations that staff should offer everyone with a long-term condition a personalised care plan. A person-centred care plan ensures that that people's preferences, needs and values guide clinical decisions, and provides care that is respectful of and responsive to them.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.**

Staff could refer patients to dietitians for nutritional support and dietary information. Staff did not record time taken to accessing community dieticians therefore we were unable to assess whether patients had timely access to nutrition and hydration support.

Staff completed malnutrition universal screening forms (MUST) forms for new patients. The MUST is a simple five step screening tool which helps to identify adults who are underweight and at risk of malnutrition.

Staff completed fluid balance charts appropriately, where required, for patients and we saw evidence of these within patient records.

We observed healthcare assistants helping patients to eat and drink in the dining room.

Staff targeted support at patients to ensure they had the support required to maintain a good level of nutritional intake. Staff used a 'red tray' and 'red cup' system to highlight the patients that required additional help with eating and drinking. Staff served patient food and drink on a red coloured tray or using a red plate or cup to visually see those patients requiring assistance to eat.

Patients had a choice of meals, which included those suitable for specialist diets such as vegetarian.

Staff informed us that, as far as possible, they protected meal times from interruption from visitors and staff.

Staff collected feedback directly from patients, about how the meal services might be enhanced.

Patient led assessments of the care environment (PLACE) meal service observation audits were completed. We reviewed the PLACE audit for Eliza Tinsley in 2017. This showed 76% compliance. The 2018 audit for Leasowes Ward showed 83% compliance. This looked at areas such as whether patients received their first choice of today's meal and availability of patient allergen folder.

**Pain relief**

Medical staff were responsible for managing pain relief and prescribed in line with the British National Formulary. We reviewed nine prescription charts and found nursing staff administered pain relief as prescribed and required.

Staff assessed patient's pain as part of routine observations; and patients told us they felt staff controlled their pain well and received pain relief as required.

Staff did not have access to a specialist nurse or doctor for pain relief advice, and decisions relating to the prescription and review of pain relief were the responsibility of the General Practitioner (GP). However, we found no evidence that this affected patient care.

Nurses received appropriate, support and opportunities to develop competence in prescribing practice. All band 7 staff were completing the prescribing course with a view to rolling the course out in 2019 to band 6 staff. This meant that not only did nurses have more autonomy but patients experienced less delay in receiving pain relief medications. Senior staff told us GP's provided mentorship to nurses completing the prescribing course.

**Patient outcomes**

**The service monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.

**Audits – changes to working practices**

The trust has participated in two clinical audits in relation to the community inpatient core service as part of their Clinical Audit Programme.

| Audit | Audit scope | Date completed |
|---|---|---|
| **Falls and fragility fractures audit programme – fracture liaison service database** | Primary care and community therapies | Ongoing |
| **National audit of intermediate care (NAIC)** | Primary care and community therapies | 01/08/2017 |

*(Source: Routine Provider Information Request (RPIR) – Audits tab)*

The National Audit of Intermediate Care 2014 provided this focus. It allowed NHS England to take stock; to pose and receive answers to two fundamental questions: can intermediate care deliver good outcomes at an affordable cost; and, is it making a difference?

The audit is sufficiently mature and is in its third year. It is also sufficiently large with 75 commissioners; 124 providers, 472 services; 12,022 service user responses, for these questions to be reliably tackled.

The audit included four service models of intermediate care: crisis response teams; home-based intermediate care; bed-based intermediate care (community hospitals and care homes); and local authority funded reablement services.

We requested the results and action plan from the Falls and fragility fractures audit programme, however the trust failed to provide it to us.

Staff were committed to making sure the correct documentation and risk assessments were completed on all patients at the time they were admitted to the community inpatient wards as part of providing consistency of care. Nurses completed a continuity of care audit for every patient transferred from the acute setting to the community inpatient beds. The audit looked at areas including whether patient handover provided from the transferring ward included all the following: medical history, diagnosis, social history, plan and allergies and whether the patient arrived with medication prescription and medication. Staff explained to us that consistency of care provided was very important both with respect to having the right documentation completed at the right time, but also when considering consistency of staff involved in making those care decisions.

We reviewed the intermediate care discharge database preliminary report from March 2018 to June 2018. This showed the average length of stay (LOS) was 21 days and the average number of therapeutic contacts for LoS was 11 contacts. The average dependency score on admission showed severe dependence and on discharge this had decreased to moderate dependency. The majority of admissions were from medicine, followed by trauma and orthopaedics, the majority of referrals onward were to integrated care services and the majority of discharges were to the patients' home.

The July 2018 report showed the average LoS was 22 days and the average number of therapeutic contacts for LoS was 10.5 contacts and the rest of the results reflected the results for March to June 2018.

Staff put into practice quality improvement processes that sought to improve patient care and outcomes through systematic review of care against clear criteria. Therapy staff in the rehabilitation service used a variety of outcomes measures and staff audited all patients' therapy goals. For example, in 2018 therapists completed an audit to assess the therapy team's compliance with setting specific, measurable, achievable, relevant, and time-bound (SMART) goals with their patients, to assess the compliance with reviewing the goals which are set, to review the number of goals set per patient during their admission and to review the accuracy of timeframes for goals set. Following the audit, a service improvement was implemented to improve patient/therapy communication and address expectations between patients and the multi-disciplinary team during the patients' admission (Quality Listening Time). A proforma was created to assist with the goal setting process to aid staff compliance with the service improvement and an in-service training was completed aiming to: educate the therapy team of the benefits of goal setting, increase their confidence with setting goals for different patient populations, and educate on the correct use of the Goal Achievement Record Sheet as well as the reviewing process.

Therapists recently conducted a snap audit to assess the current use of outcome measures across the three intermediate care sites. The action plan resulting from the audit included setting a variety of outcome measures as secondary measures to be used alongside the MBI and a meeting with all clinicians who used outcome measures would take place and in line with the findings from the

survey, teaching would take place to ensure all clinicians are comfortable with the use of all outcomes to be utilised.'

**Competent staff**

**The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and monitor the effectiveness of the service.**

**Clinical Supervision**

The trust informed us that clinical supervision was not centrally monitored, with professional staff being encouraged to seek supervision should they wish to. Provision was made within a training capacity, but no formal process existed. The trust planned to create a central record by April 2019.

*(Source: Routine Provider Information Request – Clinical supervision tab)*

**Appraisal rates**

**Trust level**

From April 2017 to December 2017, 92.9% of staff within the community inpatients service at the trust received an appraisal compared to a trust target of 100%. A breakdown by staff group is provided below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Other non-medical staff | 1 | 1 | 100.0% |
| NHS infrastructure support | 1 | 1 | 100.0% |
| Support to doctors and nursing staff | 81 | 83 | 97.6% |
| Qualified nursing & health visiting staff | 60 | 69 | 87.0% |
| **Total** | **143** | **154** | **92.9%** |

The trust generally offered opportunities to ensure staff felt motivated, well supported and confident to deal with the many issues and challenges they faced in their roles. The trust encouraged staff to evaluate their performance, receive constructive feedback, build upon strengths and address any areas for development. Of the five staff groups within the community inpatients service, two groups met the trust's 100% appraisal target. However, these two groups both consisted of one eligible member of staff.

Staff told us about the new personal development review (PDR) (appraisal) process that supported employees and their managers in setting clear objectives, and recognised people's performance as well as the behaviours they have exhibited as part of the trust. Staff said they found the new process more personal and valuable.

**Leasowes Intermediate Care Centre**

From April 2017 to December 2017, 88.9% of staff within community inpatients at Leasowes Intermediate Care Centre received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Other non-medical staff | 1 | 1 | 100.0% |
| Support to doctors and nursing staff | 13 | 14 | 92.9% |
| Qualified nursing & health visiting staff | 10 | 12 | 83.3% |
| **Total** | **24** | **27** | **88.9%** |

**Rowley Regis Hospital**

From April 2017 to December 2017, 96.8% of staff of staff within community inpatients at Rowley Regis Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Support to doctors and nursing staff | 34 | 35 | 97.1% |
| Qualified nursing & health visiting staff | 27 | 28 | 96.4% |
| **Grand Total** | **61** | **63** | **96.8%** |

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

Staff told us they felt supported within their roles, and received support training and guidance and required. Improvement actions taken included to ensure all PDR's were completed, to provide one to one sessions with ward managers and matrons and role of the bleep holder to be formalised with a standard operating procedure and training. Mangers reported that as of 31 May 2018 PDR compliance was 98%, monthly one to one sessions were in place with matron and ward manager and a monthly confirm and challenge meeting was held with senior staff. The confirm and challenge meeting covered areas such as sickness levels, safer staffing, risk register and complaints and compliments. During our last inspection we found not all senior staff felt fully supported. On the current inspection we found managers valued the importance of ensuring all staff felt supported.

There were progression programmes in place for band three, four, five and six practitioners. Staff told us of development and training opportunities. For example, healthcare assistants (HCA's) said they were offered nursing associate courses. This offered a two-year training programme where students would in a range of settings gain as much experience as possible of different health and care settings and situations. Upon completion, staff would be equipped with the knowledge, understanding, skills, attitudes and behaviours to work as a nursing associate.

Nurses received appropriate, support and opportunities to develop competence in prescribing practice. All band 7 staff were completing the prescribing course with a view to rolling it out in 2019 to band 6 staff. This meant that not only did nurses have more autonomy but patients experienced less delay in

receiving medications and therefore reduced risk of hospitalisation and promoted a faster recovery. Senior staff told us GP's provided mentorship to nurses completing the prescribing course.

Staff could develop and progress in their roles. Therapy staff were offered apprenticeships. This gave staff the opportunity to complete structured training which led nationally recognised qualifications.

The trust gave Band 5 nurses the chance to fast track their nursing career. An accelerator programme was offered to nurses with aspirations to progress their career.

Staff were supported at all levels to progress and develop. The head of therapies was being supported to complete a NHS leadership course, The Elizabeth Garrett Anderson programme is a unique healthcare leadership programme. The programme is fully accredited, leading to a NHS Leadership Academy Award in Senior Healthcare Leadership and a Masters in Healthcare Leadership.

Offering development and learning opportunities not only offered staff continued professional development but encouraged staff retention.

The trust introduced staff to the values and objectives of the organisation and they understood essential safety and risk management information and gave the new employee the practical information they would need to begin their new jobs. All new members of staff completed an induction. We reviewed the induction pack and saw it covered areas such as emergency procedures, layout of the ward, access to medication rooms and the daily routine of the ward.

Nurses ensured they were updated on the latest developments in nursing practice and competent in all aspects relating to their tasks. Nursing staff could attend formal in-service sessions across all six wards, alternating sites between Rowley Regis, Sheldon and Leasowes. In the previous 12 months these had included the following:

| Date | Topic | Delivered by |
|---|---|---|
| October 2017 | Continence – products | Continence team member |
| November 2017 | Pressure relieving mattress training | Tissue Viability Team member |
| December 2017 | Recognition of the dying patient unwell – Joint MDT session | Matron/Lead Therapist |
| January 2018 | DoL/MAC | Matron and Adult Safeguarding Lead |
| February 2018 | Equality & Diversity | QIHD session |
| March 2018 | Resource Clear Training | Matron |
| April 2018 | Medicine Management | Ward Pharmacist |
| May 2018 | Consistency of Care | Deputy Director of Nursing PCCT |
| June 2018 | Point of Care Testing | Matron from Admission Avoidance Team |
| July 2018 | QIHD DDD Training | DDD Team |

| | | |
|---|---|---|
| August 2018 | No training or QIHD secondary to annual leave | |
| September 2018 | CQC Preparation | Deputy Director of Nursing and Matrons PCCT |

Nursing staff completed extra training to evidence they were meeting the trust's expectations for safe and effective practice. Nursing staff completed community clinical competency workbooks. The competencies covered areas such as male catheterisation, non-oral feeding techniques (for example, Percutaneous endoscopic gastrostomy (PEG) or tube feeds) and intermediate life support.

Healthcare assistants were offered opportunities to practice clinical skills and gain *competence*. The Nurse Education Team developed a HCA competency workbook to support staff completing this competency portfolio. It included a range of questions and exercises which the HCA could use to develop and demonstrate competence. The workbook was not mandatory and it was up to each individual HCA and their assessor to identify whether it would be helpful in supporting their development.

During our previous inspection we raised concerns regarding the competency of staff nurses undertaking 'nurse in charge' duties overnight. On this inspection we found the group head of nursing and matron had developed in house training for all staff undertaking role of the bleep holder and a full risk assessment regarding out of hours working for Rowley Regis was undertaken by the group head of nursing.

Medical and nursing staff were committed to better and safer care for patients, by improving their professional development. All eligible staff were up to date with their revalidation. The aim of revalidation is to give extra confidence to patients that their doctor or nurse can provide this care by being up to date and fit to practise.

**Multidisciplinary working and coordinated care pathways**

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

Multidisciplinary staff made up the teams across the division. For example, physiotherapists, occupational therapists, speech and language therapists, dieticians, nutrition nurses and support workers assessed and treated patient's physical, functional, communication, swallowing and nutritional needs.

They worked closely using each other's skills and expertise and with other agencies to deliver effective care and treatment. Staff worked collaboratively with external local providers to ensure patients received person-centred care based on their personal needs and preferences. There was an integrated approach to reduce delayed discharges, avoidable admissions to acute beds and a reduction in residential and nursing home placements.

There were good examples of multidisciplinary working throughout all services. Patients had access to specialist teams when it was identified as a need. There were link nurses across disciplines and specialist nurses in addition to specialists who supported patients. These specialists were available to provide specific support and training and development to staff to improve skills and patient care.

Social workers, GP's, and other healthcare staff worked together to enable appropriate transition arrangements upon discharge. Multidisciplinary team meetings were held weekly. The teams completed a review of each patient and set key actions for care planning, rehabilitation and well managed discharge. Staff worked with their community colleagues to support discharge back to community or another care setting. The wards were nurse and GP led.

There were a wide range of people involved in supporting patients throughout their journey while in hospital and during the process of discharge. Staff and patients worked with internal and external partners to ensure smooth transition and discharge. We saw examples of good working relationships with clinical commissioning groups (CCG's), local authority social workers and third sector organisations to support patients following discharge and during the patients' transition. Families and carers were involved throughout and we saw this recorded in patient records, through discussion with families and patients.

Staff were developing links with the voluntary sector to ensure patients had access to support and care from their local community including Agewell.

Therapy staff demonstrated the importance about working within the local community to promote their service. Therapists described good working relationships with community staff and described joint home visits for more complex patients. Therapy staff had held talks at local schools, universities and charitable events and a staff member regularly visited university career days.

The success in the discharge pathway management on these wards depended on close working relationships across the health and social care economy in both Sandwell and Birmingham local authorities.

**Health promotion**

Staff enabled individuals to live as independently as possible and empowered them to be self-determined. Therapy staff on the wards helped patients to regain their confidence to do everyday tasks. They helped patients to do therapy exercises and to become as independent as possible.

We observed nursing and therapy staff encourage patients to mobilise within their abilities throughout the day, not just during formalised therapy sessions. For example, staff supported patients to independently use toilets and move between rooms to promote their independence before discharge and patients were given exercises to do on their own and when they returned home.

Therapy staff provided patients with therapy led exercise classes twice a week. These groups involved targeted therapeutic exercises to help meet the patient's therapy goals.

Care staff offered patients activity groups. These groups encompassed mainly social interaction and mood enhancement but gentle exercise was offered if the care staff deem this appropriate.

Patients who wanted to address their nicotine habit could access smoking cessation services

The sessions were available for both staff and patients.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 had improved since our last inspection. However, the way staff undertook capacity assessments, documented findings and deprived patients of their liberty was not always in line with the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards 2010.**

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

## Mental Capacity Act and Deprivation of Liberty training completion

The trust reported Mental Capacity Act and Deprivation of Liberty Safeguards training was included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of trust level compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 64 | 64 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 64 | 64 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 63 | 64 | 98.4% | 95% | Yes |

Nursing staff in the community inpatient core service met the trust's target of 95% overall, with a completion rate of 99.5%. The target was met for all four safeguarding training courses made available to them, three of these attaining a score of 100%.

**Healthcare assistants**

A breakdown of trust level compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 75 | 75 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 75 | 75 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 73 | 74 | 98.6% | 95% | Yes |

Healthcare assistants in the community inpatient core service met the trust's target of 95% overall, with a completion rate of 99.6%. The target was met for all three safeguarding training courses made available to them, two of these attaining a score of 100%.

**Medical and dental staff**

The trust did not provide safeguarding training data for medical staff as part of the community inpatient core service. They informed us their community inpatients service was predominantly a nurse-led therapy service with medical provision provided by local GPs.

**Nursing staff**

**Leasowes Intermediate Care Centre**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 14 | 14 | 100.0% | 95% | Yes |

Nursing staff in the community inpatient core service at Leasowes Intermediate Care Centre met the trust's target of 95% overall, with a completion rate of 100%.

**Healthcare assistants**

A breakdown of compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients at Leasowes Intermediate Care Centre is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 14 | 14 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 14 | 14 | 100.0% | 95% | Yes |

Healthcare assistants in the community inpatient core service at Leasowes Intermediate Care Centre met the trust's target of 95% overall, with a completion rate of 100%.

**Rowley Regis Hospital**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 24 | 24 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 24 | 24 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 24 | 24 | 100.0% | 95% | Yes |

Nursing staff in the community inpatient core service at Rowley Regis Hospital met the trust's target of 95% overall, with a completion rate of 100%.

**Healthcare assistants**

A breakdown of compliance for safeguarding training courses as at July 2018 for healthcare assistants in community inpatients at Rowley Regis Hospital (McCarthy and Eliza Tinsley wards) is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 32 | 32 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 31 | 31 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 32 | 32 | 100.0% | 95% | Yes |

Healthcare assistants in the community inpatient core service at Rowley Regis Hospital met the trust's target of 95% overall, with a completion rate of 100%.

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

**Deprivation of Liberty Safeguards**

From April 2017 to March 2018 the trust reported that 295 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority, 64 of which were pertinent to community inpatients services. Sixty of these (93.8%) were approved.

Over this time period, no DoLS direct notifications were sent to CQC.

A breakdown of DoLS applications by location and ward is shown below:

**Leasowes Intermediate Care Centre**

| Location | Number of DoLS applications made | Number of DoLS applications approved |
|---|---|---|
| Leasowes | 1 | 1 (100%) |
| **Total** | **1** | **1 (100%)** |

**Rowley Regis**

| Location | Number of DoLS applications made | Number of DoLS applications approved |
|---|---|---|
| Henderson ward | 2 | 2 (100%) |
| McCarthy ward | 10 | 10 (100%) |
| Eliza Tinsley Ward | 25 | 23 (92%) |
| **Total** | **37** | **35 (94.6%)** |

The greatest numbers of DoLS applications were made in December 2017 (seven applications) and January 2018 (eight applications).

Within the RPIR, the trust noted that discharges and deaths were not included in the dataset and some of the applications would not have been reviewed. The individual directorates collated the information.

*(Source: Routine Provider Information Request (RPIR) – P13 DoLS)*

The way staff undertook capacity assessments, documented findings and deprived patients of their liberty was not in line with the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards 2010. We observed care delivered that was not consistently in line with the Human Rights Act 1998, specifically Article 5 (right to liberty and security) and Article 8 (respect for your private and family life, home and correspondents).

We found there appeared to be some confusion amongst staff around the difference between a DoLs application and a mental capacity assessment.

We reviewed five patient files for patients identified as lacking capacity. When reviewing patient files, we could not always see how staff had come to the decision that the person lacked mental capacity. Staff were using a generic deprivation of liberty safeguard checklist, however there was no comprehensive assessment of mental capacity covering areas such as record of decision to be made and whether the patient could retain information for long enough to make this decision.

## Is the service caring?

**Compassionate care**

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

Teams of NHS and private/independent health care providers undertake self-assessments, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration; the extent to which the provision of care with privacy and dignity is supported; and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The PLACE score for privacy, dignity and wellbeing at the trust was 100% from March to June 2018, based on data for the Leasowes Intermediate Care Centre, compared to the national average of 83.7%. Please note that PLACE scores relate to the whole site and are not specific to inpatient settings.

| Site Name | Privacy, Dignity and Wellbeing |
|---|---|
| Leasowes Intermediate Care Centre | 100% |
| England average (NHS community only) | 83.7% |

*(Source: NHS Digital)*

All patients we spoke with told us they were happy with the care provided and staff were kind and caring. For example, we saw a ward clerk regularly responding to a patient living with dementia who was shouting and distressed. We saw the clerk talking with the patient and using appropriate humour to make her feel at ease. We saw a ward sister sitting and reading a magazine with another patient living with dementia who was visibly distressed to help them feel calm.

Staff understood the importance of their patient's general wellbeing and value in boosting their mental welfare. A pet assisted therapy dog visited the wards for mood enhancement and functional task practice.

Staff went out of their way to help patients feel at home. Staff on the Elisa Tinsley ward told us the senior sister had ordered music DVD's a patient living with dementia enjoyed.

Staff understood the importance of patients having a good night sleep and creating a healing environment. Staff followed a quiet protocol. For example, staff asked patients how they slept and if there was anything they could do to support them get a good rest, bins were all soft close and staff offered night time comfort packs (ear plugs and mask).

We saw that staff closed curtains for privacy before any personal care. They explained what they were planning to do and obtained the patient' s consent before providing personal care.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress**. Patient's told us and we observed staff were sensitive and compassionate in supporting patients and those close to them.

The trust provided a chaplaincy service for patients and their relatives where specialist faith chaplains were available. An on-call service was available 24 hours a day.

We saw staff on a ward providing reassurance and support to a patient living with dementia who were distressed.

Staff supported the well-being of patients and their relatives by offering quality listening times so relatives could ask any questions.

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

Staff supported patients to make informed choices about their care or treatment and feel confident and in control. Staff provided patients and relatives/and or carers with quality listening time within five days of the patient's admission onto the ward. Therapy staff told us this also gave them the opportunity to discuss realistic goals and what was expected of patients whilst they were on the ward. For example, patients were expected to attend breakfast club one day a week. The aim of the club was to enable more patients to be discharged back into their own homes by encouraging confidence and ensuring they did not become de-skilled during their hospital stay. It was also hoped the patient would be better prepared to return home after their hospital care is complete. This was in line with The Intermediate Care including Re-ablement NICE guidelines (2017) which highlighted the

importance of agreed goal setting between patients and practitioner's, and the need to review the goals on a regular basis.

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

Managers had completed work to ensure all staff had regard for the protected characteristics under the Equality Act 2010. The matron for community beds led ward quality improvement half day (QIHD) sessions to focus on the Equality Act. The trust head of diversity and inclusion reviewed knowledge of protected characteristics and all staff completed questionnaires. Ward managers provided support for staff by working alongside them when completing patient assessments to ensure assessments were carried out with respect for protected characteristics. Since making these improvements managers found there had been no complaints around dignity. The patient experience questionnaires (PEQ) illustrated good feedback. All patient comments were reviewed and there were none relating to dignity of protected characteristics. The trust diversity lead had completed bespoke training for community wards and observational audits were carried out to monitor individual compliance. The QIHD February agenda item was 'Recognising & Responding to lesbian, gay, bisexual and transgender (LGBT) patient needs' and another was Equality and diversity – going for good and E learning module'.

We spoke with staff to explore their understanding of the Equality Act and how this related to their roles. We found staff now showed an understanding of equality and diversity issues, demonstrating the improvement plans had been successful.

Staff had mechanisms in place to help identify, and support carers. This helped carers to provide better care and to stay well themselves which contributed to better lives for those needing care and more effective use of NHS resources. We saw posters and leaflets advertising carer support groups and a speaker attended the QIHD in 2018 to speak about carers groups. Therapy staff recently visited the charitable association for carers.

## Is the service responsive?

**Accessibility**

The table below shows the four largest ethnic minorities within the trust's catchment population. The largest ethnic minority group within the trust catchment area is Asian/Asian British Indian. The percentage of the catchment population was not known.

| | Ethnic minority group |
|---|---|
| First largest | Asian/Asian British Indian |
| Second largest | Asian/Asian British Pakistani |

| | |
|---|---|
| Third largest | White - any other white |
| Fourth largest | Black/Black British Caribbean |

*(Source: Routine Provider Information Request – P48 Accessibility)*

**Planning and delivering services which meet people's needs**

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

The facilities and premises were generally appropriate for the services that were planned and delivered. The services provided reflected the needs of the population served and offered patients flexibility, choice and continuity of care.

Staff were aware how to contact chaplaincy in and out of hours to support patients.

All wards had specific admission criteria due to being nurse and therapy led, with no onsite medical staff. Admission criteria included, patients must be medical stable, be likely to benefit from up to four weeks of therapy care and patients had a suitable and safe environment in which they can be discharged.

The referring and accepting clinicians planned the best pathway for the patient, for example, admission to a community inpatient bed, discharge home with a care package in place, or to remain in acute care for longer period. Referring staff assessed patients using the trusted assessor system.

Staff made sure those patients with complex or changing needs could still achieve a safe discharge from hospital. Staff undertook discharge meetings with nursing, therapy, medical and outside agencies, where needed.

Staff offered interpretation in a variety of languages as well as British Sign Language interpretation. Hearing loops were available

Staff could access a telephone interpreting service to communicate effectively with patients who had difficulties communicating in the English language.

**Mixed sex breaches**

Patients care and dignity and privacy was not compromised. Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. While these are specifically for mental health providers the same definitions apply to community health services and Acute providers from a CQC perspective. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be

in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported no mixed sex breaches within community inpatient services from April 2017 to March 2018.

*(Source: Routine Provider Information Request (RPIR) P47 –Mixed sex)*

**Meeting the needs of people in vulnerable circumstances**

**The service took account of patients' individual needs.**

Staff made reasonable adjustments to ensure accessibility for people with a disability, impairment or sensory loss. There was disabled access and hearing loops for those with hearing impairments.

The trust recognised the value of employing volunteers to provide further support to staff and patients. Healthcare assistants provided additional support such as activities to provide a stimulating environment for patients living with dementia. At the time of inspection, the number of volunteers were low and the aim was to increase this.

Staff told us about how they had adopted the John's Campaign to promote partnership working with relatives and carers for patients with cognitive disorders to enable the carer to support patients while in hospital, day or night. For example, staff at Leasowes purchased fold away beds to enable relatives and carers to sleep next to patients living with dementia to offer vital support when they needed it most.

Staff knowledge and understanding of the additional support people living with dementia may require was good across all clinical areas. Staff used 'All about me' booklets with patients who were living with dementia. This provided staff with an easy and practical way of recording who the person was. The form included space to include details on the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality.

Digital reminiscence therapy (DRT) was available for staff to use with patients who lived with dementia. This was a digital programme that allowed relatives, staff or patients to choose music, pictures or sounds that reminded them of past events. Relatives could record key phrases, for example, "it is time for dinner", to bring familiarity to the patients stay in hospital and reduce anxiety. The ward manager told us that they generally used the machine to play old music as the other functions were only appropriate for care homes or other long-term settings. This meant staff missed valuable opportunities to offer patients with dementia and elderly inpatients to have a more comfortable stay by providing access to archives of historic photos, music, games and even by allowing patients to take their own photos.

Senior staff told us a survey of all signage was undertaken by the matron and group head of nursing and the matron collected feedback from patients and carers. We found all wards had been updated

to have clear signs, contrasting colours such as on the walls and floors, safe flooring and quiet gardens and conservatories. This was in line with the Department of Health, Health Building Note 08-02 Dementia-friendly Health and Social Care Environment, 2015.

Staff demonstrated person centred care. For example, staff at Leasowes offered a dedicated relatives room. Relatives could also use the adjoining kitchen. This was mostly for relatives of palliative patients.

**Access to the right care at the right time**

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

**Bed occupancy**

The trust provided information regarding average bed occupancies from June 2017 to May 2018. A breakdown of average bed occupancy levels by site for community health inpatient services is shown in the table below:

| Site | Ward | Average bed occupancy |
|---|---|---|
| Leasowes Intermediate Care Centre | Leasowes | 87.9% |
| Rowley Regis Hospital | Eliza Tinsley Ward | 89.4% |
| Rowley Regis Hospital | Henderson ward | 85.3% |
| Rowley Regis Hospital | McCarthy ward | 83.5% |

*(Source: Routine Provider Information Request (RPIR) Community CHS7 – Bed occupancy & LOS)*

**Average length of stay data**

The trust provided information for average length of stay from June 2017 to May 2018. A breakdown of average length of stay by site for community health inpatient services is shown in the table below:

| Site | Ward | Average length of stay |
|---|---|---|
| City Hospital | Ward D43 | 9.5 days |
| City Hospital | Ward D47 | 18.8 days |
| Leasowes Intermediate Care Centre | Leasowes | 19.9 days |
| Rowley Regis Hospital | Eliza Tinsley Ward | 11.8 days |
| Rowley Regis Hospital | Henderson ward | 21.7 days |
| Rowley Regis Hospital | McCarthy ward | 12.4 days |

Henderson ward at Rowley Regis had the highest average length of stay, at 21.7 days. Over the 12-month period, the average length of stay on this ward ranged from 16 days in May 2018 to 28 days in September 2017.

(Source: Routine Provider Information Request (RPIR) Community CHS7 – Bed occupancy & LOS)

The difference in the length of stay may have been due to the level of patients need and associated factors such as delayed discharges sue to difficulties accessing social care.

**Referrals**

The trust reported that the median number of stays from referral to initial assessment for all their community inpatient services was one day. The trust does not have a target. They noted that initial assessment to onset was taken as the admission to procedure date. Safety checks were completed within 24 hours, with discharge planning commenced within 24 hours of admission.

The trust did not have any assessment to treatment targets. No data was available for Eliza Tinsley and McCarthy wards at Rowley Regis Hospital.

| Site | Inpatient ward or unit | Service Type | Median days from referral to initial assessment | Median days from assessment to treatment |
|---|---|---|---|---|
| Leasowes Intermediate Care Centre | Leasowes | IMC | 1 day | 12 days |
| Rowley Regis Hospital | Eliza Tinsley Ward | MFFD | 1 day | n/a |
| Rowley Regis Hospital | Henderson ward | IMC | 1 day | 10 days |
| Rowley Regis Hospital | McCarthy ward | MFFD | 1 day | n/a |

MFFD – Medically fit for discharge
IMC – Intermediate care

*(Source: CHS Routine Provider Information Request – CHS10 Referrals)*

The importance of limiting waiting times had been recognised in the recently published National Institute for Clinical Excellence (NICE) guideline, which states that bed based intermediate care should be started within two days of receiving an appropriate referral. The above data showed that none of the wards we inspected achieved this. This meant unnecessary delays could have contributed to older people deteriorating rapidly while waiting for a treatment

Staff had processes in place to ensure patients received the most appropriate model of intermediate care, avoiding wherever possible the need for acute hospital admission. Intermediate care services had an inclusion / exclusion criterion. Exclusion criteria included not medically stable with unpredictable care needs and no recourse to public funds.

Staff ensured reflective learning techniques to minimise extra steps in any patient pathway which would add risk and adversely affect the patient experience. Staff recorded transfer of data information received from referrers such as acute wards. This data highlighted cases where no handover was provided, no medication was sent, safety checks were incomplete or the patient was not medically fit. Staff fed inappropriate referrals back to the source.

Trusted referrers completed holistic assessment of need avoiding duplication and speeding up response times so people could be discharged in a safe and timely way. Staff received referrals from trusted referrers. Trusted Assessor' schemes are a national initiative designed to reduce delays when people are ready for discharge from hospital. It is based on providers adopting assessments carried out by suitably qualified 'Trusted Assessors' working under a formal, written agreement. The referral form included patient demographics, a quality and safety check which took place between the trusted referrer and senior therapist which explored whether the patient was medically for discharge and the *Modified Early Warning Score* and rehabilitation needs and goal planning.

We were unable to assess whether patients needing to be seen by the diabetes team were seen in a timely manner. This was because managers collected the number of referrals made a month, however they did not collate data capturing time from referral to being seen by the diabetes clinical team.

Staff were required to complete the ‘Think Glucose’ assessment for every admitted patient identified as diabetic during their clinical review / clerking. Once completed and submitted, the form generated an email message to the diabetes department, and identified patients to be seen as part of the diabetes clinical team ward round. The trust told us the patient stayed on the work list until they were discharged from the diabetes team and that this “could be weeks”.

**Delayed discharges**

From June 2017 to May 2018, the trust did not report any delayed discharges in community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal P49 – DTOC)

The trust reviewed delays to patient care and patient care was monitored. Daily board rounds took place with discussions to highlight any delays in care, the trust collected delayed transfers of care and this data was explored daily by senior staff, all the wards used the red/green approach and improvement in reducing red days were now monitored through group performance reviews, expected date of discharge performance for all ward admissions were tracked and made visible at ward level and over seven-day length of stay reviews were completed.

Staff were proactive in discharge planning and followed guidelines for effective discharge such as the Department of Health's 'Ready to go?', Planning the discharge and the transfer of patients from hospital and intermediate care before or on admission',

The trust provided dedicate staff to help manage patients effectively with minimal delays as they moved through stages of care. A discharge tracker attended the board round we observed.

Staff worked towards patients not spending unnecessary days in hospital that did not directly contribute toward their discharge. Staff used the Red and Green Bed Days' which was a visual management system to assist in the identification of additional time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. Senior staff told us most delays were due to social care package delays.

Managers worked jointly with commissioners to address some of the barriers in the system that were causing delays. A delayed transfer of care telephone call took place with the clinical commissioning group every day across site. A 21-day length of stay meeting took place fortnightly to discuss difficult to move on patients such as those with no rights to refunds or homeless.

Complex patients awaiting discharge were escalated appropriately. The director of nursing met with the chief nurse weekly to discuss 'stranded patients' where community inpatient patients would be discussed.

We asked the trust whether they collected data on the time it took for patients to be seen by specialists or other services such as dieticians or diagnostics. The trust told us each service monitored their own waiting times and all patients were seen based on clinical need, regardless whether they were in an acute or community bed.

**Ward moves**

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient had to move wards several times because there was no room in the speciality ward they should be on.

From June 2017 to May 2018, the trust did not report any ward moves for non-clinical reasons within community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal P43 – Ward moves)

**Moves at night**

In some cases, patient's continuity of care may have been disrupted due to being transferred at night.

The trust was asked to list ward moves between 8pm and 8am for each core service for the most recent 12 months.

From June 2017 to May 2018, the trust reported that there were 63 moves at night for community health inpatient services. Twenty-four of these related to the areas we inspected.

The data below shows the number of ward moves by hospital site from June 2017 to May 2018 in community health inpatient services by site:

**Leasowes Intermediate Care Centre**

| Ward name | Number of moves |
|---|---|
| **Leasowes** | **0** |

**Rowley Regis Hospital**

| Ward name | Number of moves |
|---|---|
| Eliza Tinsley Ward | **1** |
| Henderson ward | **15** |
| McCarthy ward | **8** |

*(Source: Universal Routine Provider Information Request (RPIR) Universal P44 – Moves at night)*

**Summary of complaints**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, complaints were not investigated and closed in line with their complaints policy.**

**Trust level**

People who used the services were encouraged to raise concerns and make complaints. Staff tried to resolve complaints locally and informally before proceeding to formal processes. Issues raised were investigated and lessons learned were shared with all staff to improve the quality of care. Patients and carers were advised how they could make a complaint or raise a concern on a leaflet or feedback form. They could also complain using the trust's internet site.

Patients may have been caused unnecessary distress waiting to be heard, understood and waiting for confirmation that their concerns had been addressed. From April 2017 to March 2018, there were 17 complaints about community inpatients at the trust. The trust took an average of 38.1 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 6 | 35.3% |
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 4 | 23.5% |
| Patient care | 3 | 17.6% |
| Staff values and behaviours | 3 | 17.6% |
| Access to treatment or drugs | 1 | 5.9% |
| Total | 17 | 100% |

**Leasowes Intermediate Care Centre**

From April 2017 to March 2018, there was one complaint about community inpatients at Leasowes Intermediate Care Centre. The hospital took 41 days to investigate and close this complaint. This was not in line with their complaints policy, which stated complaints should be completed within 30 days.

The complaint related to staff values and behaviours.

**Rowley Regis Hospital**

From April 2017 to March 2018, there were four complaints about community inpatients at Rowley Regis Hospital (Eliza Tinsley and McCarthy wards). The hospital took an average of 55.8 days to investigate and close complaints. This was not in line with their complaints policy, which

stated complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 2 | 50.0% |
| Access to treatment or drugs | 1 | 25.0% |
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 1 | 25.0% |
| Total | 4 | 100.0% |

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

Staff investigated and learnt from complaints. We reviewed the previous three complaints relating to the service. We found managers dealt with these appropriately and proportionately. For example, a relative made a complaint regarding walking aids being shared between patients and soiled clothes

were not kept separate from clean clothes. Managers ordered new red walking frames to ensure there were a sufficient number for patients to have their own as appropriate. An apology was made regarding soiled clothes and the matter was discussed at ward huddles for staff to be mindful of this and to ensure there were sufficient bags on wards to keep soiled and clean clothes separate.

**Number of compliments made to the trust**

From January 2018 to June 2018 there were two compliments relating to the community inpatient core service. A breakdown by site is shown below:

- City Hospital (ward 43): One compliment
- Rowley Regis Hospital (Henderson ward): One compliment

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

Information about how to feedback a concern, complaint, comment or compliment was displayed clearly in all the wards we visited.

We saw numerous thank you cards and positive feedback from patients in feedback books. This supported the positive feedback patients gave us about the service.

## Is the service well-led?

**Leadership**

**The trust had managers at all levels with the right skills and abilities to run the service effectively.**

All wards were nurse and General Practitioner (GP) led and there were additional staff, for example, healthcare assistants available to guide and support staff. All staff we spoke with told us that managers at ward level were visible and approachable.

In April 2018, the Trust launched Quality Improvement Half Days (QIHDs) to provide dedicated time every month for teams to meet to consider how best to improve the quality of care or services provided to patients and staff. The four-hour afternoon sessions were a change for the Trust involving all non-emergency activity being paused to give whole multi-disciplinary teams the chance to get together. They offered staff a chance to take time out to learn and develop new ideas. They also helped to tackle the cross-organisational learning that the trust wanted to improve. One of the largest sessions in April 2018? was held in the iBeds directorate, with 97 people meeting in the physiotherapy department at City Hospital. This was aimed to motivate and inspire staff across the Trust. Senior managers told us QIHD's were run jointly with other disciplines and mapped to the patient's pathway.

Leaders saw the importance of building capability and capacity of its managers as being essential to meet the challenges facing health and social care. Senior staff told us about the new accredited

manager training programme. Included in the programme were bespoke courses on managing wellbeing, recruiting for success, managing resources effectively and governance. On completion of the programme each manager received accreditation and a passport that formed part of their own performance development.

Senior staff were all knowledgeable about the CQC community inpatient action plan resulting from the previous inspection. The matron at Rowley Regis felt having a matron based at Leasowes meant she now had more time to implement the changes needed and more time to support her staff. This was supported by the evidence of positive changes that had been made since our last inspection.

Senior leaders engaged with and supported staff to help improve their services. For example, all staff we spoke with told us members of the executive board attended Listening into Action events.

**Vision and strategy**

**The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**

Staff worked in line the trust's 'care closer to home' strategy. Working in partnership with primary and social care the trust aimed to deliver an increasing range of seamless and integrated services across hospital and community settings. This was evident in the community impatient services. For example, the team included a whole range of staff including nurses, therapists and social workers providing specialist community interventions.

The trust used different mechanisms to engage staff with their vision and strategy. The new style of personal development reviews asked employees to demonstrate how well they had demonstrated the Trust's nine care promises, performance and behaviours as well as giving them a score for their potential. All managers were trained in this new process that formed part of the new accredited manager training programme.

Staff took part on a QIHD where the shared learning topic was 'Using the Aspiring to Excellence PDR to improve quality'. Learning identified was all staff who completed PDR's aware of the April-June completion plan, all staff to think about what part they play in the Trusts' vision and what was pertinent to them to achieving these visons and reflect on PDR using SMART objectives, the management team to quality control PDR's, what are staff's aspirations and do they employ the ethos of out Trust values.

The trust held the monthly 'hot topics' sessions, the Commitment through 'Our promises to you' and the '10 out of 10' patient safety standards checklist.

Leaders looked to build solutions on current workforce issues. We reviewed the trust wide workforce consultation 2018/19. It was raised that to maximise rehabilitation potential it was intended that the service was altered to a therapy led staffing model with nursing in reach provided by community

matrons and specialist nurses as required. Managerial and clinical oversite of the unit would be undertaken by existing therapy leads. It was believed that providing nursing input from specialist nurses and community matrons would enable a more tailored programme for patients and therefore improve satisfaction and outcomes. At the time of our inspection, the directorate was led by the Director of Therapies in close collaboration with the Group Director of Nursing.

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Staff told us that they felt well support by their line managers and they promoted a culture of openness and inclusivity amongst all levels of staff.

We found a supportive and enthusiastic culture in teams we inspected. Staff were proud of the quality of service they delivered and spoke positively about the organisation. There was constructive engagement with staff; staff at all levels were encouraged to raise concerns.

Nursing staff told us they felt positive and proud to work in the organisation. They said they felt supported, respected and valued.

We found a patient focussed culture which addressed gaps in care, or poor care co-ordination which could lead to adverse impact on care experiences and care outcomes. Staff told us they offered a service that focussed around the needs of the patient. This was corroborated with coordinated care which was tailored to the needs and preferences of the patients.

Staff kept to the trust values. The trust had developed a set of care promises to reflect how they expected their staff to treat patients, visitors and each other. These were I will make you feel welcome, I will make time to listen to you, I will be polite, courteous and respectful, I will keep you informed and explain what is happening. I will admit to mistakes and do all I can to put them right, I will value your point of view, I will be caring and kind, I will keep you involved and I will go the extra mile. We saw staff keeping to these values. For example, staff were polite, courteous and respectful when interacting with patients and visitors.

On the first day of our inspection the trust was holding a Speak Up Day aimed to raise awareness of the number of ways colleagues can raise a concern about safety at work. We spoke with the Freedom to speak up Guardian for community services and they described good open leadership and described community services as involving fewer levels of management and more employee autonomy in the decision-making process compared to the acute setting.

Staff at a focus group said that there were open modes of communication between staff and senior leaders, inducing the chief executive such as social media including twitter.

**Governance**

**The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

All the medically fit for discharge and intermediate care wards sat within the Primary Care, Community and Therapies Group.

Managers had a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff.

The organisation was split into clinical groups with community inpatient care under the therapy and community group (TCG). A group director of nursing, group head of nursing and clinical directorate lead managed the TCG.

The TCG was split into three divisions, with inpatient services part of the 'iBeds' division, managed on a day-to-day basis by a matron. A ward manager, supported by a team of senior staff nurses, managed each Henderson, Eliza Tinsley and McCarthy wards.

Specialty services across all teams fed issues into their respective Directorate Governance Meetings attended by Band 8 staff. The Group Director was in daily liaison with the Group Director of Nursing and the Director of Therapies to discuss and respond immediately and proactively to any issues as they arose. A monthly directorate governance meeting took place. This fed in to the group management board which was chaired by the group director which fed into the bi-monthly Group Review Chaired by the Chief Operating Officer and the Monthly Executive Quality Committee Chaired by the Director of Governance.

All ward managers told us they felt confident within their roles, and supported by each other and through meetings such as monthly meetings with the matron and group director for a confirm and challenge meeting and monthly meetings.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. There were clear divisional governance arrangements and there were teams and accountable personnel to oversee governance. There were clear and effective processes for managing risks, issues and performance. This was in seen in their evidence based practice, competency and skills mix of staff and in their documentation and minutes from meetings.

We reviewed meeting minutes. Band 6 nursing staff held regular meetings where they discussed sickness, staffing, complaints, incidents recruitment, communication with team and current pertinent issues.

Band 7 nursing staff collaborated in a multi-disciplinary setting, to share ideas and feedback, and to outline any governance/quality initiatives required. Therapy leads and ward managers met up every six weeks.

**Management of risk, issues and performance**

**Although the trust had systems for identifying risks, managers did not always use them effectively.** There was no alignment between the recorded risks and what staff said was on their worry list.

Following our previous inspection, we were not assured that ward managers regularly reviewed and updated their risks, that the documented risks fully reflected those found during inspection or that ward managers had a robust way of measuring the impact of changes.

During this inspection, we reviewed each of the risk registers and found they mostly contained generic environmental risks but not the clinical risks managers had identified. These included delays in discharging patients due to social care delays with external agencies or staffing issues such as high use of bank/agency staff and difficulty recruiting Band 5 nurses. For example, in relation to the Eliza Tinsley Ward, managers identified sharps/splashes and a risk that patients, staff or visitors could slip, trip or fall within trust premises because of environmental hazards and personal illness/disability.

Managers failed to identify control measures to reduce or prevent risks. For example, managers identified one risk related to McCarthy Ward which was ‘increasing number of falls’ as a risk factor and one of the risks relating to Eliza Tinsley Ward as ‘Conservatory internal doors could close behind the person using the conservatory and they would be unable to open them again from inside the conservatory’. Neither had control measures or actions in place.

Although the risk register for Leasowes identified three risks which were more location specific, such as lack of hospital profile beds, these still did not reflect the scope of what staff and managers identified as risks during our visits.

Managers had a framework to oversee the quality and safety of patient care. We requested the previous six sets of clinical governance meeting minutes. The trust sent us minutes from May to August 2018, however there were none for June 2018. The agenda included areas such as, sickness, PDR, mandatory training, patient experience, finance, budget update, savings schemes, individual service highlights (dietetics, Intermediate Care, Medicine, Nursing, Speech and Language, Stroke, Neuro Surgery, Paediatrics) and electronic patient record updates. The June meeting did not take place due to many staff being on annual leave

**Information Management**

**The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.**

Following our inspection, we asked the trust to describe an account of how information management differed to the acute trust including which records were shared electronically and which were not. The trust did not provide us with this information, however staff told us they had access to all relevant information they needed to provide good quality care to their patients.

Staff told us the new electronic patient record was about to go live. The new system promised to provide clinicians with more time to care as they were less reliant on paper systems and duplication of entries into multiple existing systems. A major benefit was introduction of electronic prescribing, which should reduce medication errors significantly. Staff told us they were worried the infrastructure would not support the new system. Staff had escalated their concerns and the trust were working towards a solution.

**Engagement**

**The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**

We found improvements in public and patient engagement. For example, we saw a patient and family notice board. Each ward held a patient forum monthly where patients and relatives were encouraged to attend.

The service gathered feedback from patients and relatives through the Friends and Family Test and ad hoc feedback to staff. Feedback from the friends and family test demonstrated staff provided a good level of care. The number of returns for the friends and family test between April and August 2018 ranged from 17 to 36. The friends and family test results for this period showed all of patients would recommend the service to family and friends. The friends and family score ranged from 85 to 95%.

Managers looked for ways of collecting patient feedback on a local basis. Managers designed their own patient feedback questionnaire to measure patient's satisfaction with the service.

The service aimed to promote open and meaningful conversations between patients and staff to make improvements to the inpatient services. Local feedback forms were given to patients to complete upon their discharge. Leasowes had gained full compliance with patient completion.

The trust aimed to help resolve patient's issues whilst they were still in the trust's care, so that they could make a difference at the time, rather than when the patient had gone home. Patients and

relatives could access phones at the Purple Points to speak to advisors between 9am and 9pm any day and they would help. The purple points offered dialogue in six languages including English, Romanian, Polish and Urdu.

The trust gave staff the opportunity to share their experiences and make suggestions for service improvements. For example, staff were offered the opportunity to participate in the annual staff survey. We reviewed the trust wide staff survey results for 2017. Following the results of the survey, the trust asked senior managers to reflect on the findings and together with their teams discuss the actions they would take within their teams to improve engagement. Teams were asked to consider three questions. The first was, "What are your ideas for continuing to improve the trust as a place to work?" Eliza Tinsley Ward staff answered, "pressure put on staff when patient flow was compromised and review of bank pay rates". The second question was "How can you improve on communication within your team, directorate and group?", Eliza Tinsley staff answered, "Attend meetings and disseminate information, QIHD, access to computers". The final question was "How can you involve colleagues in important decisions? And Eliza Tinsley staff responded, "Work life balance help to ensure there is a healthy balance, often staff feel they are at work all of the time".

We did not see feedback from any the other inpatient community teams.

Staff attended team meetings monthly.

Managers involved staff in decisions that affected them and the services they provided. A QIHD learning topic was 'Your contributions to our quality plan goals' CQC action plan Going for Good. Staff reviewed the action plan, discussed improvements made and how to achieve higher standards, discussed multi-disciplinary team working together to sustain improvements and deprivation of liberty and mental capacity act refresher. We saw a copy of the SWB Team Talk for August 2018. This was communication from the monthly corporate communication team.

**Managers thanked all nurses for their contribution in providing safe, effective, compassionate care for patients and those they care for.** Henderson unit celebrated International Nurses Day in May 2018. Staff were encouraged to bring in food/pop and put this into the staff room.

We saw a shared learning topic in a 2018 QIHD was 'Learning from patient stories'. This gave staff the opportunity to learn from their patient's own perspective and provided staff with an opportunity to understand their experience of the care they received helping staff to learn the good, and what could be done to improve their experience.

**Learning, continuous improvement and innovation**

**The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.**

Staff told us about the listening into action events. Listening into Action was a way of engaging and empowering clinicians and staff around making improvements that will improve the care they give to their patients.

The purpose of LiA was to listen to staff and support them to make the changes, removing any barriers so they could take the lead and contribute to the success of their trust. Staff specifically told us about their LiA event which was attended by social workers, looking at how staff and social workers could work together to provide more seamless care for their patients and to address delayed discharges.

Therapy staff showed innovative ways to access training and development opportunities. Therapy staff told us they brought in external training and sold places to external professionals. Which meant staff did not have to leave the trust and made it more financially viable for them to complete the training.

In October 2017 at the staff awards the Clinical Group Director of Primary Care, Community and Therapies was awarded the Chairman's award for her notable contribution to the local Health and Social Care systems.

Therapy staff showed innovative ways of sourcing the newest up to date equipment for patients. For example, staff told us they had a loan of an exercise bike trainer for six weeks on one of the units. Staff audited its use and found they used the device an average of eight times a day over this period, with patients quoting "it's fantastic, I can work up a sweat without worrying about falling" and "I love it, it's great". The bike allowed staff to work the cardiovascular system using upper and lower limb exercises but in a safe posture for the individual (essential for the frail elderly cohort). This helped patients become stronger, with better exercise tolerance and helped avoid hospital related deconditioning. Staff used their positive audit data to apply for charitable funds to purchase three bikes for the three sites.

**Accreditations**

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

The trust did not report any accreditations relevant to the community inpatient core service.

# Sandwell General Hospital

## Evidence appendix

Sandwell General Hospital

Lyndon

West Bromwich

West Midlands

B71 4HJ

Tel: 0121 553 1831

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Date of inspection visit:

4 September 2018

Date of publication:

5 April 2019

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

# Acute services

## Urgent and emergency care

### Facts and data about this service

**Departments**

The trust has the following emergency departments:

1) The City Hospital main emergency department takes adults and children. This includes the Birmingham Midland Eye Centre (BMEC), which is an ophthalmology emergency department
2) The Sandwell General Hospital main emergency department takes adults and children and is a designated trauma unit.

The trust saw 218,904 attendances including General Practitioner (GP) streamed patients last year and achieved 83.38% against the four hour standard. Both main emergency departments have a GP front end pathway provided for the trust from another registered provider Malling Health.

The trust admitted over 40,000 patients as emergencies last year which was a significant rise. They grew ambulatory alternatives by over 300% in the year. Bed based outward flow was to the acute

medical units (both sites), paediatric assessment units (both sites), an emergency gynaecology unit (City site) and a surgical assessment unit (Sandwell site).

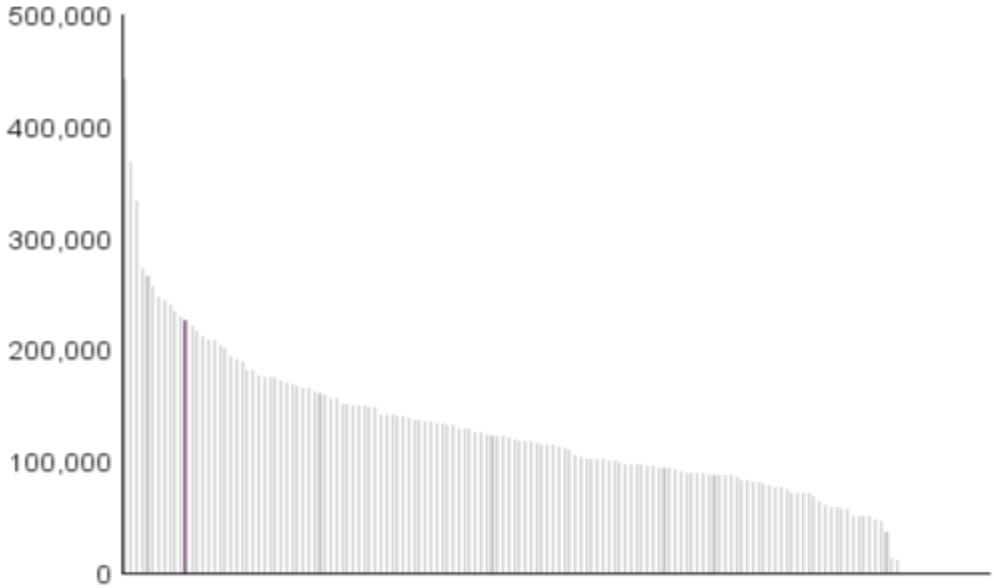
Mental health urgent care is supported on the City and Sandwell sites by two Mental Health providers.

*(Source: Routine Provider Information Request (RPIR) – Context acute)*

**Activity and patient throughput**

From July 2017 to June 2018 there were 226,152 attendances at the trust's urgent and emergency care services as indicated in the chart below.

**Total number of urgent and emergency care attendances at Sandwell and West Birmingham Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018**

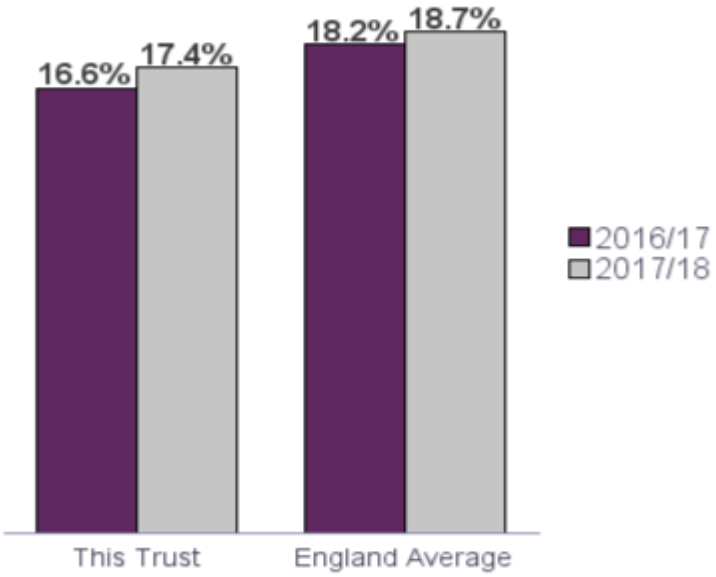



*(Source: NHS England)*

**Urgent and emergency care attendances resulting in an admission**

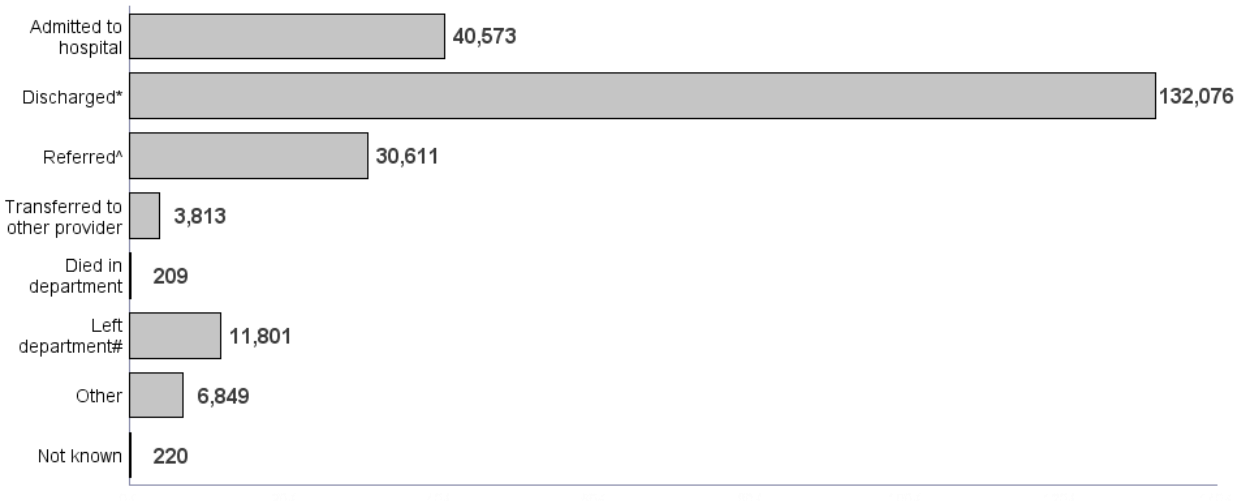
The percentage of Accident and Emergency (A&E) attendances at this trust that resulted in an admission increased slightly in 2017/18 when compared to previous year. In both years, the proportions were lower than the England averages.

**Percentage of A&E attendances at Sandwell and West Birmingham Hospitals NHS Trust 2016/17 and 2017/18**




*(Source: NHS England)*

**Urgent and emergency care attendances by disposal method, from April 2017 to March 2018**




* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

*(Source: Hospital Episode Statistics)*

Throughout the inspection we reviewed 10 sets of patient records. We spoke with six patients and three relatives. We spoke with 24 staff, including consultants, nurses, managers and senior nursing staff.

# Is the service safe?

## Mandatory Training

**The service provided mandatory training in key skills to all staff; however, the service did not ensure everyone completed it.**

## Mandatory training completion rates

The trust set a target of 95% for the completion of mandatory training.

**Trust level**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Moving and handling – non-patient limited load handling | 1 | 1 | 100.0% | 95% | Yes |
| Medical devices competency form | 190 | 193 | 98.4% | 95% | Yes |
| Equality & diversity | 188 | 193 | 97.4% | 95% | Yes |
| Harassment & bullying level 1 | 187 | 193 | 96.9% | 95% | Yes |
| Fire safety - workplace training | 186 | 192 | 96.9% | 95% | Yes |
| Health & safety | 182 | 193 | 94.3% | 95% | No |
| Introduction to information governance | 80 | 85 | 94.1% | 95% | No |
| Blood collection | 78 | 86 | 90.7% | 95% | No |
| Conflict resolution initial training | 175 | 193 | 90.7% | 95% | No |
| Resuscitation: basic life support | 162 | 185 | 87.6% | 95% | No |
| Infection control | 162 | 193 | 83.9% | 95% | No |
| Medical devices training | 151 | 182 | 83.0% | 95% | No |
| Medicines management | 152 | 193 | 78.8% | 95% | No |
| Conflict resolution update | 78 | 101 | 77.2% | 95% | No |
| Moving and handling - patient handling | 143 | 189 | 75.7% | 95% | No |
| Transfusion | 107 | 166 | 64.5% | 95% | No |
| Information governance refresher module | 55 | 108 | 50.9% | 95% | No |

In urgent and emergency care at the trust, the 95% completion target was met for six of the 18 mandatory training modules for which qualified nursing staff were eligible. Two of these courses had a completion rate of 100%, although these are based on only one eligible member of staff having completed the training. The lowest completion rate was for the information governance refresher module, which had a rate of 50.9%.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - basic consent | 16 | 16 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 48 | 50 | 96.0% | 95% | Yes |
| Medical devices competency form | 45 | 50 | 90.0% | 95% | No |
| Infection control | 43 | 50 | 86.0% | 95% | No |
| Moving and handling - medical staff | 31 | 42 | 73.8% | 95% | No |
| Equality & diversity | 34 | 50 | 68.0% | 95% | No |
| Information governance refresher module | 7 | 11 | 63.6% | 95% | No |
| Fire safety - workplace training | 31 | 50 | 62.0% | 95% | No |
| Resuscitation: basic life support | 30 | 50 | 60.0% | 95% | No |
| Conflict resolution initial training | 29 | 50 | 58.0% | 95% | No |
| Health & safety | 27 | 50 | 54.0% | 95% | No |
| Medicines management | 27 | 50 | 54.0% | 95% | No |
| Transfusion | 22 | 47 | 46.8% | 95% | No |
| Medical devices training | 20 | 44 | 45.5% | 95% | No |
| Introduction to information governance | 17 | 39 | 43.6% | 95% | No |
| Conflict resolution update | 4 | 12 | 33.3% | 95% | No |

In urgent and emergency care at the trust, the 95% completion target was met for two of the 16 mandatory training modules for which medical and dental staff were eligible. Two of these courses had a completion rate of 100%. In contrast, only 43.6% of the eligible medical and dental staff had completed the introduction to information governance and only four of the 12 eligible staff (33.3%) had completed the conflict resolution module.

**Sandwell General Hospital**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Medical devices competency form | 109 | 110 | 99.1% | 95% | Yes |
| Equality & diversity | 107 | 110 | 97.3% | 95% | Yes |
| Harassment & bullying level 1 | 106 | 110 | 96.4% | 95% | Yes |
| Blood collection | 46 | 48 | 95.8% | 95% | Yes |
| Fire safety - workplace training | 105 | 110 | 95.5% | 95% | Yes |
| Introduction to information governance | 48 | 51 | 94.1% | 95% | No |
| Health & safety | 103 | 110 | 93.6% | 95% | No |
| Conflict resolution initial training | 96 | 110 | 87.3% | 95% | No |
| Resuscitation: basic life support | 88 | 102 | 86.3% | 95% | No |
| Medical devices training | 79 | 102 | 77.5% | 95% | No |
| Moving and handling - patient handling | 84 | 110 | 76.4% | 95% | No |
| Infection control | 81 | 110 | 73.6% | 95% | No |
| Medicines management | 80 | 110 | 72.7% | 95% | No |
| Conflict resolution update | 33 | 50 | 66.0% | 95% | No |
| Transfusion | 65 | 110 | 59.1% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Information governance refresher module | 21 | 59 | 35.6% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% target was met for five of the 16 mandatory training modules for which qualified nursing staff were eligible. The lowest completion rate was for the information governance refresher module, which had a rate of 35.6%. Nursing staff were not required to complete fire marshal training or non-patient moving and handling.

We requested an action plan following the inspection to improve all aspects of mandatory training compliance at Sandwell Hospital's emergency department for nursing staff. The trust updated the action plan in September 2018 and it showed actions in place to improve mandatory training compliance. However, we found the action plan specifically looked at basic life support, advanced life support (adults and children), moving and handling, and patient group directive (PGD) use training. From this, we were not assured the trust had a robust plan in place to improve all aspects of mandatory training that had not met the target of 95% compliance.

The action plan did contain actions and a red, amber, green (RAG) rating for each action. Staff recorded the responsible person and clearly set a target date for completion of each action. However, the action plan did not contain a next review date; therefore, we were unsure at what frequency the action plan was being reviewed.

The trust provided updated figures as of 31 August 2018 for life support training for nursing staff.

| Life Support Level | Compliance |
|---|---|
| Intermediate Life Support – Adult | 100% |
| Intermediate Life Support – Paediatric | 93.4% |
| Advanced Life Support – Adult | 60% |
| Advanced Life Support – Paediatric | 80% |

The trust told us that for intermediate life support (paediatric), two nurses required this training and both had dates booked in September 2018. For advanced life support (adult), eight nurses required this training. Seven nurses were booked to attend training between September and December 2018, with the eighth nurse a new member of staff and awaiting training dates. For paediatric advanced life support, four nurses required this. Three nurses had training dates in December and one was awaiting training dates.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - basic consent | 7 | 7 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 21 | 21 | 100.0% | 95% | Yes |
| Medical devices competency form | 19 | 21 | 90.5% | 95% | No |
| Infection control | 18 | 21 | 85.7% | 95% | No |
| Moving and handling - medical staff | 15 | 19 | 78.9% | 95% | No |
| Equality & diversity | 16 | 21 | 76.2% | 95% | No |
| Fire safety - workplace training | 14 | 21 | 66.7% | 95% | No |
| Conflict resolution update | 2 | 3 | 66.7% | 95% | No |
| Resuscitation: basic life support | 13 | 21 | 61.9% | 95% | No |
| Health & safety | 12 | 21 | 57.1% | 95% | No |
| Conflict resolution initial training | 12 | 21 | 57.1% | 95% | No |
| Medicines management | 11 | 21 | 52.4% | 95% | No |
| Information governance refresher module | 3 | 6 | 50.0% | 95% | No |
| Transfusion | 10 | 21 | 47.6% | 95% | No |
| Medical devices training | 9 | 19 | 47.4% | 95% | No |
| Introduction to information governance | 7 | 15 | 46.7% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% target was met for two of the 16 mandatory training modules for which medical and dental staff were eligible. The lowest completion rate was for the introduction to information governance module, which had a rate of 46.7%. Medical staff were not required to complete fire marshal training or non-patient moving and handling.

We requested an action plan from the trust following the inspection in relation to improving compliance amongst medical staff in all areas of mandatory training. The action plan provided details ongoing concerns, actions to improve or mitigate the risk, who is responsible and a date for the actions to be completed. However, we found no review date within the action plan; therefore, we were unsure when the action plan was last reviewed, or next due to be reviewed.

The trust provided up dated figures for life support training for medical staff.

We found that all consultants and middle grades of doctors had completed basic and advanced life support for adults. All consultants and middle grade doctors had completed their advanced trauma life support training except one consultant. All consultants had completed advanced paediatric life support. However, we found that one out of nine middle grade doctors had completed advanced paediatric life support. This was of concern as middle grade doctors (registrar level) were in charge of the emergency department overnight and out of hours.

We found that of the five junior doctors specifically allocated to the emergency department, two were compliant with basic life support and one was compliant with advanced trauma life support and advanced paediatric life support.

**'Other' urgent and emergency care department**

Please note the trust provided a small amount of data for nursing staff for which the site was assigned to 'other'. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing

staff in the urgent and emergency care department at sites classified as 'other' by the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Information Governance: Introduction to Information Governance | 1 | 1 | 100.0% | 95% | Yes |
| Blood Collection | 1 | 1 | 100.0% | 95% | Yes |
| Medical Devices Competency Form | 7 | 7 | 100.0% | 95% | Yes |
| Health & Safety | 7 | 7 | 100.0% | 95% | Yes |
| Equality & Diversity | 7 | 7 | 100.0% | 95% | Yes |
| Conflict Resolution Initial Training | 7 | 7 | 100.0% | 95% | Yes |
| Moving and Handling – Non-Patient Limited Load Handling | 1 | 1 | 100.0% | 95% | Yes |
| Conflict Resolution Update | 7 | 7 | 100.0% | 95% | Yes |
| Resuscitation: Basic Life Support | 7 | 7 | 100.0% | 95% | Yes |
| Fire Safety - Workplace Training | 7 | 7 | 100.0% | 95% | Yes |
| Harassment & Bullying Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Infection Control | 7 | 7 | 100.0% | 95% | Yes |
| Medicines Management | 6 | 7 | 85.7% | 95% | No |
| Moving and Handling - Patient Handling | 5 | 6 | 83.3% | 95% | No |
| Medical Devices Training | 5 | 6 | 83.3% | 95% | No |
| Information Governance: Information Governance Refresher Module | 3 | 6 | 50.0% | 95% | No |

In urgent and emergency care at sites classified as 'other' by the trust, the 95% target was met for 12 of the 16 mandatory training modules for which qualified nursing staff were eligible. All 12 of the courses which met the target attained a 100% completion rate, although it should be noted that the number of eligible staff for each course was smaller than at other sites. Therefore, each staff member represents a higher proportion of the total.

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

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it; however, compliance with training did not always meet the trusts targets.

We reviewed the safeguarding children policy, updated August 2018. We found the policy lacked detail and did not specifically discuss the specific challenges within the emergency department setting. The policy did not contain any definitions of what abuse was. The policy did not state the frequency at which staff should undertake training and refresher training. We found no reference to female genital mutilation (FGM) within the policy. It is a requirement for healthcare bodies to report all instances of actual or suspected FGM. The policy did not contain a reference to Prevent, the national antiracialisation programme. The document control section of the policy states that the Prevent strategy was added as an appendix in 2014; however, the trust did not provide this so we were unable to assess the effectiveness. The policy did contain up to date contact information for both local authorities covered by the trust, including emergency out of hours details.

The children's safeguarding policy posed a risk that staff would not have the information at hand to deal with concerns regarding children and young people.

We asked two senior nurses during the inspection for the policy on abduction and missing children; however, staff did not know of a policy covering abduction and could not locate one on the trusts internal policy system. We requested a policy covering abduction and removed children from the emergency department. The trust told us this was within the children's safeguarding policy; however, we could not find specific guidance for staff on how to deal with an abducted, taken or missing child from the service. Both senior nurses asked told us they would ring the police; however, did not know of an internal process specifically for abducted, taken or missing children.

We reviewed the policy for the safeguarding and protection of adults at risk, updated August 2017. The policy was detailed with regards definitions of abuse and the process to undertake where staff have concerns about a patient. However, the policy does not contain contact information for the local authority, which could cause a delay in the referral process. The policy did contain information on modern slavery and Prevent.

We reviewed the trusts Mental Health Act policy, due for review in October 2017; however, not updated. The policy contains information on the different section under which a patient could be held, the accountability and responsibilities of staff and how to gain additional support for patients with a mental health condition. Although not updated, the policy was reflective of current requirements and practices.

Staff asked did understand their responsibilities in relation to safeguarding patients. Senior nursing staff were aware of the increased risk of harm to children and young people when the children's area closed overnight. Staff could articulate the signs of abuse and harm within children, young people and adults and knew how to escalate their concerns.

## Safeguarding training completion rates

The trust set a target of 95% for the completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 30 | 31 | 96.8% | 95% | Yes |
| Safeguarding Children Level 3 | 101 | 120 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 59 | 73 | 80.8% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with two of these courses achieving a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 80.8%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 11 | 13 | 84.6% | 95% | No |
| Safeguarding Adults Level 2 | 16 | 20 | 80.0% | 95% | No |
| Safeguarding Children Level 2 | 23 | 37 | 62.2% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both of these courses achieving a 100% completion rate. The safeguarding children level 2 module had the lowest completion rate, at 62.2%.

**Sandwell General Hospital**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 2 | 11 | 11 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 53 | 63 | 84.1% | 95% | No |
| Safeguarding Children Level 2 | 37 | 47 | 78.7% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 78.7%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 2 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 1 | 21 | 21 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 21 | 21 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 10 | 11 | 90.9% | 95% | No |
| Safeguarding Children Level 2 | 7 | 10 | 70.0% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% completion target was met for three of the five safeguarding training modules for which medical and dental staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 70%.

**‘Other’ urgent and emergency care department**

Please note that the trust provided a small amount of data for nursing staff for which the site was assigned to ‘other’. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at sites classified as ‘other’ by the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 7 | 7 | 100.0% | 95% | Yes |
| Safeguarding Children Level 2 | 6 | 7 | 85.7% | 95% | No |

In urgent and emergency care at sites classified as ‘other’ by the trust, the 95% completion target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 85.7%.

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

## Cleanliness, infection control and hygiene

**The service did not control infection risk consistently well. Staff did not ensure the emergency department was clean to prevent the spread of infection.**

We found a mixed compliance with cleanliness and hygiene practices across the emergency department at Sandwell General Hospital. We found areas within the emergency department that were visibly dirty and contaminated with bodily fluids. We observed staff did not routinely clean their hands between patient contact.

Within the resuscitation area, we found spots of blood on the floor and on an equipment trolley within one of the bed spaces. We found used electro cardiogram (ECG) electrodes attached to three of the 10 leads on the ECG machine and two of the three ultrasound probes had lubricant gel on them from previous patient use. The blood gas machine and room had blood splatter on the surface, floor and on top of the sharps bin. We observed dried blood around the connection points on the blood gas machine.

The ambulance handover corridor and five bedded bay were visibly un-clean and we observed used blooded swabs on the floor in the corridor. We found a cage of equipment in the ambulance corridor containing immobilisation equipment and oxygen cylinders. Immobilisation equipment was hanging out of the cage and had a large amount of dried blood visible. We raised our concerns to the departments matron and hospital ambulance liaison officer (HALO) who took swift action to remove the blooded equipment and ensure the cage and surrounding area was cleaned and safe.

Within the paediatric area in ‘majors’, we found trays within treatment rooms that had visible dust and dirt within them. These stored airways, monitoring leads and other immediate care equipment. We found the rest of the paediatric area to be visible clean and tidy. We requested environmental cleaning audits for the emergency department. The trust provided cleaning audits from 20 August to

2 September 2018. We found mixed compliance amongst the results; however, the results showed a mostly positive outcome.

The emergency nurse practitioner (ENP) ‘minors’ area was visibly clean and tidy.

Throughout the inspection, we did not observe staff washing their hands or using sanitising gel between patient contact. We observed three members of staff not complying with being ‘bare below the elbows’, with one wearing a wrist watch, one wearing bracelets and the third wearing a ring with a large stone in. We requested hand hygiene audits from the trust, which showed mixed compliance with hand hygiene. The below information shows compliance with hand hygiene requirements in Sandwell General Hospitals emergency department, against a 95% target.

| September 2017 | October 2017 | November 2017 | December 2017 | January 2018 | February 2018 | March 2018 | April 2018 | May 2018 | June 2018 | July 2018 | August 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 99% | 99% | 52% | No data | 94% | 93% | No data | 88% | No data | 98% | 98% | 86% |

The trust told us that when compliance falls below target of 95%, staff should undertake weekly audits. However, the trust did not provide evidence to support this for the emergency department at Sandwell General Hospital.

We did not observe staff cleaning equipment between patient use or cleaning trolleys between patient use. The department did not use ‘clean’ stickers or equivalent to identify when equipment had been cleaned. Staff were unable to provide assurance of when equipment had been cleaned. We requested how senior staff had assurance equipment was cleaned between patient use and what systems were in place to monitor this. However, the trusts response was a quick reference guide on what cleaning products to use on what equipment. No assurance was provided by the trust to demonstrate oversight of cleanliness of equipment.

The observed lack of hand hygiene combined with a visibly untidy and un-clean department and lack of assurance around the oversight of cleaning posed an infection risk to patients and staff.

## Environment and equipment

**The service did not have suitable premises and equipment to care for patients.**

We found equipment management mixed across the department. The environment within the emergency department was not always fit for purpose and did not consistently promote the safety of patients.

We found the resuscitation area, where the most unwell patients were taken, was suitable and fit for purpose. The resuscitation area consisted of four bays, with one of these allocated as the paediatric bay. Each bay contained a resuscitation trolley and other appropriate equipment such as monitoring, oxygen and venepuncture equipment. Each bay was set out in the same way to promote the knowledge of the location of equipment within this area and reduce delays in patient care and treatment.

We reviewed the four resuscitation trolleys and found these to contain life support equipment suitable for adults (in three) and children (in one). Resuscitation drugs were readily available within these trolleys. Staff undertook daily checks, and after each use, to ensure all equipment was present and in date. We found completed check sheets for each trolley for the past month. Each

trolley was tagged and this number noted to identify any tampering of equipment.

All equipment looked at across the department had been electrical safety tested, and each had a sticker detailing the previous and or next service date. Staff ran daily checks on the defibrillators within the department and we saw these had been completed.

Within the paediatric area of 'majors' and within the paediatric resuscitation bay we found a number of items out of date, including: dressings, saline for injection, oropharyngeal airways and pH testing strips. We found an out of date bag of intravenous (IV) fluids within the paediatric resuscitation trolley.

The department had three transfer bags to assist in the movement of sick patients, two for adults and one for paediatric patients. One of the adult bags was not sealed on examination and we found out of date saline for injection within both adult transfer bags. The paediatric transfer bag was sealed and all equipment in date.

The emergency hypoglycaemia box within the resuscitation room should have contained three forms of glucose to treat hypoglycaemia in an emergency. However, we found the box contained three packets of biscuits and a packet of sweets.

We raised the concerns regarding out of date equipment, IV fluids and the concerns regarding the hypoglycaemia box with the emergency department matron and the nurse in charge of paediatrics who ensured the equipment was replaced immediately.

The paediatric area within 'majors' was operational 9am to 9:30pm seven days a week. Staff triaged and treated all children attending the department within these hours in the paediatric area. Access was restricted to this area to keep children and young people safe. Out of hours (9:30pm to 9am) children and young people of all ages were treated within the adult areas of the emergency department. There was a risk children and young people may be exposed to situations involving violence and aggression, alcohol and confused adult patients. The trust reported a total of 878 incidents involving children across City Hospital and Sandwell Hospitals emergency department from March 2018 to August 2018. However, the trust did not provide the dates of the incidents; therefore, we were unable to undertake any analysis of the information to establish any days of the week or months that had a particular spike in incidents.

The emergency department had a designated room to treat patients with a mental health condition or at risk of suicide. The room was a cubicle in the main 'majors' area of the department. Although the room had reduced equipment within it and had been modified (for example the door opened inwards and outwards), we found ligature risks with the room. This posed a risk to patients at risk of suicide. We raised concerns during our previous inspection regarding the 'safe space' for patients at risk of suicide. We found little improvement during this inspection.

## Assessing and responding to patient risk

## Emergency Department Survey 2016

The trust scored about the same as other trusts for the five Emergency Department Survey questions relevant to safety.

| Question | Score | RAG |
|---|---|---|
| Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff? | 7.6 | About the same as other trusts |
| Q8. How long did you wait before you first spoke to a nurse or | 5.7 | About the same as |

| | | |
|---|---|---|
| doctor? | | other trusts |
| Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse? | 6.1 | About the same as other trusts |
| Q33. In your opinion, how clean was the emergency department? | 8.0 | About the same as other trusts |
| Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? | 9.6 | About the same as other trusts |

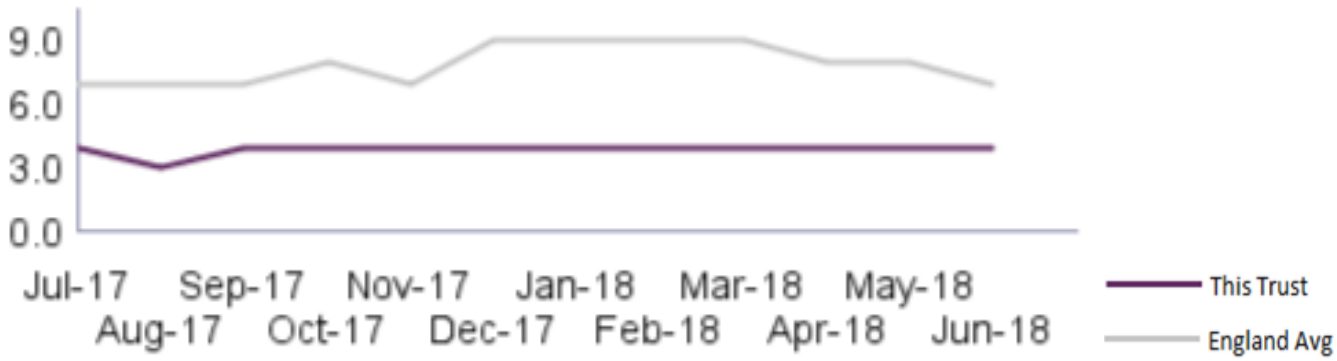
*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

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

The median time from arrival to initial assessment was consistently better than the overall England median in all 12 months over the period from July 2017 to June 2018.

In the most recent month, June 2018, the median time to initial assessment was four minutes at the trust compared to the England average of seven minutes.

**Ambulance – Time to initial assessment from July 2017 to June 2018 at Sandwell and West Birmingham Hospitals NHS Trust**




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

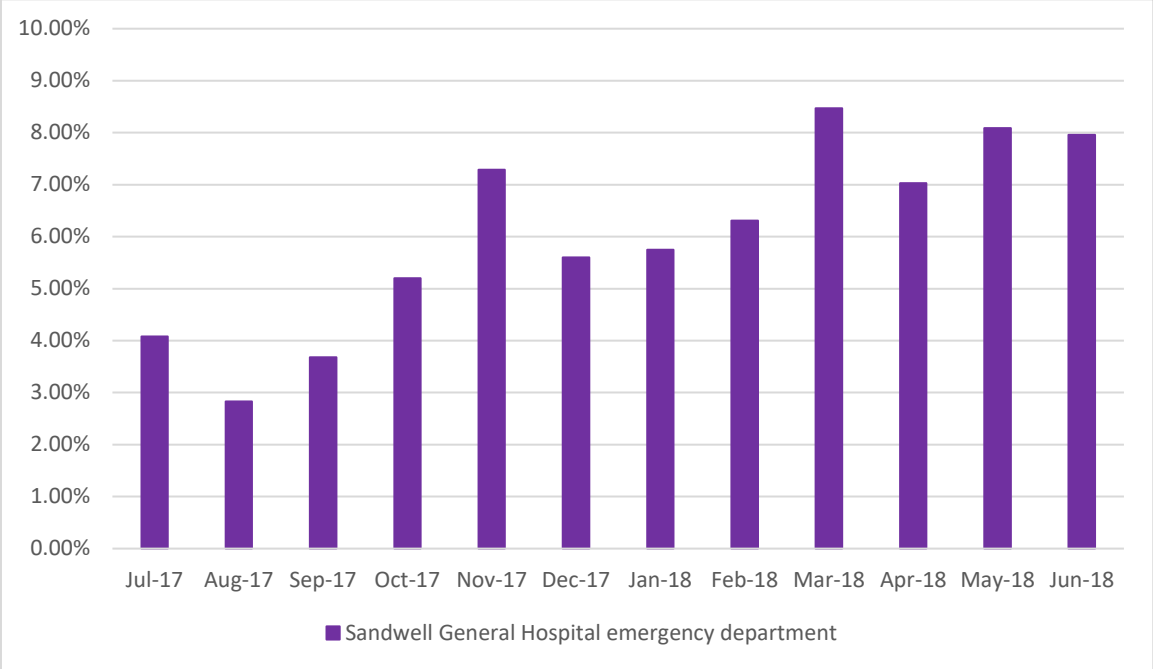
## Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

### Sandwell General Hospital

There is no data available relating to ambulance turnaround times at Sandwell General Hospital.

*(Source: National Ambulance Information Group)*

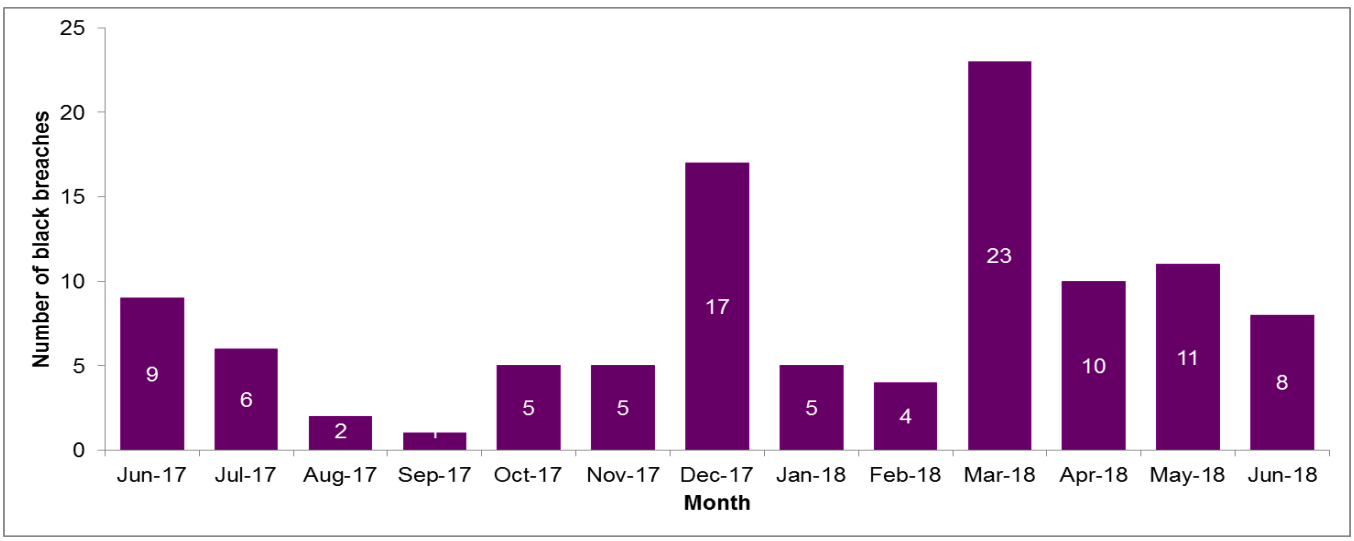
The trust provided data on ambulance turnaround times following the inspection. The trust reported no ambulance turnaround times at Sandwell General Hospital of more than 60 minutes between July 2017 and June 2018. The trust reported an average of 6% of ambulance handovers taking between 30 and 60 minutes. The worst performing month was March 2018 where an average of 8.4% of handovers took between 30 and 60 minutes. The latest month, June 2018, saw an average of 7.9% of handover taking between 30 and 60 minutes.




## Number of black breaches for this trust

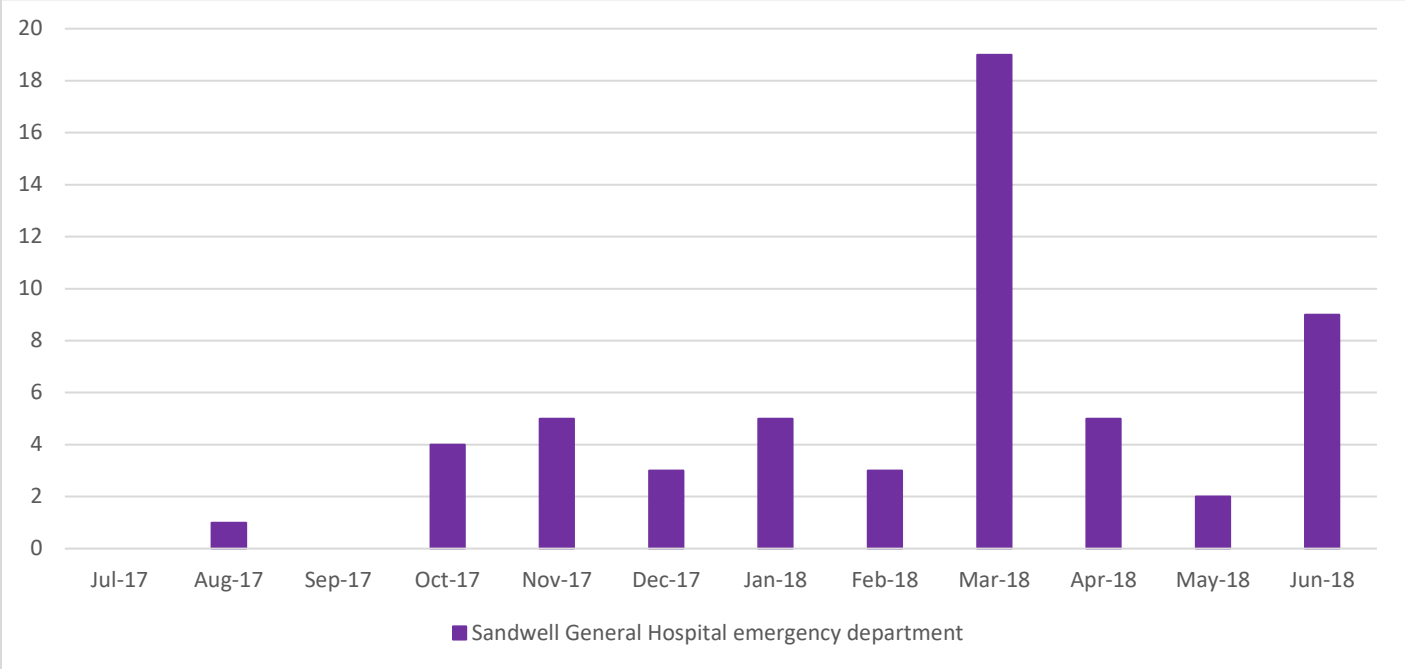
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From June 2017 to June 2018 the trust reported 106 “black breaches”, with peaks in December 2017 (17) and March 2018 (23). The majority of the “black breaches” were attributed to gaps in the registrar rota and a lack of patient flow.




*(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)*

**Sandwell General Hospital Black Breaches – July 2017 to June 2018**




**Sepsis**

The emergency department (ED) assessed sepsis in adults in line with The UK Sepsis Trust guidance on screening adults, children and young people 12 years and over. We saw staff use the sepsis screening tool in adults and implement the sepsis six pathway, which is the national best practice approach to sepsis care. However, senior nursing staff told us that the department does not have a separate screening tool for children under the age of 12. This poses a risk of miss diagnosis in children, as the presentation and observations would fall outside the parameters of an adult. The UK Sepsis Trust does produce assessment and screening tools for children under five years and aged five to 11 years.

The trust provided data in relation to sepsis care and neutropenic sepsis care within the emergency department, specifically relating to how quickly antibiotics were administered. Staff should administer antibiotics within one hour of identifying actual or potential sepsis or neutropenic sepsis.

Percentage of patient who received antibiotics within one hour for neutropenic sepsis at Sandwell General Hospital emergency department

| July 2017 | June 2017 | Aug. 2017 | Sept. 2017 | Oct. 2017 | Nov. 2017 | Dec. 2017 | Jan. 2018 | Feb. 2018 | March 2018 | April 2018 | May 2018 | June 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 74% | 89% | 81% | 82% | 86% | 80% | 88% | 67% | 92% | 89% | 82% | 83% | 74% |

Between July 2017 and June 2018, the emergency department achieved an average of 83% in relation to administering antibiotics within one hour. This was the lowest average score for the trust.

For sepsis care (non-neutropenic), the emergency department began monitoring if staff had ticked the ‘sepsis box’, showing sepsis had been considered, in February 2018. Individual record audits of patients arriving with sepsis begun at the end of August 2018, with one weeks worth of data available. Therefore, we were unable to conclude the timeliness of antibiotic administration in non-neutropenic sepsis patients.

The trust did a snap shot audit of 20 records within the emergency department in relation to sepsis care in March 2018. The audit results were:

| Audit Question | Percentage of Records |
|---|---|

| | |
|---|---|
| Observations on arrival and appropriate action where triggered | 100% (20 out of 20 patients) |
| Received antibiotics within one hour | 90% (18 out of 20 patients) |
| Received appropriate intravenous fluids within one hour | 95% (19 out of 20 patients) |
| Had blood culture tests done | 85% (17 out of 20 patients) |
| Number of patient who required oxygen had this prescribed and administered | 100% (eight out of 20 patients required and all eight had this prescribed and administered) |
| Urine output was documented | 80% (16 out of 20 patients) |
| Sepsis proforma was completed | 75% (15 out of 20 patients) |

During the inspection we reviewed the trusts Patient's Aged 16 and Above who are Missing from Sandwell and West Birmingham Hospitals NHS Trust policy. The policy was detailed and contained escalation actions should an adult or young person aged over 16 years go missing from the trust. It contained specific actions should the person missing be at risk to themselves or others. However, the trust did not have a policy for if a patient aged under 16 years went missing or was abducted from the emergency department. Senior nursing staff did not know of a policy and could not locate one on the trusts internal intranet system. We requested this from the trust; however, the trust told us that this was contained within the children's safeguarding policy. On reviewing this, we were unable to find a specific protocol for children who abscond or were abducted from the trust. This posed a risk that should a child go missing or be abducted that there could be a delay in responding proportionately and cohesively to the incident.

## Nurse staffing

**The service did not have enough nursing staff with the right qualifications, skills, training and experience to provide the right care and treatment.**

The trust reported the following nurse staffing numbers in urgent and emergency care both for April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| City Hospital and Sandwell General Hospital | 241.4 | 299.0 | 80.8% | 220.6 | 277.5 | 79.5% |

The nursing staffing levels were similar in both time periods.

The trust was unable to provide this data broken down by site, indicating that the nursing staff worked at both City Hospital and Sandwell General Hospital.

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

## Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of 2.8% for nursing staff in urgent and emergency care at trust level, which was similar to the trust's target of 3%. A breakdown of

vacancies at site level is provided below.

- City Hospital emergency department: 0.8% (including a rate of -5.2% at BMEC indicating the service was over-established)
- Sandwell General Hospital emergency department: 3.0%
- Staff assigned to 'other' sites within urgent and emergency care: 21.8%

There was a high vacancy rate among staff assigned to 'other' sites, which included nursing staff in the emergency care management team and the resuscitation team. However, this analysis is based on a small number of nursing staff which has inflated the rate and so should be interpreted with care.

The trust noted that the discrepancy between their planned versus actual staffing data and their data for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 19.2% for nursing staff in urgent and emergency care at trust level. There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses. A breakdown of turnover at site level is provided below.

- City Hospital emergency department: 21.2% (including a rate of 11.3% at BMEC based on 1.6 WTE staff leaving over the 12 months)
- Sandwell General Hospital emergency department: 17.3%
- Staff assigned to 'other' sites within urgent and emergency care: 28.8%

None of the sites met the target of 10.5% for band 5 nurses.

The highest turnover rate was among staff assigned to 'other' sites, which included nursing staff in the emergency care management team and the resuscitation team. However, this analysis is based on only two WTE staff leaving over the 12-month time period.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 6.1% in urgent and emergency care at trust level, which was higher than the trust target of 3%. A breakdown of sickness rates by site is found below:

- City Hospital emergency department: 4.1% (including a rate of 4.2% at BMEC)
- Sandwell General Hospital emergency department: 7.5%
- Staff assigned to 'other' sites within urgent and emergency care: 3.2%

The sickness rate at each site was also worse than the trust target.

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

## Bank and agency staff usage

**Trust level**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in urgent and emergency care at the trust from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 1,938 shifts were filled by bank staff and 379 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 1,184 shifts were filled by bank staff and 28 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 1,938 | 1,184 | 3,122 |
| Agency | 379 | 28 | 407 |

**Sandwell General Hospital**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in urgent and emergency care at Sandwell General Hospital from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

Ninety-nine shifts for qualified nurses were filled by bank staff and 185 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

One hundred and seventeen shifts for healthcare assistants were filled by bank staff and four shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 99 | 117 | 216 |
| Agency | 185 | 4 | 189 |

The planned nurse staffing for each shift was:

| Role | Early (7am to 1:30pm) | Late (1pm to 7:30pm) | Night (7pm to 7:30am) |
|---|---|---|---|
| Registered Nurses | 10 | 11 | 11 (until 2am)<br>10 (after 2am) |
| Emergency Nurse Practitioners | 2 | 2 | 0 |
| Healthcare Technicians | 1 | 1 | 1 |
| Healthcare Assistants | 2 | 2 | 2 |

| | | 9am to 9:30pm | 9:30pm to 9am |
|---|---|---|---|
| Paediatric Nurses | 2 | 2 | 0 |

Included within the registered nurses was a shift coordinator and a nurse in charge. The nurse in charge had oversight of the whole department and the shift coordinator manged patient flow through the department. Throughout the inspection, both the nurse in charge and the shift coordinators had a good understanding of the department, the number of patients, reason for admission and length of stay.

The nurse in charge allocated two registered nurses to the resuscitation area per shift. Between 9am and 9:30pm, a registered children's nurse would attend the resuscitation area whenever a sick child was admitted.

The department did not meet the Royal College of Paediatric and Child Health (RCPCH) Facing the Future – Standards for Children and Young People in Emergency Care Settings (published June 2018). The RCPCH standard states that every emergency department treating children should have a minimum of two registered children's nurses on each shift. Sandwell General Hospital's emergency department did not have registered children's nurses on shift between 9:30pm and 9am seven days a week.

**'Other' urgent and emergency care department**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The trust provided some bank and agency data for nursing staff for which the site was assigned to 'other'. These are staff working across multiple sites.

The table below shows the numbers of shifts in urgent and emergency care where the site was not specified from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 563 shifts were filled by bank staff and 45 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 355 shifts were filled by bank staff and 23 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 563 | 355 | 918 |
| Agency | 45 | 23 | 68 |
| Not filled | 104 | 40 | 144 |

*(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)*

## Medical staffing

**The service did not have enough medical staff with the right qualifications, skills, training and experience to provide the right care and treatment.**

The trust reported the following medical and dental staffing numbers both for April 2017 to March 2018 and, more recently, in April/May 2018.

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| City Hospital and Sandwell General Hospital | 110.4 | 125.6 | 87.9% | 112.5 | 130.2 | 86.4% |

The medical and dental staffing levels were similar in both time periods.

The trust was unable to provide this data broken down by site, indicating that the medical and dental staff worked at both City Hospital and Sandwell General Hospital.

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

Planned consultant staffing within the emergency department:

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 8am to 4pm | 1 | 1 | 1 | 1 | 1 |
| 10am to 6pm | 1 | 1 | 1 | 1 | 1 |
| 4pm to 10pm | 1 | 1 | 1 | 1 | 1 |
| 10pm to 8pm (on call) | 1 | 1 | 1 | 1 | 1 |

| | Saturday | Sunday |
|---|---|---|
| 9am to 3pm | 1 | 1 |
| 3pm to 9pm | 1 | 1 |
| 9pm to 9pm On call – no on site | 1 | 1 |

The 3pm to 9pm weekend shift for a consultant shift was a locum, optional shift. The trust provided information to show that between July 2017 and June 2018, this shift was not covered on four occasions.

The department had no specific paediatric medical cover. The trust had one paediatric emergency medicine (PEM) consultant; however, they worked across both emergency departments at the trust and had no set or designated shifts at Sandwell General Hospital.

A number of tier two (middle grade) and their one (junior) supported the consultant and took the clinical lead role when the consultant in charge was not on site. The trust planned staffing for tier two doctors was a minimum of two registrars on site 24 hours a day, seven days a week.

Tier Two medical staff cover

| | Monday to Friday |
|---|---|
| 8am to 4:30pm | 2 |
| 12pm to 10:30pm | 2 |

| | |
|---|---|
| 4pm to midnight | 2 |
| 10pm to 8am | 2 |

Tier Two medical staff cover

Saturday and Sunday

| | |
|---|---|
| 8am to 8pm | 1 |
| 8am to 4:30pm | 1 |
| 12:30pm to 10:30pm | 1 |
| 4pm to midnight | 1 |
| 10pm to 8am | 2 |

Planned tier one doctor cover within the emergency department was:

Tier one medical staff cover

Monday to Friday

| | |
|---|---|
| 8am to 4pm | 2 |
| 10am to 6pm | 1 |
| 12pm to 10pm | 2 |
| 4pm to midnight | 2 |
| 10pm to 8am | 3 |

Tier one medical staff cover

Saturday and Sunday

| | |
|---|---|
| 8am to 6pm | 2 |
| 12pm to 10pm | 1 |
| 2pm to midnight | 2 |
| 10pm to 8am | 3 |

## Vacancy rates

From July 2017 to June 2018, the trust reported that medical and dental staff in urgent and emergency care at trust level were over-established by 17.3%, which was lower than the trust's target of 3%. A breakdown of vacancies at site level is provided below.

- City Hospital emergency department: 9.1% over-established
- Sandwell General Hospital emergency department: 26.0% over-established

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 32.5% for medical and dental staff in urgent and emergency care at trust level. There is no overall trust-wide turnover target. A breakdown of turnover at site level is provided below.

- City Hospital emergency department: 31.2%
- Sandwell General Hospital emergency department: 34.0%

It should be noted that trainee grades may have been included in the turnover data which would have impacted on the rate.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 1.2% in urgent and emergency care at trust level, which was lower than the trust target of 3%. A breakdown of sickness rates by site is found below:

- City Hospital emergency department: 0.6%
- Sandwell General Hospital emergency department: 1.9%

The sickness rate at each site was also better than the trust target.

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

## Bank and locum staff usage

### Trust wide

From June 2017 to May 2018, the trust reported that 2,731 shifts within urgent and emergency care trust-wide were filled by bank staff and 6,562 shifts were filled by locum staff. There were no shifts not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

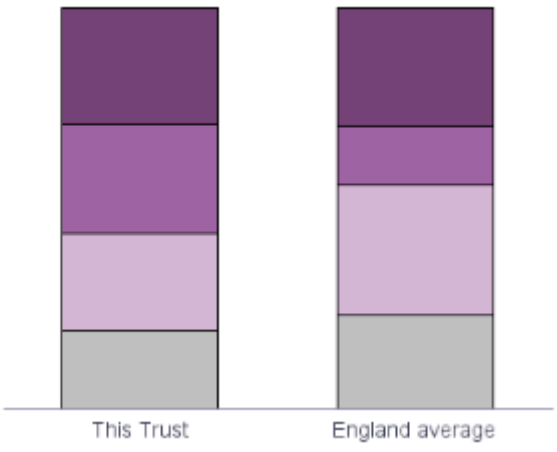
| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank, locum and unfilled) |
|---|---|---|---|---|
| Consultant | 0 | 7 | 0 | 7 |
| Middle Grade | 1,642 | 1,880 | 0 | 3,522 |
| Doctor in Training | 1,089 | 4,675 | 0 | 5,764 |
| **Total** | **2,731** | **6,562** | **0** | **9,293** |

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

### Staffing skill mix

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

**Staffing skill mix for the 46 whole time equivalent staff working in urgent and emergency care at Sandwell and West Birmingham Hospitals NHS Trust**




| | This Trust | England average |
|---|---|---|
| Consultant | 29% | 30% |
| Middle career^ | 27% | 15% |
| Registrar group~ | 24% | 33% |
| Junior* | 20% | 23% |

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

*(Source: NHS Digital Workforce Statistics)*

We observed handover at 10pm from the day consultant to the clinical lead and medical team overnight. The handover was detailed and reviewed each patient within the department, gave an overview of the expected wait time and the number of patients currently waiting for treatment. The handover took place in the medication room within the 'majors' area of the department. We observed two nurses waiting to get medication for patients; however, they were unable to for around 15 minutes whilst handover took place. Senior nursing staff told us this happened at each handover (8am, 4pm and 10pm) and prevented treatment from continuing uninterrupted.

## Records

**Staff did not keep appropriate records of patients' care and treatment. Records were not clear or up-to-date.**

We reviewed 10 patient records, which included a selection of records from adult and paediatric patients. On arrival at the emergency department (ED), each patient is booked in and a set of notes created. These consisted of a front page with basic information about the patient, including presenting complaint, questions relating to mental capacity and safeguarding, and assessment and evaluation sheets for medical and nursing staff to document care delivery. Each patient also had an

observation chart and where appropriate a cannula insertion sheet.

We found mixed compliance in the completion and understanding of patient records within the ED. We found records were generally completed; however, these were not accurate. Medical staff told us that they document the time at which they reviewed the patient, not the time that they document within the record. This could result in the records not being in chronological order and misrepresentative of the time of documentation.

Each record contained a mental capacity assessment section that was made up of tick boxes and statements. The statements within the records were ambiguous and no guidance given as to how to complete. We asked four nurses, and two told us they would tick the boxes if a patient lacked capacity and two said they would not tick the same boxes if a patient had capacity. We were not assured that patient records were contemporaneous, accurate and completed in a timely manner.

The trust undertook weekly audits of records within the emergency department. The audits looked at 10 areas within adult records (including national early warning score (NEWS) completion, pain scoring, care rounds and sepsis screening) and seven areas within children and young patient records (including pain review, parental responsibility documented and observations taken). The emergency department consistently scored above 95% in all areas audited throughout July and August 2018.

Compliance with the Data Protection Act 2018 was mixed across the department. We found staff did not protect the privacy of patient's or their records in the department. Staff routinely left computers logged on and with patient identifiable and personal information visible. We observed scans and test results left open on computers within the 'majors' area. Within the monitored beds, information was easily accessible to patients and visitors as staff did not have sight of paper records at all times.

## Medicines

**The service prescribed, gave and recorded medication well; however, the service did not store medication well. Patients received the right medication at the right dose at the right time.**

The prescribing, dispensing and administering of medication was safe across the department. We found prescription charts completed and nursing staff administering medication in line with the Nursing and Midwifery Council standards for medicine management. Patients with allergies had red name bands so clearly identify they had an allergy.

However, we found two records where allergies had been incorrectly documented. Both records had allergies documented on the front of the admission paperwork and within the medical records. However, these did not match in both cases. For example, one record stated: "no known drug allergies" on the front, but documented an allergy to a specific antibiotic within the medical records. We raised both records with the consultant in charge who actioned the concerns immediately.

The medication room within the 'majors' area of the department had locked medication cupboards within it. All medication was within a locked cupboard. All nursing staff had a personalised key to enter the medication cupboards. However, we found the medication room door was insecure as it

did not have a lock. This posed a potential risk of patients and visitors gaining access to the medication room.

Within the resuscitation room, intravenous (IV) fluids were accessible and we found a risk of them being tampered with. Staff regularly left he resuscitation room with patients and visitors left in there. We found the medication fridge in the resuscitation room was not locked. The fridge contained medication such as eye drops, creams and anaesthetic drugs. We raised out concerns with the nurse in charge and the site manager who told us the fridge used to have a lock on it. Staff could not tell us when the lock was removed or why. Staff ensured that a lock was found for the following day. Although a pad lock was present the following day, it was hanging open from the latch on the fridge leaving the contents insecure.

## Incidents

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

Staff across the department, including nursing, medical and support staff, knew how to report incidents and could talk through the incident reporting process. staff told us they were supported to report incidents and this was encouraged.

## Never Events

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

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

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

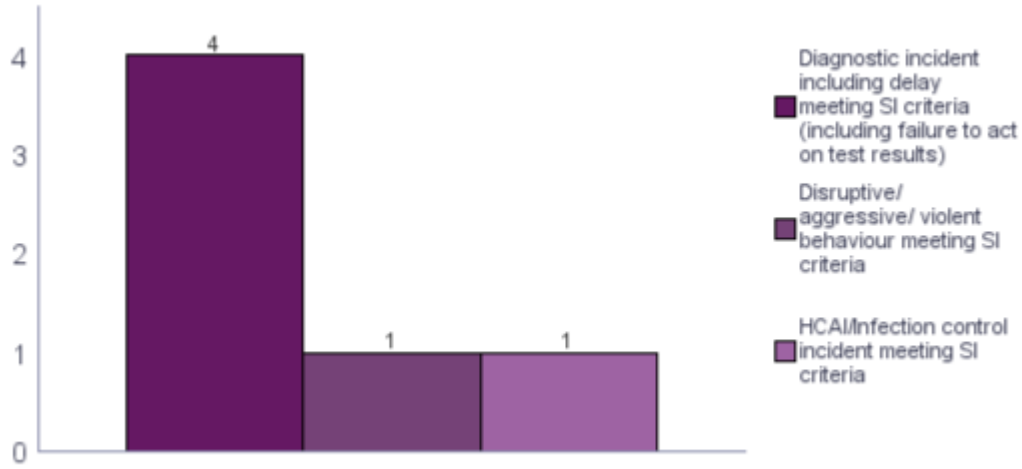
## Breakdown of serious incidents reported to STEIS

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

Of these, the most common type of incident reported was:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): four incidents.

**Serious Incidents (SIs) reported in Urgent and Emergency Care from July 2017 to June 2018**




Site specific information can be found below:

- City Hospital: Three serious incidents
- Sandwell General Hospital: Three serious incidents

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

We requested the six RCAs from the trust relating to serious incidents within the emergency care pathway. The trust provided us with four of these. Of the four, one related to City Hospital, one related to Sandwell General Hospital, however, we were unable to identify which department or hospital the remaining two serious incidents related too.

We reviewed the serious incident relating specifically to Sandwell General Hospital's emergency department. The incident related to the failure to act of blood test results for a patient in November 2011. The RCA was detailed and contained information relating to the incident, background to the situation leading to the incident, actions and learning, and duty of candour.

The actions following this incident included ensuring all clinicians were informed of blood tests requested by triaging staff and to ensure that referral documentation was attached to patients records within the department. During the inspection, we found no concerns with regards accessing and reviewing test results. We observed that referral paperwork, such as from GPs, was available to medical staff and kept with the patient's records. We found evidence that duty of candour had been considered and carried out appropriately.

We reviewed the two RCAs that could not be clearly attributed to either City Hospital, Birmingham Midland Eye Centre or Sandwell General Hospital emergency department. We found these to be detailed and contain the same headings as the previously reviewed RCA. One related to the miss diagnosis of a condition and the second related to the failure to act on test results. One of the actions from the second RCA was to review and change the way abnormal scan results were 'flagged' to clinicians. The RCA states a new system was being rolled out and we saw this in action during the inspection.

All three RCAs stated that lessons were shared during Quality Improvement Half Days (QIHD), which the trust held monthly in each department. We found that staff could tell us about incidents and actions taken as discussed at QIHDs.

We requested the number of incidents involving children and young people under the age of 18 years within the department from March to August 2018. In this six-month period, 877 incidents involving children and young people were recorded at the trust. Of those, 416 happened between 9am and 9:30pm and 412 between 9:30pm and 9am. No time was recorded for the remaining 49 incidents. The average age of the child involved was 12 years, and 144 incidents involved children

under the age of five years.

From July 2017 to June 2018, an average of 1,505 patients under 18 years of age attended the department each month. On average, the department recorded 146 incidents against children and young people each month from March to August 2018. On average, 9.7% of children and young people attending the department have an incident recorded in relation to their care, treatment or circumstances.

**Safety Thermometer**

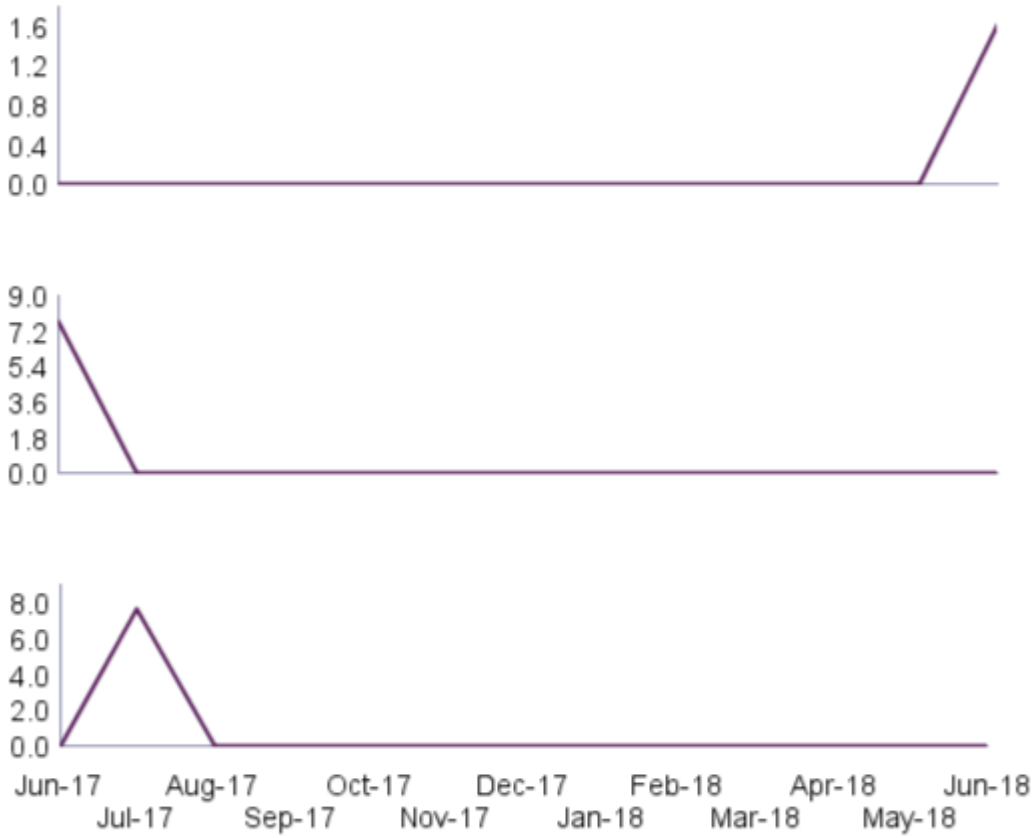
**The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.**

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer (which occurred in June 2018), three falls with harm and three new urinary tract infections in patients with a catheter from June 2017 to June 2018 within urgent and emergency care.

The three new falls all occurred in June 2017 and the three urinary tract infections in July 2017.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Sandwell and West Birmingham Hospitals NHS Trust**




1 Pressure ulcers levels 2, 3 and 4

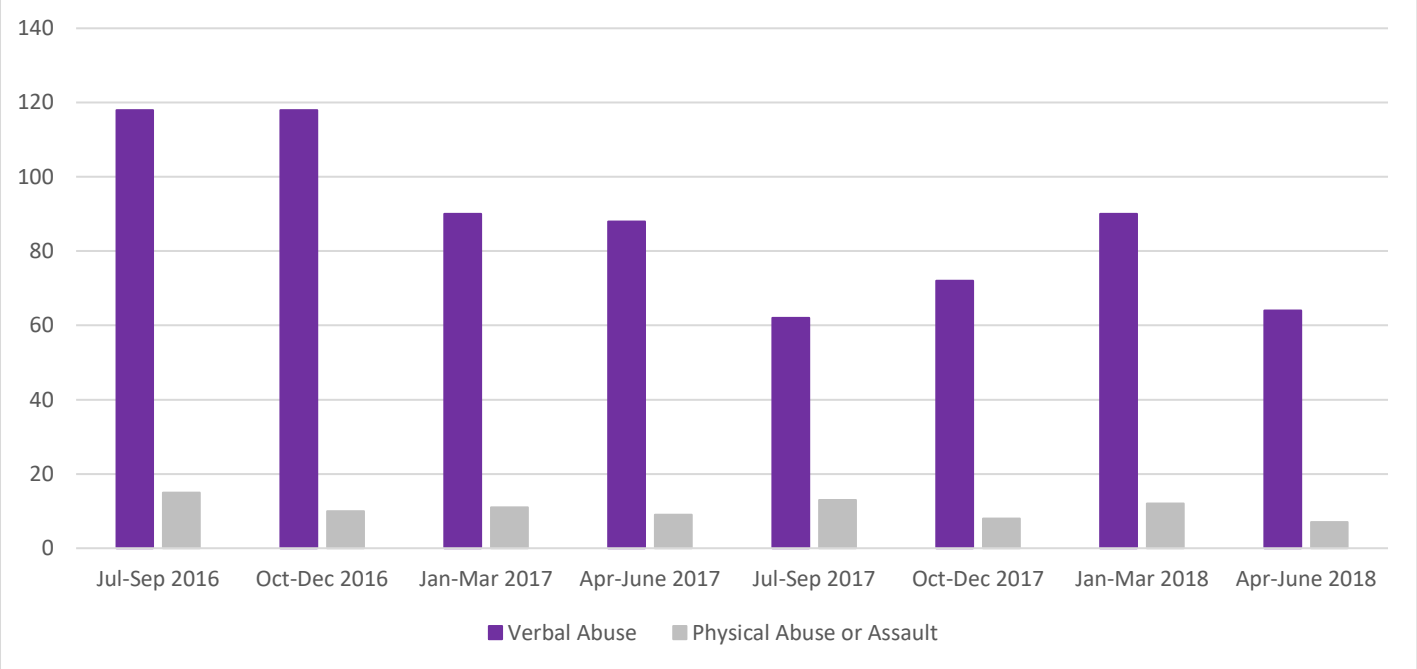
2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital - Safety Thermometer)*

We requested site specific information from the trust in relation to falls, pressure ulcers and urinary tract infections. The trust told us they do not monitor these within the emergency department.

The trust provided information on the number of assaults on staff as reported via the incident reporting procedures within the trust.




The trust provided an action plan that showed measures had been put in place to reduce and mitigate the risk to staff from verbal and physical assault by patients and visitors. The action plan did not have a date of implementation, no review date and no allocated person or persons to lead on the actions. Therefore, we were unable to gain assurance of the effectiveness or review of the actions put in place.

# Is the service effective?

## Evidence-based care and treatment

**The service did not consistently provide care and treatment based on national guidance and evidence of its effectiveness.**

We reviewed multiple policies, procedures and standards during the inspection including:

- Mental Capacity Policy
- Resuscitation protocols
- Sepsis pathways
- Ebola Policy and pathways
- Paediatric trauma handbook
- Emergency department paediatric liaison service policy
- Compliance with Royal College of Paediatric and Child Health (RCPCH) and Royal College of Emergency Medicine (RCEM)

We found a mixed approach to compliance with national best practice, guidance and standards.

Sandwell General Hospital was the designated Ebola referral unit in the Birmingham area. The emergency department had a policy and protocol in place to effectively and safely assess, treat and monitor patients with suspected or confirmed Ebola. We found the policy was in line with the current RCEM guidance on Ebola care. Staff were aware of the policy and senior staff were confident in the implementation of this within the department.

We found that the emergency department (ED) at Sandwell General Hospital did not meet all of the standards of RCPCH Facing the Future – Standards for Children and Young People in Emergency Care Settings (published June 2018), particularly in relation to the availability of children's nurses. The RCPCH standards state that: "staffing levels and skill mix of nursing staff are just as crucial in the effective emergency care of children."

We found Resuscitation Council (UK) guidelines for paediatric advanced life support on the wall of the paediatric resuscitation bay. However, the guidelines were from 2010. The Resuscitation Council (UK) updated the guidelines in 2015. This posed a risk of staff initiating less effective life support to critical ill children compared to the national best practice guidance.

The ED had an established sepsis pathway in place for adults and children. The adult pathway followed the recommendations and sepsis screening tool from The UK Sepsis Trust. However, staff told us that the ED uses the same adult version of the screening tool to assess children and young people. The UK Sepsis Trust produces assessment tool for under five-year olds and five to 11 year olds to enable an effective assessment of a child. Following the inspection, the trust information to show the department did have a specific sepsis screening tool for children and young people. However, staff were unable to explain or show us this at the time of the inspection.

We found the process for assessing the mental capacity of patients was not in line with the Mental Capacity Act 2005. We did not see a clear and contemporaneous record of a mental

capacity assessment in any patient records looked at, including those patients where staff determined patients lacked capacity.

The paediatric trauma handbook available for staff within the resuscitation area had not been reviewed in line with documented dates. The policy should have been last reviewed in June 2017. The emergency department paediatric liaison service policy was last updated in 2016, and had not been reviewed since.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health.**

Staff assessed patients with specific dietary needs as part of the assessment process on admission to the emergency department. We observed staff undertaking blood sugar tests on patients as required.

The department had a meal time routine and this was clearly displayed within the department. The department provided food at set times to ensure that patients within the department were offered food at set intervals. One of these meals was a hot meal and one was overnight. We observed staff offering patients, and visitors, food and drinks throughout their stay in the department.

Patients told us that they had been offered food and drink throughout during their stay.

## Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

| Question – Effective | Score | RAG |
|---|---|---|
| Q35. Were you able to get suitable food or drinks when you were in the emergency department? | 5.9 | About the same as other trusts |

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

The emergency department (ED) had a water cooler available for all patients and visitors to us. We observed staff offering patients and visitors hot drinks, water and food throughout the day. The ED had a ‘meal times’ plan in place to ensure that all patients within the department were offered food and drink as a minimum at certain set times. Patients and visitors told us that they were offered food and drink throughout their stay, where appropriate. Staff support patients with conditions effected by nutritional intake, such as diabetes, ensuring that patients received sufficient nutrition to meet their needs.

## Pain relief

**The service assessed patients pain and prescribed and administered pain relief to patients.**

## Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust did not provide data in relation to the question “How many minutes after you requested pain relief medication did it take before you got it?”

The trust scored 7.4 out of 10 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

| Question – Effective | Score | RAG |
|---|---|---|
| Q31. How many minutes after you requested pain relief medication did it take before you got it? | - | Not applicable |
| Q32. Do you think the hospital staff did everything they could to help control your pain? | 7.4 | About the same as other trusts |

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

Staff offered patients pain relief on admission and reassessed at regular intervals. Patients told us they had been offered pain relief and staff had asked them periodically if they had any pain.

We saw documentation of pain scores in patient records, as part of the National Early Warning Score assessment.

## Patient outcomes

**The service monitored the effectiveness of care and treatment; however, did not always use the findings to improve them in a timely manner.**

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

### Sandwell General Hospital

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Sandwell General Hospital’s emergency department did not meet any of the RCEM audit standards of 100%.

The department was in the upper UK quartile when compared to other hospitals for three metrics:

- Standard 1a (fundamental): $O_2$ should be given on arrival to maintain sats 94-98%. This department: 60.0%; UK: 19%.

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 42.1%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 54.8%; UK: 28%.

The department was between the upper and lower quartile for the remaining four metrics:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 36.0%; UK: 26%.

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 34.0%; UK: 25%.

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 81.8%; UK: 77%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  - This department: 52.2%; UK: 52%.

*(Source: Royal College of Emergency Medicine)*

The trust provided us with a current action plan for improvement against the standards of the RCEM audit for moderate and severe asthma. This was a 15 point action plan, with each action point aligned to an RCEM audit standard. The action plan had a timescale for compliance of February 2018 for 12 action points, one action point had a compliance date of May 2018 and two had no target date for compliance. Sandwell General Hospital was not fully compliant with any of the standards set out within the action plan; however, were performing the same or better than the national compliance rate for 11 out of the 15 standards.

The department was 0% compliant with one standard, Standard 10 – written discharge advice given to the patient. We request further information from the trust on current compliance with this standard; however, the trust did not respond to the data request.

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

**Sandwell General Hospital**

In the 2016/17 Consultant sign-off audit, Sandwell General Hospital's emergency department failed to meet any of the RCEM audit standards of 100%.

The department did not submit any data for standards 2 and 3. The hospital's results for the remaining two standards were between the upper and lower UK quartiles when compared to other hospitals:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 13.6%; England: 11%.

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 16.7%; UK: 10%.

*(Source: Royal College of Emergency Medicine)*

The trust provided us with a current action plan for improvement against the standards of the RCEM audit for consultant sign off. This was a six point action plan, with each action point aligned to an RCEM audit standard. The action plan had a timescale for compliance of September 2017 for five of the action points, and one had no compliance date. Sandwell General Hospital was not fully compliant with any of the standards set out within the action plan. Two of the six actions had no compliance level noted. The action plan did not contain information on when it had been reviewed or by who. This action plan did not provide assurance

of the ongoing monitoring of the RCEM standards for consultant sign off or improvements made.

## RCEM Audit: Severe sepsis and septic shock 2016/17

### Sandwell General Hospital

In the 2016/17 Severe sepsis and septic shock audit, Sandwell General Hospital's emergency department failed to meet any of the national standards of 100% (based on NICE guidance).

The department was in the upper UK quartile when compared to other hospitals for two metrics:

- Standard 1: Respiratory rate, oxygen saturations ($SaO_2$), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 92.0%; UK: 69.1%.

- Standard 3: $O_2$ was initiated to maintain $SaO_2$>94% (unless there is a documented reason not to) within one hour of arrival. This department: 70.0%; UK: 30.4%.

The department was in the lower UK quartile when compared to other hospitals for one metric:

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 20.0%; UK: 44.9%.

The department's results for the remaining five metrics when compared to other hospitals were all between the upper and lower UK quartiles.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 70.0%; UK: 64.6%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 44.0%; UK: 60.0%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 32.7%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 32.0%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 30.4%; UK: 18.4%.

*(Source: Royal College of Emergency Medicine)*

The trust provided us with a current action plan of improvement against the standard of the RCEM audit of sepsis. The action plan contained 17 action points, aligned to the standards of the RCEM audit. Sandwell General Hospital had made improvements against the audit results in the majority of the standards on the action plan and performed better than the national comparative in the majority of the standards. Sandwell General Hospitals emergency department also performed better than City Hospitals emergency department in the majority of standards for sepsis care. However, 10 of the 17 action points did not have an allocated lead or a predicted date for compliance.

Throughout the three RCEM audit action plans, we found a long period of time between the

RCEM audit publication and the base line assessment of improvements to form the action plan. For example, the audit of sepsis care was published May 2017; however, the base line assessment was completed March 2018, 10 months later. For the RCEM asthma audit, this was published May 2017 and the base line assessment completed February 2018. The RCEM audit on consultant sign off was published May 2017 and the base line assessment completed September 2017. The timescale between publication and assessment of improvement, particularly for the asthma and sepsis audits, did not provide assurance of an effective and timely system for the review of concerns.

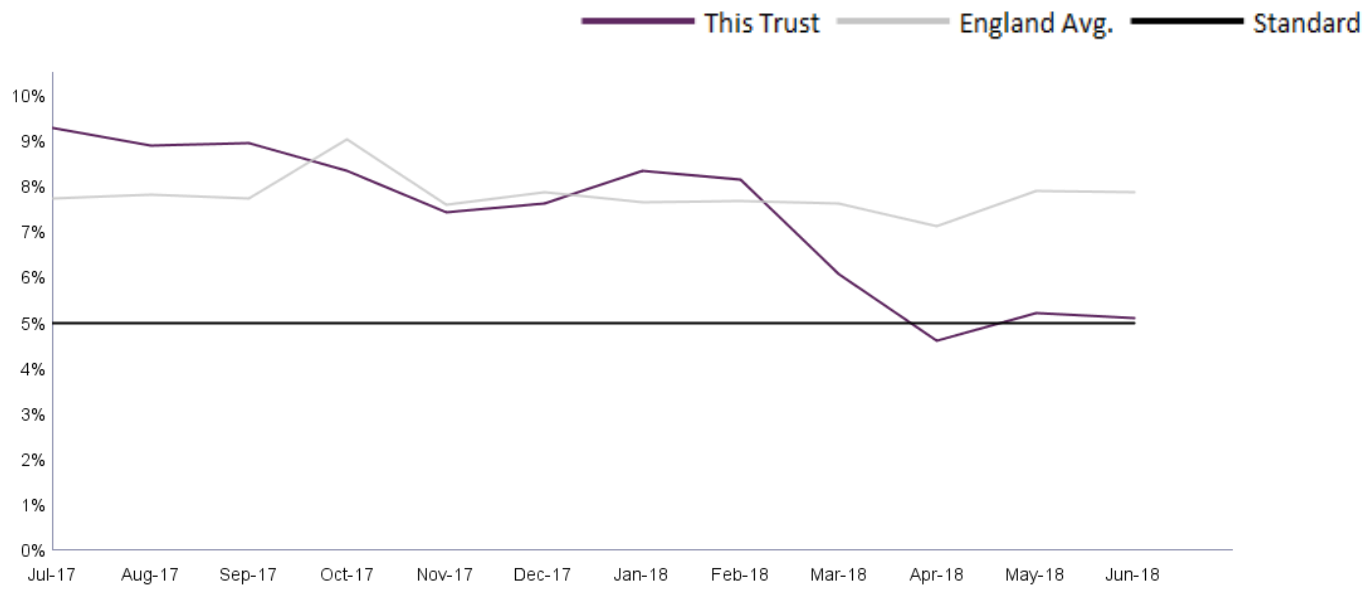
We requested an update from the trust on the completion of actions within all three RCEM audits, and when the action plans with go through the governance committee, as all three have "to be confirmed" as the date. The trust did not respond to this data request.

## Unplanned re-attendance rate within seven days

From July 2017 to March 2017, the trust's unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. The trust performed most poorly in July 2017, when they had a 9.3% unplanned re-attendance rate compared to an England average of 7.7%.

In April 2018, the rate at the trust was 4.6% compared to an England average of 7.1%, therefore meeting the national standard of 5%. In the most recent month, June 2018, the trust had an unplanned re-attendance rate of 5.1% compared to an England average of 7.9% which was just higher than the national standard.

**Unplanned re-attendance rate within seven days - Sandwell and West Birmingham Hospitals NHS Trust**




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

## Competent staff

**The service did not make sure staff were competent for their roles.** Managers did not consistently appraise staff's work performance.

## Appraisal rates

**Trust**

From April 2017 to December 2017, 64.8% of staff within urgent and emergency care at trust level received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Public Health & Community Health Services | 6 | 6 | 100.0% |
| Other Non-Medical staff | 3 | 3 | 100.0% |
| Support to doctors and nursing staff | 59 | 85 | 69.4% |
| Qualified nursing & health visiting staff | 121 | 185 | 65.4% |
| NHS infrastructure support | 6 | 11 | 54.5% |
| Medical & Dental staff - Hospital | 24 | 47 | 51.1% |
| Qualified ambulance service staff | 2 | 4 | 50.0% |
| **Total** | **221** | **341** | 64.8% |

**Sandwell General Hospital**

From April 2017 to December 2017, 60.9% of staff within urgent and emergency care at Sandwell General Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| NHS infrastructure support | 1 | 1 | 100.0% |
| Other Non-Medical staff | 3 | 3 | 100.0% |
| Public Health & Community Health Services | 3 | 3 | 100.0% |
| Qualified nursing & health visiting staff | 70 | 111 | 63.1% |
| Support to doctors and nursing staff | 35 | 57 | 61.4% |
| Medical & Dental staff - Hospital | 8 | 20 | 40.0% |
| Qualified ambulance service staff | 0 | 2 | 0.0% |
| **Total** | **120** | **197** | **60.9%** |

**'Other' urgent and emergency care department**

Please note that the trust provided a small amount of data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

From April 2017 to December 2017, 68.8% of staff within urgent and emergency care at sites classified as 'other' by the trust received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Qualified nursing & health visiting staff | 7 | 9 | 77.8% |
| NHS infrastructure support | 4 | 7 | 57.1% |
| **Total** | **11** | **16** | **68.8%** |

*(Source: Routine Provider Information Request (RPIR) - Appraisal tab)*

All nurses within the emergency department can be asked to care for children and young people. We found that between the hours of 9:30pm and 9am, the nursing care provided to children and

young people was delivered by adult nurses. We requested the induction package given to all nurses and the competencies undertaken by adult nurses to safely care for children and young people. The trust told us adult nurses did not have competencies to care for children but these would be added into the current competency package.

The trusts induction package for staff entering the emergency department covered multiple areas including how to assess patients, the layout of the department and how to set up certain pieces of equipment. The induction pack suggested that staff spend some time in the children's area of the department to familiarise themselves with the area and care of children. However, the induction programme does not specifically cover the care of children and young people. This posed a risk overnight when no children's nurses were on duty.

## Multidisciplinary working

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

We observed staff attending to a child within the resuscitation area where emergency department nurses and doctors worked simultaneously with paediatricians and nursing staff from the children's high dependency ward to ensure the child was treated and transferred safely, effectively and in a timely manner.

Staff who highlighted patients who had or were at risk of having a mental health problem liaised with the departments mental health team. We observed assessments of patients by the mental health specialists who handed the information back to the emergency department medical staff to continue treatment in the most effective way.

The domestic violence team within the department worked closely with the nursing and medical staff to provide support and guidance to patients and relatives who were victims of domestic abuse. We found an effective system to assess and provide support and help to patients without putting them at further risk of the perpetrator finding out.

Emergency department staff worked closely with the local NHS ambulance service, with the ambulance service hospital liaison officer and nurse in charge working closely together to ensure patients were moved through the department as quickly as possible.

Speciality staff, for example surgeons and medical staff, worked well with the emergency department staff to assess and admit (where required) patients from the emergency department. However, we found some delays in the speciality staff attending the emergency department to assess patients. Consultants told us that delays waiting for speciality review were common. During the inspection, we observed patients within the department waiting for review before admission or discharge who breached the four-hour target to admit, discharge or transfer.

## Seven-day services

**The service did not provide all types of services 24-hours a day, seven days a week.**

Sandwell General Hospital's emergency department (ED) was open 24 hours a day, seven days a week. The department accepted patients of all ages, and was a dedicated trauma unit.

A full range of adult services were available within the emergency department 24 hours a day, seven days a week. However, we found a reduced service for children and young people overnight (between 9:30pm and 9am).

The children's area within the department closed at 9:30pm, with no children's nurses on site overnight. Staff treated children and young people within the main adult areas of the department overnight.

The mental health and domestic violence teams were available during day time hours and not overnight. Staff left referrals for both teams where patients arrived out of hours.

## Health Promotion

**The service had limited assessments and information to identify and support patients with their own health.**

Admission paperwork for all patients attending the emergency department did not contain information such as smoking status, alcohol and drug dependency or caring responsibilities. We did not observe staff having conversation with patients about health promotion and we saw no documentation with records about health promotion.

Within the department, we saw some limited information leaflets with regards health promotion; however, these were not routinely given to patients on discharge. Staff utilised the National Institute of health and Care Excellence (NICE) patient information leaflets, e.g. following a head injury.

## Consent, Mental Capacity Act and Deprivation of Liberty safeguards

**Staff did not always understand their roles and responsibilities in relation to the Mental Health Act 1983 and the Mental Capacity Act 2005. They did not always know how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**

We asked nurses and medical staff about their understanding of the Mental Capacity Act (MCA) 2005 and their understanding of capacity assessments. All staff asked could tell us about the MCA and the importance of assessment a person's capacity.

During admission to the emergency department, nursing staff undertake an assessment of patient's capacity. However, the assessments did not meet the requirements as set out in the MCA 2005. We asked four nurses to explain how they would document a patient's capacity on the admission paperwork. Two nurses told us one way, the second two nurses a different way. This posed a risk to people who have capacity being documented as not, and those that don't being documented as having capacity.

Medical staff undertook capacity assessments as part of the routine clerking and assessment of patient's. However, we found no medical records that contained a full mental capacity assessment as required under the Mental Capacity Act 2005. Therefore, we were not assured that staff were treating patients lawful in accordance with the MCA.

Staff were unaware if they could access mental capacity advocates for those patients who did not have someone to advocate on their behalf.

We found a culture within the service of one assessment covered all decisions. Although staff could tell us and explain that capacity assessments were decision specific, we found no evidence

of the reassessment and documentation of capacity following initial assessment. This is not in line with the Mental Capacity Act 2005.

The trust provided mental capacity training as part of the adult safeguarding training given to all clinical staff. Staff did not complete any mandatory training in relation to the care and treatment of patient detained under the Mental Health Act 1983.

## Mental Capacity Act and Deprivation of Liberty Safeguards training completion

The trust has reported that Mental Capacity Act and Deprivation of Liberty Safeguards training is included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for the completion of safeguarding training.

### Trust level

### Nursing staff

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 193 | 193 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 2 | 30 | 31 | 96.8% | 95% | Yes |
| Safeguarding Children Level 3 | 101 | 120 | 84.2% | 95% | No |
| Safeguarding Children Level 2 | 59 | 73 | 80.8% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with two of these courses achieving a 100% completion rate. The lowest completion was for safeguarding children level 2, with a rate of 80.8%.

### Medical staff

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in urgent and emergency care is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 50 | 50 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 11 | 13 | 84.6% | 95% | No |
| Safeguarding Adults Level 2 | 16 | 20 | 80.0% | 95% | No |
| Safeguarding Children Level 2 | 23 | 37 | 62.2% | 95% | No |

In urgent and emergency care trust-wide, the 95% completion target was met for two of the five safeguarding training modules for which medical and dental staff were eligible, with both of these courses achieving a 100% completion rate. The safeguarding children level 2 module had the lowest completion rate, at 62.2%.

**Sandwell General Hospital**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 2 | 11 | 11 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 53 | 63 | 84.1% | 95% | No |
| Safeguarding Children Level 2 | 37 | 47 | 78.7% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 78.7%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical and dental staff in the urgent and emergency care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding Adults Level 2 | 6 | 6 | 100.0% | 95% | Yes |
| Safeguarding Adults Level 1 | 21 | 21 | 100.0% | 95% | Yes |
| Safeguarding Children Level 1 | 21 | 21 | 100.0% | 95% | Yes |
| Safeguarding Children Level 3 | 10 | 11 | 90.9% | 95% | No |
| Safeguarding Children Level 2 | 7 | 10 | 70.0% | 95% | No |

At Sandwell General Hospital's urgent and emergency care department, the 95% completion target was met for three of the five safeguarding training modules for which medical and dental staff were eligible, with all three courses achieving a 100% completion rate. The safeguarding children level 2 course had the lowest completion rate, at 70%.

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

# Is the service caring?

## Compassionate care

**Staff did not always treat patients with compassion. Feedback from patients was mixed and confirmed that staff did not consistently treat them well and with kindness**.

We spoke to six patients and three relatives during the inspection, including children and adult patients, and parents, relatives and carers of patients.

All patients and relatives we spoke to gave positive feedback about the care and service provided by the emergency department (ED) at Sandwell General Hospital during the inspection. Patients we spoke with told us that staff were kind and listened to them.

We observed staff pulling curtains around bed spaces or closing side room doors within the 'majors' area when care was being provided. However, we overheard conversations about patient care within the 'see and treat' and emergency nurse practitioner (ENP) area of the department as staff left side room doors open during treatment and conversations.

Staff within the paediatric area of the department were kind and compassionate in the delivery of care. Staff spoke to parents and carers equally to the child or young person. We observed a family centred approach to care delivery.

Staff provided compassionate care to patients in the department who had a mental health condition or a learning disability. We spoke to one patient with a mental health condition and one patient with a learning disability and their carer. The patient with a learning disability stated that staff were kind and they had been given food and drink. The carer stated that the care provided had been "great" and they had no concerns.

Senior nursing staff within the department had a good understanding of the patients within the department, including those most vulnerable and at risk. The nurse in charge and shift coordinators were able to explain the reasons for admission and why patients had breached the four-hour target to be admitted or discharged. We observed nursing staff go into the most vulnerable patients in the department on a regular basis to ensure both safety and comfort of the patient.

We found staff did not always maintain patient's privacy and dignity within the ambulance handover area. We observed on two occasions two patients within the same bay. Staff took handover of patients in a way that did not promote their privacy due to the layout of the handover area. We observed that the staff taking handover did not always speak to the arriving patient, instead relaying on the ambulance crew to share information.

Out of hours, staff told us they found it difficult to maintain the dignity of and provide care to children and young people as these patients were treated within the ambulance handover bay before being transferred to the main adult area of the 'majors' department. Staff told us of examples of when children and young people were treated within sight and sound of adult patients under the influence of alcohol, drugs and who were aggressive.

Staff within the 'majors' area of the ED did not always promote compassionate care or maintain patient's dignity. Staff routinely discussed patient's personal and medical information in the middle of the department, within hearing distance of other staff, patients and visitors, and within corridors.

For example, on one occasion we observed a nurse loudly state personal and medical information (including the name and date of birth) about a patient from one end of the nurses station to the other whilst on the phone. We heard one senior nurse state “you’ll smell him before you see him” in answer to another staff member asking where a particular patient was in the department. The patient in question was homeless and vulnerable.

Within the resuscitation room, we observed a doctor take blood from a patient who was unwell, but conscious. The doctor did not speak to the patient or their relative once throughout the procedure. The doctor did not ask for consent, explain what they were going to do and walked away without speaking. This did not promote compassionate care to the patient or relative.

Staff moved patients around the department, for example from ambulance handover bay to the main area of the department. We observed staff did not consistently do this with kindness and compassion, particularly to unaccompanied or distressed patients. One patient who was confused and distressed was not spoken to during transfer and was left in a bay by a healthcare assistant. We observed the patient shout for help on six occasions; however, staff did not attend to the patient for 10 minutes, despite staff being available to attend to the patient. We observed staff walk past the patient whilst they were shouting for help. The patient was not given their nurse call button.

We observed a distressed patient brought into the emergency department via ambulance. The patient was struggling to walk due to their distress. Staff sat the patient on a plastic chair in the corridor for around 10 minutes outside the resuscitation room. The location and volume of staff and visitors walking past did not promote the patient’s dignity as visitors and other patients were able to see the patient in distress.

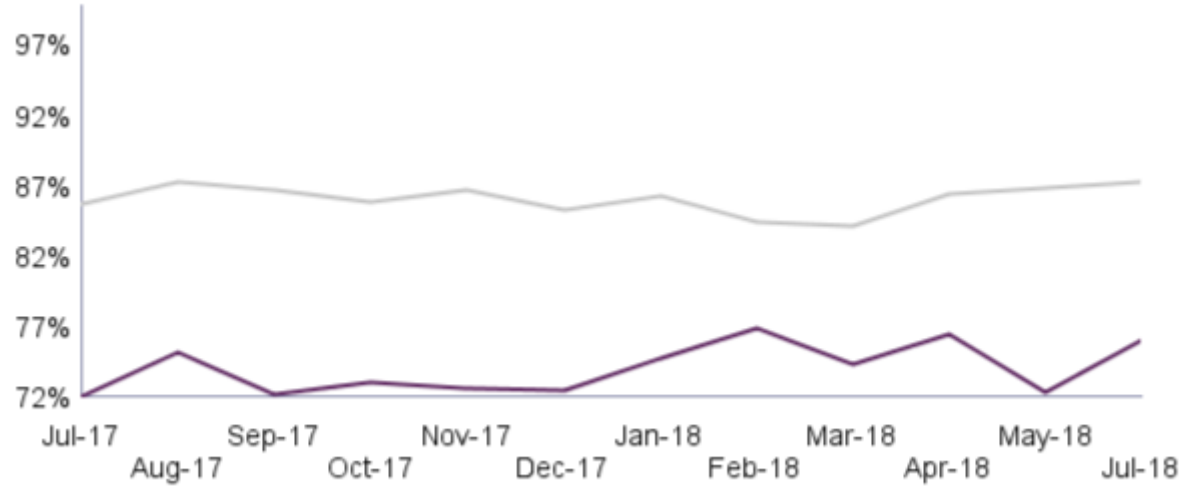
Staff did not give patients nurse call buttons within the department. We did not see any patients with nurse call buttons. This meant, where able to, patients needed to shout for help, which did not promote a culture of kindness and thoughtfulness. Those patients unable to shout for help waited for staff to do routine checks to ask for help or assistance.

## Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from July 2017 to July 2018.

In the most recent month, July 2018, 76.3% of patients recommended the trust’s A&E department, compared to the England average of 87.4%.

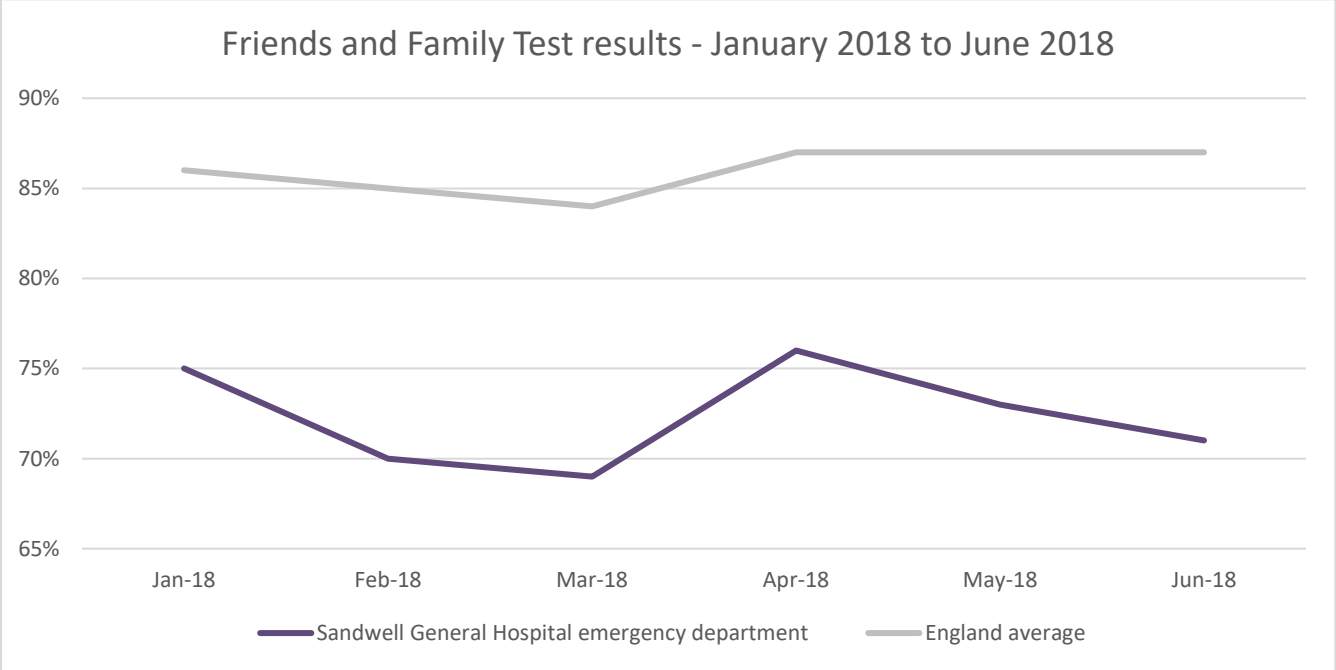
**A&E Friends and Family Test performance - Sandwell and West Birmingham Hospitals NHS Trust**




*(Source: NHS England Friends and Family Test)*

**Sandwell General Hospital**

Sandwell General Hospital's emergency department performed worse than the national average in the Friends and Family Test. Between January 2018 and June 2018, the department achieved an average 'recommended' score of 72.3%, compared to the national average of 86%.




*(Source: NHS England Friends and Family Test)*

## Emotional support

**Staff provided emotional support to patients to minimise their distress.**

All staff observed provided patients and relatives with emotional support tailored to the individual situation.

Staff developed a repour with patients and relatives and altered their approach to providing

support based on the individual situation. We observed a staff nurse engaging with a family in a way that provided reassurance, but was also personable and specific to that patient.

Within the paediatric resuscitation area, we observed staff providing support and reassurance to the family of child admitted with sepsis. All the staff involved in the care of the child engaged with the family and explained all aspects of care. Staff allowed time for the parents to ask questions and provided answers in a way that were reassuring and honest.

The mental health assessment team provided support to all patients admitted to the emergency department with a mental health condition, where this was the reason for attendance or not. We observed interactions that were kind and compassionate, and provided support to patients with a mental health condition.

The trust provided a chaplaincy service to all patients and relatives, and staff could access this 24 hours a day. Staff knew how to access this service and we saw staff offering this to patients and families.

During the inspection, a patient died within the resuscitation area. Staff provided the family with a quiet area to wait and be together. Staff offered the trusts chaplaincy service to the family, as both the patient and family were practicing Muslims.

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

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

## Emergency Department Survey 2016

The trust scored worse than other trusts for two questions (questions 42 and 43) and about the same as other trusts for 21 of the 22 remaining Emergency Department Survey questions relevant to the caring domain. The trust did not provide any data relating to the final question, question 39 “Did a member of staff tell you about medication side effects to watch out for?”

| Question | Trust 2016 | 2016 RAG |
|---|---|---|
| Q10. Were you told how long you would have to wait to be examined? | 2.9 | About the same as other trusts |
| Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse? | 8.5 | About the same as other trusts |
| Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand? | 8.5 | About the same as other trusts |
| Q14. Did the doctors and nurses listen to what you had to say? | 8.8 | About the same as other trusts |
| Q16. Did you have confidence and trust in the doctors and nurses examining and treating you? | 8.8 | About the same as other trusts |
| Q17. Did doctors or nurses talk to each other about you as if you weren't there? | 8.6 | About the same as other trusts |
| Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so? | 7.8 | About the same as other trusts |
| Q19. While you were in the emergency department, how much information about your condition or treatment was given to you? | 8.6 | About the same as other trusts |
| Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you? | 7.2 | About the same as other trusts |

| Question | Trust 2016 | 2016 RAG |
|---|---|---|
| Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department? | 8.8 | About the same as other trusts |
| Q23. Were you involved as much as you wanted to be in decisions about your care and treatment? | 7.8 | About the same as other trusts |
| Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department? | 8.6 | About the same as other trusts |
| Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you? | 6.5 | About the same as other trusts |
| Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you? | 5.4 | About the same as other trusts |
| Q26. Did a member of staff explain why you needed these test(s) in a way you could understand? | 8.7 | About the same as other trusts |
| Q27. Before you left the emergency department, did you get the results of your tests? | 8.0 | About the same as other trusts |
| Q28. Did a member of staff explain the results of the tests in a way you could understand? | 9.1 | About the same as other trusts |
| Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand? | 9.0 | About the same as other trusts |
| Q39. Did a member of staff tell you about medication side effects to watch out for? | - | Not applicable |
| Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car? | 5.1 | About the same as other trusts |
| Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department? | 4.1 | About the same as other trusts |
| Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 4.4 | Worse than other trusts |
| Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 5.5 | Worse than other trusts |
| Q45. Overall | 7.9 | About the same as other trusts |

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

We found that staff included patients and relatives (where appropriate) in conversations and decisions about care needs. All the patients spoken to told us that staff listened to their concerns and questions and had provided all the information they wanted in a way in which they could understand it.

We spoke with a parent of a child awaiting a transfer to the children's ward. The parent told us that the staff had kept them informed of the plan of care, allowed them to have a say in the plan and had updated them periodically about the delays in transferring the patient to the children's ward. The parent told us staff had given them adequate information about their child's condition and the plan of care being considered.

We found the domestic violence team within the department involved the person experiencing domestic violence in the plan of care. For example, if the patient did not want to engage with services during this visit to the emergency department, information was offered in a discrete way

to enable them to make a decision at a later date.

# Is the service responsive?

## Service delivery to meet the needs of local people

**The trust did not plan and provide services in a way that met the needs of local people.**

The resuscitation room was fit for purpose and designed to maintain the privacy of paediatric patients and their families. The paediatric resuscitation bay was segregated from the three adult bays by a wall, meaning children could not see adult patients during their care. the adult resuscitation bays were spacious and were fit for purpose.

During the day, the emergency department had a separate paediatric waiting room and treatment area, specifically designed for children and young people. The glass windows were tinted to prevent adult patients looking into the children's area. The children's area had fob access doors, providing additional security for young children. Toys, games and other distraction equipment was available for children and young people to use during their visit to the emergency department.

However, out of hours (between 9:30pm and 9am), seven days a week, staff treated children and young people within the main adult area of 'majors'. This area was not child friendly and posed risks to both the safety and welfare of children, young people and their families.

The emergency department layout generally promoted the needs of patients. The most 'at risk' patients that needed monitoring were positioned opposite the nurses' station. Those at least risk, for example those patients with a relative, were generally allocated a room further from the nurses' station. The minor injuries stream had nurse practitioner rooms that were fit for purpose and easily accessible from the main department in the event of an emergency.

However, the ambulance handover bay was not fit for purpose. This area was open plan and consisted of five bed spaces separated by curtains. On two occasions we found two patients in the same bay due to capacity issues. Ambulance staff and nursing staff handed over the reason for admission in a way that all other people within the handover bay could hear.

The department was the designated Ebola receiving centre in the west midlands. A comprehensive policy and plan was in place in the event of a patient presenting with Ebola symptoms. However, the room designated for Ebola patients was screened off using mobile screens and was still accessible by patients, relatives and staff.

The department had a dedicated side room near the nurses' station for patients with a mental health condition or at risk of self-harm or suicide. The side room was not ligature free, but ligature risks had been reduced. The side room door opened in both directions and could not be locked from the inside.

The department was well signposted externally to the building and from the main entrance. Signage within the department was clear, for example on toilet doors. However, the department did not have access to a hearing loop for patients using hearing aids.

The reception area promoted the privacy of patients. Seating was far enough away from the reception desk that patients and visitors were less likely to overhear conversations between reception staff and patients.

## Meeting people's individual needs

**The service took account of patients' individual needs.**

## Emergency Department Survey 2016

The trust scored about the same as other trusts for the three Emergency Department Survey questions relevant to the responsive domain.

| Question – Responsive | Score | RAG |
|---|---|---|
| Q7. Were you given enough privacy when discussing your condition with the receptionist? | 7.5 | About the same as other trusts |
| Q11. Overall, how long did your visit to the emergency department last? | 7.0 | About the same as other trusts |
| Q20. Were you given enough privacy when being examined or treated? | 9.2 | About the same as other trusts |

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

We found some good practice in relation to meeting individual needs of patients. The domestic violence team based within the emergency department provided assessment, guidance and support to victims of domestic abuse and violence. The team was available on site during the day, but provided an emergency on call system out of hours. We found the team worked well with the onsite mental health teams and nursing staff to safeguarding victims. The domestic violence team had innovative ways of ensuring helpline numbers were given to victims discretely to avoid further risk of violence from the perpetrator.

We observed a patient within the resuscitation area who died with his family at his bedside. The patient was a practicing Muslim and the staff organised for prayer music to play in the resuscitation room, as no other patients were in there, as the patient died to bring comfort to him and his family.

Staff had received dementia training as part of their mandatory training. Staff had also received equality and diversity training within their required mandatory training package. However, we found limited materials to help in the delivery of care and treatment to those living with dementia or a learning disability. The department did not have distraction equipment or other equipment to help occupy those with dementia, therefore reducing anxiety and distress, whilst in the department.

The service highlighted those patients that had dementia or a significant disability within the electronic records. However, this was only visible once fully inside the record. The flags were not visible from the initial information screen for each patient.

We found a mixed approach to communicating with patients. Staff had access to, and knew how to access, translators. This included both verbal and British sign language interpreters. However, we found written information was only available in English. The demographic of the area covered by Sandwell Hospital is mixed, and many people do not speak English as their first spoken or written language.

The trust had access to its own patient transport service. We observed staff using this service to assist in transporting vulnerable patients and those with additional needs (for example those using a wheelchair or with dementia) home following discharge from the department.

## Access and flow

**People could not access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were not in line with good practice.**

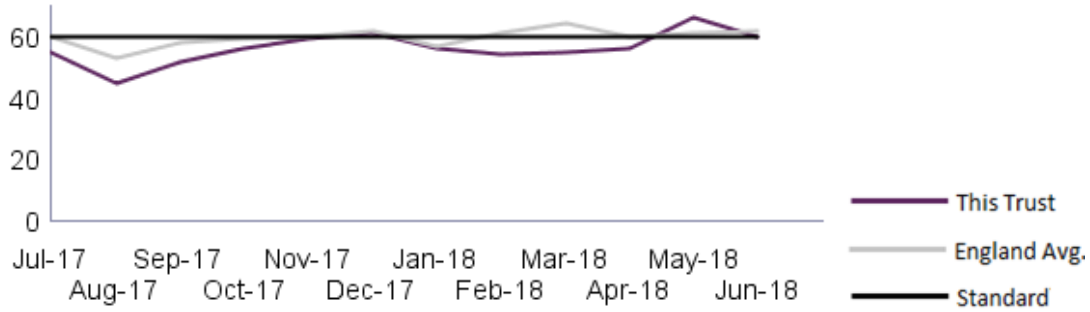
## Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 10 months over the 12-month period from July 2017 to June 2018.

The trust performed most poorly in May 2018 when the median time to treatment was 66 minutes compared to the England average of 61 minutes.

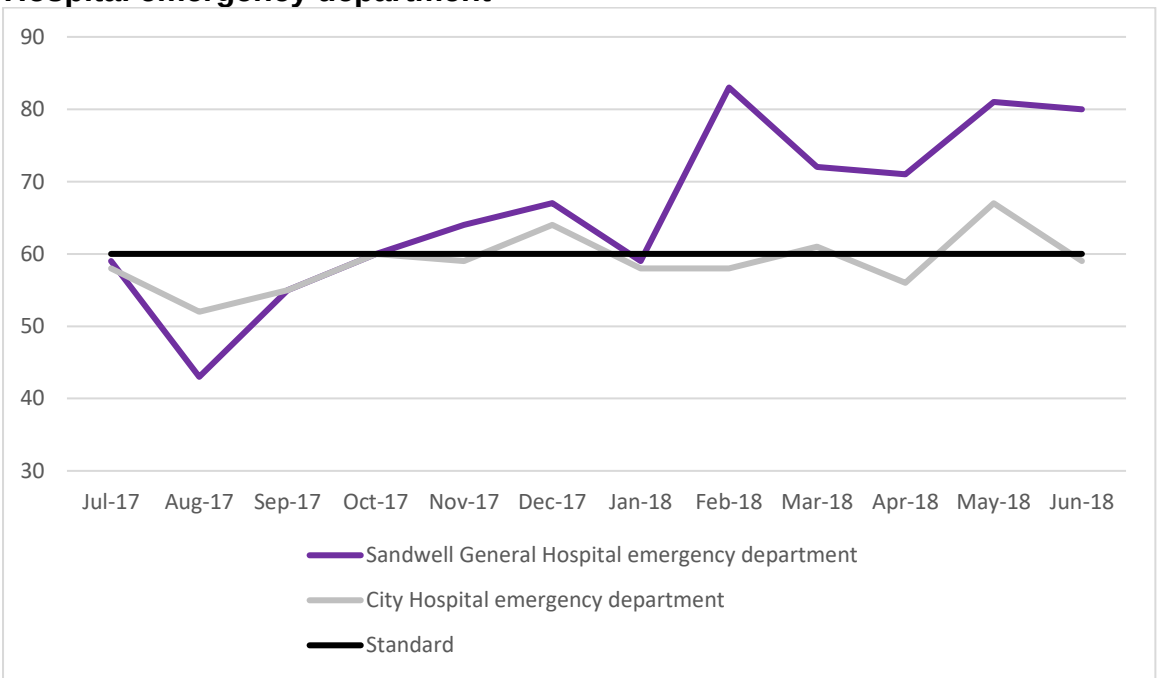
In the most recent month, June 2018, the median time to treatment was 60 minutes compared to the England average of 62 minutes, meeting the standard.

**Median time from arrival to treatment from July 2017 to June 2018 at Sandwell and West Birmingham Hospitals NHS Trust**




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

**Median time from arrival to treatment from July 2017 to June 2018 at Sandwell General Hospital emergency department**




Sandwell General Hospital performed better than or the same as the national standard for patient receiving treatment within 60 minutes of arrival within the emergency department between July 2017 and October 2017. Sandwell General Hospital performed worse than the national standard

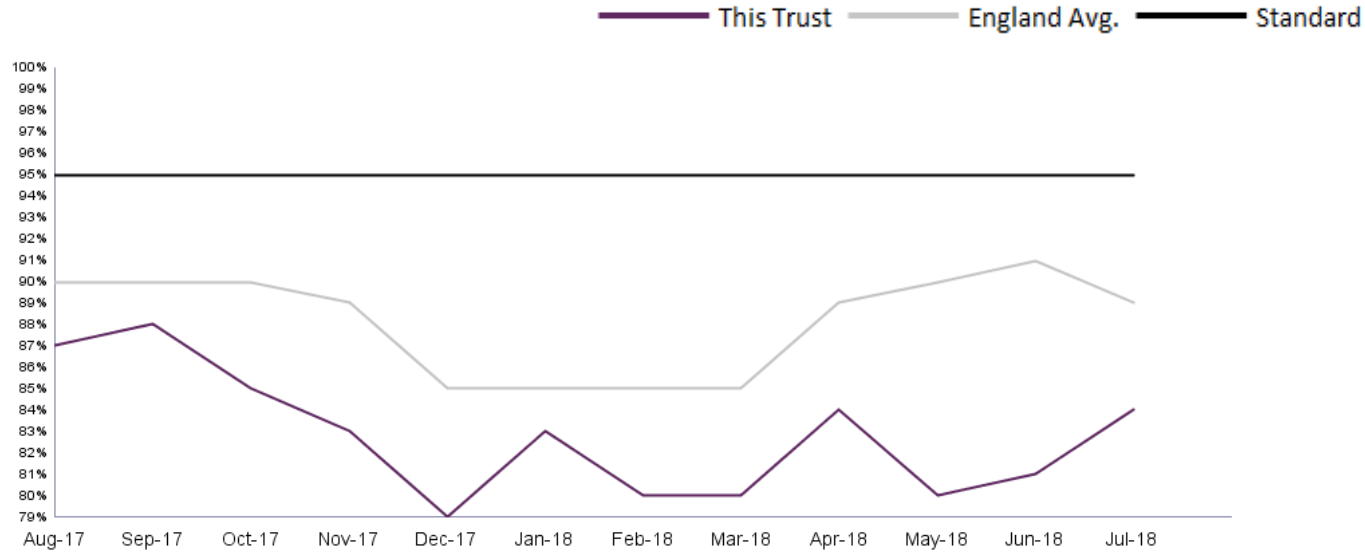
for patient receiving treatment within 60 minutes of arrival within the emergency department between November 2017 and June 2018. The worst performing month was February 2018, where on average patients waited 83 minutes from arrival to receiving treatment. The latest month, June 2018, showed patients waited an average of 80 minutes from arrival to treatment.

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

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

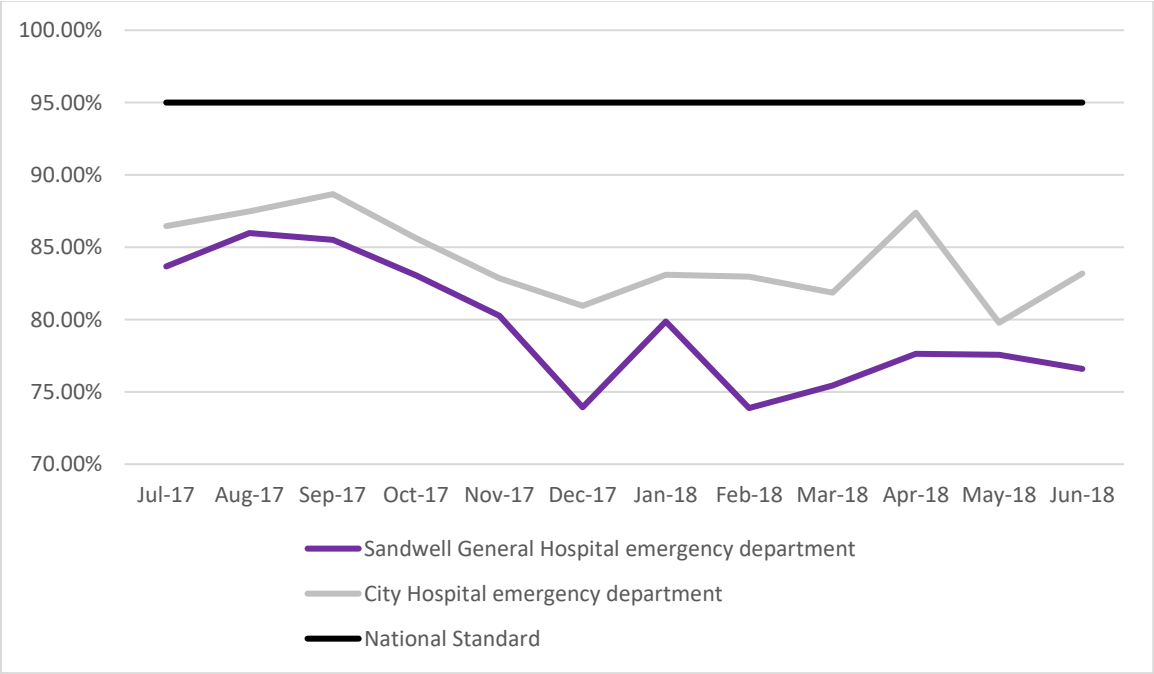
From August 2017 to July 2018 the trust failed to meet the standard in any month and consistently performed worse than the England average.

**Four hour target performance - Sandwell and West Birmingham Hospitals NHS Trust**




*(Source: NHS England - A&E waiting times)*

**Four hour target performance – Sandwell General Hospital emergency department**



Sandwell General Hospitals emergency department consistently did not meet the national target of 95% to admit, transfer or discharge patients within four hours of arrival. Between July 2017 and June 2018, an average of 79.4% of patients were admitted, transferred or discharged within four hours. This compares to an average of 84.1% at City Hospital and the national target of 95%. The England average for the same period was between 85% and 90%.

The trust had a comprehensive 50 point action plan in place to improve performance against the four hour target to admit, discharge or transfers patients. The action plan including leads for each action, areas for improvement and planned actions to ensure the improvements happened.

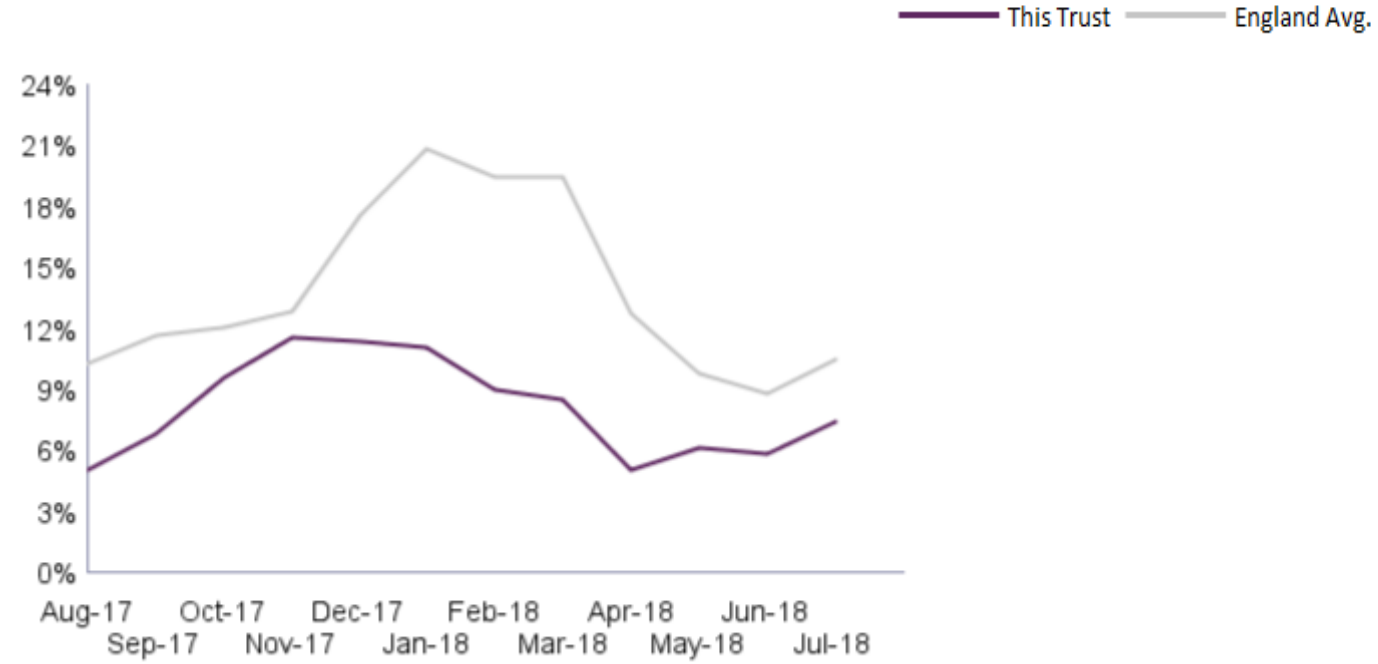
## Percentage of patients waiting more than four hours from the decision to admit until being admitted

From August 2017 to July 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average.

There is evidence of a trend of improvement in performance from November 2017 to April 2018.

In the most recent month, July 2018, 7.4% of patients waited more than four hours from the decision to admit to being admitted compared to the England average of 10.5%.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Sandwell and West Birmingham Hospitals NHS Trust**




The table below shows the number of patients waiting more than four hours to admission from August 2017 to July 2018:

| Month | Number of patients waiting more than four hours to admission |
|---|---|
| August 2017 | 154 |
| September 2017 | 208 |
| October 2017 | 305 |
| November 2017 | 366 |
| December 2017 | 386 |

| | |
|---|---|
| January 2018 | 389 |
| February 2018 | 275 |
| March 2018 | 292 |
| April 2018 | 164 |
| May 2018 | 201 |
| June 2018 | 184 |
| July 2018 | 245 |

*(Source: NHS England - A&E waiting times)*

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

Sandwell and West Birmingham Hospitals NHS Trust

Over the 12 months from August 2017 to July 2018, one patient waited more than 12 hours from the decision to admit until being admitted. This instance occurred in December 2017.

*(Source: NHS England - A&E waiting times)*

Sandwell General Hospital

Sandwell General Hospital emergency department did not have any patients that waited longer than 12 hours from the decision to admit until being admitted from August 2017 to July 2018.

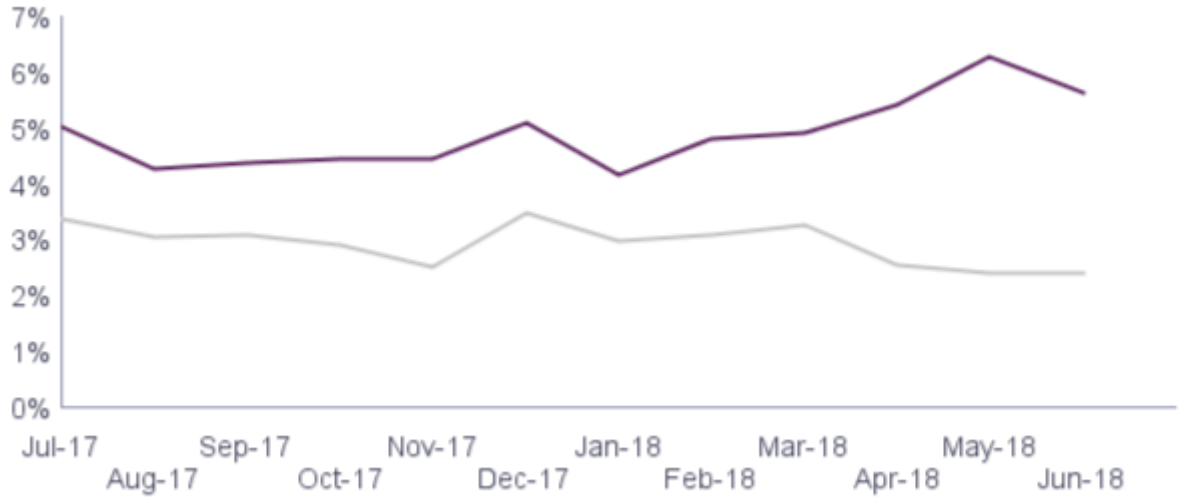
## Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

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

Performance on this metric at the trust was relatively stable from July 2017 to April 2018, at between 4.3% (August 2017) and 5.4% (April 2018), before deteriorating to 6.3% in May 2018, compared to the England average which was 2.4%.

In the most recent month, June 2018, the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 5.6%, compared to the England average of 2.4%.

**Percentage of patient that left the trust's urgent and emergency care services without being seen - Sandwell and West Birmingham Hospitals NHS Trust**



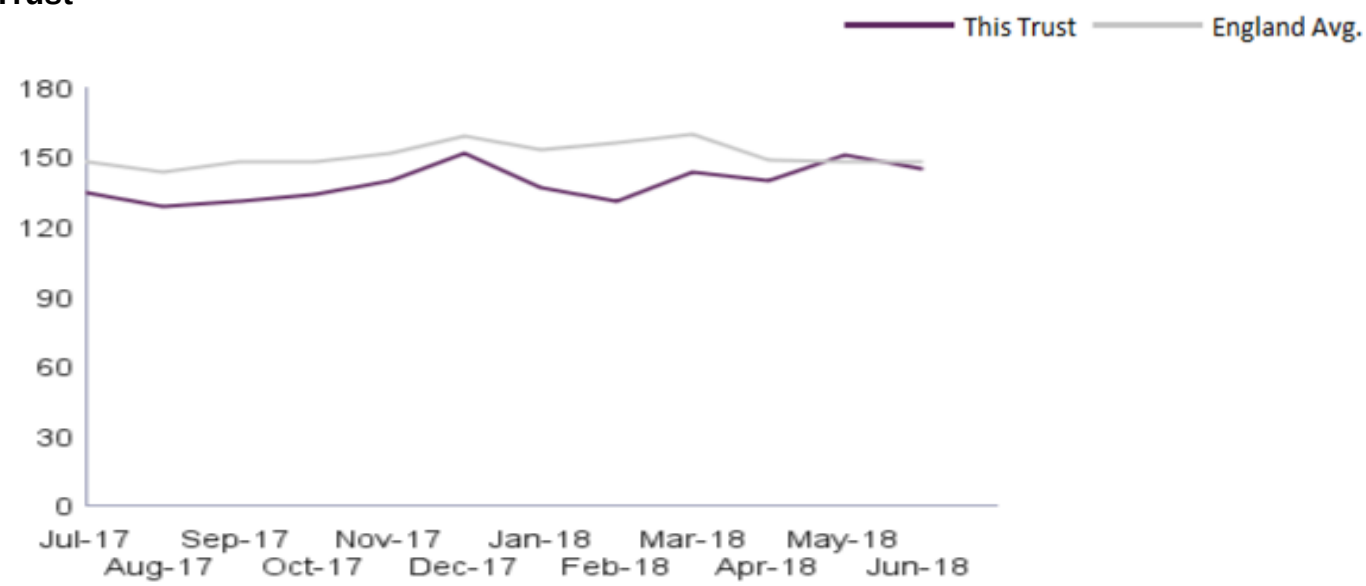

*(Source: NHS Digital - A&E quality indicators)*

## Median total time in A&E per patient (all patients)

From July 2017 to April 2018 the trust's monthly median total time in A&E for all patients was consistently lower than the England average followed by two months, May and June 2018, when performance was similar to the England average.

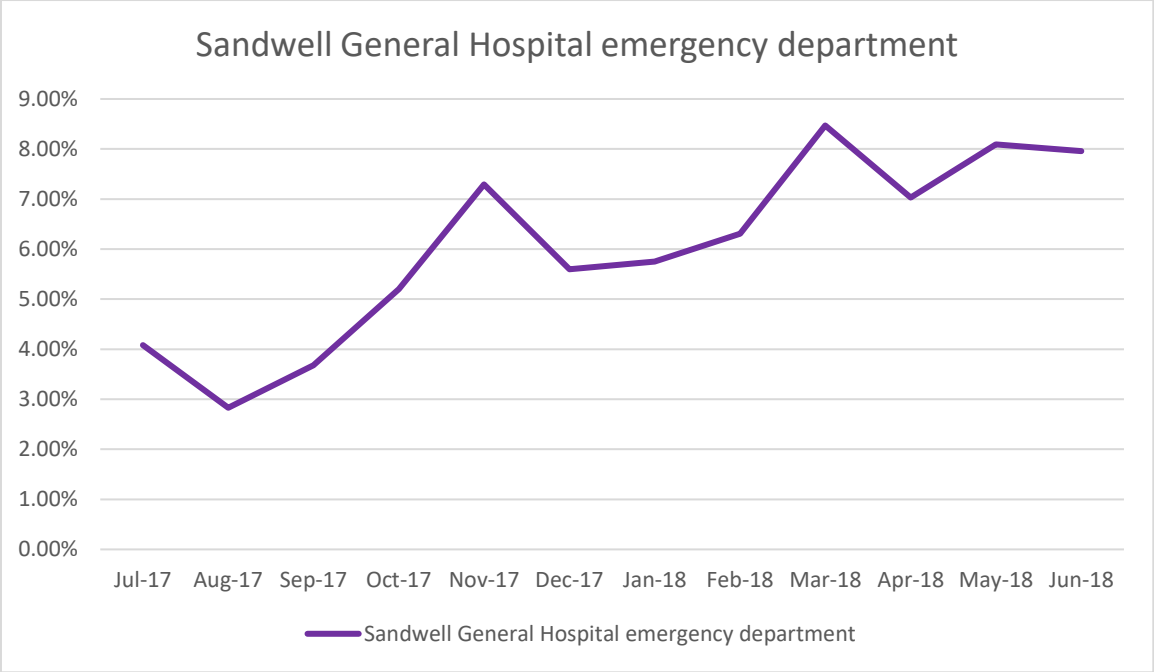
In the most recent month, June 2018, the trust's monthly median total time in A&E for all patients was 145 minutes which was slightly lower when compared to the England average of 148 minutes.

**Median total time in A&E per patient - Sandwell and West Birmingham Hospitals NHS Trust**




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

**Percentage of ambulance arrivals with greater than a 30 minute handover time**




## Learning from complaints and concerns

## Summary of complaints

**The service treated concerns and complaints seriously, investigating them and learned lessons from the results, which were shared with all staff.**

### Trust level

From April 2017 to March 2018, there were 187 complaints about urgent and emergency care at trust level. The trust took an average of 38.8 days to investigate and close complaints. This is not in line with their complaints policy, which states all complaints should be investigated and closed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 81 | 43.3% |
| Staff values & behaviours | 31 | 16.6% |
| Access to treatment or drugs | 23 | 12.3% |
| Patient care | 18 | 9.6% |
| Waiting times | 9 | 4.8% |
| Communications | 7 | 3.7% |
| Privacy, dignity & well being | 5 | 2.7% |
| No subject specified | 5 | 2.7% |
| Appointments | 3 | 1.6% |

| | | |
|---|---|---|
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 2 | 1.1% |
| Administration/policies/procedures (including patient records) | 1 | 0.5% |
| Facilities | 1 | 0.5% |
| Other | 1 | 0.5% |
| Total | 187 | 100% |

**Sandwell General Hospital**

From April 2017 to March 2018, there were 84 complaints about urgent and emergency care at Sandwell General Hospital. The hospital took an average of 38.5 days to investigate and close complaints. This is not in line with their complaints policy, which states all complaints should be investigated and closed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 41 | 48.8% |
| Staff values & behaviours | 11 | 13.1% |
| Access to treatment or drugs | 11 | 13.1% |
| Patient care | 9 | 10.7% |
| Waiting times | 5 | 6.0% |
| Privacy, dignity & well being | 2 | 2.4% |
| Appointments | 1 | 1.2% |
| Administration/policies/procedures (including patient records) | 1 | 1.2% |
| No subject specified | 1 | 1.2% |
| Facilities | 1 | 1.2% |
| Other | 1 | 1.2% |
| Total | 84 | 100% |

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

## Number of compliments made to the trust

From January to June 2018, there were eight compliments recorded for urgent and emergency care at the trust.

Site specific information can be found below:

- City Hospital: Four compliments (including two relating to BMEC)
- Sandwell General Hospital: Four compliments

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

We requested six complaints, with responses and action plans, in relation to Sandwell General Hospital's emergency department. The trust provided four complaints in relation to the hospital's emergency department. On review, the trust had responded to the complaints in a courteous and professional manner, acknowledging where care could have been better. Where required, actions and lessons learnt were identified and shared with the complainant or their family.

# Is the service well-led?

## Leadership

**The trusts did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**

A matron, supported by a group of senior nurses, had responsibility for the management of the emergency department. A lead consultant oversaw the medical staff and a designated paediatric emergency medicine (PEM) consultant worked across the trust.

A nurse coordinator and a nurse in charge, along with the clinical lead for that shift, managed the emergency department on a shift by shift basis. A designated lead nurse for paediatrics was allocated each shift.

Staff told us the matron was visible and approachable. Matron had been in post since April 2018, although had previously held the post of matron at City Hospital emergency department. Matron demonstrated a good knowledge of the challenges within the department, for example those on the risk register. However, we found a lack of drive and ambition from senior staff to make change due to increasing pressures and demands on the service with limited trust wide support.

Staff told us that they see board members on walk rounds of the hospital and they do visit the emergency department. However, staff told us that the executive team will not spend long in the department and do not take the time to engage with staff or understand and average day within the department.

We spoke with eight senior nurses throughout the inspection. We found the nurse in charge and shift coordinators were knowledgeable about the department and its process. When asked, senior nurses could explain the delays in patient care (for example the reason for breaching the four hour target to admit or discharge), where the vulnerable patients in the department were (for example with a learning disability) and the number of patients waiting to be triaged or on route via ambulance.

We spoke within three consultants throughout the inspection. Each consultant demonstrated a good knowledge of the department. When asked, consultants knew where in the department the sickest patients were and why patients were delayed.

When asked, staff told us that local management were visible and approachable. Most staff told us they felt listened to and support. However, staff told us that senior management (for example the executive team) were not as visible. Staff told us that senior staff would often visit the department but for a very short time and then leave. Two senior members of staff told us that they did not feel senior staff listened to concerns about staffing and safety. Both members of staff told us they had previously escalated concerns about patient safety and staffing; however, no changes had been made and senior staff discouraged the completion of incident forms.

## Vision and Strategy

**The trust had a vision for what it wanted to achieve; however, no workable plans to turn it**

**into action developed with involvement from staff, patients and key groups representing the local community.**

The emergency department at Sandwell General Hospital followed the Trust vision and values. The trust had a vision known as '2020 vision', which was a Trust wide initiative formulated in 2015 to improve and develop the trust by 2020.

Staff we spoke with understood the 2020 vision and where the trust was aiming to get, which included the building and opening of a new hospital.

At the time of the inspection, the trust was in the process of reviewing its 2020 vision and objectives in light of the delays to the new Midland Metropolitan Hospital site and the impact this will have on urgent and emergency pathways.

We saw the trusts values on display throughout the department, and staff were able to tell us about them. Staff spoke positively about the trust values.

## Culture

**Managers across the trust did not promote a culture that supported and valued staff. Local managers did create a sense of common purpose based on shared values amongst staff.**

We spoke with 23 staff during the inspection, including nursing, medical, allied health and support staff. We found a mix response when we asked staff how supported they were from their managers. The majority of staff told us they did feel supported and that their managers were approachable. The majority of staff felt confident in the decisions taken by their immediate line manager. We found this particularly evident amongst junior nurses when asked about shift coordinators and leaders.

Some senior nurses did not feel supported by senior staff. Two senior nurses told us that they felt senior managers within the organisation did not listen to concerns and act upon them. The two senior nurses told us that the executive member of staff on call has rang the trust overnight and made decisions that could compromise the safety of patients and staff.

We found doctors within the department were supportive of each other, and junior staff felt supported by their senior colleagues. However, we found a culture that did not fully support the development of junior doctors. We found senior staff did not have the time to deliver effective teaching to junior medical staff due to a lack of staff and time spent on site. Consultants told us they wanted to use handover time to deliver teaching to junior doctors; however, they told us senior managers at trust level have told them that they could not use this time to do that.

When asked, staff knew about duty of candour and their requirements under the regulation. 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 reason able support to the person.We observed staff acknowledging and apologising for any minor concerns raised by patients or their relatives during the inspection.

The culture regarding the care of children and young people was mixed within the department. We found frontline staff delivering good care to children during daytime hours due to the availability of children's nurses and a separate children's area within 'majors'. Overnight, this was not available. Senior staff had no contingency plans in place to ensure the safety of children and young people within the department. For example, one senior nurse did not know the protocol for if a child or young person either absconded from the department or was abducted out of hours.

We found a mixed approach to the safety of staff within the department. Security staff were available at the hospital; however, due to staff shortages within the security team, security staff were not always available to attend to incidents. The trust reported two incidents in August 2018 relating to security staff not being available. Both incidents were due to staff sickness.

We found no concerns in relation to equality and diversity across the department. Staff did not raise any concerns with us regarding discrimination or non-equal treated based on a protected characteristic, as defined within the Equality Act 2010.

## Governance

**The trust did not use a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

The emergency department had a governance system in place. There was a clear pathway from the department to the executive team. However, this pathway was complex and consisted of several layers of management.

All staff spoken to understood how to raise and escalate concerns. Junior staff were able to escalate concerns via the shift coordinator or hospital manager to be dealt with locally and effectively. Wider concerns could be raised either via an incident form or through the departments matron.

The department held monthly staff meeting and we reviewed the meeting minutes from the June, July and August 2018 meetings. We found the meetings had a set agenda, allowing for any other business to be raised at the end. The meetings covered agenda items including: incidents and serious incidents, audit results, risk and an update on actions from the previous meeting. Each action point had a person or group allocated as the lead and in the June and July minutes a timescale for completion. The August meeting minutes did not contain any timescales from completion of actions.

Meeting minutes were shared with staff each month and staff told us that they have seen these and feel able to attend meetings if they wanted to.

## Management of risk, issues and performance

**The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

We reviewed the emergency departments risk register and found it contained 19 risks relating to

Sandwell Hospitals emergency department. The risks identified included staffing, security, flow of patients through the department and risks associated with care delivery. The risks identified on the risk register correlated to the risks found by us during the inspection, except one risk that we identified that was not mentioned on the risk register.

However, we found that of the 19 risks, 14 had not been reviewed within the review frequency window and four had no 'last review' date documented. One risk had been reviewed in line with the review frequency. We were not assured the trust reviewed risks routinely and update the risk register to reflect this.

We found that children's care overnight (between 9:30pm and 9am), when no children's nurses or paediatricians were on site and the children's area was closed, was not on the risk register. We found a significant risk to children and young people attending the department overnight, both from a care delivery and safety and welfare perspectives. Staff within the department were aware that this was a risk; however, this had not been escalated to the trust board via the risk register.

We asked the trust how it was assured that children and young people were safe overnight, and were not exposed unnecessarily to adult patients under the influence of alcohol or drugs, or who were aggressive. However, the trust responded with the protocol for closing the children's area overnight. We were not assured that the trust had sufficient safeguards in place to mitigate the risk to children or a robust process in place to maintain the safety and welfare of children and young people overnight.

Management review risks on the risk register through the clinical leadership executive committee and trust board where required. Senior nurses within the department were aware of the risks that affected the department and were able to explain some of the measures in place to mitigate the risks.

## Information Management

**The trusts collected and analysed information well to support its activities. The trust did not manage and use information well, or effectively use electronic systems with security safeguards.**

The information technology (IT) systems used by the trust did not work well. During the inspection, the IT systems failed twice leading to delays in accessing information. Staff told us that IT was their biggest concern and caused problems on a day-to-day basis. Staff used a mix of electronic and paper records within the department. This provided significant challenge in ensuring that all relevant information was stored securely together.

Staff did not comply with information governance standards in relation to keeping people's information secure. We observed staff leaving computer logged on with patient identifiable information, including test results and personal data, visible and leaving these unattended. Staff left paper records unattended in parts of the department that were not immediate visible at all times.

## Engagement

**The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**

We observed good engagement between staff and patients and relatives in the majority of cases throughout the inspection. Patients could leave feedback about their care using the ‘purple phone’ system at the trust. This was a system where patients or visitors to could pick up a ‘purple phone’ (located around the hospital) and leave any piece of feedback about the trust or care.

The trust participated in the Friends and Family Test, which looks at whether patients would recommend the service to their friends or family.

The trust undertook quality improvement half days (QIHD) each month, which staff told us they attended and found useful. The QIHDs encouraged the sharing of information, knowledge and experiences to improve patient care across the trust. Staff were encouraged to attend other departments days to share learning wider than their own team.

Medical staff had a closed social media group that was used to organise cover for shifts or share urgent information about the department. We saw senior staff use this during the inspection and fill outstanding shifts.

## Learning, continuous improvement and innovation

**The trust was not consistently committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.**

Staff knew about the improvements that were required following the previous inspection report. We were told that these had been a focus for improvement. However, we found actual improvement to be mixed across the department.

The work done with a local women’s aid charity around domestic violence has seen more people (of all genders) get support and advice following domestic violence. Staff spoke highly of the impact that this project has had within the department.

The trust had employed 1.4 whole time equivalent paediatric emergency medicine (PEM) consultant. This was an improvement from the last inspection; however, the PEM consultants time was limited as they covered both sites, providing training and clinical care.

The department could not demonstrate timely changes and improvements following the latest Royal College of Emergency Medicine (RCEM) audit results.

The trust could not demonstrate significant improvements made following the previous inspection in March 2017. We highlighted concerns with the RCEM audit results but have found limited improvements during this inspection. We previously raised concerns about staff mandatory training, specifically basic life support. We found little improvement in mandatory training rates during this inspection.

Senior department staff were aware of the challenges facing the department due to the delay in building the new Midland Metropolitan Hospital. The trust was in the process of writing contingency and sustainability plans to cover until the year 2022, when Midland Metropolitan Hospital is scheduled to open.

# Medical care (including older people's care)

## Facts and data about this service

Medical care is delivered on both the Sandwell and City Hospital sites and provides both urgent and planned care. There are total of 383 winter inpatients beds which reduce during the summer months to 355, admitting between 42 and 49 patients a day from assessment units to the main in-patient bed base.

The cardiology service including the catheter lab is situated on the city site and stroke services are consolidated on the Sandwell site. Respiratory, gastroenterology, clinical haematology and elderly care services are available on both sites.

The Sandwell site benefits from a newly established older persons assessment unit which aims to provide multi-disciplinary comprehensive older persons assessment; this frailty model, tested on a smaller footprint, is in development at scale of 20 beds this year.

The trust works closely with primary care, communities and therapies clinical group to facilitate safe discharges for our patients to either their usual place of residence, community bed base or alternative care facility.

The medicine service has recently put in place a consultant of the week model across all main admitting specialities which has improved continuity of care and aims to contribute to a reduction in length of stay and increased morning discharge rates.

The trust has a ward based clinical team leadership which ensures a robust multi-disciplinary approach to inpatient care and treatment. They deliver 109,000 outpatient appointments and procedures annually as well as 8,000-day case and elective treatments. Both sites have endoscopy units which are accredited by the Joint Advisory Group (JAG).

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

The trust had 51,255 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 26,363 (51.4%), 1,328 (2.6%) were elective, and the remaining 23,564 (46.0%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 23,480
- Medical oncology: 7,339
- Clinical Haematology: 5,390

*(Source: Hospital Episode Statistics)*

We inspected the medical care service at Sandwell Hospital over three days from the 4 September 2018 to the 6 September 2018. During the inspection we spoke with eleven patients and some of their relatives, reviewed fifteen patient records and spoke to thirty-two staff. We spoke with consultants, service leads, matrons, ward managers, nurses, therapy staff, health care assistants, a discharge facilitator and ward service officers.

# Is the service safe?

## Mandatory training

## Mandatory training completion rates

**The service had not provided mandatory training in key skills to all staff and made sure everyone completed it.**

The trust set a target of 95% for completion of mandatory training.

**Trust level**

**Nursing staff**

A breakdown of trust level compliance for mandatory training courses as at July 2018 for qualified nursing staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 13 | 13 | 100.0% | 95% | Yes |
| Medical devices competency form | 429 | 431 | 99.5% | 95% | Yes |
| Equality & diversity | 426 | 437 | 97.5% | 95% | Yes |
| Conflict resolution initial training | 425 | 436 | 97.5% | 95% | Yes |
| Fire safety - workplace training | 400 | 412 | 97.1% | 95% | Yes |
| Harassment & bullying level 1 | 424 | 437 | 97.0% | 95% | Yes |
| Health & safety | 420 | 436 | 96.3% | 95% | Yes |
| Introduction to information governance | 192 | 204 | 94.1% | 95% | No |
| Blood collection | 58 | 62 | 93.5% | 95% | No |
| Infection control | 385 | 437 | 88.1% | 95% | No |
| Resuscitation: basic life support | 367 | 436 | 84.2% | 95% | No |
| Medicines management | 359 | 430 | 83.5% | 95% | No |
| Medical devices training | 305 | 372 | 82.0% | 95% | No |
| Conflict resolution update | 237 | 290 | 81.7% | 95% | No |
| Moving and handling - patient handling | 329 | 435 | 75.6% | 95% | No |
| Fire response team leader or refresher training | 8 | 11 | 72.7% | 95% | No |
| Transfusion | 256 | 369 | 69.4% | 95% | No |
| Information governance refresher module | 145 | 233 | 62.2% | 95% | No |

Nursing staff in medicine did not meet the trust's completion target for training, with a rate of 88% overall. However, the target of 95% was met for seven of the 18 courses made available to nursing staff. A rate of 100% was achieved for one course, however the number of eligible staff for this course was much lower than for other courses. Therefore, each member of staff accounts for a greater proportion of the total. The course with the lowest completion rate was the information governance refresher module with 62.2%.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 for medical staff at trust level in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Harassment & bullying level 1 | 191 | 197 | 97.0% | 95% | Yes |
| Consent - basic consent | 94 | 97 | 96.9% | 95% | Yes |
| Medical devices competency form | 174 | 182 | 95.6% | 95% | Yes |
| Equality & diversity | 175 | 197 | 88.8% | 95% | No |
| Fire safety - workplace training | 161 | 192 | 83.9% | 95% | No |
| Moving and handling - medical staff | 154 | 184 | 83.7% | 95% | No |
| Moving and handling - patient handling | 5 | 6 | 83.3% | 95% | No |
| Resuscitation: basic life support | 150 | 196 | 76.5% | 95% | No |
| Infection control | 148 | 197 | 75.1% | 95% | No |
| Health & safety | 146 | 196 | 74.5% | 95% | No |
| Conflict resolution initial training | 144 | 195 | 73.8% | 95% | No |
| Conflict resolution update | 46 | 66 | 69.7% | 95% | No |
| Medicines management | 126 | 196 | 64.3% | 95% | No |
| Introduction to information governance | 96 | 151 | 63.6% | 95% | No |
| Medical devices training | 88 | 143 | 61.5% | 95% | No |
| Transfusion | 98 | 173 | 56.6% | 95% | No |
| Information governance refresher module | 22 | 46 | 47.8% | 95% | No |

Medical staff in the medical care core service did not meet the trust's target of 95% for training completion, achieving 77.2% overall. However, the completion rate target was met for three of the 17 courses made available to medical staff. As with nursing staff, the course with the lowest completion rate was the information governance refresher module with a rate of 47.8%.

**Sandwell General Hospital medicine department**

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 3 | 3 | 100.0% | 95% | Yes |
| Medical devices competency form | 108 | 109 | 99.1% | 95% | Yes |
| Equality & diversity | 106 | 110 | 96.4% | 95% | Yes |
| Fire safety - workplace training | 100 | 104 | 96.2% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Conflict resolution initial training | 104 | 110 | 94.5% | 95% | No |
| Harassment & bullying level 1 | 104 | 110 | 94.5% | 95% | No |
| Health & safety | 103 | 110 | 93.6% | 95% | No |
| Introduction to information governance | 48 | 52 | 92.3% | 95% | No |
| Blood collection | 32 | 35 | 91.4% | 95% | No |
| Medical devices training | 75 | 85 | 88.2% | 95% | No |
| Resuscitation: basic life support | 93 | 110 | 84.5% | 95% | No |
| Infection control | 92 | 110 | 83.6% | 95% | No |
| Medicines management | 92 | 110 | 83.6% | 95% | No |
| Conflict resolution update | 58 | 71 | 81.7% | 95% | No |
| Moving and handling - patient handling | 80 | 110 | 72.7% | 95% | No |
| Fire response team leader or refresher training | 2 | 3 | 66.7% | 95% | No |
| Transfusion | 61 | 104 | 58.7% | 95% | No |
| Information governance refresher module | 26 | 58 | 44.8% | 95% | No |

Nursing staff in the medicine department at Sandwell General Hospital did not meet the 95% training completion target, with a rate of 85.6% overall. However, staff did meet the target for four of the 18 courses made available to them. The course with the lowest completion rate was the information governance refresher module with 44.8%.

**Mandatory training compliance rates, including basic life support had been identified as a concern on our previous inspection in 2017 and remained a concern.**

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 for medical staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - Basic Consent | 5 | 5 | 100.0% | 95% | Yes |
| Medical Devices Training | 2 | 2 | 100.0% | 95% | Yes |
| Medical Devices Competency Form | 6 | 6 | 100.0% | 95% | Yes |
| Fire Safety - Workplace Training | 8 | 8 | 100.0% | 95% | Yes |
| Moving and Handling - Patient Handling | 2 | 2 | 100.0% | 95% | Yes |
| Harassment & Bullying Level 1 | 10 | 10 | 100.0% | 95% | Yes |
| Equality & Diversity | 9 | 10 | 90.0% | 95% | No |
| Health & Safety | 8 | 10 | 80.0% | 95% | No |
| Conflict Resolution Initial Training | 8 | 10 | 80.0% | 95% | No |
| Infection Control | 7 | 10 | 70.0% | 95% | No |
| Moving and Handling - Medical Staff | 5 | 8 | 62.5% | 95% | No |
| Resuscitation: Basic Life Support | 6 | 10 | 60.0% | 95% | No |
| Medicines Management | 5 | 10 | 50.0% | 95% | No |
| Conflict Resolution Update | 3 | 6 | 50.0% | 95% | No |
| Information Governance: Introduction to Information Governance | 3 | 7 | 42.9% | 95% | No |
| Transfusion | 4 | 10 | 40.0% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Information Governance: Information Governance Refresher Module | 1 | 3 | 33.3% | 95% | No |

At Sandwell General Hospital's medicine department, the 95% target was met for six of the 17 mandatory training modules for which medical staff were eligible. Overall, medical staff in this core service achieved a completion rate of 72.4% for all training courses made available to them. The course with the lowest completion rate was the information governance refresher module with 33.3%.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for mandatory training courses as at July 2018, for qualified nursing staff in the medical care core service at sites described as 'other' by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire response team leader or refresher training | 1 | 1 | 100.0% | 95% | Yes |
| Fire safety warden or refresher training | 4 | 4 | 100.0% | 95% | Yes |
| Health & safety | 109 | 109 | 100.0% | 95% | Yes |
| Conflict resolution initial training | 109 | 109 | 100.0% | 95% | Yes |
| Harassment & bullying level 1 | 109 | 110 | 99.1% | 95% | Yes |
| Equality & diversity | 109 | 110 | 99.1% | 95% | Yes |
| Medical devices competency form | 104 | 105 | 99.0% | 95% | Yes |
| Fire safety - workplace training | 103 | 104 | 99.0% | 95% | Yes |
| Introduction to information governance | 50 | 52 | 96.2% | 95% | Yes |
| Blood collection | 25 | 26 | 96.2% | 95% | Yes |
| Infection control | 101 | 110 | 91.8% | 95% | No |
| Conflict resolution update | 71 | 84 | 84.5% | 95% | No |
| Medical devices training | 70 | 85 | 82.4% | 95% | No |
| Medicines management | 84 | 103 | 81.6% | 95% | No |
| Transfusion | 52 | 66 | 78.8% | 95% | No |
| Resuscitation: basic life support | 83 | 109 | 76.1% | 95% | No |
| Moving and handling - patient handling | 83 | 109 | 76.1% | 95% | No |
| Information governance refresher module | 37 | 58 | 63.8% | 95% | No |

At sites classified as other by the trust, nursing staff in medical care did not meet the mandatory training target of 95% for training overall, achieving a rate of 89.7%. However, the target was met for 10 of the 18 training modules for which qualified nursing staff were eligible. The course with the lowest completion rate was the information governance refresher module with 63.8%.

**Medical and dental staff**

A breakdown of compliance for mandatory training courses as at July 2018 medical staff in the medicine core service for sites classified as other is shown below.

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Consent - basic consent | 89 | 92 | 96.7% | 95% | Yes |
| Harassment & bullying level 1 | 175 | 181 | 96.7% | 95% | Yes |
| Medical devices competency form | 162 | 170 | 95.3% | 95% | Yes |
| Equality & diversity | 160 | 181 | 88.4% | 95% | No |
| Moving and handling - medical staff | 144 | 170 | 84.7% | 95% | No |
| Fire safety - workplace training | 147 | 178 | 82.6% | 95% | No |
| Resuscitation: basic life support | 139 | 180 | 77.2% | 95% | No |
| Moving and handling - patient handling | 3 | 4 | 75.0% | 95% | No |
| Infection control | 135 | 181 | 74.6% | 95% | No |
| Health & safety | 132 | 180 | 73.3% | 95% | No |
| Conflict resolution initial training | 130 | 179 | 72.6% | 95% | No |
| Conflict resolution update | 43 | 60 | 71.7% | 95% | No |
| Medicines management | 115 | 180 | 63.9% | 95% | No |
| Introduction to information governance | 90 | 141 | 63.8% | 95% | No |
| Medical devices training | 84 | 139 | 60.4% | 95% | No |
| Transfusion | 93 | 161 | 57.8% | 95% | No |
| Information governance refresher module | 19 | 40 | 47.5% | 95% | No |

At sites classified as other by the trust, medical staff in the medicine department did not meet the mandatory training target of 95% for training overall, achieving a rate of 77%. However, the target was met for three of the 17 training modules for which qualified nursing staff were eligible. The course with the lowest completion rate was the information governance refresher module with 47.5%.

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

Staff told us that limited computers, IT problems, training being held on different dates and not being able to access all the training from home impacted on training uptake.

During the inspection we spoke with several staff in relation to training. We found that although staff felt training was available, they also felt staffing issues, limited computers, IT issues and not being able to access all the training from home prevented uptake. Staff told us that if they were behind with any training they received an email alert. We saw there was a big drive at the trust to train staff in the new electronic recording system (planned to be implemented in October 2018), some staff told us they had been made champions in relation to this. During our last inspection in 2017 we noted that basic life support (BLS) compliance rates across the medical core service was low at 56%; although we saw a slight improvement in these figures both nursing and medical staff training compliance rates were still below the trusts target.

The trust had put processes in place to alert staff if they were behind with training. Staff were responsible for booking their own mandatory training. Staff who did not complete their on-line training within two months would need to link in with the Matron for a plan to manage their training requirements. The trust told us they had put various actions in place to improve training rates in medicine. These included regular reminder e-mails to staff whose training was out of date. Leaders told us that all ward areas had cascade assessors to carry out practical training sessions such as Basic Life Support (BSL) and moving and handling. BLS classroom sessions were offered and advertised, usually taking place on a two-weekly basis.

The medical wards had developed a RAG rated approach to promote achieving compliance with mandatory training; green being all mandatory training completed, amber to complete within two months and red to complete within one month. Consultant and senior doctor mandatory training days were being repeated every six weeks. We reviewed the minutes from the staff meeting held on Newton 5 in July 2018 and saw staff were advised their mandatory training compliance was poor and remined it was the individuals responsibility to ensure they were up to date.

The trust had arranged for back-fill staff so staff could attend electronic patient record training. Senior staff told us bank back-fill staff had been provided to ensure staff could attend electronic patient record training. They also told us all wards had scope within their budget to support staff training. The trust provided us with the details around the number of hours booked which ranged between 7.5 hours on Lyndon 5 to 60.5 hours on Lyndon 4 so a significant variance between wards.

## Safeguarding

## Safeguarding training completion rates

**Nursing and medical staff did not meet the trust target in safeguarding training.**

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 2 | 379 | 433 | 87.5% | 95% | No |
| Safeguarding adults level 2 | 62 | 73 | 84.9% | 95% | No |

In medicine the 95% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff at a trust wide level met the target for safeguarding training overall, with a rate of 95.2%. The course with the lowest completion rate was the safeguarding adults level 2 module with 84.9%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding children level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding adults level 2 | 73 | 89 | 82.0% | 95% | No |
| Safeguarding children level 2 | 153 | 191 | 80.1% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

In medicine the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible. Medical staff at a trust wide level did not meet the target for safeguarding training overall, with a rate of 91.6%. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however, this was based on only one of the two members of eligible staff not completing it.

**Sandwell General Hospital medicine department**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 109 | 110 | 99.1% | 95% | Yes |
| Safeguarding children level 1 | 109 | 110 | 99.1% | 95% | Yes |
| Safeguarding children level 2 | 88 | 110 | 80.0% | 95% | No |
| Safeguarding adults level 2 | 10 | 15 | 66.7% | 95% | No |

At Sandwell General Hospital, nursing staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.6%. Of the four mandatory safeguarding courses made available to nursing staff, two met the trust's target. The course with the lowest completion rate was the safeguarding adults level 2 module with 66.7%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 10 | 10 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 5 | 5 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 10 | 10 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 7 | 10 | 70.0% | 95% | No |

At Sandwell General Hospital, medical staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.4%. Of the four mandatory safeguarding courses made available to nursing staff, three met the trust's target. The course with the lowest completion rate was the safeguarding children level 2 module with 70%.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018, for qualified

nursing staff in the medicine department at sites classified as other by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 99 | 106 | 93.4% | 95% | No |
| Safeguarding adults level 2 | 31 | 36 | 86.1% | 95% | No |

Within medicine departments classified as other by the trust, the 95% mandatory training completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff met the target overall with a completion rate of 96.7%. The course with the lowest completion rate was the safeguarding adults level 2 module with 86.1%.

**Medical staff**

A breakdown of compliance for safeguarding training courses as at July 2018, for medical staff in the medicine department at sites classified as other by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 180 | 181 | 99.4% | 95% | Yes |
| Safeguarding children level 1 | 180 | 181 | 99.4% | 95% | Yes |
| Safeguarding children level 2 | 143 | 178 | 80.3% | 95% | No |
| Safeguarding adults level 2 | 63 | 79 | 79.7% | 95% | No |

At sites classified as other by the trust, medical staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.4%. Of the four mandatory safeguarding courses made available to medical staff, two met the trust's target. The course with the lowest completion rate was the safeguarding adults level 2 module with 79.7%.

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

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

All staff we spoke with knew how to raise an alert if a safeguarding situation occurred. Staff could provide us with examples of when safeguarding situations had arose; including how they had needed to liaise with the safeguarding team and with social services. Staff knew the name of the trusts safeguarding lead and where to find the safeguarding policies and procedures.

We saw there were policies in place for the safeguarding and protection of adults at risk and safeguarding children. The adult safeguarding policy had an approval date of August 2017, and was due to be reviewed in 2020. We reviewed the content of the policy and found it was version controlled. The policy referred to PREVENT (a part of the UK, s counter terrorism strategy). It also had information for staff on the different types of abuse such as modern slavery, roles and responsibilities of staff and included a flow chart on what to do if an alleged perpetrator was a staff member; additionally, it contained the contact details of the safeguarding team. The children's safeguarding policy was dated July 2018, was version controlled, contained a flow

chart and links to relevant guidance. We asked the trust what was in place around Female Genital Mutilation (FGM). The trust provided us with information, however the information was specific to maternity services and not medical care. There was no information on FGM in the safeguarding adults and children's policies.

## Cleanliness, infection control and hygiene

**Control measures to prevent the spread of infection were not effective in all the areas we looked at.**

Medical wards displayed cleaning rotas at their entrance. These set out the wards cleaning schedules and what equipment needed to be cleaned and when. However, we spoke with ward service officers who were responsible for domestic tasks on one ward and they told us the daily cleaning schedule did not need to be signed and dated; this meant that other staff would not always know if something had been cleaned. The service officers followed a routine which included the cleaning of medical equipment, beds, lockers and floors and high and low dusting.

We saw daily infection control audit sheets were available to staff, these included areas such as toilet seats, hand hygiene and commodes; however, these had not been completed daily.

We reviewed patient records and found infection control checklists and assessments for *Clostridium difficile (C-diff)* were not always completed.

Most staff were arms bare below the elbow, except for one doctor. We saw there was enough personal protective equipment (PPE) in place. PPE was easily accessible to all staff on the wards. We saw staff gelled their hands after patient contact. Patents with infections could be nursed in side rooms. We saw portering staff visit a ward area and not wash their hands. We tried several hand gel dispensers and found three were empty, these were on Lyndon 5, the acute medical unit and in the endoscopy department.

There were gaps in recording around hand hygiene compliance rates, especially in the endoscopy unit when hand hygiene compliance rates were not recorded between December 2017 and May 2018. We asked the trust to provide us with action plans in relation to poor compliance, however these were never received.

The trust completed commode audits, we reviewed several audit results and found the Sandwell site only met the target compliance rate of 90% on one occasion (April to June 2018; these results included other core services). Regular cleaning audits were completed; we reviewed the results from three audits and three different medical wards between April 2018 and August 2018 and saw that the target of 90% was achieved in all instances. The audits looked at areas such as lockers, beds, wash bowls and showers.

The facilities directorate completed remedial action plans to address any problems found during audit. Areas found in recent action plans included TV screens being smeared and floors needing cleaning.

Reusable sharps containers were available on wards to dispose of any sharps. There were processes in place for the collection and disposal of these.

The medical department monitored hand hygiene compliance monthly, between August 2017 and August 2018 most medical wards achieved a compliance rate of above 95%.

The trust screened and monitored infection rates including MRSA, *Clostridium difficile (C-diff)* and methicillin susceptible Staphylococcus aureus (MSSA). The rates were collated by the trust and

reported in an infection and prevention control report. We reviewed the report and found that the results for medicine and emergency care were mainly combined so we were unable to break them down individually. However, infection rates for C-diff were broken down by ward. From April 2017 to August 2018 the wards with the highest rates for C-diff were Lyndon 4 with seven cases and Priory 5 with six cases. We asked the trust to provide us with actions plans that had been completed as a result of infection rates however we did not receive these.

There was suitable systems and processes in place to decontaminate endoscopy equipment. The trust were managing and decontaminating reusable scopes in line with national guidance. In the endoscopy department systems were in place to transfer clean scopes and collect dirty ones. The area where scopes were decontaminated was some distance from the endoscopy department; therefore, staff used wipeable trolleys to transfer clean and dirty scopes; dirty and clean scopes were not transported together. Different coloured bags were used to differentiate between clean and dirty scopes, red for dirty and clear for clean; there was a machine that sealed the bags. Staff cleaned down the trolleys used for transporting the scopes after each use. We visited the scope decontamination area and noted that all staff were wearing PPE (personal protective equipment) including disposable hair nets and gowns. We observed that staff washed their hands before they entered the clean area. We saw there was a dirty and clean area to prevent cross infection. There were special machines in place which sterilised the scopes as well as drying cabinets.

There was a daily cleaning schedule in place which staff signed, however we saw this was not always completed. Staff in the department told us the cleaning schedule was not audited. We spoke to the person in charge about the gaps in the cleaning schedule who said they would follow this up.

Staff in the endoscopy department told us there was no specific deep cleaning schedule in place. However, if necessary staff would close rooms and arrange for a deep clean. Staff took precautions if a patient had any suspected communicable diseases for example the flu. Staff told us if a patient had an infection they would try to reschedule their appointment; if this was not possible staff would see the patient at the end of the day and clean the room thoroughly after use.

## Environment and equipment

### Resuscitation trolleys were not tamperproof.

Resuscitation trolleys were not tamperproof and in some areas contained medications, meaning that insufficient safety measures were in place to ensure emergency medicines, intravenous fluids and equipment were safe to be used. We escalated our concerns and were advised that lockable trolleys had been ordered.

Wards had resuscitation trolleys that had equipment for emergencies. We reviewed trolleys on Lyndon 5, the acute medical unit and Priory 5 and found these were not tamperproof and were stored in accessible areas on the wards. This meant that safety measures were not in place to ensure emergency medicines such as adrenaline, intravenous fluids and equipment were safe to be used. The risk of patients or visitors accessing the trollies was not mitigated. Some areas had tried to disguise the trolleys with a cover. These same issues had been raised on our earlier inspection in 2017. We raised the concerns again with a senior staff member on a ward who escalated our concerns. We were told that lockable trolleys had now been ordered. We reviewed the checking of resuscitation trolleys and found that staff had signed these to verify their checks.

**Processes were in place to ensure ward areas were secure, waste was disposed of appropriately and equipment was tested for safety.**

Wards we visited were secure. There was an intercom system in place which meant visitors needed to use the intercom to gain access. All equipment we viewed had up to date stickers to show it had been tested for electrical safety.

Processes were in place for checking and replenishing stock. We reviewed consumables in storage areas and found these were all in date. We found some areas were short of space and as a result appeared cluttered.

Wards had enough equipment such as specialist mattresses and systems were in place for the replenishment of stock. We saw that specialist mattresses were in place for patients that needed them. Clinical waste was managed appropriately, yellow bags were in place for clinical waste.

## Assessing and responding to patient risk

**Processes were in place for monitoring and escalating deteriorating patients. Policies referred to sepsis and early warning systems.**

We saw that there was a policy in place named the Physiological Observation Monitor and Escalation Policy. Staff we spoke with knew where they could access the policy. The policy covered early warning systems and referred to sepsis. The policy had been due for renewal in July 2018, therefore was slightly out of date.

We saw that there were information boards in some areas to inform staff, patients and visitors of sepsis protocols at the trust. Staff we spoke with felt that there was a good understanding of sepsis. The sepsis consistency of care collection tool was available to staff on the wards.

Staff identified and responded appropriately to the changing risks of people who used the service such as deteriorating patients**.** Staff used a handheld computer system to record patients "National Early Warning Score" (NEWS), however, on some wards wi-fi issues meant that paper documentation was used. An early warning score is a guide used by medical services to quickly decide the degree of illness of a patient and is based on vital signs. Patients triggered escalation to a doctor when they scored five or above; staff we spoke with were aware of this trigger.

Processes were in place so that patients with sepsis could be identified within their medical notes. We saw there was lots of visible information for staff on sepsis. Staff could show us examples in records of when they had needed to escalate a deteriorating patient. We saw that stickers with red writing were used to alert staff to sepsis within the patient's medical notes. We noted that the trust had a sepsis consistency of care tool in place.

Processes were in place to assess, audit and respond to patient risk through a range of risk assessments; however, incompleteness of recorded checks may adversely impact the identification of risks. Staff carried out risk assessments on patients at the point of admission; these included a patient's risk of falls, pressure damage, and any nutritional risks. However, we found that some risk assessments had been dated but not timed, therefore we were unable to establish if the assessments had been timely. Wards had daily safety briefings; patient notes had a red alert form in place to alert to a risk of pressure areas developing.

The trust had a safety plan in place that set out ten promises for patients. Wards carried out safety checks on patients in accordance with the plan. Safety indicators included areas such as venous throembolism (VTE) assessment, vital signs, falls, pressure ulcers and expected date of discharge

We saw staff completed regular audits around patient observations through consistency of care standards. Information from these audits was displayed on wards. A three-strike rule was in place to ensure any omissions were captured at the beginning of each shift. Wards had introduced a check and challenge process which involved the nursing staff reviewing documentation from the previous shift. If a nurse did not assess or document any inconsistency in care standards this would be raised in the first instance at check and challenge handover' between two nurses. If concerns continued it would be escalated to a senior sister when reflection and expectations would be explored; a third time would result in a formal meeting with the ward matron and a note on the staff members file.

**Staff on wards were looking at ways in which they could reduce and monitor risks to patient's in areas such as falls and pressure sores.**

We saw the trust monitored the risk of inpatient falls. These included tracking where patient falls occurred on each ward. Each ward had a floor map where staff marked falls that happened at night with a red dot and falls that happened in the day with a black dot, collection of this data started in August 2018 so it was too early to determine any overall results. The plan was to review the data monthly to find any trends. We visited ward areas and saw low profile beds were in place for patients at risk of falls. Wards also had access to falls mats and grab bags. Grab bags were kept in patient toilets and contained continence products and wipes; this meant staff did not need to leave patients alone to go looking for such items.

A blue pillow initiative had been developed to reduce skin pressure damage. This involved two blue pillows being kept at the bottom of each bed at all times to raise heels of the mattress, leaders told us this had led to a significant reduction in pressure damage. The initiative was being rolled out across the trust, regionally and had also won an award.

The trust had a safety plan in place which set out ten clear promises to patients; promises included monitoring patients vital signs at the right time so they could quickly act if the patient's condition worsened, involving patients in discharge planning and giving patients their medication at the right time.

**Staff did not consistently update risk assessments or ensure they were complete.**

Staff checked patients' ongoing risk using documentation such as fluid balance charts, focused care observations and nutritional charts. However, we noted there were some gaps in recording. For example, we saw a fluid input chart had not been totalled throughout the day, a malnutrition universal screening tool (MUST) score that had not been reviewed and a wound assessment chart that had not been signed or dated. We also noted that some risk assessments had not been reviewed routinely for some long stay patients.

## Nurse staffing

**The service did not always have enough nursing staff with the right qualifications, skills, training and experience to provide the right care and treatment.**

The trust reported the following nurse staffing numbers for medical care both from April 2017 to March 2018 and, more recently in April/May 2018:

| Site | April 2017 to March 2018 | April 2018 and May 2018 |
|---|---|---|

| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
|---|---|---|---|---|---|---|
| All sites | 307.4 | 374.4 | 82.1% | 297.3 | 375.9 | 79.1% |

Staffing numbers for both periods were similar, with the fill rate in April and May 2018 being just three percentage points lower than the fill rate from April 2017 to March 2018.

The trust was unable to provide this data broken down by site, indicating that the staff worked across the City Hospital and Sandwell General Hospital sites.

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

Nursing shifts on the older peoples' assessment unit (OPAU) were not being sufficiently covered. We looked at data from the OPAU from 3 September 2018 to 30 September 2018 and found 75 shifts had been under minimum staffing levels. Staffing issues were prominent of the unit's risk register.

We reviewed information on staffing levels in the OPAU from 3 September 2018 to 30 September 2018 and found that 75 shifts had been under minimum staffing levels. Of these sixteen shifts were under established by two staff, five shifts by three staff and the remainder of the shifts were under established by one member of staff.

Leaders told us staffing was reviewed daily by the matron and if there was a deficit staff would be moved across wards. The reporting system used by the trust did not reflect this as staff moved remained on their base wards off duty. Nursing staff told us it was not unusual to be working with two nurses on a shift instead of four. The OPAU worked on a staffing model of four registered nurses and three health care assistants.

Most staff across the medical wards told us they felt they needed more permanent staff. Staff in the acute medical unit (AMU) told us that although they had the time to provide patients with support in activities of daily living, they were unable to spend time any quality time with patients, for example to sit and chat or to complete any activities other than providing basic care.

However, leaders told us that they were actively recruiting and that nurses had either already been recruited, were awaiting recruitment checks, had been shortlisted or that vacancies were going out to post shortly.

## Vacancy rates

From July 2017 to June 2018, the trust reported an over-establishment in medicine of 2.7% across the trust, compared to the trust's target of 3%. A site breakdown can be seen below;

- City Hospital: an over-establishment of 2%
- Sandwell General Hospital: an over-establishment of 8.2%
- Staff assigned to 'other' sites within medical care: a vacancy rate of 2.1%.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

From July 2017 to May 2018 nursing staff at Sandwell Hospital had a turnover rate of 9%. There was no overall trust-wide target, however the turnover rate for band 5 nurses was 10%.

From June 2017 to May 2018, the trust reported a turnover rate of 12.9% for nursing staff in medical care. There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses. A site breakdown can be found below:

- City Hospital: 18.3%
- Sandwell General Hospital: 8.9%
- Staff assigned to 'other' sites within medical care: 5.7%

Both Sandwell General Hospital and the sites classified by the trust as 'other' met the target for band 5 nurses, however City Hospital performed worse than the target with a rate of 18.3%.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 4.7% in the medical care core service, which was worse than the trust target of 3%. A breakdown of sickness rates by site can be found below:

- City Hospital: 4.9%
- Sandwell General Hospital: 5.5%
- Staff assigned to 'other' sites within medical care: 3.6%

The sickness rate at each site was also worse than the trust target.

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

The trust had an action plan in place with a focus on long term sickness. Actions included the use of the check and challenge approach to focus on robust management of long and short-term sickness via one stop ward meetings and to ensure that return to work interviews were carried out in at least 95% of sickness cases. We reviewed the agenda for a quality improvement half day in September 2018 from respiratory medicine and saw that staff sickness was on the agenda.

## Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in medicine at a trust wide level from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff in medical care.

For qualified nurses, 16,277 shifts were filled by bank staff and 5,514 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 10,772 shifts were filled by bank staff and 443 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 16,277 | 10,772 | 27,049 |
| Agency | 5,514 | 443 | 5,957 |

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in the medical care core service, due to the format of the data provided by the trust.

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

We visited the OPAU at night and found all nursing staff were agency staff, the only permanent member of staff was a health care assistant. Senior staff told us they did try to swap agency nurses with other areas if this happened. They also told us this can be an issue as most of the agency nurses did not do cannulas or intravenous therapy (IVs) so this impacted on skill mix. We reviewed incident reports from OPAU and saw a report on the 4 August 2018 that a bank nurse had been the only nurse on the ward who could administer IV medications.

To mitigate some of the risk senior staff told us they tried to use the same agency staff and that before finishing their shift they would ensure there were staff on duty who could do IV's and cannulas. We asked the trust for details on the number of shifts where only agency staff were on shift, however we did not receive this.

We reviewed the policy for agency/locum staff, due for review September 2016.The purpose of the policy was to ensure all managers responsible for booking agency/locum temporary staff were aware of and observed safer recruitment practice. The policy did not cover what would happen in the event only temporary staff were available to cover a shift and how this would be managed safely.

The medical service had staffing escalation processes and flow charts in place for safe staffing. The processes included responsibilities of the matron and senior nurses such as one matron being on site before 7.30 am to co-ordinate a conference call to ensure safe staffing within medicine and to discuss live acuity using cross site co-ordination.

## Medical staffing

The latest trust wide data showed that the medical staffing fill rate in April/May 2018 was 99%.

The trust reported the following medical staffing numbers in medical care both from April 2017 to March 2018 and, more recently in April/May 2018:

| Site | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 197.3 | 189.4 | 104.2% | 188.7 | 190.3 | 99.1% |

From April 2017 to March 2018, the trust had a fill rate of 104.2% which equates to 7.9 more members of staff than they planned. However, by April/May 2018, the rate was 99.1%.

The trust was unable to provide this data broken down by site, indicating that the staff worked

across the City Hospital and Sandwell General Hospital sites.

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

**There were instances within medical care when there was no registrar cover. We were not assured the trust had taken sufficient actions to address this.**

We asked the trust how many occasions there had been medical rota gaps within medical care over the last two months and what was being done to improve. The trust provided us with information in relation to on call registrar shifts for the last six months. We saw that from February 2018 to July 2018 there had been 14 full shifts when there had been no registrar cover and 18 partial shifts not covered by a registrar. There was a policy in place for managing absent medical posts dated 2018 that aimed to describe the actions that could be taken to minimise unfilled posts, however we were not assured sufficient actions had been taken to address this.

## Vacancy rates

Data provided by the trust showed an over establishment of medical staff at Sandwell hospital of 15% from July 2017 to June 2018.

From July 2017 to June 2018, the trust reported an over-establishment of 8.8% overall for medical staff in the medicine core service compared to the trust's target of 3%. A site breakdown can be seen below;

- City Hospital: an over-establishment of 1.6%
- Sandwell General Hospital: an over-establishment of 15%
- Staff assigned to 'other' sites within medical care: an over-establishment of 8.8%.

The trust reported over-establishment for medical staff at all sites, with Sandwell General Hospital having the largest over-establishment with 15%.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them.

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

## Turnover rates

Trust turnover rates for medical staff was high at 29%. However, the trust confirmed that trainee grade staff were included in this data.

From June 2017 to May 2018, the trust reported a turnover rate of 18.2% for medical staff in medical care. There is no overall trust-wide turnover target. A breakdown of turnover by site is provided below;

- City Hospital: 23.2%
- Sandwell General Hospital: 28.7%
- Staff assigned to 'other' sites within medical care: 17.5%

Trainee grades have also been included in this turnover data.

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

## Sickness rates

Sickness rates for medical staff at Sandwell Hospital were low at 0%.

From June 2017 to May 2018, the trust reported an annual sickness rate of 0.6% in the medical care core service, which was better than the trust target of 3%. A breakdown of sickness rates by site is found below:

- City Hospital: 0%
- Sandwell General Hospital: 0.2%
- Staff assigned to 'other' sites within medical care: 0.6%

The sickness rate at each site was better than the trust's target, with the rate at City Hospital being reported as 0%.

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

## Bank and locum staff usage

From June 2017, to May 2018, 3,891 shifts within medical care were filled by bank staff and 3,293 shifts were filled by locum staff.

From June 2017 to May 2018, the trust reported that 3,891 shifts within medical care trust-wide were filled by bank staff and 3,293 shifts were filled by locum staff. There were 1,176 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank + locum + unfilled) |
|---|---|---|---|---|
| Consultant | 963 | 2,171 | 569 | 3,703 |
| Middle Grade | 1,209 | 306 | 141 | 1,656 |
| Doctor in Training | 1,719 | 816 | 466 | 3,001 |
| **Total** | **3,891** | **3,293** | **1,176** | **8,360** |

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

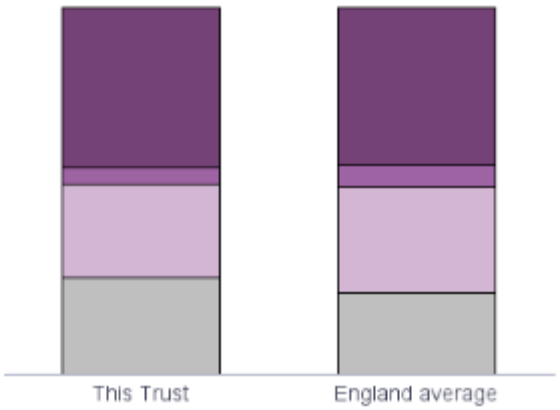
## Staffing skill mix

The proportion of junior (foundation year 1-2) was higher than the England average by 4%.

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

**Staffing skill mix for the 174-whole time equivalent staff working in medicine at Sandwell and West Birmingham Hospitals NHS Trust**

| | This Trust | England average |
|---|---|---|




| | | |
|---|---|---|
| Consultant | 43% | 43% |
| Middle career^ | 5% | 6% |
| Registrar group~ | 26% | 29% |
| Junior* | 26% | 22% |

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

*Source: NHS Digital - Workforce Statistics - Medical (01/03/2018 - 31/03/2018).*

## Records

**Staff did not always keep appropriate records of patients care and treatment. In some instances they did not keep them securely.**

We reviewed fifteen patient records and found there were gaps in recording. For example, we saw a fluid chart not totalled up at the end of the day, a focussed care chart not complete, an infection control checklist not completed, and a wound assessment chart that had not been signed or dated. Most records were completed legibly and in black ink. We saw staff had completed an entry in relation to oral intake for midday when it was only 11.40am; this record was completed on the artificial feeding column when the patient was not on normal diet and fluids.

There were lockable record cabinets in place with keypads, we found that some were locked and that others were not; this meant some patient information was accessible to anyone passing by. Most record trolleys were kept in close vicinity to the nurse's stations.

At the time of the inspection most patient records were kept in paper format, some wards also used a handheld computer system to record patient observations. The trust was hoping to move away from paper records soon and staff were receiving training in relation to this.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) had been completed appropriately. We reviewed six Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and found they had been completed appropriately.

## Medicines

**The service did not always store medication safely.**

At the time of the inspection visit medicines in AMU were not stored securely. The clean utility door was open and no staff were present, the inspector was able to enter the room unchallenged for 10 minutes. Medicine cupboards and the medicine refrigerator were left unlocked. We returned to the unit on several occasions following this and found the door was closed.

On one ward Lyndon 5, Intravenous fluid saline and potassium bags were being stored close together and labelling was not clear.

We saw some gaps in recording in fridge temperatures.

Temperatures of medicine storage areas were monitored, records documented that medicines were stored within the recommended temperature range; however, we did see some gaps in recording. In one instance we saw there were seven gaps in recordings of fridge temperatures**.**

Staff completed medication administration charts, most medication fridges with the exception of AMU were padlocked.

In the AMU clinical checks were made by the ward pharmacist with any issues being dealt with and followed up. Members of the pharmacy team undertook patient medicine histories and medicine reconciliation to ensure patients medicines were available and up to date to reduce the risk of medicines errors.

Checks to ensure that any known allergies or sensitivities to medicines were recorded on medication charts. This information is important to prevent the potential of a medication being given in error.

In AMU we saw that patient's weights had been completed in four out of five medicine charts. This helped to support the prescriber to ensure they prescribed the correct dose of medicine.

We noted that prescription variation charts were in place when a medication was not available. We saw one patient had been prescribed haloperidol, however this had been documented as being unavailable for six days.

Controlled drugs which required special storage and recording were stored following good guidance including twice daily checks by two nurses. Most medication trollies were locked, we saw one on Lyndon 5 that had a broken lock, however this was being kept in a locked room.

We saw nursing staff wearing red tabards to show they were completing medication rounds and they should not be disturbed; being distracted could lead to medication errors

## Incidents

From July 2017 to June 2018 the trust reported no incidents classified as never events.

## Never Events

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

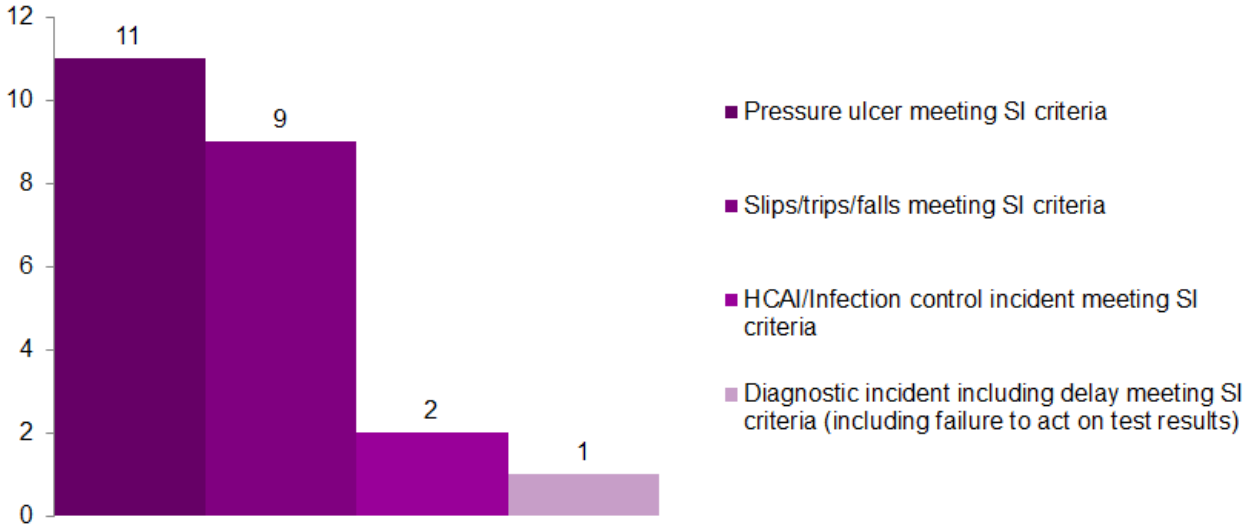
From July 2017 to June 2018, the trust reported no incidents classified as never events for medicine.

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

## Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2017 to June 2018.

**Serious Incidents (SIs) reported in Medical Care from July 2017 to June 2018**




A breakdown of the types of incidents reported is:

- Pressure ulcer meeting SI criteria with 11 (47.8% of total incidents).
- Slips/trips/falls meeting SI criteria with nine (39.1% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (8.7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (4.3% of total incidents).

Site specific information can be found below:

- City Hospital: Six serious incidents
- Sandwell General Hospital: 17 serious incidents

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

For further details around what the trust were doing around pressure areas and falls please see the heading assessing and responding to patient risk.

**Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with whole team.**

All staff we spoke with knew how to report an incident and felt encouraged to do so, we saw examples on incidents forms that staff had been completed. Staff received feedback via email or through face to face discussions. Staff could give examples of when they had needed to report an incident and give examples of investigation findings. We reviewed the meeting minutes from a quality improvement half day from Haematology from dated July 2018 and saw incidents such as a missed VTE assessment and chemotherapy not arriving on the ward on time had been discussed. Matrons told us incident data was collected and shared with ward managers; the importance of sharing positive feedback in addition to negative was also recognised by leaders. We saw a case study had been used to aid reflection around an incident involving a patient with grade three hospital acquired pressure damage. A lesson learnt included was that it was the responsibility of all staff to ensure patients were repositioned as documented on care rounding.

**Root cause analysis investigations were not robustly completed and action plans did not fully address all of the issues found.**

We reviewed three root cause analysis (RCA) documents in relation to serious incidents that had occurred within medicine. Two in relation to pressure areas and another in relation to falls. We found that there were gaps in the documentation, errors, they contained limited information and had not been validated by senior staff such as the director of nursing and the tissue viability lead nurse. From the three we reviewed an action plan was in place for only one of the investigations, however, this did not address all the issues found. For example, the RCA identified a delay in a dietitian review and that staff had inadequate or limited training and experience in grading and managing pressure areas; these potential learning points were not identified on the action plan. The action plan did not include any dates for completion. We requested evidence of staff learning in relation to the RCA's such as staff meeting minutes, however, the trust did not provide this.

**Staff we spoke with had limited understanding around the phrase duty of candour; however, were aware of the importance of being open and honest.**

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 reason able support to the person. We asked the trust to provide us with copies of three letters they had sent in relation to duty of candour along with any learning in relation to each incident. However, the trust did not provide us with these within the timescales requested.

Mortality (including mortality reviews) was discussed and learning identified at quality improvement half days (QIHD). Mortality was discussed at quality improvement half days (QIHD). We saw that mortality review presentations were included in QIHD with learning points identified such as the need for improvement around Do Not Attempt Resuscitation (DNAR) and admitted pathways. We spoke to one staff member who was able to provide an example of learning from a death where the learning included the need for improved communication. There was no specific medicine mortality and morbidity meetings. Leaders told us that the learning approach across the organisation was due for revision in January 2019.

## Safety thermometer

**The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.**

The trust collected data on the safety thermometer to record prevalence of patient's harm. This showed a reduction in falls, that the number of pressure areas remained around the same and that urinary tract infections in patients varied.

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

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

Data from the Patient Safety Thermometer showed that the trust reported 24 new pressure ulcers, 24 falls with harm and six new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Sandwell and West Birmingham Hospitals NHS Trust**


1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

*Source: NHS Digital - Safety Thermometer*

We saw that wards displayed information on falls and pressure areas in visible ward areas. These were colour coded red or green.

## Major incident awareness and training

**Processes were in place should the trust have a major incident such as a fire, flooding or a bomb threat.**

Wards operated on a winter and summer basis. This meant that some wards increased beds in the winter and reduced in the summer. Staffing impact was considered with staff being given more annual leave in the summer or were disseminated across the trust.

We saw that there were processes in place for if a major incident should occur which included a business impact analysis; incidents such as flooding, bomb threats and snowfall were included. We saw a folder on a ward that contained relevant information. The folder contained simple instructions for staff alongside a staff contact list.

# Is the service effective?

## Evidence-based care and treatment

**The hospital collected information about patient care and took part in national and local audits.**
For example, the Sentinel Stroke National Audit Programme (SSNAP), Lung Cancer Audit, and the National Audit of Inpatient falls. Policies and procedures were evidence based.
The trust had a programme in place in relation to research which included research around the role of hippocathpal pathology in post stroke cognitive impairment and cerebral vasomotor regulation in Arterial Fibrillation.

Ward staff undertook consistency of care audits. The reason for the audits was to monitor if essential observations were being completed. The daily audits took place in relation to five patients and considered areas such as medication being administered as prescribed, patient observations being completed, falls risk, if a care plan was in place and if waterlow scores were completed. A waterlow score gives an estimated risk for the development of a pressure sore. The trust kept consistency of care assurance data where compliance with the five a day audit which was rag rated red, green or amber. We reviewed the assurance data from July 2018 to September 2018 and saw that most wards achieved an overall compliance rate of above 95%.

**Staff teams completed daily board rounds and safety huddles to discuss patients progress.**

Daily board rounds took place on medical wards to discuss patients progress and risks. We attended a board round and found it to be well attended. Daily consultant ward rounds took place on weekdays; staff told us these were consistent. Afternoon safety huddles took place to discuss patient updates.

**The endoscopy department was Joint Advisory Group (JAG) accredited. Leaders identified areas for improvement and that action plans had been implemented.** The accreditation certificate was dated May 2018.An action plan was in place for areas that needed improvement such as ensuring that there was clear information available about the range of endoscopy services provided and the leadership team to review and to set service objectives on an annual basis.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health.**

Patients nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) score system. MUST is a five-step screening tool to identify adults, who are at risk of malnutrition. Staff could contact speech and language therapists (SALT) and dietitians to provide support to patients with nutritional/swallowing needs. Staff told us it was easy to access a dietitian and they could complete an on-line referral form.

We saw that patients had water jugs at their bedsides and that these were replenished regularly. Staff and volunteers provided patients with regular drinks.

Systems were in place to support patients who required additional support with nutrition. The hospital used a red tray system to identify patients who needed additional support.

Staff recorded patients diet and fluid intake; however, there were some gaps in recording. Three patients told us they were not happy with the food the hospital provided commenting on the quality, choice and presentation.

**Wards used an electronic ordering system for patient meals, however this did not always work well due to issues with the wi-fi.**

Staff on some wards told us wi-fi issues could cause problems with ordering food as the system was computerised.

**Staffing shortages in the speech and language therapy department were having an impact in some areas of the trust.**

This was recognised by leaders and identified as a risk on the medical risk register. Speech and language therapy had scored poorly in the Sentinel Stroke National Audit Programme (SSNAP). Staff told us how the speech and language therapy service was short staffed.

## Pain relief

**Staff managed patients pain well and could refer to the pain management team if needed.** Patients told us that their pain was managed well. Patients were asked about their level of pain and pain scores were completed in patients' records.

We saw examples of when pain scores had been completed for patients on a handheld computer system. Patients told us nursing staff managed their pain well and they had adequate pain relief.

Staff could refer patients to a pain management team if needed. The pain management team consisted of staff from various specialities including consultants, nurses, physiotherapists, health care assistants and clinical nurse specialists.

## Patient outcomes

**The trust had scored poorly or deteriorated in some areas of national audits.**

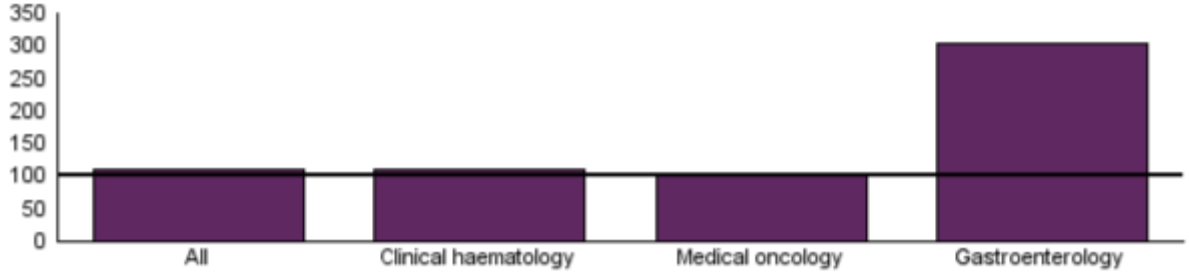
**Sandwell General Hospital**

From March 2017 to February 2018, patients at Sandwell General Hospital had a similar to expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical haematology and medical oncology had a similar to expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions.

We asked the trust about any actions they had taken in relation to gastroenterology having a higher than expected risk of readmission for elective admissions. The trust told us that they had only been able to identify one patient who was discharged and then readmitted into gastroenterology.

**Elective Admissions - Sandwell General Hospital**

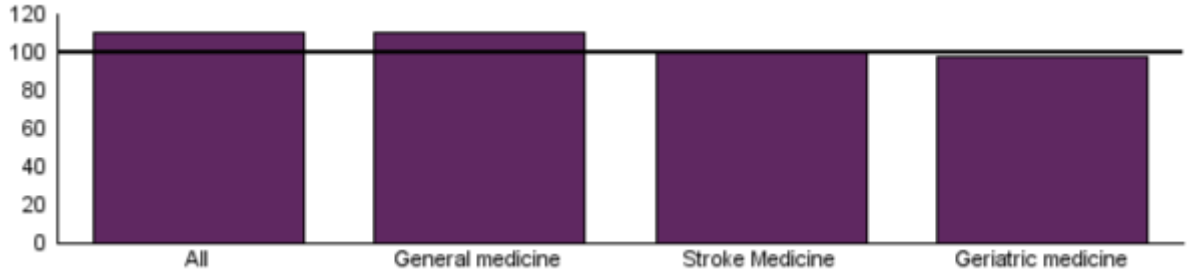



*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count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

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in stroke and older persons had a similar to expected risk of readmission for non-elective admissions

We asked the trust for any action plans and evidence of learning in relation to patients in medicine having a higher than expected risk of readmission for non-elective admissions. We saw that the trust reviewed readmissions and identified categories such as if the readmission was due to chest pain or worsening diseases; however, we did not receive information that demonstrated the trust had looked at how these figures could be improved.

**Non-Elective Admissions - Sandwell General Hospital**




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

## Sentinel Stroke National Audit Programme (SSNAP)

The trust participated in the Sentinel National Audit Programme (SSNAP). The patient centred stroke unit indicator deteriorated to grade D for the most period. However, action plans were in place to improve.

**Sandwell General Hospital**

Sandwell General Hospital takes part in the quarterly Sentinel Stroke National Audit programme.

On a scale of A-E, where A is best, the hospital's overall SSNAP level was B from August to November 2017, which was an improvement on the previous time period, April to July 2017, when it was grade C. The hospital's patient- and team-centred total key indicator levels were also grade B in the most recent time period.

The hospital's score for the patient-centred stroke unit indicator (domain 2) deteriorated to grade D for the most recent time period. The trust's score for this indicator was B in the previous reporting period. Performance also deteriorated in relation to the patient- and team-centred discharge processes indicators (domain 10) from B to C.

In contrast, performance improved on domain 7 (speech and language therapy) from E to D in terms of both patient- and team-centred performance.

| **Overall Scores** | Jan-Mar 16 | Apr-Jul 16 | Aug-Nov 16 | Dec 16 - Mar 17 | Apr 17 - Jul 17 | Aug 17 - Nov 17 |
|---|---|---|---|---|---|---|
| SSNAP level | C↓ | C | C | B↑ | C↓ | B↑ |
| Case ascertainment band | A | A | A | A | A | A |
| Audit compliance band | C | C | C | B↑ | B | B |
| Combined total key indicator level | B | B | B | B | C↓ | B↑ |

| **Patient centred performance** | Jan-Mar 16 | Apr-Jul 16 | Aug-Nov 16 | Dec 16 - Mar 17 | Apr 17 - Jul 17 | Aug 17 - Nov 17 |
|---|---|---|---|---|---|---|
| Domain 1: Scanning | A | A | A | A | A | A |
| Domain 2: Stroke unit | B | C↓ | C | C | B↑ | D↓↓ |
| Domain 3: Thrombolysis | B | B | C↓ | B↑ | D↓↓ | B↑↑ |
| Domain 4: Specialist assessments | A↑ | B↓ | B | B | B | A↑ |
| Domain 5: Occupational therapy | C↓ | C | E↓↓ | C↑↑ | C | C |
| Domain 6: Physiotherapy | A↑ | B↓ | B | B | B | A↑ |
| Domain 7: Speech and language therapy | D↓ | C↑ | C | E↓↓ | E | D↑ |
| Domain 8: Multi-disciplinary team working | C↓ | C | B↑ | B | C↓ | B↑ |
| Domain 9: Standards by discharge | D↓ | D | B↑↑ | B | B | B |
| Domain 10: Discharge processes | B↓ | B | A↑ | A | B↓ | C↓ |
| Patient-centred total key indicator level | B | B | B | B | C↓ | B↑ |

| Team centred performance | Jan-Mar 16 | Apr-Jul 16 | Aug-Nov 16 | Dec 16 - Mar 17 | Apr 17 - Jul 17 | Aug 17 - Nov 17 |
|---|---|---|---|---|---|---|
| Domain 1: Scanning | A | A | A | A | A | A |
| Domain 2: Stroke unit | B | C↓ | C | B↑ | B | B |
| Domain 3: Thrombolysis | B | B | C↓ | B↑ | D↓↓ | B↑↑ |
| Domain 4: Specialist assessments | A↑ | B↓ | B | B | B | A↑ |
| Domain 5: Occupational therapy | C↓ | C | E↓↓ | C↑↑ | C | C |
| Domain 6: Physiotherapy | A↑ | B↓ | B | B | B | A↑ |
| Domain 7: Speech and language therapy | D↓ | C↑ | C | E↓↓ | E | D↑ |
| Domain 8: Multi-disciplinary team working | C↓ | C | B↑ | B | B | B |
| Domain 9: Standards by discharge | D↓ | D | B↑↑ | B | B | B |
| Domain 10: Discharge processes | B↓ | B | A↑ | A | B↓ | C↓ |
| Team-centred total key indicator level | B | B | B | B | B | B |

*(Source: Royal College of Physicians London, SSNAP audit)*

The trust displayed the latest SSNAP results at the entrance to the stroke ward. Senior staff shared with us the most audit results from April to June 2018, however these were not yet in the public domain. We reviewed the most recent action plan to improve SSNAP levels for this reporting period and found actions had been put in place to improve such as ensuring that all stroke patients were seen for not less than 45 minutes daily and ensuring that referrals were made to speech and language therapy for patients who had swallowing and communication issues. The action plan did not contain any dates to aim towards, with timescales stating each action was ongoing.

## Lung Cancer Audit

At the time of our inspection oncology had transferred out of the trust.

The trust took part in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 69.4%, which does not meet the audit aspirational standard of 90%. The 2016 figure was 67.3%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 62%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 68%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was 37%. This is within the expected range. The 2016 figure was not significantly different to the national level.

*(Source: National Lung Cancer Audit)*

We saw the trust had completed a National Audit Baseline Assessment in relation to the National Lung Cancer Audit. The assessment included recommendations, actions required, if the trust were compliant, gave timescales and identified a responsible lead. Actions included multidisciplinary discussion on how to improve pathological confirmation and working with the clinical commissioning group towards the optimal lung cancer pathway and to provide accurate and timely information of the cancer pathway challenges. At the time of our inspection oncology had transferred out of the Trust.

## National Audit of Inpatient Falls 2017

Data from the National Audit of Inpatient Falls, 2017 showed the trust scored poorly in percentage of patients who had a vision assessment, completing lying to standing blood pressure assessments and assessing patients for the presence or absence of delirium and the proportion of patients not having a call bell within reach.

**Sandwell General Hospital**

The crude proportion of patients who had a vision assessment (if applicable) was 20%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 15%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 36%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 87%. This did not meet the national aspirational standard of 100%.

*(Source: Royal College of Physicians)*

We were not assured the trust had acted on results from the National Audit of Inpatient Falls, 2017. We asked the trust to provide us with action plans and evidence of actions in relation to findings from the National Audit of inpatient falls which included vision assessments, lying to standing blood pressure and delirium. However, the trust did not provide this.

**A delirium care pathway was in place and staff were completing delirium assessments**.

We noted that the trust had developed a delirium care pathway. The pathway looked at areas such as if the patient had difficulty focusing attention, if there was evidence of an acute change in mental status from the patient's baseline and if the patient was alert, vigilant or stupor.
We saw examples of when staff had completed delirium assessments and saw the pathway was being implemented.

**During the inspection we saw several patients that did not have their call bells within reach.**

We asked the trust for evidence of ongoing audit, action plans and learning in relation to the crude proportion of patients having a call bell in reach not meeting the aspirational standard as identified in the National Audit of Inpatient Falls, 2017. The trust told us that they had not completed any audits in relation to this. An action plan had been initiated by a ward at City hospital dated 4 September 2018 and we are told this has been cascaded to all medical wards. Actions included to ensure that patient call bells were within reach of the patient and for matrons to review on walkabouts, however we received no evidence of learning.

**The trust audited screening and timeliness of treatment for sepsis. Results showed that they were doing well at ward level with timeliness of treatment but not so well at screening patients for sepsis.**

There was a sepsis Commissioning for Quality and Innovation (CQUIN). In 2009 the Department of Health introduced the framework as a way for commissioners of healthcare to encourage and reward improvements in service quality. Data showed between April 2017 and March 2018. The service was doing well at ward level for timely treatment for sepsis scoring 100% in seven out of twelve months. However, the trust had not done so well in sepsis screening at ward level scoring above 70% on two occasions only in the same time period. There was some improvement in figures since November 2017 (44%) with the latest data (March 2018) showing 75%. The data did not show us individual ward performance or which hospital site the data related to. Leaders told us that the trust had made sepsis one of their top projects within their quality plan but did not provide us with any action plans when asked

**Competent staff**

**The completion rate for appraisals was low. None of the staff groups met the trust's target compliance rate.**

## Appraisal rates

**Trust level**

From April 2017 to December 2017, 70.4% of staff within medical care at the trust received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Public Health & Community Health Services | 5 | 5 | 100.0% |
| Other Qualified Scientific, Therapeutic & Technical staff | 1 | 1 | 100.0% |
| Support to ST&T staff | 48 | 56 | 85.7% |
| Qualified Healthcare Scientists | 60 | 76 | 78.9% |
| Qualified Allied Health Professionals | 22 | 28 | 78.6% |
| Other Non-Medical staff | 7 | 9 | 77.8% |
| NHS infrastructure support | 18 | 24 | 75.0% |
| Qualified nursing & health visiting staff | 326 | 457 | 71.3% |
| Support to doctors and nursing staff | 228 | 339 | 67.3% |
| Medical & Dental staff - Hospital | 131 | 206 | 63.6% |
| **Total** | **846** | **1,201** | **70.4%** |

Two of the staff groups within medical care at the trust met the target of 100% for completion of appraisals. However, it should be noted that both groups had a lower number of required staff than other staff groups, therefore each person accounts for a higher proportion of the total.

**Sandwell General Hospital**

From April 2017 to December 2017, 63.6% of staff within medical care at Sandwell General Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Qualified nursing & health visiting staff | 79 | 113 | 69.9% |
| Support to doctors and nursing staff | 52 | 88 | 59.1% |
| Medical & Dental staff - Hospital | 5 | 10 | 50.0% |
| Other Non-Medical staff | 0 | 2 | 0.0% |
| NHS infrastructure support | 0 | 1 | 0.0% |
| **Total** | **136** | **214** | **63.6%** |

All staff groups within this core service at Sandwell General Hospital did not meet the trust's appraisal target of 100%.

However, staff we spoke with were happy with the appraisal process. We reviewed some examples of staff performance objectives which were recorded electronically. Areas covered included values, trust promises, what was going well and not so well, comments from senior staff on performance and behaviour, development needs and how staff could be supported. Staff then rated themselves on how they thought they were doing. Staff were scored a grade from A to D for potential with D indicating a member of staff with potential and from one to four for performance with four indicating a high performing individual.

Senior staff told us that during the personal development review (PDR) cycle, groups received weekly reports of staff who had an outstanding PDR date booked on the system and this was then cascaded through operational and clinical team meetings. We saw appraisals were an agenda item on the ward managers governance agenda dated March 2018, this was the most recent evidence the trust supplied. We saw that the trust had a PDR tracker in place.

We saw that there was a scenario based e-learning module that included information on sepsis dated July 2017, the module included information about the sepsis six. We also saw slides used for a presentation on sepsis dated 2015.The presentation included what sepsis is and about the golden hour. The golden hour of sepsis stresses the importance of timely initiation of antibiotic treatment. However, the medical department were unable to provide any figures of how many staff had completed this training. We asked two staff if they had received any additional training from the trust in relation to sepsis, both told us they hadn't.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

From April 2017 to December 2017, 68.6% of staff assigned to other sites by the trust within medical care received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Support to ST&T staff | 4 | 4 | 100.0% |

| | | | |
|---|---|---|---|
| Other Non-Medical staff | 1 | 1 | 100.0% |
| Public Health & Community Health Services | 5 | 5 | 100.0% |
| Other Qualified Scientific, Therapeutic & Technical staff | 1 | 1 | 100.0% |
| NHS infrastructure support | 11 | 12 | 91.7% |
| Support to doctors and nursing staff | 66 | 88 | 75.0% |
| Medical & Dental staff - Hospital | 124 | 190 | 65.3% |
| Qualified nursing & health visiting staff | 66 | 103 | 64.1% |
| Qualified Allied Health Professionals | 0 | 1 | 0.0% |
| **Total** | **278** | **405** | **68.6%** |

Four groups of staff assigned to 'other' sites by the trust, met the target of 100% for appraisal completion. However, as with data presented at a trust level, the number of staff within these groups was lower than other groups. Therefore, each person represents a higher proportion of the total.

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

There were checklists in place for the induction of agency staff, however there was some inconsistency in how the checklist was implemented across the service.

The trust used an induction checklist for Bank/Agency/Temporary staff. We reviewed an induction folder with completed inductions on Priory 5. It contained an induction checklist covering areas such as uniforms, policies and performance, if staff were IV and cannulation trained and if an ID check had been performed. Once completed these were signed by both the agency worker and the supervisor. The checklist also had an area where end of shift feedback could be completed by the nurse in charge, this information could then be used to give feedback to the staff member and their employing agency. There appeared to be some inconsistency in this as leaders in another area told us that there was no specific competency checklist for agency staff and that they would presume that agency staff had completed their training.

We saw an excellent induction information sheet for junior doctors used within stroke medicine. The induction sheet included an introduction, details of staff, on-call information, an overview of the stroke pathway and guidelines and protocols.

**There were specific competencies in place that staff in specialist areas such as stroke and non-invasive ventilation needed to complete.**

We saw staff on the stroke unit had specific competencies to complete. These included competencies on reducing the risk of stroke, swallowing and nutrition, communication and thinking processes and emotional and behaviour. Staff received a certificate of achievement on completion.

Staff involved in Non- Invasive Ventilation (NIV) of patients completed specific competencies under the guidance and supervision of the outreach team; competencies included specific machine use and patient care. Senior leaders provided details of fifteen staff that had received the training.

There were competency assessments in place for registered nursing staff. Skills included vital signs monitoring, administration of intravenous drugs, fluids and blood, catheterisation and bladder scanning.

## Multidisciplinary working

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

All necessary staff were involved in assessing planning and delivering peoples care and treatment. We saw evidence of this for example multidisciplinary board rounds and huddles. Leaders of the stroke service spoke of stroke action team meetings which were attended by consultants, senior nurses and therapists.

We saw further evidence of multidisciplinary working from reviewing patient notes. We attended a board meeting and saw the team engaged in decision making and staff reported on patients' progress. Social workers and the rapid response team attended board rounds on the older people's assessment unit (OPAU).

Staff worked well together, for example to support patients with discharge. Staff spoke of how they felt there was good multidisciplinary working.

## Seven-day services

**The service offered seven-day services to ensure patients admitted to medical care would receive constant care and outcomes, whenever they entered the hospital.**

There was a 24-hour consultant on call rota for stroke medicine with the on-call stroke consultant being contacted whenever thrombolysis for acute stroke was considered. There were ten consultants on the stroke on call rota, in addition to four stroke physicians and three neurologists. Out of hours cover was also provided by the consultants in acute medicine and elderly care. There was six stroke alert nurses who were specialists in stroke care. The on-call stroke bleep was carried by a stroke specialist registrar. Between 5pm and 9am the bleep was carried by the on call medical registrar. The consultant on call for stroke was contactable via switchboard for thrombolysis and advice on other urgent aspects of stroke care.

The haematology service based on the Walkden Unit provided patients and relatives with a 24 hour, seven days a week advice line. The Walkden unit was open from 8.30 am to 4.30pm Monday to Friday, however these hours could be extended if required to accommodate patient's needs.

The physiotherapy service was available 7 days a week from 8am to 8pm.Dietitions were available from 8am to 4pm Monday to Friday.

The trust had an ambulatory care service saw patients from 7am to midnight from Monday to Friday. There was a limited service at weekends for reviews only.

The pharmacy was open Monday to Friday from 9am to 5pm, Saturdays 10am to 3pm, Sundays from 10am to 3pm and on bank holidays from 10am to 1pm.

The pain management service operated between 8am and 4.30pm Monday to Friday.

The speech and language service operated Monday to Friday, a call-in service for stroke patients operated out of hours (weekends and bank holidays) for patients who failed their nursing swallow screen.

The endoscopy service was open Monday to Friday, however leaders told us that it would sometimes open on a Saturday if the service was needed. In respect of gastrointestinal bleeding the hospital had on call endoscopy cover 365 days a year, with a consultant gastroenterologist on

call and two endoscopy nurses, the rota was trust wide covering both Sandwell and City hospital. Out of hours patients were scoped in theatres or endoscopy units.

## Access to information

There were pathways in place for when patients moved between services, for example when stroke patients transferred to an alternative hospital for thrombectomy and patients attending ambulatory care.

We saw that wards completed handover sheets to share information when patients moved wards. These included details around the patients', allergies, risks and past medical history.

Staff had access to computers on wards; patient's records were in paper format. There were plans in place to implement an electronic record system. Staff shared concerns around a potential back-up plan in case the new computer system failed.

Consultants completed discharge letters electronically. We reviewed several discharge letters and found they had information such as allergies, diagnosis, discontinued medications, if any investigations had been completed and if the patient had any surgery. Discharge letters could be sent to the patients GP electronically or printed off and a copy given to both the GP and the patient.

**We were not assured issues around uncompleted discharge summaries had been robustly investigated, recorded or around ongoing monitoring and audit.**

During the inspection period concerns were raised that there were issues in AMU around backlogs of patient notes that did not contain medical summaries. We asked the trust to provide us with all incident forms in relation to this from the last six months. We reviewed all the incident forms provided by the trust and there were no incident forms in relation to this. We asked the trust to provide us with any action plans and investigations into discharge summaries and any audits around discharge summaries not being sent out on time. We were provided with e-mail evidence from March 2018 following a consultant forum when concerns had been raised around uncompleted discharge summaries which had led to patient safety problems, complaints and difficulties with GPs. In a QIHD day in April 2018 it was raised that there were difficulties in completing discharge summaries for patients once they had been taken of the system. QIHD notes advised that it was acceptable for a letter to be done in these instances. However, the trust were unable to provide evidence that incidents around discharge summaries had been robustly recorded, investigated or around ongoing monitoring and audit.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training was included within the trusts safeguarding training.

## Mental Capacity Act and Deprivation of Liberty training completion

The trust has reported that Mental Capacity Act and Deprivation of Liberty Safeguards training was included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for qualified nursing staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 1 | 436 | 437 | 99.8% | 95% | Yes |
| Safeguarding children level 2 | 379 | 433 | 87.5% | 95% | No |
| Safeguarding adults level 2 | 62 | 73 | 84.9% | 95% | No |

In medicine the 95% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff at a trust wide level met the target for safeguarding training overall, with a rate of 95.2%. The course with the lowest completion rate was the safeguarding adults level 2 module with 84.9%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical staff in medicine is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding children level 1 | 196 | 197 | 99.5% | 95% | Yes |
| Safeguarding adults level 2 | 73 | 89 | 82.0% | 95% | No |
| Safeguarding children level 2 | 153 | 191 | 80.1% | 95% | No |
| Safeguarding children level 3 | 1 | 2 | 50.0% | 95% | No |

In medicine the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible. Medical staff at a trust wide level did not meet the target for safeguarding training overall, with a rate of 91.6%. The course with the lowest completion rate was the safeguarding children level 3 module with 50%; however, this was based on only one of the two members of eligible staff not completing it.

**Sandwell General Hospital medicine department**

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 109 | 110 | 99.1% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Safeguarding children level 1 | 109 | 110 | 99.1% | 95% | Yes |
| Safeguarding children level 2 | 88 | 110 | 80.0% | 95% | No |
| Safeguarding adults level 2 | 10 | 15 | 66.7% | 95% | No |

At Sandwell General Hospital, nursing staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.6%. Of the four mandatory safeguarding courses made available to nursing staff, two met the trust's target. The course with the lowest completion rate was the safeguarding adults level 2 module with 66.7%.

**Medical and dental staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for medical staff in the medicine department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 10 | 10 | 100.0% | 95% | Yes |
| Safeguarding adults level 2 | 5 | 5 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 10 | 10 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 7 | 10 | 70.0% | 95% | No |

At Sandwell General Hospital, medical staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.4%. Of the four mandatory safeguarding courses made available to nursing staff, three met the trust's target. The course with the lowest completion rate was the safeguarding children level 2 module with 70%.

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018, for qualified nursing staff in the medicine department at sites classified as other by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding children level 3 | 3 | 3 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 110 | 110 | 100.0% | 95% | Yes |
| Safeguarding children level 2 | 99 | 106 | 93.4% | 95% | No |
| Safeguarding adults level 2 | 31 | 36 | 86.1% | 95% | No |

Within medicine departments classified as other by the trust, the 95% mandatory training completion target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible. Nursing staff met the target overall with a completion rate of 96.7%. The course with the lowest completion rate was the safeguarding adults level 2 module with 86.1%.

**Medical staff**

A breakdown of compliance for safeguarding training courses as at July 2018, for medical staff in

the medicine department at sites classified as other by the trust, is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 180 | 181 | 99.4% | 95% | Yes |
| Safeguarding children level 1 | 180 | 181 | 99.4% | 95% | Yes |
| Safeguarding children level 2 | 143 | 178 | 80.3% | 95% | No |
| Safeguarding adults level 2 | 63 | 79 | 79.7% | 95% | No |

At sites classified as other by the trust, medical staff in the medical care core service did not meet the 95% training target overall, with a rate of 91.4%. Of the four mandatory safeguarding courses made available to medical staff, two met the trust's target. The course with the lowest completion rate was the safeguarding adults level 2 module with 79.7%.

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

**Staff did not always understand their roles and responsibilities or follow policy in relation to the Mental Capacity Act 2005.**

We reviewed three patients notes who had a DoLs in place and found that in one case a mental capacity assessment and a best interest decision had not been recorded. This was not in line with trust policy which states that in order to decide whether an individual has the mental capacity to make a particular decision a two-stage capacity assessment should be made. There appeared to be some confusion amongst staff around the difference between a DoLs application and a mental capacity assessment. In one instance we found that the DoLs application had been made in July 2018.The patient had been seen by the appropriate professionals; however, there was no evidence in the notes that the application had been approved. We escalated this to the nurse in charge who agreed to make enquiries. We saw that the trust had an up to date policy in place (September 2018) for assessing mental capacity and compliance with the Mental Capacity Act, 2005.

We saw that staff gained patients consent and recorded this on forms or in-patient notes**.** In the endoscopy department we saw that patients signed consent forms ahead of any procedures.

# Is the service caring?

## Compassionate care

Most wards achieved 85% and above in response to the question if they would recommend the service to friends and family.

## Friends and Family test performance

### Sandwell General Hospital

The Friends and Family Test response rate for medicine at Sandwell General Hospital was 22%, which was worse than the England average of 25% from July 2017 to June 2018.

A breakdown of FFT performance by ward for medical wards at this hospital with total responses over 100 for the period from July 2017 to June 2018 is shown below:

| Ward name | Total Resp | Resp. Rate | Percentage recommended | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Ann. Perf. |
| Lyndon 4 | 592 | 41% | 44% | 54% | 50% | 47% | 53% | 53% | 55% | 51% | 57% | 54% | 50% | 57% | 53% |
| Lyndon 5 | 317 | 32% | | | | | 100% | 79% | 96% | 73% | 81% | 90% | 62% | 100% | 85% |
| Newton 4 | 300 | 130% | 100% | 69% | 100% | 86% | 82% | 89% | 93% | 100% | 95% | 84% | | | 89% |
| Priory 5 | 103 | 10% | | 86% | 82% | 86% | | | 60% | 67% | | | | 94% | 85% |

| Key | Highest score to lowest score | | |
|---|---|---|---|
| | 100% | 50% | 0% |

Four wards received more than 100 responses. Of these, Lyndon 4 had the lowest annual recommendation rate, with 53%, based on 592 responses.

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

*(Source: NHS England Friends and Family Test)*

**Response rates for the Friends and Family Test were low when compared to the national average. However, the trust had implemented an action plan to improve.**

We asked the trust what they had done to improve in this area, the trust provided an action plan dated September 2018. The action plan was not ward specific and contained actions such as ward to use incident forms, risk registers to demonstrate when staffing levels fell below minimum, to review private space on Lyndon 4 and to incorporate call bells within monthly audits.

**Staff respected patient privacy and dignity by drawing curtains around them when they were supported with personal care.**

We noted that staff drew curtains around patients to protect their privacy when carrying out personal care tasks.

**However, staff left computers which displayed patient details unlocked when they left the computer.**

We saw that patient confidentiality was not always protected. This was because computers were not always locked after use, therefore patients test results were not always kept confidential.

**Most patients were happy with the care staff provided. Staff recognised the importance of providing person centred care.**

Feedback from patients was mixed with most patients saying they were happy with the care they received. Areas patients felt required improvement related mainly to staffing levels, food and communication.

Staff told us they strived towards a person-centred approach. We saw staff and volunteers acted in a caring manner, listened to patients and provided patients with explanations of what they were doing.

## Emotional support

**Staff provided emotional support to patients and their relatives to minimise their distress.**

We saw staff on a ward providing reassurance and support to a patient living with dementia who wanted to leave the ward.

The stroke rehabilitation ward (Newton 4) supported the well-being of patients and their relatives by offering quality listening times, a dedicated slot where relatives were given the opportunity to meet with the ward sister and a therapist and to ask any questions.

**However, staff on the acute medical unit wished they could spend more quality time with their patients.**

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

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

Interpreters and one to one carers were requested when a need was identified.

Information for patients and their relatives was displayed at ward entrances and throughout ward areas.

We saw that staff recognised if a patient needed more support. For example, we saw staff requested one to one care when a patient had additional support needs and that interpreters were requested when the patients first language was not English. We observed a doctor working with in an interpreter to discuss their condition.

We saw that staff displayed information to keep relatives and patients updated on boards outside and inside ward areas.

We observed a consultant taking the time to explain about a stroke to a relative and show them a scan to support in their understanding. They showed the relative a scan to support in their understanding. Most patients we spoke with felt that ward staff had kept them up to date and informed about their care.

# Is the service responsive?

## Service delivery to meet the needs of local people

**Average length of stay was worse than the England average in some areas.**

## Average length of stay

The average length of stay for medical elective patients was significantly higher than the England average of 6 days.

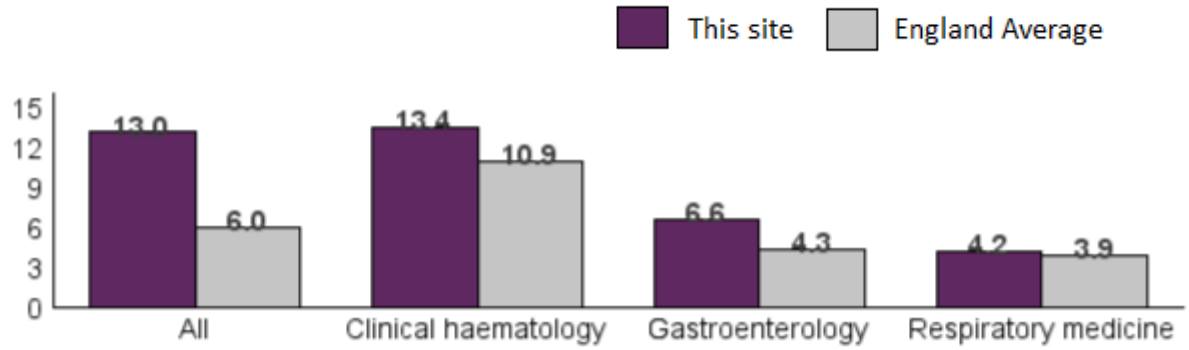
**Sandwell General Hospital**

From April 2017 to March 2018 the average length of stay for medical elective patients at Sandwell General Hospital was 13.0 days, which is significantly higher than England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.9 days, which is higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology, gastroenterology and respiratory medicine is higher than the England average.

**Elective Average Length of Stay - Sandwell General Hospital**



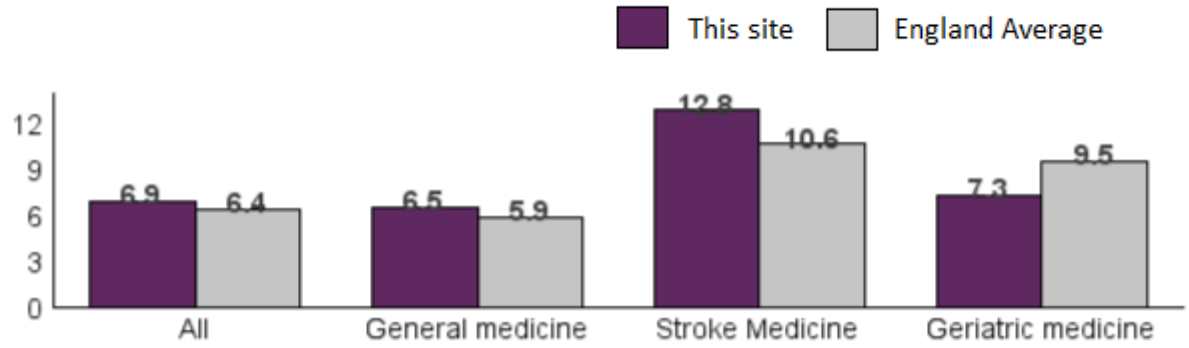

*Note: Top three specialties for specific site based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine and stroke medicine is higher than the England average.

- Average length of stay for non-elective patients in older persons medicine is lower than the England average.

**Non-Elective Average Length of Stay - Sandwell General Hospital**




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

*(Source: Hospital Episode Statistics)*

**The trust were completing key pieces of work in an attempt to improve length of stay.**

The trust had a range of initiatives to improve patient length of stay. The three key pieces of work included daily flow/rhythm of the day, a weekly 'golden patient' (staff aimed to discharge the patient before 10am) and a weekly estimated discharge date report. Leaders told us that the daily flow/rhythm of the day had been undertaken collaboratively with ward clinical team's engagement, plus work with the trusts capacity team. There were several purposes to the work; these were putting the patient at the centre of all decisions and conversations, ensuring consistent standards across wards and ensuring clear processes were in place for managing and escalating stranded patients. Reports were shared with all wards weekly and formed part of the multi-disciplinary board round.

There were patient information leaflets available on entrance to wards, we saw some leaflets had been printed in different languages. The stroke service had an abundance of specialist information available.

## Meeting people's individual needs

**The service took account of individual needs and staff were responsive to vulnerable patients.**

Systems and processes were in place to give care and support to different groups of patients such as patients living with dementia, that had suffered a stroke or required non-invasive ventilation or had translation needs.

We saw that the ward environment and approach of staff supported people living with dementia. For example, a coloured system for cutlery to identify patients in need of additional support was used on Lyndon 4 and Lyndon 5. Staff encouraged relatives to bring in small personal items for example a photograph or a familiar blanket; a reminiscence room was available for patients on Lyndon 4. Several wards had open visiting throughout the day, this meant families could visit their relatives at any time, however protected meal times were in place on some wards. The hospital supported John's Campaign a campaign for extended visiting rights for family carers of patients living with dementia. Leaders told us they did not have direct access to the memory clinic but they could make a referral if needed.

Communication tools were available on some wards including pictures of drinks, food and the alphabet that staff could use with patients to aid in communication. However, these were available on one ward but not on another.

We reviewed the records of two patients who required additional support based on their mental health needs. We found that care plans and relevant mental health paperwork were in place to support the patients' mental health and there was support from the local mental health consultant psychiatrist. Activity boxes were in place for patient activity; these contained items such as stress balls and colouring books, however at the time of our inspection these needed replacing but no funding was available. This meant it would be difficult to continue the work that had taken place. There was a learning disability nurse based at the trust for patients with a learning disability who needed support.

The dementia, delirium and distress team (DDT) supported patients with mental health needs. The team visited wards to assess patients and determined if they needed one to one support (one staff member to one patient). Staff told us if they made a referral to the team they came quickly and usually within one day. However, staff also told us that if one to one support was needed outside the hours of the DDT team operated that a spare health care assistant would usually be found from another area of the trust and that some health care assistants were not confident with dealing with challenging behaviour.

We reviewed the nursing therapeutic observations policy due for review March 2017 and found it did not contain any information on referral to the DDT team. We were unable to obtain evidence of

any robust pathways and guidance of referral to the service or for the process for out of hours support when one to one care was required but not available.

The trust provided a haematology service on Newton 5 which included the Walkden Unit for day case patients and a 24-hour advice line**.** Staff told us that any chemotherapy was made up in the hospital pharmacy. The service provided a 24-hour advice line for patients and their family carers. The unit no longer provided an oncology service.

There was an older people's assessment unit at the trust. The service had an inclusion criteria which included being 65 years old or above and needing specialist input. However, staff told us this criteria was not always followed when the trust had capacity issues.

The hospital had a restaurant and some outlets where patients or their visitors could buy food and drink.

The trust provided a chaplaincy service for patients and their relatives where specialist faith chaplains were available. An on-call service was available 24 hours a day.

There was a Non-Invasive ventilation (NIV) unit based on Priory 5, which was a respiratory ward, the unit was a monitored bay for level 2 patients. Consultants accepted patients onto the unit. The unit did not accept level 3 patients. There are different levels of care for patients that require more intense monitoring with levels ranging from 0-3. Level 2 monitoring is for patients who need higher levels of care and more detailed observation and intervention. Nurses must monitor patients respiratory rate, level of consciousness, chest wall movement and muscle use and comfort every 15 minutes after NIV starts. Staff told us they had specialist training in NIV which including training on the machines and settings. When we visited the ward, there were no patients that required NIV and the ward was being utilised for non NIV patients.

The hospital had a dedicated stroke ward (Priory 4) with a stroke rehabilitation unit (Newton 4) based opposite. Priory 4 was a 25-bedded unit with six hyper acute beds that cared for patients with acute stroke symptoms or a neurological condition. Newton ward had 28 beds including six side bays and focused on rehabilitation for patients who had suffered a severe stroke or had complex care and discharge needs. The hospital provided a thrombectomy screening service only, patients requiring thrombectomy were transferred to another hospital and would return for rehabilitation. A seven-day thrombolysis service was provided at the trust. Arrangements were in place 24/7 for the registrar and specialist stroke nurses to carry the stroke bleep. When bleeped they would attend other areas of the hospital such as the accident and emergency department to assess patients alongside a registrar. A psychologist was based alongside the stroke team for two days a week.

Relatives of patients on Newton 4 (stroke rehabilitation unit) were provided with the opportunity to have quality listening times. This provided a dedicated slot where relatives were given the opportunity to meet with the ward sister and a therapist and to ask any questions.

We saw that there were stroke specific policies in place including guidelines for the management of stroke which provides staff with guidance on the management of patients with suspected stroke, stroke and Transient Ischaemic Attack (TIA) and for the management of Thrombolysis in acute stroke, however, evidence both were due for review in 2017.

Staff had arranged for therapy dogs and their owner to visit Newton 4 on a regular basis.

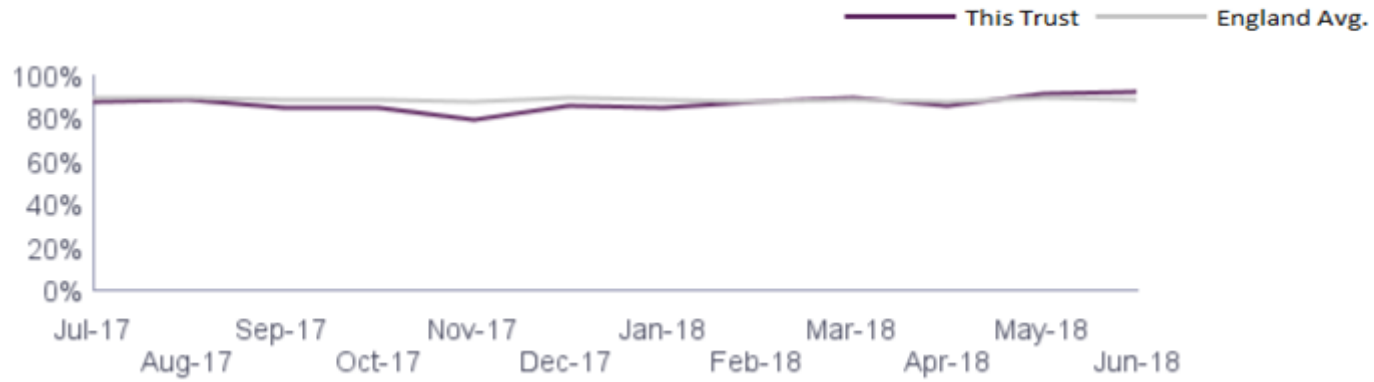
Staff could request a translator either in person or via the telephone if a patients first language was not English. We saw a doctor working with an interpreter to discuss a patient's condition whose first language was not English.

## Access and flow

### Referral to treatment (percentage within 18 weeks) - admitted performance

The graph below shows the trust's referral to treatment time (RTT) within 18 weeks for admitted pathways for medicine from July 2017 to June 2018. Over time, the trust has performed similarly to the England average, with a decrease in the number of patients being referred for treatment within 18 weeks in November 2017 (79.5% compared with 88.2% nationally).

The latest data for June 2018 shows that 92.4% of this group of patients were referred to treatment within 18 weeks, compared to the England average of 88.7%.




*(Source: NHS England)*

### Referral to treatment (percentage within 18 weeks) – by specialty

**Three specialities were above the England average for admitted RTT (percentage within 18 weeks) these were neurology, rheumatology and thoracic medicine.**

Three specialties were above the England average for admitted RTT (percentage within 18 weeks). These specialties are shown in the table below.

| Specialty grouping | Result | England average |
|---|---|---|
| Neurology | 93.4% | 91.1% |
| Rheumatology | 98.5% | 94.5% |
| Thoracic medicine | 95.2% | 93.0% |

Older persons medicine was the only specialty which was below the England average for admitted RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Older persons medicine | 85.7% | 97.0% |

*(Source: NHS England)*

### Patient moving wards per admission

**Sandwell General Hospital**

**Data showed that most patients did not move wards during their admission.**

From June 2017 to May 2018, 96.4% of individuals did not move wards during their admission, and 3.6% moved once or more.

*(Source: Routine Provider Information Request – Ward moves tab)*

## Patient moving wards at night

From June 2017 to May 2018, 2,816 patients moved wards at night. The Acute Medical Unit accounted for the majority of the moves.

**Sandwell General Hospital**

From June 2017 to May 2018, there were 2,816 patient moving wards at night within medicine. AMUA accounted for the majority of these moves with 2,481 moves at night.

*(Source: Routine Provider Information Request - Moves at night tab)*

We asked the trust to provide us with any audits and action plans on reducing the number of bed moves within medicine, however we did not receive this.

**We visited the Acute Medical Unit and found there were several mixed sex bays (bays with male and female patients). With a rearrangement of beds some of the mixed sex breaches were avoidable.**

We visited the 52 bedded Acute Medical Unit (AMU) and found that several of the bays had both male and female patients (mixed sex). Bathroom facilities were being used by patients of both gender as there was no segregation. We escalated our concerns to the senior management team and requested further assurance. We returned to the ward the following day and found that all but one monitored bay were now single sex. Data from the trust showed that there were no mixed sex breaches between December 2017 and July 2018.From 6 August 2018 to 2 September 2018 ,611 mixed sex patients had been placed in AMU's monitored beds. Leaders told us that agreement for mixed sex beds had been provided by the local clinical commissioning group (CCG) due to patients on the ward needing to be treated as a clinical priority. However, only one bed bay had dedicated monitoring facilities, other bays contained standard equipment. Leaders told us they were reporting in line with agreed protocols and would shortly be changing their approach.

**The trust were implementing various initiatives in an attempt to reduce the number of outliers. Leaders felt this had led to improvement.**

The trust had implemented a right person right place initiative. This involved ward managers dialling into a daily call to ensure all the patients were in the correct place, to consider any overnight admissions and if patients needed moving to a more appropriate area. The aim of the initiative was to ensure patients were in the most appropriate place at the beginning of their pathway. There was a dedicated medical team to care for medical outliers providing consistency of care. Additionally, leaders told us there was a standard operating procedure in place on responsibilities. Patients over 75-years-old patients were reviewed daily to ensure they were on

the correct older people's ward when this was their primary need.

We asked the trust to provide us with audits and action plans on outliers within the medicine core service; however, the trust did not provide this. We saw that there was a standard operating procedure for outlying patients due to acknowledgement by the trust that at times medical inpatients need to be managed outside of the bed base. The procedure included prioritisation, accountability for ward cover arrangements, locum cover and junior support.

**Staff began the discharge process as soon as possible; discharge facilitators supported in the process.**

Discharge co-ordinators were based on wards to support in arranging discharge. Staff told us that the discharge process started as early as possible in the patient journey. Inconsistency in paperwork for out of area patients, transport delays and waiting for reassessments by care establishments were some of the reasons for delays staff cited for delays in patient discharge. We saw that a discharge lounge was available on Lyndon 5 for medically fit patients. When we visited the discharge lounge at the trust it was empty; the discharge lounge had six chairs. There were criteria in place for the discharge lounge this included the patient not being confused, that the patient would be home by 6pm and that the discharge summary had been written. Daily board rounds took place where teams looked at discharge.

The medical core service had implemented a golden patient initiative. The aim was that patients were home before 10am. The wards that came closest to this target were Priory 5 and Lyndon 4.

We saw that a golden patient initiative was in place and being monitored. Golden patients were patients who were discharged from the ward before 10am. We reviewed data in relation to this and saw that the golden patient data improved slightly in July and August 2018 but then decreased significantly in September 2018. The trusts aim was to achieve an average of one golden patient per day. The wards at Sandwell Hospital that came closest to this target included Priory 5 at 0.64 patients per ward per day and Lyndon 4 at 0.54 patients per day. We saw that a rag rated, performance dashboard that monitored expected date of discharge was in place. We reviewed the seven-day working patient flow timeline; the daily timeline included capacity meetings, fourteen-day escalation, the right patient right place, team huddles and board rounds.

## Learning from complaints and concerns

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.**

Complaint themes included delayed discharge, staff values and behaviours and communication.

## Summary of complaints

### Trust level

From April 2017 to March 2018, there were 229 complaints about medical care at the trust. The trust took an average of 37.4 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|

| | | |
|---|---|---|
| Integrated care (inc delayed discharge due to the absence of a care package) | 84 | 36.7% |
| Patient Care | 44 | 19.2% |
| Values & behaviours (staff) | 22 | 9.6% |
| Admissions and discharges (excluding delayed discharge due to the absence of a care package) | 19 | 8.3% |
| Access to treatment or drugs | 18 | 7.9% |
| Communications | 15 | 6.6% |
| Appointments | 9 | 3.9% |
| Waiting times | 6 | 2.6% |
| Privacy, dignity & well being | 5 | 2.2% |
| Facilities | 2 | 0.9% |
| End of life care | 2 | 0.9% |
| Transport (ambulances) | 1 | 0.4% |
| Admin/policies/procedures (inc patient record) | 1 | 0.4% |
| Consent | 1 | 0.4% |
| Total | 229 | 100% |

**Sandwell General Hospital**

**The trust took on average longer than 30 days to investigate complaints, this was not in line with the trust complaints policy.**

From April 2017 to March 2018, there were 125 complaints about medical care at Sandwell General Hospital. The hospital took an average of 39.9 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 days.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (inc delayed discharge due to absence of care package) | 38 | 36.5% |
| Patient Care | 25 | 24.0% |
| Admissions and discharges (excluding delayed discharge due to absence of care package) | 13 | 12.5% |
| Values & behaviours (staff) | 9 | 8.7% |
| Communications | 6 | 5.8% |
| Access to treatment or drugs | 6 | 5.8% |
| Appointments | 2 | 1.9% |
| Privacy, dignity & well being | 2 | 1.9% |
| Waiting times | 1 | 1.0% |
| Facilities | 1 | 1.0% |

| | | |
|---|---|---|
| Transport (ambulances) | 1 | 1.0% |
| Total | 104 | 100% |

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

### Number of compliments made to the trust

From January 2018 to June 2018 there were 11 compliments within medicine. A breakdown by site is shown below:

- City Hospital: Six compliments
- Sandwell General Hospital: Five compliments

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

The trust provided patients with information on how to make a complaint and acted appropriately when they did. Staff could give examples of when practice had been changed because of a complaint.

There were posters and leaflets around the trust and wards to inform people how to make a complaint. Purple phone points had been introduced outside ward areas where there was a direct telephone line to a team of advisors were available, the situation of these did not always afford privacy. People could raise their complaints using this service from 9am to 9pm Monday to Sunday. The aim of the initiative was to address concerns quickly prior to patients being discharged. There were also numbers that non-English speakers could call. The phone line could also be used to give positive feedback around care.

Staff could give examples of complaints the ward had received, how it had been managed and how practice had changed as a result. This included the implementation of a discharge checklist to ensure nothing was missed. Staff were able to explain what they would do if they received a complaint and were aware of the purple point system.

We reviewed several complaints letters and reports and found they contained an apology and that meetings were held to address any concerns. Complaints investigation reports contained areas of learning such as ensuring incident forms were completed and that appropriate documentation was used. We asked the trust to provide us with information on what they were doing to reduce the time taken to investigate complaints however they did not provide us with this.

## Is the service well-led?

### Leadership

**Leaders did not consistently demonstrate the skills, knowledge and experience needed to carry out their role.**

The leadership team consisted of a group of directors, a director of operations and director of nursing. There were also clinical directors, speciality leads, matrons and ward managers.

Some policies were out of date and that others did not contain enough information such as how patients in the acute medical unit would be safeguarded when mix sex breaches occurred.

In the AMU department risks in relation to mixed sex breaches had not been considered or incorporated into relevant policies to safeguard vulnerable patients. There was not sufficient oversight in some areas for example there was no oversight in AMU to determine if all was being done to ensure, where possible, bays were single sex.

**Some issues raised at our previous inspection in 2017 had not been resolved.**

Areas identified during our previous inspection continued to be of concern for example resuscitation trollies that were not tamperproof, a reliance on temporary staff and low staff training rates. However, we recognise the work the trust had been doing to try to improve in some of these areas such as ongoing recruitment and the processes for non-completion of training.

However, staff found leaders approachable, supportive and they felt listened to.

Staff told us and we saw that leaders were visible on the wards, staff told us leaders were approachable, supportive and that they felt listened to.

**Vision and strategy**

**The trust had a set of promises, these were on the trust intranet and formed part of continuing professional development.** Staff were unable to recall all of these, however knew they could access them on the intranet.

Trust promises were embedded in systems, for example they formed part of the staff continuing professional development documentation.

Staff behaviours were consistent with trust promises we saw staff being polite, courteous, respectful and keeping patients involved.

However, we asked the trust to provide us with the dementia strategy or how they were working towards it, however we did not receive this.

## Culture

**Staff spoke of a supportive culture and invaluable peer support where they were encouraged to give feedback on new projects. Leaders aspired to a culture of challenge.**

Matrons spoke of invaluable peer support from other matrons, for example they met regularly to share information, discuss cases and quality.

Leaders spoke of how they strived for a culture where staff felt able to challenge both leaders and each other. The check and challenge initiative was an example of this.

Staff felt the culture was supportive, that their opinions were taken on board and told us if anything new was put into place they were encouraged to give feedback.

## Governance

**Governance structures were in place with regular forums, meetings and quality improvement half days.**

Staff we spoke with were clear about their roles and understood what they were accountable for.

The trust held quality improvement half days and listening into action events which included a variety of topics included consistency of care and performance. Quality improvement half days were protected learning time for teams and all staff were expected to take part.

Meetings took place at directorate level in addition to speciality reviews. Senior staff discussed quality and actions at twice monthly quality meetings. Regular forums and cluster meetings were held where staff could discuss governance issues.

The medical department carried out audits to improve the overall service. Leaders shared findings from audits with staff and patients through a variety of means such as on notice boards, through staff meetings and safety huddles.

## Management of risk, issues and performance

**Systems and processes in place to monitor ongoing risk were not always robust or effective.**

Processes and systems were in place to monitor ongoing risk. However, these were not always robust or effective. We saw that there was a medical departmental risk register in place in addition to individual ward risk registers. The ward risk registers were rag rated (red, amber and green) and contained relevant information such as the risks around staffing levels and impact and patient falls.

We found there were no dates when risks were added to register, however leaders told us that this was automated on their electronic system so that they could be reviewed live. There was no latest review dates on some of the risks and there were some gaps in recording of actions and existing controls, the latest reviews in some instances were not up to date or completed within agreed timescales. Some risks were not included or mitigated on the wards risk registers such as the risks of pressure areas, sepsis, falls and the resuscitation trolleys not being tamperproof. However, leaders could verbalise the risks that related to their areas.

We reviewed the incident reports from OPAU from 4 August 2018 to 8 September 2018 and found that staffing issues had only been reported on one occasion. This was despite trust systems showing that between 6 August 2018 and 2 September 2018, 70 shifts had been under established.

Improvement was needed around the quality of root cause analysis investigations and associated action plans, including the implementing of action plans when areas of improvement were identified.

**There was insufficient oversight around mix sex bays in the acute medical unit.**

We reviewed the Acute Medical Unit Operational Policy which had been due for renewal in July 2018 and found it did not contain reference to the management of any mixed sex breaches and keeping patients safe. Senior leaders told us they adhered to the trust safeguarding policies. Since April 2011 hospitals have had to provide a monthly report of the number of times they breach the Department of Health's same-sex accommodation guidance. Hospitals can face a fine of up to £250 pound for a breach. There are times when mixing patients is justified, this is mainly confined to patients needing highly specialised care. Leaders told us they were reporting in line with agreed protocols and would shortly be changing their approach.

There was no evidence that patients were offered a choice about being placed on mixed sex bays. There were no audits completed by the ward to gain oversight of if all was being done to

ensure, where possible, bays were single sex. We saw that mixed sex breaches on the unit were on the risk register and were reviewed following our visit. We escalated our concerns to the senior management team; we returned the next day and found that all wards except a monitored bay were single sex.

However, the trust took part in national and local audits to assure itself around performance. Leaders were knowledgeable about what impacted on their performance and were taking steps and implementing initiatives to address this.

## Information Management

**The trust did not always manage and use information well to support all of its activities**

During the inspection we saw examples of when staff did not comply with information governance standards such as keeping records secure.

We heard of examples from staff of issues with the trust IT structure which impacted on training uptake and other areas such as the electronic ordering system for patient meals.

## Engagement

**The trust engaged well with patients, staff and the public to plan and manage appropriate services.**

Staff were involved in Listening into Action (LIA) groups where they could share their views and concerns at a trust wide level and turn them into actions.

Feedback opportunities were available for patients and staff to give feedback and to remain anonymous if they wished. You said we did posters were displayed outside ward areas, actions in response to patient feedback included a review of visiting times and the implementation of the quiet protocol helping patients to sleep well.

Patient stories were discussed at the trusts board meetings. The trust collected family and friends test data to obtain feedback about individual experience.

## Learning, continuous improvement and innovation

**The trust did not consistently learn when things went wrong or take action to improve services when concerns were identified**

We requested various action plans from the trust in areas such as infection control, in response to The National Survey of Inpatient falls 2017, bed moves and discharge summaries however these were never received. Additionally, areas identified in our previous inspection continued to be a concern.

**However, leaders had ideas of how their department could improve and had taken steps to put ideas into action. There were examples of innovation.**

The trust had set its priorities for improvement in 2019, improvements included improving the consistency of care for patients.

Leaders recognised the need for improvement and had taken steps to understand the areas they needed to improve; for example, by completing consistency of care audits and displaying the results and actions.

The stroke department leads were looking to advertise for a stroke nurse in the community. The aim was that the nurse would link in with the hospital and be able to follow up patients after discharge.

The check and challenge initiative saw nurses checking each other's documentation for quality and a blue pillow initiative which had led to a reduction in hospital acquired pressure areas of the heel.

We saw that leaders on Lyndon 5 had implemented a model admission document. This was displayed prominently in a folder in the MDT room and had examples of how documentation should be completed.

**Staff performance issues were recognised and managed by leaders and leaders recognised and celebrated staff achievements.**

Leaders could give examples of when action was taken to address staff performance issues, including when staff were temporary. The new process for appraisal supported leaders to identify staff performance issues and behaviour and ensure they were addressed.

Staff could be nominated by other staff or a relative for a staff recognition award, wards recognised such achievement individually and nominated staff received a certificate.

# Critical care

Critical care includes areas where patients receive more intensive monitoring and treatment for life-threatening conditions. The Department of Health have defined levels of care dependent on the severity of the patient's condition. The critical care service at Sandwell General Hospital includes care at levels 2 and 3. Patients that require a more detailed observation or intervention that includes an extended post-operative care, receiving support for a single failing organ system and requiring additional respiratory, renal, neurological or dermatological support fall under level 2 care. Patients that require support for multi-organ failure and basic respiratory support, or for advanced respiratory support alone fall under level 3 care.

*(Source: Department of Health Comprehensive Critical Care 2000)*

We inspected critical care services at Sandwell General Hospital on 18 and 19 September 2018 and the inspection was unannounced. Our inspection team consisted of one lead inspector and one specialist critical care nurse advisor.

During our inspection, we visited the critical care unit, spoke with 24 members of staff including two consultants, two junior doctors, 12 nurses, five allied health professionals (AHPs), one health care assistant (HCA), one domestic services and one ward clerk. We reviewed five patient records and spoke with three patients and their relatives.

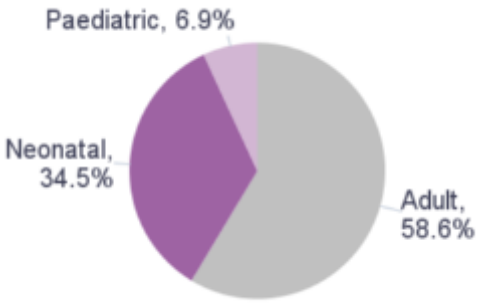
The unit was last inspected in October 2014 and the service was rated good overall and for all five key questions. There were no 'must' or 'should' improvements identified in the last inspection however, there were a couple of areas for improvement in the report. These were, "The full multi-disciplinary team did not attend all ward rounds," "complaint signposting literature was only available in English," and some comments around communication from, and visibility of the executive team. We found these areas had been resolved and were no longer a concern.

## Facts and data about this service

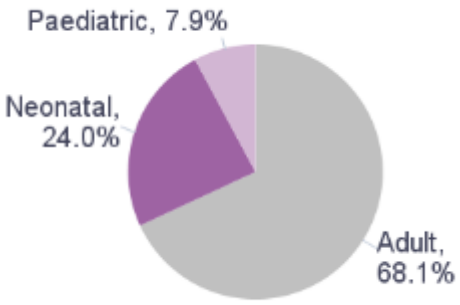
The trust has a total of 30 critical care beds across two sites. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Sandwell and West Birmingham Hospitals NHS Trust and England.**

**This trust**




**England**




*(Source: NHS England)*

Sandwell General Hospital has one Critical Care Unit that has 15 physical bed spaces, including two isolation rooms where patients can be treated either as level 2 or level 3 care. There is a separate paediatric bed space solely used to stabilise a critically ill child should the need arise, before transferring the patient to another local hospital with paediatric intensive care facilities.

The service uses a point system that allows them to be flexible on the level of care that they can provide at one time across both of the trust's critical care units. The trust is funded to deliver the equivalent of 15 level 3 beds; this is split between two sites, each site delivering level 2 and 3 care.

From September 2017 to August 2018, the unit had 600 patient admissions of which 9% were elective surgical admissions, 12% were emergency surgical admissions and 79% were non-surgical admissions. There were 499 discharges from the unit in the same reporting period.

The critical care units are supported by a 24-hour a day, 7 days a week outreach team, who review all discharges from critical care and identify deteriorating patients in the ward areas.

It is also supported by a Follow Up Support Service (FUSS) that is commissioned from the Clinical Commissioning Group (CCG). The FUSS team work within the critical care service with long term patients, devising ventilation weaning plans and planning complicated discharges with the multi-disciplinary team. They also provide patients with physical and psychological support after discharge from the critical care unit. They run a patient forum quarterly to offer patients and their relatives support, and to gain patient feedback.

The professional development team support the wider team, co-ordinating training and development for the critical care workforce. They liaise with the trust's education team and local university to support the pre-registration students during their placements on critical care.

The unit provides limited renal dialysis, commissioned on a case by case basis, in the form of continuous veno-venous hemofiltration (CVVH) for patients with acute renal failure as a temporary treatment before transferring the patient to a specialist renal dialysis unit.

The critical care service is pivotal to the trust's wider critical care effort, providing support to outplaced units of risk like the Non-Invasive Ventilation (NIV) unit based on the respiratory ward.

*(Source: Routine Provider Information Request – Acute context tab)*

## Is the service safe?

People were protected from avoidable harm and abuse. Legal requirements and professional standards were met. There was a good track record of safety and staff were proactive in learning lessons to improve their service.

### Mandatory training

**The service provided mandatory training in key skills to all staff and had systems to ensure everyone completed it.**

Staff received up-to-date training in all safety systems, processes and practices. Staff were regularly reminded when a mandatory training module was due to expire and were given time to complete the training.

### Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Please note, the trust included data for medical staff within critical care under anaesthetics and these are reported in a separate table below.

**Sandwell General Hospital critical care department**

A breakdown of compliance for mandatory training courses as at July 2018, for qualified nursing staff in the critical care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Fire safety warden or refresher training | 1 | 1 | 100% | 95% | Yes |
| Introduction to information governance | 16 | 16 | 100% | 95% | Yes |
| Equality & diversity | 53 | 53 | 100% | 95% | Yes |
| Health & safety | 53 | 53 | 100% | 95% | Yes |
| Medical devices competency form | 53 | 53 | 100% | 95% | Yes |
| Medicines management | 53 | 53 | 100% | 95% | Yes |
| Fire response team leader or refresher training | 4 | 4 | 100% | 95% | Yes |
| Infection control | 53 | 53 | 100% | 95% | Yes |
| Harassment & bullying level 1 | 52 | 53 | 98.1% | 95% | Yes |
| Conflict resolution initial training | 52 | 53 | 98.1% | 95% | Yes |
| Resuscitation: basic life support | 52 | 53 | 98.1% | 95% | Yes |
| Conflict resolution update | 36 | 37 | 97.3% | 95% | Yes |
| Blood collection | 32 | 33 | 97% | 95% | Yes |
| Fire safety - workplace training | 45 | 48 | 93.8% | 95% | No |
| Moving and handling - patient handling | 49 | 53 | 92.5% | 95% | No |
| Transfusion | 48 | 53 | 90.6% | 95% | No |
| Information governance refresher module | 32 | 37 | 86.5% | 95% | No |
| Medical devices training | 45 | 53 | 84.9% | 95% | No |

Nursing staff at Sandwell General Hospital's critical care department met the 95% target for 13 of the 18 mandatory training modules for which qualified nursing staff were eligible. Eight of the courses attained a 100% completion rate.

**Other critical care department**
Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

A breakdown of compliance for mandatory training courses as at July 2018, for qualified nursing staff in the critical care department at sites classified as 'other' by the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Introduction to information governance | 5 | 5 | 100% | 95% | Yes |
| Fire response team leader or refresher training | 1 | 1 | 100% | 95% | Yes |
| Medical devices training | 16 | 16 | 100% | 95% | Yes |
| Health & safety | 16 | 16 | 100% | 95% | Yes |
| Equality & diversity | 16 | 16 | 100% | 95% | Yes |
| Conflict resolution initial training | 16 | 16 | 100% | 95% | Yes |
| Medical devices competency form | 16 | 16 | 100% | 95% | Yes |
| Fire safety - workplace training | 15 | 15 | 100% | 95% | Yes |
| Blood collection | 3 | 3 | 100% | 95% | Yes |
| Harassment & bullying level 1 | 16 | 16 | 100% | 95% | Yes |
| Infection control | 16 | 16 | 100% | 95% | Yes |
| Information governance refresher module | 11 | 11 | 100% | 95% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Medicines management | 15 | 16 | 93.8% | 95% | No |
| Resuscitation: basic life support | 14 | 16 | 87.5% | 95% | No |
| Transfusion | 14 | 16 | 87.5% | 95% | No |
| Conflict resolution update | 12 | 14 | 85.7% | 95% | No |
| Moving and handling - patient handling | 13 | 16 | 81.3% | 95% | No |

In the critical care department at sites classified as 'other' by the trust, staff met the 95% target for 12 of the 17 mandatory training modules for which qualified nursing staff were eligible.

All 12 of the courses that met the target attained a 100% completion rate, although it should be noted that the number of eligible staff for each course is smaller than that at Sandwell General Hospital. Therefore, each staff member represents a higher proportion of the total.

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

On inspection in September 2018, senior staff told us their average compliance rate for nursing staff in the unit was 97%. This compliance rate had improved since July 2018. The reason compliance was not 100% was due to staff being on maternity leave, on long-term sickness leave and on sabbatical.

A breakdown of compliance for mandatory training courses as at September 2018, for medical staff in the critical care department is shown below. Please note, medical staff are not allocated to a specific site as they work across the trust.

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Conflict resolution initial training | 22 | 22 | 100% | 95% | Yes |
| Medical devices competency form | 22 | 22 | 100% | 95% | Yes |
| Equality and diversity | 22 | 22 | 100% | 95% | Yes |
| Fire safety – workplace training | 22 | 22 | 100% | 95% | Yes |
| Harassment and bullying level 1 | 22 | 22 | 100% | 95% | Yes |
| Health and Safety | 22 | 22 | 100% | 95% | Yes |
| Infection control | 22 | 22 | 100% | 95% | Yes |
| Transfusion | 21 | 22 | 95.5% | 95% | Yes |
| Resuscitation: basic life support | 20 | 22 | 90.9% | 95% | No |
| Conflict resolution update | 20 | 22 | 90.9% | 95% | No |
| Medicines management | 20 | 22 | 90.9% | 95% | No |
| Moving and handling medical staff | 18 | 22 | 81.8% | 95% | No |
| Information governance refresher module | 18 | 22 | 81.8% | 95% | No |

Medical staff that worked within the critical care department at the trust met the 95% target for eight of the 13 mandatory training modules for which medical staff were eligible. Seven of the courses attained a 100% completion rate. It is important to note that the number of eligible staff is reasonably small, therefore each member of staff represents a higher proportion of the total. There was also one member of the medical team who was currently on sabbatical and had a couple of expired training modules.

The mandatory training was comprehensive and met the needs of patients and staff. The training included core statutory and clinical modules to keep patients and staff safe. Staff said the training modules were effective and enabled them to use systems within the trust.

Managers monitored mandatory training and there were systems that alerted staff when they needed to update it. They used an electronic system to monitor completion of training modules and staff received regular communication around training expiry dates. The critical care service had two professional development nurses (PDN) that were trained in critical care. It was the responsibility of the PDN to check compliance and alert staff when their mandatory training was due to expire.

## Safeguarding

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

Staff received up-to-date training in safeguarding adults and children. The training was effective and staff could explain what to do if they suspected abuse.

**Safeguarding training completion rates**
The trust set a target of 95% for completion of safeguarding training.

**Sandwell General Hospital critical care department**
A breakdown of compliance for safeguarding training courses as at July 2018, for qualified nursing staff in the critical care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 53 | 53 | 100% | 95% | Yes |
| Safeguarding adults level 2 | 6 | 6 | 100% | 95% | Yes |
| Safeguarding children level 1 | 53 | 53 | 100% | 95% | Yes |
| Safeguarding children level 2 | 52 | 53 | 98.1% | 95% | Yes |

At Sandwell General Hospital's critical care department, nursing staff met the 95% completion target for all four of the safeguarding training modules, with three achieving a completion rate of 100%.

**Other critical care department**
Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.
A breakdown of compliance for safeguarding training courses as at July 2018, for qualified nursing staff in the critical care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 16 | 16 | 100% | 95% | Yes |
| Safeguarding children level 1 | 16 | 16 | 100% | 95% | Yes |
| Safeguarding children level 2 | 15 | 16 | 93.8% | 95% | No |
| Safeguarding adults level 2 | 9 | 10 | 90.0% | 95% | No |

At the site assigned to 'other', staff met the 95% completion target for two of the four safeguarding training modules for which qualified nursing staff were eligible. It is important to note that the number of staff is small therefore each staff member represents a bigger portion of the total.

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

A breakdown of compliance for safeguarding training courses as at August 2018, for medical staff in critical care across the trust is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 22 | 22 | 100% | 95% | Yes |
| Safeguarding adults level 2 | 20 | 22 | 90.9% | 95% | No |
| Safeguarding children level 1 | 22 | 22 | 100% | 95% | Yes |
| Safeguarding children level 2 | 21 | 22 | 95.5% | 95% | Yes |

The medical staff in the critical care department across the trust met the 95% completion target for three of the four safeguarding modules for which medical staff were eligible. It is important to note that the number of staff is small therefore each staff member represents a bigger portion of the total.

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These were reliable, reflected national and professional guidance and legislation, and were appropriate for the care setting. Staff reviewed these processes regularly and improved them when needed. Safeguarding was an item on the safety brief agenda that took place twice a day before handovers.

Staff followed local safeguarding procedures where necessary and knew who they needed to contact. All staff we spoke with were knowledgeable about and understood safeguarding. They knew who the safeguarding lead for the hospital was and they knew the processes they needed to follow if they suspected abuse. Staff said that the hospital safeguarding lead was easily accessible.

Staff were aware of the potential needs of patients with mental health conditions and there were arrangements to keep patients safe when at risk of self-harm. Staff were aware of the Mental Health Act 1983 and the trust's local procedures for keeping patients safe. There were policies and procedures for extra observation or supervision, restraint and if necessary, rapid tranquilisation for patients that were assessed as being at risk of self-harm. The policies were based on best practice guidance and legislation, they were reviewed regularly and updated when required.

## Cleanliness, infection control and hygiene

**The service had systems to control infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection and the arrangements for managing waste and clinical specimens, including the segregation, labelling and storing, kept people safe.**

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safeguarded from the spread of infection. These were reliable and minimised the potential for error. They reflected national, professional guidance and legislation, and were appropriate for the care setting. All staff understood the systems and implemented them consistently. They were reviewed monthly through audit and staff received action plans and reminders of practice if results fell short of 100%.

All staff and visitors to the unit had to wash their hands with soap and water on arrival. There was a sink near the entrance of the unit directly opposite the admin clerks desk. We saw staff

professionally challenging people on entering if they had not washed their hands on arrival. There were signs above every sink with pictured instructions on how to wash your hands effectively.

Staff used personal protective equipment (PPE) when treating patients and they washed their hands with soap and water every time they entered and left the bed space. There were PPE, sharps bins and sinks within each bed space with separate clinical and general waste bins. All waste bags were colour coded and clinical waste was marked so they were clearly defined. Sharp bins were below the fill line and lids were closed.

The critical care unit had a designated domestic service cleaner that worked on the unit and kept the unit visibly clean and tidy.

Senior staff monitored the effectiveness of implementing infection prevention and control (IPC) policies and procedures through monthly audits. The audits had several measures that looked at IPC practices that included hand hygiene and sharps bins for example. Any measure that did not score 100% was marked in red and action plans were developed and disseminated to staff to improve in those measures. Audit results were variable but showed continued improvement during the 12-month reporting period. In the latest August 2018 audit, all IPC measures were at 100%.

Infection rates on the unit were consistently low and there were robust arrangements for screening and monitoring the spread of infection. From August 2017 to July 2018, there were five cases of *Clostridium difficile (C.Diff)* infection, two cases of unit acquired *Vancomycin-resistant enterococci (VRE)* and no cases of *Methicillin-resistant Staphylococcus aureus (MRSA)* or *Methicillin-sensitive Staphylococcus aureus (MSSA).*

Consultants carried out daily review of all central lines, took daily blood tests to screen for infection and microbiology staff attended the daily ward round. The latest Intensive Care National Audit and Research Centre (ICNARC) report for April 2017 to March 2018, showed that the unit had no incidences of unit-acquired infections in the blood, which was better than similar units in the UK.

Staff screened every patient that was an emergency admission for human immunodeficiency virus (HIV) due to the high population of HIV within the community they served. Senior staff had explored guidance around encouraging uptake of HIV testing before implementing this procedure in January 2018.

There was a lack of isolation areas available for patients that required respiratory isolation and those areas that were available were not suitable for all patient groups. There were two isolation rooms on the unit. Both isolation rooms did not have reversible air flow and therefore were not suitable for patients with neutropenic sepsis. Neutropenic sepsis is a life-threatening complication of anticancer treatment where there is an inflammatory response to a presumed bacterial infection.

Staff raised the lack of isolation rooms as a concern and a challenge for them. We saw the concern had been escalated, discussed with relevant committees and was on the directorate risk register.

There had been discussions with the IPC Advisory Committee around increasing isolation facilities and an outline of what staff needed to do in the interim. The interim arrangements had clearly defined roles and steps staff needed to take to ensure all patients on the ward were kept safe from cross-contamination. Arrangements had been made with the IPC advisory committee to consider the cost of sliding doors for an area of the critical care unit to increase the provision of isolation areas.

Until there were suitable isolation areas for patients with neutropenic sepsis, staff were using a corner of the unit with an empty bed space between them and the next patient. Staff would put up

signs indicating the area was for an isolated patient and would use a trolley that contained PPE for staff and visitors.

Staff caring for patients in the isolation rooms stayed inside the room with the patient and always wore PPE. Any equipment that was needed to record notes or for care and treatment of the patient came from and stayed inside the room. There were trolleys dedicated to each isolation room just outside the door that had PPE for staff and visitors to use. There was also a clinical waste bin outside each isolation room door.

## Environment and equipment

**The service had suitable premises and equipment that were maintained well. The design, maintenance and use of the facilities and premises kept people safe.**

All equipment was visibly clean, conformed to relevant safety standards and were regularly serviced. We saw up-to-date service stickers on most equipment. We saw two stickers that were confusing as had been dated with a future date. We escalated this on inspection and the staff on the unit dealt with the issue quickly and appropriately. The machines had been serviced within the month of September but the engineers had put the last day of the month on the stickers. Senior staff on the unit explained to the servicing department that this was confusing and in future they would prefer an accurate date of service.

Staff were appropriately trained, competent and familiar with the use of equipment on the unit. New staff to the unit carried out a competency module that incorporated training for specific equipment and were not permitted to use this equipment until they had been signed off by a senior nurse. This included a hoist that was attached to the ceiling and moved from one bed space to the other, to enable patients to be lifted in and out of bed when appropriate. Staff were proficient in the use of the hoist and had completed manual handling as part of their mandatory training.

There was a program in place for the routine replacement of capital equipment and managers were aware that one program was due to end. This was on the service's risk register. Senior staff had researched different types of specialist equipment to test which would be best for the unit, minimising human error, and improving patient outcomes. Senior staff standardised the monitors on the unit for vital observations to ensure consistency in monitor display colours to avoid human error. The ventilators they had been using were about to be replaced by a new ventilator that had automated ventilation weaning programmes for weaning consistency, to reduce the time spent on a ventilator and to improve patient outcomes.

The unit was prepared for treating patients they did not routinely provide care for on the unit. The unit did not provide treatment for children but had a designated paediatric bay for critically ill children if the unit was the most suitable place in the hospital for them to be treated. The bay was set up with paediatric equipment, including a paediatric resuscitation trolley and had guidance and processes on the walls for staff. Children were only stabilised on the unit before being transferred out to the regional paediatric critical care centre. There was support from a paediatric consultant intensivist from another trust and a paediatric nurse when a critically ill child was on the unit.

The admission process for critically ill children on to the unit before transfer was robust and had clear steps to ensure staff with the right skills and qualifications were able to provide safe care. All transfers out of the unit were arranged and facilitated by KIDS, who were an external acute transport and advice service for the management of critically ill children requiring intensive care in

the Midlands. The intensive care consultants had advanced paediatric life support (APLS) and maintained core continual professional development. There were a core team of nurses within critical care that had paediatric intermediate life support (PILS) training and all band six and above nurses attended paediatric study days. Staff trained in PILS on the unit had annual refresher training that consisted of familiarisation of the paediatric bed space, scenario based training and updated PILS training.

However, the unit had lots of paediatric stock in the paediatric bay that had the potential of expiring before being used as the unit did not routinely treat children. We saw that there were a couple of items that were out of date or had been opened. We raised this with the nurse in charge who took appropriate action and removed the items from the stores.

Staff maintained the resuscitation trolleys on the unit according to the resuscitation council guidelines. The trolleys were not locked, or kept in locked rooms. They contained all drugs and equipment recommended for immediate access in the event of an emergency. The emergency medicines, including pre-filled adrenaline syringes were stored in tamper-evident containers on the trolleys and staff signed to say they had checked and maintained the trolleys daily. All checks were routinely monitored by senior staff through monthly audit. Not all drawers on the trolleys were tamper-evident however, there were systems in place to ensure evidence of theft or tampering was reported immediately. These were more robust for the adult resuscitation trolleys than they were for the paediatric resuscitation trolley.

There were two adult resuscitation trolleys, a difficult airway trolley and a paediatric resuscitation trolley on the unit. The checklists for the adult trolleys had each individual item written on the list so staff could check and sign against each individual item. The paediatric trolley checklist was not as detailed and only had a general daily check of the trolley. There was a list of items that were meant to be on the trolley attached to it, but we saw there were items that were missing. We raised this with senior staff on inspection, who took appropriate action to deal with the issue.

Storage was limited on the unit for big pieces of equipment. Staff were using a disused bed space and the transfer area for storing equipment that they needed to use often. All other big equipment used less regularly was stored appropriately across the corridor from the critical care unit in the old person’s assessment unit (OPAU).

The unit was not fully compliant with the Health Building Note for Critical Care Units (HBN 04-02) national standard. Senior staff were aware that the unit was not fully compliant with HBN 04-02 as the unit was built before the standard was implemented. The non-compliance was recorded on their risk register. The bed spaces were large enough for staff to work in should there be an emergency however, they were not quite as large as they should be to conform to the standard.

A new hospital was being built and the HBN 04-02 had been used to design the new unit at the new hospital. However, the build has been delayed due to the collapse of the construction company and is now expected to be completed in 2022.

## Assessing and responding to patient risk

**Staff assessed and responded to patient risk well. There was a proactive approach to anticipating and managing risks to people who use services that was embedded and recognised as the responsibility of all staff.**

Staff completed and updated risk assessments for each patient and developed risk management plans in line with national guidance. They kept clear records and asked for support when necessary. Risk assessments were person-centred, proportionate and staff reviewed these regularly. Staff identified and responded appropriately to changing risks to people including deteriorating health and wellbeing, and medical emergencies.

Staff monitored patients constantly and recorded hourly vital observations in patients' notes. There were clear guidance and protocols for staff to escalate a deteriorating patient if any of their vital signs were out of normal range. Nursing stations were positioned at the bottom of each bed so they could constantly observe patients. The unit did not routinely use the National Early Warning System (NEWS) for level 2 or 3 patients, as patients were continually monitored on a one to two, or one to one basis dependent on the patient's acuity. Once a patient was identified as ready for discharge from the unit, the staff recorded NEWS scores ready for the general ward staff.

Staff identified and managed sepsis well and in line with best practice guidelines. They were aware of sepsis and what to do if they suspected a patient of having sepsis. Identification and management of severe infection was a core role of staff on the unit. Training on sepsis was delivered in the Basic Life Support training module, on induction, on the preceptorship programme and critical care nurses were taught about sepsis in detail on the Care of the Critically Ill Adult course. There was a large resource available for staff to access through the trust intranet pages and on the unit in the form of standard operating procedures and flowcharts. Staff knew that observations outside the normal ranges that showed signs of sepsis were to be reported and managed in line with the Sepsis 6 Care Bundle. We saw appropriate application of the sepsis 6 bundle in patient records, this is a screening tool that is completed should a patient's condition deteriorate.

There was not a specific tool used for monitoring sepsis as the trust's sepsis screening tool was not suitable for use in critical care due to the reliance on early warning scores. The service had researched the use of a specifically adapted national sepsis tool for use in critical care by submitting a data request to the National Critical Care Network and found there was not a sepsis tool solely for use in critical care. There was a low incidence of line infection and the consultants carried out daily reviews of all lines. Staff monitored temperature, blood pressure and oxygenation ranges constantly alongside daily review of blood results and a daily microbiology ward round.

There was appropriate liaison with critical care in the event of a patient requiring transfer or input from the critical care service, with a clear admissions criteria and escalation policy. The critical care service could respond to critically ill medical emergencies anywhere in the hospital and outside of the hospital if needed. They were included in the Emergency Medical Response team (EMRT) and a member of the critical care medical staff and a critical care nurse from each shift held the EMRT bleep. Internal referral pathways were either non-direct through the outreach team or direct through the lead critical care consultant. Non-direct referrals were for patients deemed as level 1 with the potential of deteriorating to level 2 care. The outreach team stayed on the ward to support ward staff and treat the patient if they were level 1 until they became level 2, at which time the patient was referred to the critical care consultant for admission to the unit.

Staff on the unit were proactive in managing and anticipating risk. They had developed a local safety checklist for invasive procedures that was based on the World Health Organisation (WHO) Checklist. This checklist was monitored and reviewed during monthly audit. It was implemented several years previous after a never event incident had occurred. They had also developed and embedded a safety brief checklist that they carried out twice a day before each ward round. This checklist covered an array of items that had caused issues in the past and enabled the team to proactively anticipate any risk they may incur during their shift.

## Nurse staffing

**The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. The unit was appropriately staffed to meet Guidelines for the Provision of Intensive Care Services (GPICS) standards.**

Senior staff planned, implemented and constantly reviewed their nursing staff levels to keep people safe at all times. They worked to a points system that allowed them complete flexibility and the ability to respond to increased or unexpected demand across both critical care units at the trust.

The points system was based on the acuity of the patient. Level 3 patients required a registered nurse to patient ratio of a minimum 1:1 to deliver direct care. They accrued a higher number of points than level 2 patients that required a registered nurse to patient ratio of a minimum 1:2. This allowed the ward to respond to changes in demand on the service on a shift by shift basis, whilst ensuring the GPICS standards were upheld.

Staff we spoke with were happy with the staffing levels and were accommodating to being moved across site when needed.

There were sufficient supernumerary staff to support the unit in line with GPICS standards. Newly qualified nurses on the unit were not included in the planned staffing levels and were supported by a more senior nurse mentor. The nurse in charge for the shift was also not included in the planned staffing levels to allow them to coordinate the unit. On top of this, the matron was situated on the unit and was on hand if a patient escalated to level 3+, which means they required a registered nurse to patient ratio of 2:1.

Senior staff planned the rota to a minimum of eight nurses at Sandwell General Hospital critical care unit and would flex up or down when required." The planned versus actual rotas for the previous four weeks showed there was a minimum of eight nurses on most shifts. There were four shifts in week commencing 10 September 2018, where there were seven nurses on shift. The seven nurses were appropriate for the number of points needed on the unit at that time. The trust did provide us with the last six months' worth of nursing rotas but the data was not provided in a format where it was easy to establish the number of staff on one shift.

Staff shortages were responded to quickly and adequately. Senior staff used their own bank of nursing staff for unfilled shifts before they went out to agency as those staff had the advantage of being familiar with the unit. They planned nursing rotas eight weeks in advance and any gaps were sent out with the rota, so staff could book in for extra bank shifts. Most agency staff used were familiar to the unit and were sourced from pre-approved agencies. There was no formal competency checklist for agency nurses but there were processes in place for induction on to the unit.

Emergency unfilled shifts on the unit were filled by using outreach nurses until alternative arrangements through bank or agency were arranged. The outreach team told us that they would go to bank first and did not use agency staff for staff shortages. They said that in the event of an emergency unfilled shift, they would pull someone from the unit to fill their shift and the unit would back fill with bank or agency.

There were relevant, effective handovers and shift changes to ensure that staff could manage risk to people who used services. The service ensured that long-term patients had a small team of nurses that looked after them to provide a continuity of care and consistency.

The Follow-Up Service (FUSS) consisted of 1.6 whole time equivalent (WTE) in the form of one

band 7 and one band 6 nurse. The outreach team consisted of a band 8a nurse lead, 8.3 WTE band 7 nurses and 3.5 WTE band 6 nurses. All outreach team nurses were critical care trained and they provided a 24-hour a day, seven days a week service. The outreach nurses had attended nurse prescribing courses and advanced health assessment modules so they were able to support nurses on wards with critically ill patients. In general, they supported monitored beds on the respiratory non-invasive ventilation (NIV) unit, on surgery wards and on the acute medical units (AMUs).

The unit had three healthcare assistants (HCAs) that supported registered nursing staff during the day shifts. Depending on competency and training, some of the HCAs could care for patients under supervision of a registered nurse.

The trust reported their nursing staffing numbers both from April 2017 to March 2018 and, more recently in April 2018 to May 2018.

| | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| Site | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| Sandwell General Hospital | 116.5 | 130.1 | 89.5% | 116.5 | 130.1 | 89.6% |

As at April 2018 to May 2018, the critical care service had a fill rate of 89.6% at Sandwell General Hospital. This equates to 13.6 fewer whole time equivalent (WTE) staff than planned.

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

## Vacancy rates

From July 2017 to June 2018, the trust reported an over-establishment of 3.6% for nursing staff in critical care at Sandwell General Hospital, which was slightly higher than the trust's target of 3%. Staff assigned to 'other' sites within critical care had a vacancy rate of 6%.

The trust noted that the discrepancy between their planned versus actual staffing data and their data for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited via their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

## Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 12.9% for nursing staff in Sandwell General Hospital's critical care department. There is no overall turnover target for the trust, however there was a target of 10.5% for band 5 nurses. Sandwell General Hospital was the only site at the trust to miss the band 5 nursing target. The trust reported a turnover rate of 6.1% for staff assigned to 'other' sites within critical care.

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

## Sickness rates

From June 2017 to May 2018, the trust reported an annual sickness rate of 5.2% in the Sandwell General Hospital critical care department, which was worse than the trust target of 3%. The trust reported an annual sickness rate of 6.6% for staff assigned to 'other' site for the same period, which was also worse than the trust target.
*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

## Bank and agency staff usage

**Sandwell General Hospital**
Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in critical care at Sandwell General Hospital from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 498 shifts were filled by bank staff and 790 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 951 shifts were filled by bank staff and 42 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 498 | 951 | 1,449 |
| Agency | 790 | 42 | 832 |

**Intensive care outreach**
Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in critical care at Sandwell General Hospital from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 261 shifts were filled by bank staff and 583 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 81 shifts were filled by bank staff and two shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 261 | 81 | 342 |
| Agency | 583 | 2 | 585 |

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

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. The unit was appropriately staffed to meet Guidelines for the Provision of Intensive Care Services (GPICS) standards.**

Senior staff had planned, implemented and reviewed their staffing levels to keep people safe at all time. Medical staff in critical care worked as one service across both sites and therefore data

pertaining to medical staffing was trust wide and not site specific. The lead consultant was a consultant intensivist and a fellow of the Faculty of Intensive Care Medicine in line with GPICS standards.

There was an establishment of 14 consultants that worked across site, one of which was on a sabbatical and another position was vacant. All consultants that covered the intensive care unit had a Certificate of Completion of Specialist Training (CCST) in anaesthesia and intensive care medicine, or were appointed before CCST in intensive care medicine was available in which case the CCST was only in anaesthesia. Twelve of the 13 consultants held the CCST in anaesthesia and one held the CCST in anaesthesia and intensive care medicine.

Consultant work patterns delivered continuity of care and a consultant in intensive care was immediately available 24-hours a day, seven days a week. There was always a consultant available to undertake twice daily ward rounds including on the weekends, in line with GPICS standards. Rotas for anaesthetics in theatres and intensive care cover were separate. They were planned and ensured that all consultants worked seven weeks in a year on critical care and one week in seven weeks on-call for critical care. The unit ensured continuity of care for patients by having a consultant of the week where the consultant worked Monday to Friday from 8am until 6pm.

On-call consultants worked from out-of-hours Monday to Friday and all-day Saturday and Sundays. The on-call consultant was physically present on the unit from 5pm to 9pm in the evenings for the handover, and on Saturday and Sundays they were physically present on the unit from 8am to 2pm, and 7pm to 9pm. Handovers were detailed and structured using the Situation, Background, Assessment, Recommendation (SBAR) approach.

The role of the on-call consultant was to support and continue to implement the care and treatment plan derived by the consultant of the week. Consultants on-call were within 30 minutes away from the hospital.

The clinical lead was aware of and very concerned about consultant burn out due to an increase in demand and pressure, and because of an aging staff group. This was reflected on the risk register and there had been projects that had secured funding for extra recruitment. The service had secured funding for four additional critical care consultants to share workload. This would allow the service to move to six weeks of the year on critical care and a one week in nine weeks on-call rota. The service had appointed these additional consultants who were due to start in November 2018.

The consultant team were supported by two tiers of additional doctors 24-hours a day, seven days a week at both sites. The first tier had middle grade speciality doctors and senior trainees from anaesthetics. The second tier had junior doctors comprising of core trainees from anaesthetics, core medical trainees and foundation year doctors. In addition, supernumerary foundation level 1 doctors and middle grade doctors from the accident and emergency department. These doctors covered the medical on-call rota on a one in eight basis to support consultants. Staff on the night shift were always supported by a senior anaesthetic registrar with advanced airways skills

The unit was struggling to recruit speciality grade doctors due to the national shortage of middle grade doctors in intensive care. Gaps in rotas were either covered internally or by long-term locums who worked at the unit on a regular basis. The rotas for the critical care service were managed by the anaesthetics team.

The unit was supported by a highly experienced consultant pharmacist in critical care as per the GPICS standards. The pharmacy team was a very small team consisting of two consultant pharmacists equating to 1 WTE. The consultant pharmacists worked as a job share where they

each worked 16 to 17 hours a week to provide cover for five days across both sites. The pharmacy service had support from a full-time band 7 pharmacist who was completing the critical care training pack whilst on a three-month rotation.

The trust reported their medical staffing numbers both from April 2017 to March 2018 and, more recently in April 2018 to May 2018.

| | April 2017 to March 2018 | | | April 2018 and May 2018 | | |
|---|---|---|---|---|---|---|
| Site | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| Sandwell General Hospital | 92.3 | 94.9 | 97.3% | 90.2 | 94.9 | 95% |

As at April 2018 to May 2018, medical staff within critical care at the trust had a fill rate of 95%. This equates to the service having 4.7 fewer WTE staff than planned.
*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

## Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust did not provide data for medical staff within critical care as they informed us that these staff are included under anaesthetics. We requested information specifically for medical staff in critical care on inspection. Unfortunately, this data was not received in a format where we were able to establish a vacancy rate. The trust only provided the total number of vacancies but not the amount of staff they initially needed.

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

## Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust did not provide data for medical staff within critical care as they informed us that these staff are included under anaesthetics. We requested information specifically for medical staff in critical care on inspection. Unfortunately, this data was received in a format where we were able to establish a turnover rate.

Senior staff told us on inspection that there were three consultants and two other permanent critical care medical staff that had left Sandwell and West Birmingham Trust in the previous 12 months. Of the three consultants, one consultant retired and one consultant was on sabbatical and was due to return in Spring 2019.

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

## Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust did not provide data for medical staff within critical care as they informed us that these staff are included under anaesthetics. We requested information specifically for medical staff in critical care on inspection. Unfortunately, this data was not received in a format where we were able to establish a sickness rate.

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

## Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust did not provide data for medical staff within critical care as they informed us that these staff are included under anaesthetics. We requested information specifically for medical staff in critical care on inspection. Unfortunately, this data was not received in a format where we were able to establish bank and locum staff usage.

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

## Records

**Staff kept appropriate records of patients' care and treatment. Records were clear, detailed, up-to-date and available to all staff providing care.**

Staff wrote and managed patient's individual care records, including clinical data in a way that kept people safe. We reviewed five patient records. All entries were legible, dated, signed and some were additionally stamped with the relevant professional number for example, General Medical Council (GMC) and Nursing and Midwifery Council numbers. Most entries were timed but we did see a small number of entries that were not timed. There was evidence of twice daily consultant review and input from multidisciplinary teams in people's care plans. There was evidence of appropriate Deprivation of Liberty Safeguards (DoLs) applications following correct procedures and of implementation of the sepsis six pathway. Staff assessed and recorded delirium assessments three times a day to ensure that patients' mental health needs were detailed alongside their physical health needs.

Staff could access the information they needed to deliver safe care and treatment in a timely and accessible way. At the time of the inspection, the critical care unit were using specific critical care assessment proformas in paper form, to assess and record information about patients. Admin ward staff archived observation and nursing records onto the computer system weekly that nursing staff could access. The trust had funded a new electronic patient record system that was to be implemented the following month. All staff had been trained on how to use the new electronic record system and testing was ongoing on how well the new system was coordinated with what was needed for critical care.

Staff appropriately shared all the information needed for patient's ongoing care on referral, discharge and transfer, in a timely way and in line with relevant protocols. The FUSS team attended general wards on discharge from the critical care unit. They discussed the patient's ongoing care with the ward nursing staff and with the patient. The outreach team also visited patients on general wards post discharge.

## Medicines

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

Staff maintained accurate and up to date records detailing prescriptions and administration of medicines. Staff recorded patients' drug allergies clearly at the top of all prescription charts. In addition, they used allergy wrist bands as a visual aid. Staff signed and dated all prescriptions, and medications that were omitted or not administered had a reason documented. When staff

prescribed an antimicrobial, the clinical indication, dose and duration of treatment was documented in the patient's clinical record.

Staff prescribed medicines in line with best practice and national guidelines. Staff prescribed antibiotics and venous thromboembolism (VTE) prophylaxis (preventative treatment) when necessary as per national guidelines. The microbiologists visited the unit daily to review antibiotics and to provide advice on blood cultures. The unit generally gave shorter courses of antibiotics to let the patient's immune system respond before re-culturing and prescribing another course if necessary. This reduced the risk of antibiotic resistance.

Staff regularly reviewed medicine prescriptions and ensured that patients' behaviour was not controlled by excessive or inappropriate use of medicines. They ensured the unit sufficiently met the needs of patients and enabled them to stop medicines when it was no longer needed so increasing the effectiveness of the medication. The service involved patients in regular medicines reviews when appropriate and these reviews included the consultant pharmacist in intensive care. The pharmacy team continually reviewed medicines alongside the medical team and refined treatment with daily tweaks when appropriate. Staff regularly assessed patients for delirium and patients that were sedated had regular sedation holds (a break in administration of sedation medicine) to enable staff to reassess the patient. The service had carefully developed the sedation pack including the medicines that were given to ensure people could come out of sedation quickly and so that sedation levels were optimal and appropriate.

Prescribing staff were sufficiently supported and had access to relevant resources to improve medicine prescribing practices. Staff were supported by a consultant pharmacist for critical care who was a Royal Pharmaceutical Society (RPS) faculty fellow. They were involved in the development of an external electronic training pack for foundation doctors that included training modules on prescribing and medical conflictions. All prescribing staff on critical care had access to this electronic training pack. Staff used an app on a handheld electronic device that had all microbiology protocols including antibiotic serum level monitoring as well as optimal prescriptions dependent on patient condition and need. The app allowed the service to upload their local protocols alongside national guidance and was maintained by a pharmacist and a microbiologist at the trust.

Staff managed and stored medicines consistently and safely. Nursing staff were aware of policies on administration and storage of controlled drugs, and had training in analgesia (pain relief) and epidural pumps. Medicines were stored correctly and disposed of safely. Staff stored controlled drugs in locked cupboards and documented the usage and stock accurately in line with national guidelines and legislation. Fridge temperatures were checked daily to ensure medicines were stored at an optimum temperature range and staff documented temperature checks.

Staff routinely monitored compliance with medicine policy and procedures and implemented action plans promptly when partial compliance was identified. Senior staff conducted monthly audits that included checking the documentation around medicines prescribing, administration and storage, and that medicines were double checked by two nurses. Audit results from March 2018 to August 2018 showed staff were consistently compliant with local policy. There was one measure (double checked by second nurse) that was variable throughout the reporting period but had improved. We saw nurses administering medicine that had been checked and observed by a second registered nurse.

Standardised and electronic processes ensured reduced potential for human error, mistakes with prescriptions and allowed the unit to maintain a clear, logged audit trail. The unit had an electronic drugs store for non-controlled drugs that was activated by a fingerprint lock that kept a time logged audit trail. The pharmacy team came to the unit three times a week to restock the medicines. Staff on the unit could order more medication if they were running low. Staff implemented a standardised medication approach across the whole service and eliminated the drawing up of

potassium by removing strong potassium vials. They had ready prepared bags of potassium that they treated as a controlled drug and were stored and documented in the same way.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Senior staff investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

The service had sustained a good track record of safety supported by accurate performance and information. There was an ongoing, consistent progress towards safety goals that was reflected in a zero-harm culture.

There was a genuinely open and transparent culture around safety and staff were encouraged to raise concerns, incidents and near misses. All staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Senior staff fully supported staff when concerns and incidents were raised. The unit had a low threshold for reporting and the level and quality of incident reporting showed the levels of harm and near misses, allowing the service to have a good oversight of quality.

Staff highly valued people who used services as being integral to learning and improvement. When things went wrong, managers investigated through an appropriate and thorough review that included all relevant staff, organisations and patients. The service learned lessons from incidents and near misses and these were communicated widely to support improvement. Staff took opportunities to learn from external safety events from other hospital services.

Staff learned lessons from incidents and near misses to improve the safety and delivery of their service. They had developed and implemented a safety brief that included items that had previously caused an incident or near miss that were routinely and proactively checked twice a day. In addition, they had implemented a safety checklist for invasive procedures based on the national WHO checklist, which had been in place for several years before the national guidance introduced a similar tool. This safety checklist was in response to a Never Event that had occurred within the service. The service reviewed and improved the safety checklist when a serious incident involving a retained wire happened a few years before our inspection.

Senior staff monitored and reviewed their incident reports monthly and these reports, including action plans were presented at the monthly critical care MDT meeting. The reports were also displayed in the staff coffee room and were sent to staff via email.

Consultants carried out mortality reviews on all patients that had passed away on the unit to ensure that any learning had been identified and disseminated to staff. Mortality reviews were conducted by a consultant intensivist that was independent to the patient's care and were presented at the monthly critical care MDT meetings. By independent, we mean the consultant was not directly involved in the patient's care. The minutes of the critical care MDT meeting was on the shared drive for all staff to access and key messages were sent via email and displayed in the staff coffee room.

## Never Events

A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers.

From July 2017 to June 2018, the trust reported no incidents classified as never events for critical care.

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

## Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

## Safety thermometer

**The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this information to improve the service.**

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

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

The service used the results from the safety thermometer to review and monitor harm free care and displayed the results in the staff coffee room.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and two new urinary tract infections in patients with a catheter from June 2017 to June 2018.

**Prevalence rate (number of patients per 100 surveyed) of new urinary tract infections at Sandwell and West Birmingham Hospitals NHS Trust**

**Total CUTIs (2)**


Note: Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital)*

# Is the service effective?

People who used the service had good outcomes because they received effective care and treatment that met their needs. Multi-disciplinary teams worked well together; there was a truly holistic approach to assessing, planning and delivering care and treatment. Staff were competent to deliver effective care in line with best practice guidance and professional standards.

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**

Staff planned and delivered patients' care and treatment in line with current evidence-based guidance, standards, best practice, legislation and technologies. Senior staff monitored this to ensure consistency of practice. The service encouraged junior doctors to develop conduct clinical audits during their placement. These audits were assessed against best practice guidance such as National Institute of Health and Care Excellence (NICE) and the Intensive Care Society standards. We saw examples of clinical audits that junior doctors had completed in the past along with recommendations for improvement, for example the Antibiotic Prescribing on Critical Care audit. The audits were comprehensive and identified areas for improvement. We saw associated actions plans that showed lessons had been learned and actions had been implemented to improve care and treatment.

Senior staff ensured that Intensive Care Society standards were reviewed and implemented by carrying out audits of the unit against the Guidelines for the Provision of Intensive Care Services (GPICS) standards. The audit assessed whether the unit was compliant, partially compliant or non-compliant with the standards.

Partial compliance were generally standards that related to data that was routinely collected and monitored through the Intensive Care National Audit and Research Centre (ICNARC) annual audit and quarterly reports. There was only one standard that the unit was non-compliant with and that was standard 2.15, *"Level 3 units should have access to a Regional Home Ventilation and weaning unit. Arrangements should be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional Centre."* There was no formal regional unit in the West Midlands so the trust had to access services outside of the region, which was not within the unit's control.

The service held regular monthly critical care multi-disciplinary team (MDT) meetings that discussed clinical, national and local audits for learning and feedback. We reviewed minutes from these meetings covering from January 2018 to June 2018. The minutes were detailed and included lessons learned and actions to be taken for mitigation of risk. The minutes were on the shared drive for all staff to access and we saw information from these meetings was also disseminated to critical care staff via email.

There were several local policies, protocols and standard operating procedures available to staff for guidance. The documents were based on up-to-date evidence of best practice and referenced NICE, professional bodies and core standards for intensive care units. The critical care specific policies were reviewed regularly and were up to date however, one of the trust wide policies for Resuscitation and Treatment escalation was due to be reviewed in December 2017. There was no evidence that this review had taken place.

There was a truly holistic approach to assessing, planning and delivering care and treatment to all patients. This included addressing clinical needs (including pain relief), mental health, physical health and wellbeing, and nutrition and hydration needs. Staff identified expected outcomes and care and treatment was regularly reviewed and updated. There were appropriate referral pathways in place to make sure that needs were addressed.

Staff monitored patients in line with NICE guideline CG50, Acutely ill patients in hospital. They continuously monitored and recorded physiological observations to assess and manage patient risk of deterioration. Staff assessed patients for delirium three times a day in line with GPICS. All patients were assessed for the risk of venous thromboembolism (VTE) on admission to the unit and were given VTE prophylaxis when necessary in line with NICE Quality Standard QS3 statement 5. We saw evidence of these assessments in patient records.

People who used critical care services were told when they needed to seek further help and advised what to do if their condition deteriorated. The service was supported by the Follow up Support Service (FUSS) who were responsible for following patients' discharge pathway from the unit and eventually to home.

The Follow up Support Service (FUSS) told patients when they needed to seek further help and advised what to do if their condition deteriorated after discharge. They offered physical and psychological support to patients, and provided information and advice for patients and relatives on what to expect after a stay in the critical care unit. This was in the form of visiting patients whilst on a medical ward, at follow up clinic appointments, during the patient forum groups that happened every three months and a "Road to Recovery" information leaflet the FUSS team developed.

Information given to patients included common physical problems they may encounter, infections that may occur from antibiotic use and changes in psychological health for example. There was information and advice on what to do, when to seek help and from whom.

Care and rehabilitation provided during patients' stay on the unit, discharge plans and pathways were in accordance with NICE CG83, Rehabilitation after critical illness.

The service used technology and equipment to enhance the delivery of effective care and treatment. A recent project into Lung Protection Ventilation (LPV) assessed different modes of ventilation against patient outcomes. The project was based on previous studies and best practice guidance, such as the acute respiratory distress syndrome (ARDS) protocol. It concluded that using limited modes of ventilation was best for consistency and to improve patient outcomes. This project led to a business case for purchasing a specific type of ventilation equipment that enabled automated weaning programmes.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.**

Patients received appropriate nutrition and hydration. Staff reviewed patients' nutritional and hydration needs as part of their daily observations. They did not use the malnutrition universal screening tool (MUST) as it was not appropriate in critical care due to the acuity of the patient case mix. Patients' nutritional and hydration status was assessed routinely as part of the hourly nursing observations. In addition, critical care consultants undertook twice daily ward rounds of

which consisted of assessing patients' nutritional input and fluid status. We saw evidence of this in patient records. Staff undertook MUST assessments once patients were identified as ready for discharge from the critical care unit to another ward, so ward staff had the patients' MUST scores on admission.

There was sufficient specialist support to the unit for nutrition and hydration. A dietetic service supported the critical care unit from Monday to Friday and outside of these hours, critical care staff could call the on-call pharmacists and gastroenterology consultants for help and advice with total parenteral nutrition (TPN) and tube feeding. TPN is a solution that provides patients with all the fluid and essential nutrients they need when they are unable to feed themselves by mouth. This is administered intravenously. There were standard protocols for tube feeds across the trust with standardised starter regimes. All TPN and tube feeds were planned and the dietitian was involved in the assessment, implementation and management of an appropriate nutrition support route. This was in line with the GPICS standards.

Multi-disciplinary team (MDT) meetings were held twice a week to discuss patients on the unit. Staff discussed nutritional and hydration needs at these meetings, and any plans for starting patients on TPN or tube feeds were arranged with the dietitian who attended these meetings. The lead dietitian told us they prioritised patients on TPN and the critical care unit during their ward rounds. Staff told us the dietitian attended the unit regularly to input in patient care and treatment and we saw evidence of this in-patient records.

The speech and language therapy (SALT) team assessed patients including patients that were intubated. One SALT told us that when appropriate, they encouraged patients to eat and drink whilst intubated if they were awake and engaging as this reduced disuse atrophy and improved patients' quality of life.

Staff made adjustments for patients' religious, cultural and other preferences. Patients we spoke with said that they could ask for food they preferred and we saw adjustments were made to meet preferences.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed and managed patients' pain well and in line with core standards for pain management services in the UK. They did pain assessments as part of their hourly nursing observations. Staff used picture aids, pointing boards and appropriate pain score assessment tools for patients that were non-verbal or had difficulty communicating their pain needs.

Patients had individualised analgesic plans appropriate to their condition and critical care consultants assessed patients' pain relief and analgesia on twice daily ward rounds, amending plans when necessary. This was in line with the Faculty of Pain Medicine standards and NICE quality standard 15, statement 10.

Patient controlled analgesia and epidural pump competencies was assessed as part of medical device competency assessments. At the time of the inspection, Sandwell General Hospital's critical care unit had a compliance rate of 99.6% for medical device training, this had improved from the data provided to us at pre- inspection. This was due to newly qualified nurses who had been on the unit for two weeks who had training dates planned in for the coming two months as part of the junior nurse competency modules for critical care.

Staff had access to the hospital's specialist pain team if they needed extra support with pain management.

Patients we spoke with said they felt comfortable and that their pain was managed well. We heard pain management discussed during nurse handovers and any difficulties in getting a patient's pain under control. There was discussion about a patient who had struggled with pain relief during the night. We saw that the on-call consultant and registrar had been to the unit to assess the patient and were successful in maintaining the patient's pain relief.

## Patient outcomes

**Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**

The service routinely collected, monitored and reviewed effectiveness of care and treatment through local and national audits, and through other monitoring activities, such as mortality reviews, peer reviews and benchmarking. Outcomes for people who used the service were positive, consistent and met expectations.

There was a clear understanding of data amongst staff and a good commitment to data quality. The service participated in the National Intensive Care National Audit Research Centre (ICNARC) audit. They had a designated nurse for ICNARC who was responsible for collecting and validating data ready for submission. The clinical lead routinely analysed the ICNARC data and presented findings to the critical care MDT meeting.

All patient deaths had a mortality reviews that were presented at the critical care monthly multi-disciplinary team (MDT) meeting. Minutes from meetings held between January 2018 and June 2018 were detailed and included lessons learned from mortality reviews and actions to be taken. Staff had access to the minutes on their shared drive and key messages were sent via email to critical care staff.

The outreach team reviewed all unplanned readmissions within 48 hours to assess whether the initial discharge was appropriate and whether the readmission was anticipated. Findings showed most cases of unplanned readmissions within 48 hours were unexpected at the point of discharge for reasons that were not anticipated. The most recent ICNARC report for April 2017 to March 2018, showed the unit was within expected range for this quality measure. Unplanned readmission reviews were a standing agenda on the monthly critical care MDT meeting.

The service included patients that were readmitted to the unit for renal dialysis as these patients were only treated on the unit whilst undergoing dialysis. In between dialysis, these patients were cared for on medical wards with the help and advice of the outreach team.

Identification and management of severe infection was staff's core role and they maintained very high infection control and prevention standards. Consultants reviewed all intravenous lines daily for infection and nurses constantly monitored patients' temperature, blood pressure and oxygen ranges. Microbiology staff undertook daily ward rounds and reviewed blood test results daily. There were clear processes for reporting and managing sepsis and staff knew how to report signs of sepsis for example, ventilator associated pneumonia and line sepsis. Staff managed infection in line with the sepsis six care bundle. The appropriate implementation of the sepsis six care bundle was evident in patient records.

The service submitted unit-acquired infections in the blood rates to ICNARC and the latest report for April 2017 to March 2018, showed that the unit had a very low incidence of line infection with a

consistent rate of zero throughout the reporting period. However, the service did not regularly review the effectiveness of sepsis management with a formal local or national sepsis audit.

## ICNARC Participation

The trust has two units that contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

## Hospital mortality (all patients)

For critical care services at Sandwell General Hospital, the risk adjusted hospital mortality ratio was 1.1 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.0.

| Number of cases | Metric | 2015/16 | 2016/17 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 603 admissions | Risk-adjusted hospital mortality ratio (all patients) | 1.0 | 1.1 | 1.0 | None | Within expected range |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

On the inspection, we reviewed the most up to date ICNARC quarterly report with a reporting period from April 2017 to March 2018. The risk adjusted hospital mortality ratio stayed the same at 1.1, which is within the expected range. The clinical lead was knowledgeable about the unit's mortality ratio and knew why it was consistently around 1. They said this was due to the complexity of patients' conditions and the demographic of the population they serve.

## Hospital mortality (for low risk patients)

For critical care services at Sandwell General Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.4. This was within expected limits. The figure in the 2015/16 annual report was 1.1.

| Number of cases | Metric | 2015/16 | 2016/17 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 345 admissions | Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk) | 1.1 | 1.4 | 1.0 | None | Within expected limits |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

On the inspection, we reviewed the most up to date ICNARC quarterly report with a reporting

period from April 2017 to March 2018. The risk adjusted hospital mortality ratio for low risk patients remained consistent at 1.4, which was within expected limits.

## Competent staff

**The service ensured staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**

All staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The service saw continuing development of staff skills, competence and knowledge as being integral to ensuring high-quality care. There was a designated clinical nurse educator referred to as a professional development nurse (PDN). They were responsible for coordinating education, training and continual professional development for critical care nursing staff and pre-registration student staff. All staff we spoke with felt they had the skills, knowledge and experience to deliver effective care.

Non-registered support staff such as health care assistants (HCAs) were appropriately trained and their competencies were assessed. There were three HCAs that worked on the unit who worked during day shifts. The unit had a specific HCA competency framework that HCAs completed. One HCA we spoke with was trained at NVQ levels 2 and 3, they could carry out blood gases and run errands for the team. HCAs could care for patients under supervision of registered nurses, dependent on their competency.

Agency nurses were shown around the unit and staff explained the local processes and policies. The nurse in charge checked competence around using the equipment on the unit and gave refresher demonstrations when necessary. There was a standardised induction form that agency nurses worked through before working with patients.

The unit had pharmacy support from an experienced consultant pharmacist for critical care who was extremely competent and knowledgeable in their field. They had written scripts for electronic training packs, taught at universities and sat on the network board for Allied Health Scientists. They were the lead for Allied Health Scientists at the trust and were one of three clinical leads at the Midlands Critical Care Network, which included providing local and national support. The consultant pharmacist was responsible for the antibiotic stewardship and maintaining the standards. They worked closely with the medical team on the unit and provided feedback on prescribing practice at prescriber level.

The critical care pharmacy team included a band 7 pharmacist working on a three-month rotation whilst completing the band 7 training pack from the Critical Care and Trauma Midlands Network. There were currently no pharmacy technicians as part of the critical care pharmacy team. The hospital wide pharmacy service had recently been re-structured with a new chief pharmacist. The consultant pharmacist in critical care was fully aware of the importance and benefit of the technician role. They were currently in discussion with the new chief pharmacist to appoint this role.

Professional and national standards for intensive care nursing staff and medical staff were met as outlined in the professional standards. The unit exceeded the minimum standard of 50% for nursing staff with a post registration award in critical care. At the time of our inspection, the unit had 69% of registered nursing staff that were in possession of a post-registration award in critical

care nursing. The remaining staff were currently undergoing the training to be in possession of this post-registration award.

Newly appointed nursing staff had a six-week period where they were additional to the planned nursing staff levels. This was in line with GPICS standards. The unit used a local version of the national framework for registered nurse in adult critical care STEPS programme, that they called modules. Staff had a 12-month period to work through the competency framework that consisted of two modules and an academic assignment over the year. The programme had nine protected study days in total and included weekly progress reviews between the PDN and new staff to check on their competencies.

Junior doctors had access to a consultant intensivist and a medic with advanced airway skills 24-hours a day, seven days a week. This was physical presence during the week and on weekends, the on-call consultant intensivist was within 30 minutes of the hospital in line with GPICS standards. Out of hours and on weekends there was a medic with advanced airway skills physically present at the hospital in the form of the on-call registrar.

Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Staff were encouraged and given the opportunity to develop. Band 6 nurses could attend a leadership programme that allowed them to undertake shift leader roles. The programme had two protected study days and included a competency based assessment book that staff had six months to complete. Outreach nurses had attended a nurse prescribing course and an advanced health assessment module. Newly qualified staff had the opportunity to follow the trust's preceptorship programme.

The unit had recently secured funding to employ advanced nurse practitioners, which was due to go out to internal staff before being advertised externally. Senior staff were currently working on an advanced competency framework for more senior nurses. We were given examples of where staff were funded to complete higher education courses relevant to their role as a critical care nurse.

Staff were fully supported to deliver effective care and treatment, which included meaningful and timely supervision, mentorship and appraisal. There was a clear and appropriate approach for supporting staff when their performance was poor or invariable. Staff felt comfortable, competent and fully supported by their peers and superiors working on the unit. Junior doctors said they had much more support at the unit compared to other hospitals they had worked in. Staff new to the unit were allocated two mentors for support and advice, and agency nurses were buddied up with a substantive nurse for their first shift.

There were processes in place to feedback or raise any concerns around agency nurses' competencies to provide care on the unit. Staff incident reported their concerns and the feedback was given directly to the agency. The service did not compromise on safety and competence, and were not afraid of telling the agency to not send nurses that were not up to standard. Senior nurses told us that recently they had two agency nurses come for a night shift that were not critical care trained. They refused the staff and adapted by moving their own staff between units due to the patient need and by utilising the outreach team.

## Appraisal rates

**Staff received regular appraisals and professional development reviews. These were effective, relevant and up to date. We requested the most recent appraisal rates for staff on the unit during inspection.**

As at September 2018, 95% of nursing staff had an up to date appraisal and valid PDR. One member of staff was not up to date and two members of staff were new to the ward but had an appraisal booked in. As at September 2018, all medical staff had received an appraisal except for a member of staff who was on sabbatical and a new member of staff to the unit. All medical staff had up to date revalidation.

**Sandwell General Hospital**

From April 2017 to December 2017, 74.1% of staff within critical care at Sandwell General Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| NHS infrastructure support | 1 | 1 | 100.0% |
| Support to doctors and nursing staff | 5 | 6 | 83.3% |
| Qualified nursing & health visiting staff | 37 | 51 | 72.5% |
| **Total** | **43** | **58** | **74.1%** |

**Staff assigned to 'other' sites by the trust**

Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

From April 2017 to December 2017, 73.7% of staff assigned to other sites by the trust within critical care received an appraisal compared to a trust target of 100%. A breakdown by staff groups is shown below:

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| Qualified nursing & health visiting staff | 14 | 18 | 77.8% |
| Support to doctors and nursing staff | 0 | 1 | 0.0% |
| **Total** | **14** | **19** | **73.7%** |

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

## Multidisciplinary working

**Multidisciplinary team (MDT) working was exemplary on the unit. Staff of different kinds were committed to working collaboratively to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The team found efficient ways to deliver more joined-up care to people who used services.**
The critical care service was supported by a variety of specialist teams enabling delivery of more joined-up and holistic care to people who used services. The unit was supported by a speech and language therapy (SALT) team that were involved in care and treatment plans for ventilated tracheostomy patients. The team had two band 7 team leaders, two band 6 and the head of service was band 8. The unit referred patients to SALT for assessments and a representative from the SALT team attended the twice weekly multidisciplinary meetings on the unit.

There was a physiotherapy team that provided respiratory management and rehabilitation components of care. Physiotherapists were involved with planning and delivering patients' ongoing care plans and saw patients throughout recovery and post-discharge. Physiotherapy staffing was adequate to provide the respiratory and rehabilitation components of care. They

were fully compliant with GPICS standards in the acute setting but were partially compliant within the community.

There was a dietetic team that supported the unit with meeting patients' nutrition and hydration needs. Dietetic staff were involved in planning and implementing specialist nutritional and hydration techniques, such as TPN and tube feeding. The team consisted of a band 7 working at 0.8 whole time equivalent (WTE), 1 WTE band 6 and 1 WTE band 5 dietetic assistant. The team covered the entire hospital and although were at full establishment, they told us they felt stretched. They had recently secured additional funding to appoint a 0.8 WTE band 5 assistant to help with demand.

The unit had a designated domestic services staff member that helped to ensure nursing staff were free to provide care and treatment to patients. They were responsible for cleaning all areas and bed spaces in the unit, cleaning beds daily and on discharge, and organising patient menus.

FUSS and outreach nurses were all critical care nurses and provided support for the unit at busy periods when staff levels fluctuated until alternative arrangements were in place. This allowed the unit to accept patients requiring admission to the critical care unit in a timely manner.

Staff spoke very highly of the team working and the sense of 'family' on the unit. Junior doctors regarded the outreach team at the hospital as an outstanding team and staff spoke very highly of the support given by FUSS for unit staff, patients and their relatives. All staff we spoke with except for the newly qualified nurses and medical staff on rotation, had worked at the trust and on the unit for more than 15 years.

Patients' ongoing care plans were regularly reviewed and planned using a multidisciplinary approach and ensuring continuity of care. There were twice weekly local MDT meetings held on the unit. They were attended by consultants, dietitians, SALTs, physiotherapists, bedside nursing staff, nurse in charge for the shift and FUSS nurses. The service ensured a continuity of care by have a consultant of the week. They covered the unit Monday to Friday to provide a consistency for the patients on the unit. They held twice daily consultant ward rounds where all staff involved in the patient's care attended.

Patients' ongoing care plans, individual circumstances, expected outcomes, psychological needs and any discharge plans were discussed in more detail during these MDT meetings. All members of staff in attendance had input for patients based on their individual needs. These meetings were well attended and well documented with attendees signing minutes taken at the end of the meeting. Staff were treated as equals and the culture was open and transparent. Staff did not hesitate to speak up if they disagreed with any aspect of a patient's care plan.

We saw evidence in patient records that patients were assessed daily by all members of the MDT when necessary to meet their ongoing individual needs. Weaning plans were developed holistically and included input from dietitians, SALT and FUSS.

There was a holistic approach to planning patients' discharge, transfer or transition to other services, which was done at the earliest possible stage. These plans took account of patients' individual needs, circumstances, ongoing care arrangements and expected outcomes. When unexpected discharges, transfers and transitions occurred, processes were in place to ensure patients were not left at risk.

There was a clear discharge protocol that was detailed in an admissions and discharge to critical care policy. The policy gave clear instructions on discharging patients safely and effectively. Discharges were anticipated and planned with appropriate arrangements made in good time. They involved the critical care team, the accepting ward, the medical team on the ward and the outreach

team. There was evidence in patient records that discharge plans were developed holistically with input from FUSS.

The FUSS and outreach team ensured patients received consistent and coordinated care and supported patients moving between services. They worked collaboratively with staff on medical and surgical wards across the hospital. They provided care and treatment, help and advice for patients classified as level 1 that needed closer monitoring.

Patients recently discharged from the critical care unit to a ward were given continued physical and psychological support from the FUSS and outreach teams. This continued until they were discharged from the hospital.

The FUSS team continued to provide patients and their families with physical and psychological support post-discharge from hospital. They held follow up clinics for one-to-one support and patient group forums to provide support and gain feedback that were held every three months.

## Seven-day services

**Staff delivered care and treatment seven-days a week in line with best practice and professional standards.**

They met the NHS services seven days a week priority clinical standard around time to first consultant review, intervention and key services, and ongoing review. Medical cover had physical presence of a consultant intensivist Monday to Friday from 8am until 8pm. The unit was covered by a doctor in specialist training supported by an on-call senior registrar out-of-hours and on weekends.

There was an on-call consultant intensivist during weekends. They started at 5pm on Friday to attend evening ward rounds and handover from the weekday consultant intensivist and were physically present until 9pm. The on-call consultant was physically present from 8am to 2pm and 7pm to 9pm Saturdays and Sundays. Outside of these hours they were on-call and were within a 30-minute distance from the hospital in line with GPICS standards.

Most specialist support teams and support roles provided a seven-day service to the unit. The physiotherapy service ran from Monday to Friday 7.30am until 4pm and outside of these hours ran an on-call rota. There were physiotherapists rostered to cover respiratory physiotherapy in addition to an on-call physiotherapist during weekends. The pharmacist's main operational days were Monday to Friday; on weekends and out of hours there was an on-call rota so the unit could access pharmacist input and advice. The hospital pharmacy was open Saturday and Sunday from 10am to 3pm. There was of admin support from 7am until 7pm, seven-days a week. The unit had designated admin clerks who supported nurses to maintain records, entered patient data onto the computer and welcomed relatives on to the unit. They also helped the matron with staffing levels and requesting extra staff when necessary.

However, there were specialist services that only ran Monday to Friday. These were the dietetic service and the SALT service. If staff needed dietetic advice during the weekend and out-of-hours for TPN and tube feeds, they could contact the on-call pharmacist and gastroenterology consultant.

## Health promotion

**The service identified people who may need extra support and provided this through follow up appointments, patient group forums and referrals to relevant services**.

Carers and relatives were welcomed to patient group forums so the FUSS team could help them come to terms and understand the impact of their loved one's conditions. Staff identified abnormalities or risk factors that required additional support or intervention. Relevant staff discussed changes to people's care and treatment and followed up between staff, people and their carers when necessary.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

Staff obtained consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005. Staff assessed and recorded mental capacity in patients' notes when appropriate and we saw evidence of this. Staff supported patients and their relatives to make decisions about their care and treatment and when people lacked the mental capacity to make a decision, they ensured that best interest decisions were made in accordance with legislation. This was evident in patient records.

Senior staff monitored staff compliance with mental capacity assessments. We reviewed six months of audit results from March 2018 to August 2018, and saw that mental capacity assessments achieved 100% for four of the six months. They achieved 93% and 86% respectively in March and May. There were action plans that included updated teaching sessions around mental capacity assessments and regular reminders on a shift-by-shift basis to ensure clear documentation.

Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff received training on the Mental Capacity Act 2005 and DoLS during safeguarding training. Staff were knowledgeable about the Mental Capacity Act 2005, DoLS and understood restraint and how to use it appropriately. They used the least restrictive option where possible. Staff knew when they needed to submit a DoLS application and were knowledgeable about the divisional court decision around DoLS in the intensive care setting. Service leaders had approached professional bodies for clarity on DoLS submissions within the intensive care setting, but had not yet received this. Until such time, they were continuing with current practice to ensure they did not deprive anyone of their liberty without following legislation. Senior staff monitored DoLS applications monthly. Audit results from March 2018 to August 2018 showed 100% compliance with DoLS referrals.

There were resources and guidance available for staff to assist with appropriate physical restraint and senior staff regularly monitored and reviewed the use of physical restraint. Only patients deemed to be critically ill and at risk of self-harm when maximum chemical sedation was no longer beneficial were considered for physical restraint. Staff were unable to give examples of where physical restraint was used but knew they had to report the use of physical restraint on their incident reporting system and refer a DoLS application to the local authority.

There was a policy for the physical restraint of adult patients in critical care services that was comprehensive, based on best practice and current legislation. The objective was to ensure physical restraint was used only for adults within the critical care unit, when it was determined by a health care professional that it was in the best interest of the patient and as a last resort. It

included a flowchart guide to decision-making for the implementation of physical restraint and a form that staff must fill out when physical restraint was used.

Staff understood delirium and the importance of using appropriate levels of sedation. Sedation was mainly used for patients that required invasive mechanical ventilation so they could tolerate the tracheal tube and synchronise with the ventilator. Staff screened all patients for delirium three times a day using the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) tool. There was a sedation policy and a management of delirium policy for guidance.

The policies had clear protocols for sedating patients and assessing delirium. They included clearly defined responsibilities of both nurses and doctors in diagnosing delirium, conducting daily sedation holds, the use of the Richmond agitation and sedation scale (RASS) scoring system to score sedation at regular intervals throughout the day and night; and using the pain, agitation and delirium (PAD) triad to rule out pain and delirium. Sedated patients had their CAM-ICU and RASS score carried out at the same time. No DoLS application was necessary for these patients.

Staff screened every patient that was an emergency admission for HIV due to the high population of HIV within the community they served. Some patients, due to the severity of their care needs, may be unable to give informed consent to a procedure which could have significant impact for them. We were unable to assess the follow-up process for this to ensure that patients were consented, informed and supported appropriately.

## Mental Capacity Act and Deprivation of Liberty Safeguards training completion

The trust has reported that Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training is included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for completion of safeguarding training. Please note, the trust did not provide data for medical staff within critical care as they were recorded under anaesthetics, therefore the following tables present data for nursing staff only.

**Sandwell General Hospital critical care department**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the critical care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 53 | 53 | 100% | 95% | Yes |
| Safeguarding adults level 2 | 6 | 6 | 100% | 95% | Yes |
| Safeguarding children level 1 | 53 | 53 | 100% | 95% | Yes |
| Safeguarding children level 2 | 52 | 53 | 98.1% | 95% | Yes |

At Sandwell General Hospital's critical care department, nursing staff met the 95% completion target for all four of the safeguarding training modules, with three achieving a completion rate of 100%.

**Other critical care department**
Please note that the trust provided some data for staff for which the site was assigned to 'other'. These are staff working across multiple sites.

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in the critical care department at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 16 | 16 | 100% | 95% | Yes |
| Safeguarding children level 1 | 16 | 16 | 100% | 95% | Yes |
| Safeguarding children level 2 | 15 | 16 | 93.8% | 95% | No |
| Safeguarding adults level 2 | 9 | 10 | 90.0% | 95% | No |

At Sandwell General Hospital's critical care department, staff met the 95% completion target for two of the four safeguarding training modules for which qualified nursing staff were eligible.

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

**Medical staffing across sites**

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 22 | 22 | 100% | 95% | Yes |
| Safeguarding adults level 2 | 20 | 22 | 90.9% | 95% | No |
| Safeguarding children level 1 | 22 | 22 | 100% | 95% | Yes |
| Safeguarding children level 2 | 21 | 22 | 95.5% | 95% | Yes |

The medical staff in the critical care department across the trust met the 95% completion target for three of the four safeguarding modules for which medical staff were eligible. It is important to note that the number of staff is small therefore each staff member represents a bigger portion of the total.

## Is the service caring?

Staff ensured patients and those close to them were truly respected and valued as individuals. Where possible, people were empowered to be partners in their care both practically and emotionally. There was a strong, visible person-centred culture and staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Staff went the extra mile to ensure patients received care and support that exceeded expectations.

### Compassionate care

**Staff always cared for patients with compassion. Feedback from patients confirmed that staff always treated them well and with kindness. Relationships between staff, patients and those close to them were strong and staff highly valued these relationships. Staff found innovative ways to interact with patients and those close to them in a respectful and considerate way.**

Consideration of people's dignity was embedded in everything staff did, including awareness of any specific needs. Staff ensured that people were always treated with kindness, dignity, respect and compassion, and that they were given emotional support when needed. Staff maintained a strong, caring, respectful and supportive relationship with their patients and those close to them.

Staff we spoke with understood and respected the entirety of people's needs including emotional and social needs, and how those related to their physical care needs. Staff gave an example of this where they made a long-term patient's stay more homely and comfortable by decorating the bay with the patient's favourite things and enabling the patient to continue accessing day to day social activities and support. For example, staff set up internet access and bought televisions on to the ward so the patient could watch their favourite team in football matches. The staff checked when games were taking place and on what channel so the patient did not miss out.

Staff took the time to interact with patients and those close to them in a respectful and considerate way. Patients who stayed on the unit long term had a continuity of care from both the medical team and the team of bed side nurses observing them. This was evident in the way that staff knew their patients and understood when they were not feeling themselves both physically and emotionally. Staff valued the relationships they had with their patients and leaders understood the importance of those relationships. Providing patients with continuity of care was viewed as being very important by all staff for reducing anxiety, confusion and for aiding patient recovery.

## Emotional support

**Staff always provided emotional support to patients to minimise their distress. Staff viewed patients' emotional and social needs as important as their physical needs. They went the extra mile to ensure patients and those close to them had a positive experience at their most vulnerable and provided people with an exceptional service.**

Staff recognised and understood the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. Staff supported people to access their advocacy and support networks in the community and people's individual preferences and needs were reflected in how care was delivered.

We saw staff comforting patients who became frightened and panicked by talking to them in a calm soft manner and holding their hand softly to help then become calm. Staff stayed close to the patient for some time after until the patient was comfortable. Staff ensured that the patient's privacy and dignity was maintained during their time of distress.

Relatives and close friends could visit the unit at all times and there were facilities available either in the bed bay, or in separate accommodation at the hospital to allow family members to stay over.

The Follow-up Support Service (FUSS) made up of critical care nurses followed the progress of recovery from critical care to the ward and on to home. The service provided emotional support to patients and their families regarding physical and psychological rehabilitation.

FUSS nurses were responsible for preparing patient diaries for patients that were on the unit for long periods of time, which was intended to 'fill in the gaps' for patients after being discharged from the hospital. The individual diaries contained information about the patient's stay on the critical care unit and messages from their family. Staff gave patients the opportunity to take these home with them during their follow-up clinic appointment post-hospital discharge.

The FUSS team held "Patient and Carer Support Groups" four times a year. The meetings gave patients and their families an opportunity to discuss their memories and experiences together with members of the critical care team.

The FUSS team also helped families emotionally come to term with bereavement. The team of nurses organised a memorial service once a year that they called "A Special Time to Remember".

The service was a time to remember all the patients from the critical care unit that had passed away during that year. Staff also gave relatives the opportunity to have a hand print and hair lock of their loved ones at the time of death.

Staff invited family members to the memorial service and provided them with cards to write messages to their loved ones for the remembrance tree. The team carefully sought poems and psalms to read and gave family members the opportunity to light candles in memory of their loved ones. Staff also provided families with a “Forget Me Not” poem accompanied by forget me not seeds the family could sow as a reminder of their loved ones. This service was also open to staff from the unit to remember the patients that they cared for.

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

**Staff involved patients and those close to them in decisions about their care and treatment. Staff recognised that patients needed access to their advocacy and support networks. They were fully committed to working in partnership with people and ensuring that patients’ family members and advocacies were involved in care and treatment plans.**

Staff communicated with patients and those close to them in a way that was understood. When family members and friends first attended the critical care unit, the staff took time out of the unit to sit down and explain what their loved one’s condition was in a caring and considerate manner. Staff explained what to expect from the environment within the critical care unit so they were not shocked by the noises and equipment. There was a dedicated room for relatives where staff could discuss life-changing diagnosis in a private and comfortable environment and offer extra emotional support.

Patients’ carers, advocates, family members and friends were identified, welcomed and treated as important partners in the delivery of their care. We witnessed discussions about involvement of patient family members and their presence on the unit. In cases where staff had not seen a patient’s relative or advocate, the staff made every attempt to contact them to ensure they had an opportunity to be involved in the patients care and treatment plan.

Staff understood their responsibility to ensure relatives and loved ones were fully supported and cared for alongside their patients. We witnessed discussions around how staff could support the wellbeing of a patient’s relative, recognising they were not coping so well with the news of their loved one’s health. The care and needs of the patient’s relative were incorporated within the plans for treatment of the patient.

Staff used visual aids and specialised models to ensure that people understood the information that was shared about them. There was a model head called Tracheostomy Tom that the staff used to educate patients and their relatives on their tracheostomy if they had one. The physiotherapy department developed a tool they called CPAX, where they plotted scores on a graph to aid rehabilitation progress and to use as a visual aid for motivating patients and their relatives.

Staff realised that they did not have the appropriate specialist skills to approach relatives for organ donation and ensured that when the decision to withdraw treatment was made, the Specialist Nurse in Organ Donation was informed and could attend and support the ward staff.

Staff ensured that patients communication needs were understood and sought best practice accessible ways to communicate with patients with protected equality or other characteristics that

made this necessary. Patients we spoke with felt they were able to make themselves understood despite having difficulty talking. They said they felt really cared for and that they mattered..

## Is the service responsive?

Staff tailored services to meet the needs of individual people and delivered them in a way that ensured flexibility and continuity of care. Patient's individual needs were central to the delivery and coordination of tailored services. There were innovative approaches to providing integrated person-centred care and to ensure that critical care services were more accessible for all patients that required it. Staff went above and beyond to ensure patients' needs and preferences were met, and to enable patients' to remain independent.

### Service delivery to meet the needs of local people

**The critical care service reflected the needs of the population it served and ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were being delivered.**

Patients' individual needs were central to the delivery of coordination of tailored services. There were innovative approaches to providing integrated person-centred pathways of care and to increase patients' accessibility to critical care services. This included patients with protected characteristics under the Equality Act, patients approaching the end of their life and patients who were in vulnerable circumstances or who had complex needs. Where patients' needs and choices were not being met, this was identified and used to inform how the service could be improved.

The service used a points system instead of a rigid number of level 2 and 3 beds, that allowed complete flexibility when providing the appropriate level of care for patients that needed to access the critical care unit. The outreach and emergency medical response team (EMRT) that consisted of critical care trained nurses and doctors, ensured that critical care services could be provided elsewhere in the hospital for patients that needed an emergency response or increased monitoring.

Consultant cover was consistent throughout the week for consistency and continuity of care. Staff understood the importance of this for patient recovery. Patients on the unit long-term were allocated the same small group of bedside nurses to enable a strong, trusted and professional relationship between the nurses and their patients. This alleviated anxiety for patients and ensured consistency when planning and implementing the patients' care plans. It was evident in the way nurses understood their patients and their individual needs that continuity of care was maintained.

Staff used reclining chairs in patient bed bays for relatives to stay over in the unit whilst still enabling quick and easy access to the patient in case of deterioration or emergency. There was also accommodation situated in the building opposite the hospital for relatives to stay over. There were no set visiting hours so relatives could stay on the unit with their loved ones for as long as they wanted.

The service had appropriate arrangements in place to collaboratively manage patients with weaning difficulties. There were facilities and protocols in place to transfer patients with complex or specialist needs to regional centres. Staff regularly checked the transfer trolley and equipment, which was set up ready for quick and easy access when transfers were necessary. Staff would ensure patients were stable before transferring them to other centres. The service had specialist physiotherapists who worked in conjunction with the staff on the unit and the FUSS team to plan and implement weaning and rehabilitation plans for patients.

There were comprehensive discharge and follow-up procedures that the FUSS team were heavily involved with planning and implementing. This involved the outreach team attending patients on

wards within 24-hours post-discharge from the unit. The FUSS team visited patients a couple of days post-discharge from the unit and where appropriate, additional visits were made before discharge from the hospital. Patients and their relatives were given follow up clinic appointments orchestrated by the FUSS team six-weeks' post-discharge from the hospital. There were four group patient forums per year for patients and relatives to get support and provide feedback.

The facilities and premises were mostly appropriate for the services that were delivered. There were robust transfer arrangements for patients that required more specialist critical care services. The unit was a general critical care unit so there was no specialist neurology critical care provided. If a patient with a severe head injury came to the unit they were stabilised before being transferred to the regional specialist centre. A consultant neurologist from the regional specialist centre would attend at the unit to facilitate care and transfer. Patients who had a stroke were cared for at the hospital's Hyper Acute Stroke Unit (HASU), which was separate to critical care.

The unit could provide continuous veno-venous hemofiltration (CVVH) , a short-term treatment renal replacement therapy, for patients with acute renal failure as a temporary treatment before transferring the patient to a specialist renal dialysis unit. The trust could provide hemofiltration (HF) and hemodiafiltration (HDF) to patients requiring renal dialysis at their other critical care unit in City Hospital. HF and HDF are types of renal replacement therapy used in the intensive care setting. Sandwell General Hospital critical care unit was unable to provide HF and HDF because of the water quality due to the older piping system.

There were robust plans in place for short-term expansion in the event of a major emergency. There was an up to date and detailed contact of operations (CONOPS) policy and a separate pandemic influenza plan that were reviewed regularly. Both documents clearly defined roles and responsibilities of staff within the critical care service and the wider hospital. It allowed the service to expand and support any incident that would produce a short-term requirement for significant increases in critical care capacity. The clinical lead had raised concerns about the facilities on the wards used for critical care expansion and these were reflected on the directorate risk register.

## Meeting people's individual needs

**Staff took a proactive approach to understanding the needs and preferences of different groups of patients. They delivered care in a way that met individual needs that was accessible and promoted equality. Staff made reasonable adjustments and took action to remove barriers when people found it hard to use or access services.**

Staff delivered and coordinated the service taking account of the needs of different people including those with protected characteristics. They identified and met the information and communication needs of people with disability or sensory loss. Staff used image and pointing boards for patients with loss of speech or of a different language to communicate basic needs with them. There was access to language line and interpreters for patients who spoke little English and we saw staff arranging an interpreter for a patient that newly admitted to the service.

Staff provided sufficient phycological support alongside patients' physical care and treatment plans. FUSS and outreach team nurses provided emotional support for patients throughout their recovery journey. Staff had access to a psychiatric team when they had concerns about a patient's mental health. They routinely involved the psychiatric team for patients that had been admitted to the unit due to psychiatric conditions such as overdose or patients that had self-harmed.

Staff made reasonable adjustments so that people with a disability could access and use the service on an equal basis to others. We saw an example of where a patient had their own wheelchair in the unit so they could access outside of the unit when they were well enough to get

some fresh air. The service was supported by a hospital wide Dementia, Delirium and DoLs team (DDDT) that staff could access to aid the delivery of care to patients in need of additional support.

Patients living with dementia or disabilities referred from other areas within the hospital came with a “This is Me” form that had detailed information about the patient’s individual needs and preferences. Staff discussed the “This is Me” document with the patient’s relatives and carers, and if this document was not available, they gathered information from relatives, carers and where necessary social services and general practitioners.

## Access and flow

**People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice and met professional standards.**

Admission pathways to critical care were clear and well defined. People had timely access to initial assessment, test results, diagnosis and treatment. There was a clear criterion for patients who would and would not benefit from admission to the critical care unit. This was communicated through an updated admissions and discharges to critical care policy. The policy included a step-by-step guide for consultants when making decisions and how to refer patients to critical care.

Patients admitted to the unit were reviewed in person by a consultant in intensive care in line with GPICS standards. Patients deemed a potential admission at level 2 to the unit were assessed by a consultant intensivist within 20 minutes of the referral and arrangements were in place for the patient to be admitted to the unit within four hours of referral. The outreach team nurses attended patients requiring level 1 care on the ward to provide care and treatment to the patients and support for ward staff.
The service was not formally collecting assessment for admissions data routinely. Senior staff had planned to implement a manual data collection system however, these plans were deferred due to the implementation of the new electronic patient record system that was due to go live the month following inspection. The new system could collect delayed admissions automatically and would allow the service to monitor and review the data. In the interim, staff reported delayed admissions as incidents through the incident reporting system.

The service had a system for booking elective surgical patients a bed on the intensive care unit when appropriate and these were limited to two bookings per day. Emergency admissions either from surgery or medical wards were prioritised over elective bed bookings.

Elective surgical patients were reassessed after surgery to ensure the appropriate use of a critical care bed. If the patient no longer required the level 2 bed but needed enhanced monitoring, the outreach team supervised the care of the patient and supported the nursing team on the surgical ward.

From September 2017 to August 2018, the unit had 78 emergency surgical admissions, 53 elective surgical admissions and 469 non-surgical admissions. That means 21% of the patients admitted to the unit in the reporting period were surgical patients of which 42% were elective surgical patients. There had been six elective post-surgical bed bookings cancelled due to not having enough beds on the unit in the same reporting period. This equated to 11% of the total elective surgical admissions in the reporting period.

Discharge processes from critical care were clear and well defined. These were detailed in an up-to-date and comprehensive admissions and discharge policy. Patients were supported throughout their discharge and transfer to other services. Discharges were planned at the earliest stage possible and patients were moved from the unit at appropriate times. Staff understood the importance of avoiding discharging patients between 10pm and 7am for their wellbeing and for

their recovery. Staff reported as an incident when patients were discharged between these hours.

Staff told us in general, patients who were discharged out-of-hours were waiting for renal dialysis beds other NHS trusts and therefore were also delayed discharges. They would also ask patients first if they wished to go late at night or wait until the morning. A consultant nephrologist from another NHS trust reviewed patients daily that were being treating for dialysis on the unit.

We reviewed the number of discharges out-of-hours per month from September 2017 to August 2018. There were 25 out-of-hours discharges for the 12-month period, which included delayed discharges. January had the highest number of hours discharges with six. Non-delayed out-of-hours discharges were consistently within the expected range. The most recent ICNARC report from April 2017 to March 2018 showed the unit had 0.9% of non-delayed discharges for the reporting period, which was an improvement on the previous year.

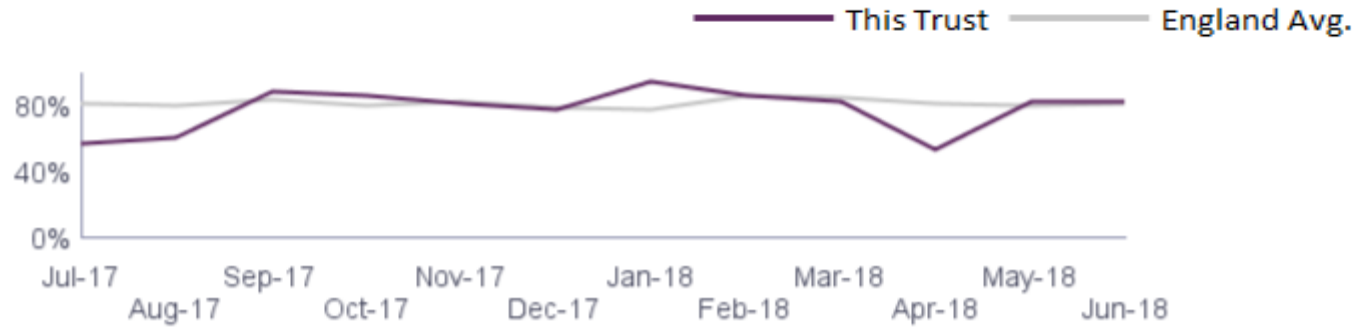
The outreach team reviewed all patients that had been discharged to a ward from the unit within 24-hours of discharge, except for patients that were receiving palliative care. From February 2018 August 2018, the outreach team had visited 90% of the patients discharged from the unit within 24-hours. Five per cent of the patients were not applicable for follow up from outreach because they were receiving palliative care.

**Bed occupancy**

Staff mentioned that at times their bed occupancy was high and they exceeded the number of points they were commissioned to provide. Staff reported when this happened via the incident reporting system.

From July 2017 to June 2018, Sandwell and West Birmingham Hospitals NHS Trust has seen adult bed occupancy mirror the England average for most of the reporting period.

**Adult critical care Bed occupancy rates, Sandwell and West Birmingham Hospitals NHS Trust.**




Please note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

## Delayed discharges

Staff recognised that delayed discharges were an issue for them and this was one of the main concerns from the service leaders. Staff incident reported any delayed discharges after eight hours in line with GPICS standards. There were appropriate processes in place to ensure that patients that had delayed discharges still had their needs met. Staff told us that the consultants would re-review patients if they were delayed for more than five hours to gain assurance that they were still medically ready for discharge to a ward.
For critical care services at Sandwell General Hospital, there were 4,380 available bed days. The

percentage of bed days occupied by patients with discharge delayed more than 8 hours was 0.7%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 0.4%. In the most up to date ICNARC report, delayed discharges more than 8 hours was 1.2%.

| Number of cases | Metric | 2015/16 | 2016/17 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 4,380 available critical care bed days | Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours) | 0.4% | 0.7% | 4.9% | 0% | Not in the worst 5% of units |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

## Non-clinical transfers

For critical care services at Sandwell General Hospital, there were 665 admissions, of which 2.3% had a non-clinical transfer out of the unit. This was worse than expected. The figure in the 2015/16 annual report was 1.1%. In the previous 12 months, the critical care unit at Sandwell General Hospital had no transfers for non-clinical reasons.

| Number of cases | Metric | 2015/16 | 2016/17 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 665 admissions | Crude non-clinical transfers | 1.1% | 2.3% | 0.4% | 0% | Worse than expected |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

## Non-delayed out of hours discharges to the ward

For critical care services at Sandwell General Hospital, 2.8% of admissions were non- delayed out-of-hours discharges to the ward. These are discharges that took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 0.5%.

| Number of cases | Metric | 2015/16 | 2016/17 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 470 admissions | Crude, non-delayed, out-of-hours discharge to ward proportion | 0.5% | 2.8% | 1.9% | 0% | Within expected range |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

## Learning from complaints and concerns

**Staff treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. People who used services were encouraged to be involved in reviews of how the service was delivered. The service could demonstrate where improvements had been made because of learning from feedback and concerns.**

There had been no recent complaints or concerns raised about the unit at Sandwell General Hospital. Staff gave us an example of a historic concern around the facilities available for giving relatives bad news about their loved ones. Staff worked with the person who raised the concern

spoke to design a better, more welcoming and comfortable place for staff to deliver bad news in memory of their loved one.

Staff said the unit had more compliments than concerns however, as lovely as it was to have compliments, they welcomed the concerns and complaints more as they saw this as a great opportunity to improve the service that they deliver.

### Summary of complaints

From April 2017 to March 2018, there were no complaints about critical care that came from the critical care department at Sandwell General Hospital.

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

## Is the service well-led?

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders demonstrated high levels of experience, capacity and capability to deliver excellent and sustainable care. They had a deep understanding of issues, challenges and priorities in their service. There were high levels of satisfaction across all staff, including those with protected characteristics under the Equality Act. Staff were proud of the service as a place to work and spoke highly of the culture. Team-working and support across the service was exemplary, all staff had a common focus on improving the quality and sustainability of care and patients' experiences.

### Leadership

**The critical care service had leaders at all levels who were highly qualified and experienced within their field. They had the right skills and abilities to run a service providing high-quality sustainable care.**

Leaders were compassionate, inclusive, effective at all levels and were visible and approachable. They demonstrated a high level of experience, capacity and capability needed to deliver high quality sustainable care. Leaders had a deep understanding of the issues, challenges and priorities in their service and identified the actions that were needed to address them. The clinical lead and lead pharmacist for intensive care in particular were extremely experienced and had an in-depth knowledge and understanding about their services.

The unit was compliant with the Guidance for the Provision of Intensive Care Services (GPICS) standards 2015 for leadership. The unit had a lead consultant for intensive care, an identified lead nurse formally recognised for the nursing elements of the service and a supernumerary clinical coordinator on duty 24-hours a day, seven days a week.

There was an embedded system of leadership development that ensured leadership represented the diversity of the workforce. Existing non shift leader band 6 nurses had the opportunity to complete the Critical Care Leadership programme that enabled them to step-up into a shift leader role.

### Vision and strategy

**The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.**

There was a clear vision and set of trust wide values that had quality and sustainability as the top priorities. The strategy for achieving the vision, priorities and delivering good quality sustainable care was realistic and comprehensive. The vision, values and strategy had been developed in collaboration with staff, patients and external partners. Staff understood the challenges to achieving the strategy and action plans were in place. They knew, understood and supported the vision and strategic goals and how their role helped in achieving them. Progress against delivery of the strategy and local plans was monitored, reviewed and presented at the trust's sustainability and quality meetings.

The unit had been heavily focused on aligning their services across sites into one harmonised service ready for the move into the new hospital. The planning of the new unit had patient care at the focus of the designs and heavily involved patients and staff at all levels. This included finer details such as mood lighting.

Senior staff were aware the service provision was inadequate for the population and were exploring a service expansion with commissioning partners. This had resulted in a high bed occupancy for a prolonged period. The service had adapted their strategy into providing a more accessible service to patients within the hospital as they were not able to physically expand the unit. This was due to the delay in the completion of the new hospital. Senior staff were focused on how the service could support other areas of the hospital for better more consistent care.

Senior staff identified the lack of national middle grade doctor availability for employment as a challenge. They had recently secured funding for the appointment and development of six advanced critical care practitioners to cover the downfall in middle tier doctors and were currently recruiting to these roles. The service was providing the advanced care practitioner training in house.

The service had recently standardised the medicine approach across critical care predominately to ensure safer practice, to reduce the risk of prescription mistakes and human errors. A by-product of this standardisation meant the service had a significant reduction in monthly expenditure for medication making the service more sustainable.

## Culture

**Leaders across the service always promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Leaders had an inspiring shared purpose and motivated staff to succeed. There were high levels of satisfaction across all staff, including those with protected characteristics under the Equality Act. Staff were proud of the service as a place to work and spoke highly of the culture. Staff told us they were supported, respected and valued. There was a clear patient-centred and safety culture at all levels and staff felt positive and proud to work at the unit. Junior doctors on rotation said how well supported they felt compared to other trusts that they had been with. They were welcomed as part of the team quickly and felt the support from staff, in particular the outreach team was of a very high standard.

There were mechanisms for providing all staff at every level with the development they needed, including high quality appraisals and career development conversations. Staff at all levels gave examples of courses the service had supported them to go on.

There was a strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and experiences. Staff at all levels were involved in improving practice to deliver a safer environment for both staff and patients. Senior

staff had a strong emphasis on the safety and wellbeing of staff. The main worry for the clinical lead was the recognition that the medical team had increased pressures due to staffing, advances in intensive care and an increase of complex conditions on top of an aging medical team. There had been a revision of rotas and funding secured for new consultant posts along with six advanced clinical practitioners to spread the pressure and the work load.

Staff at all levels were actively encouraged to speak up and raise concerns. Candour, openness, honesty, transparency and challenges to poor practice were the norm. Concerns were investigated sensitively and confidentially, and lessons were shared and acted on. There were clear leaders identified however, there was no hierarchy culture, all staff were treated as equals.

## Governance

**The critical care service used a systematic approach to continually improve the quality of the service and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The service had been working towards a cohesive and streamlined critical care service across both sites in preparation for consolidation of two sites into one at the new hospital. They had successfully achieved this with the workforce and ensuring practice was consistent across the trust wide critical care service. There were appropriate plans in place to ensure that the service remained sustainable with the delay of the new hospital development. Plans included the recruitment of four more consultants and the implementation of six advanced practitioner roles with a corresponding in-house training package.

Senior staff proactively reviewed governance arrangements and ensured they reflected best practice. They ensured that the critical care service, including outreach services were managed in accordance with professional standards, such as Guidelines for the Provision of the Intensive Care Services (GPICS). Staff audited the service against the GPICS standards that showed where they were compliant, partially compliant and non-compliant. There was only one standard where they were not compliant. This was due to not having a formal home ventilation and weaning Regional Unit in the West Midlands. Staff could access Regional Units further afield but they recognised this was not ideal for patients.

All levels of governance and management functioned effectively and interacted with each other appropriately. There was a clear route of escalation from the ward to the board and staff at all levels understood their roles and accountabilities. Staff met regularly during monthly multidisciplinary critical care meetings. The meetings had a fixed agenda and staff at all levels could attend. Meeting minutes showed that incidents and risk were running agenda items. Staff carried out detailed mortality reviews for every patient that had passed away and the findings were presented at these meetings.

The service had direct access to the board enabling senior staff to implement changes quickly. There was a dedicated Critical Care Board Meeting that was chaired by the Chief Executive Officer of the trust. The clinical lead and senior nurses for critical care attended this board meeting, which enabled them to have a good oversight of the service across the trust. Representatives from the critical care service attended several trust board level meetings such as the Infection, Prevention and Advisory Committee and the Sustainability and Quality Meetings. Information from these meetings was disseminated to all staff effectively.

## Management of risk, issues and performance

**The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

There was a demonstrated commitment to best practice performance and risk management systems and processes. Staff regularly reviewed these and ensured they were based on up-to-date best practice guidelines, legislation and professional standards. Staff performance was continually reviewed through effective appraisal, professional development and appropriate supervision. Staff were appropriately supported to improve and address areas of performance where issues had been identified.

Risk management systems and processes were effective. The directorate risk register was detailed, had clear accountability and was reviewed regularly. There was a critical care risk lead responsible for escalating risks and inputting risks on the risk register. They produced a risk report monthly. Staff actively reported risks and near misses through the incident reporting system and the risk lead had oversight of this. We saw alignment between the recorded risks on the directorate risk register and what staff said was on their “worry list”. Potential risks were considered when planning services such as seasonal demand, disruption to staffing or facilities.

Staff were proactive in identifying risks throughout the day. Staff developed and implemented a twice daily safety brief checklist and an invasive procedures safety checklist. These, along with staffing levels were continually reviewed to ensure they were prepared for expected and unexpected risks they may occur.

Senior staff reviewed how the service functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. These included a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes and systems, to identify where action should be taken.

The service had its own audit programme that incorporated the trust’s 10/10 audit and included additional quality indicators specific to critical care. Results showed consistent high-quality delivery of care and included action plans where measures fell below the service’s high standards. Areas identified as concern in audit were quickly improved. Audit results were displayed in the staff coffee rooms, via email and during the monthly critical care MDT meeting. Staff were encouraged to actively participate in both clinical and environmental audits and there was a designated individual responsible for inputting data for professional service audits.

Service developments and efficiency changes were clinically lead and the impact on the quality of care was understood. Service leaders were consultants and senior nurses. All changes to the service were developed and overseen by staff working within the clinical care setting. Staff fully understood the impact of changes on the quality of care and changes that were made were focused on patient care and experience.

There were clear and comprehensive assurance systems where performance issues could be escalated appropriately. The service had its own clinical dashboard that managed, recorded and monitored clinical effectiveness, audit results, infection rates, bank and agency use, referrals for organ donation and spend against the monthly financial budget. The clinical dashboard had data collected from both sites in preparation for the consolidation of the services and so that leaders had complete overview of the critical care service across the trust.

## Information management

**The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

There was a holistic understanding of performance, which sufficiently covered and integrated the views of people with quality, operational and financial information. Staff at all levels were involved with reviewing and improving performance and quality of care. The service held regular meetings that sufficiently covered both quality and sustainability equally.

Staff demonstrated a commitment to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. Information about care and treatment was consistently shared amongst relevant staff of the critical care MDT to ensure patients received the best possible care at the best possible time. Critical care staff were encouraged to attend trust wide meetings that covered trust wide aspects of care so the latest information was being implemented within the critical care service. There was an integrated approach to ensuring that critical care was delivered throughout the hospital when needed and not just within the critical care unit. This included resources for staff within other services to aid with decision making and to improve the appropriateness of referral to critical care. Staff within critical care interacted effectively with other services to ensure joined-up and cohesive transfers to the critical care service.

The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant. There were clear and robust service performance measures that were consistently reported and monitored. There were detailed and clear plans in place to address any weaknesses in practice. Data or notifications were consistently submitted to external organisations as required. Staff were supported to adjust and improve performance and received helpful data on a regular basis.

The service had arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Current practice involved paper nursing records being scanned and archived on the service's computer system. Staff were in the process of preparing for the implementation of a new trust wide electronic records system. The new system would allow consistency in patient records trust wide and easier, more timely access to information. Staff were working with the IT team to ensure the new system aligned with what was needed for the critical care setting.

## Engagement

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

A full and diverse range of people's views and concerns were encouraged, heard and acted on to shape the service and culture. The service proactively engaged and involved all staff in the development of the service. Staff were heavily involved in the planning and design of the new critical care unit in the new hospital. They were active partners in shaping and improving the existing service to ensure a better consistency in care and to make the service more accessible across the hospital after the delay with the new hospital development.

The service was open, transparent and collaborative with all relevant stakeholders about performance, to build a shared understanding of challenges to the service and the needs of the population, and to design improvements to meet them. Senior staff were active in sharing information with the clinical commissioning group and were currently exploring options to expand their service provision. There was a variety of resources available to staff within other services about appropriate referrals and how the rest of the hospital could reduce some of the challenges the service faced.

Staff used innovative approaches to gather feedback from the local population, including people in different equality groups, and demonstrated a shared commitment to acting on feedback. Staff proactively sought feedback from the local population including people from different equality groups, to help them understand challenges and to improve organ donation at the hospital. They visited different communities to gather cultural views on organ donations and work with those people in diminishing concerns and improving the uptake of organ donation. They used the sessions to both gain feedback and provide education and information on organ donation.

FUSS Staff held patient forums every three months. These sessions were an opportunity for patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment. Feedback included difficulties that patients experienced when transitioning from the critical care unit to a general ward. As a result, the outreach team held clinical skills days for ward staff to teach them about issues critical care patients might have to help with understanding patients' need.

We were given examples of where patient feedback was the driving force for improving aspects of the service, such as the facilities available for giving difficult or bad new to relatives. Staff told us that patients and their carer attended a Trust Board Meeting to share their experiences on the critical care unit. The service also participated in the national NHS Friends and Family test for patient satisfaction.

## Learning, continuous improvement and innovation

**The service was committed to improving by learning from when things went well and when they went wrong, promoting training, research and innovation.**

There was a fully embedded and systematic approach to improvement, which made consistent use of recognised improvement methodology. Improvement was seen as a way to deal with performance and for the service to learn. Staff were encouraged to use internal and external reviews. They regularly took time out to review individual and team objectives, processes and performance. All deaths that took place on the unit were internally investigated by an intensivist consultant independent of the patients care to ensure opportunities for learning were not missed. Learning was shared effectively across the service and was used to make improvements.

Staff gave examples of where learning from incidents resulted in implementing change. One example given was the implementation of a pre-procedure checklist for all patients that had an invasive procedure. This was because of an incident regarding a tracheotomy. The surgical checklist was based on the World Health Organisation (WHO) five steps to safer surgery. These were documented in patients' records and the steps were read out in front of all staff caring for the patient before being signed off.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. This was done through sharing work locally, nationally and internationally by participating in peer review and research projects. They were involved with the Midlands Critical Care Network and had previously undergone a peer review. Representatives from the service attended network meetings as and when they were held. The service was currently involved in two national research projects called the REST trial and the LUCAS trial.

REST trial was a national research project funded by the National Institute for Health Research UK and was considering a new way of treating respiratory failure. The research explored the damage to the lungs from mechanical ventilation in patients with respiratory failure against the addition of a new device that removed carbon dioxide from the blood allowing gentler mechanical ventilation.

LUCAS trial looked at the effectiveness of a LUCAS device, which is a chest compression system used for mechanical cardiopulmonary resuscitation (CPR). The service carried out this research alongside a local university.

Staff carried out internal research projects to improve quality of care and patient outcomes. One project involved types of monitors used on the unit to improve consistency with monitor display colours, reducing human error when observing patients. On completion, all monitors were changed to a standard model to eliminate variation in display colours.

Another project looked at different modes of ventilation for improving outcomes of patients requiring mechanical ventilators. This project was based on existing clinical studies and best practice guidelines. Project findings allowed the service to secure funding for purchasing a specific ventilator that allowed automated modes of ventilation and weaning programs.

# Services for children and young people

## Facts and data about this service

City Hospital and Sandwell Hospital were visited as part of the inspection process and each location has a separate evidence appendix. Paediatric services that fall within the Acute and Community Paediatric Directorate were managed by the same team across both hospitals. For this reason, there may be some duplication contained within the two evidence appendices.

This evidence appendix relates to services for children and young people provided at Sandwell Hospital.

During the inspection visit, the inspection team:

- Spoke with nine patients and relative and two patients
- Reviewed 17 patient records;
- Observed staff caring for patients within wards and theatres
- Reviewed trust policies and procedures
- Reviewed performance information and data from, and about the trust;
- Spoke with 30 members of staff including nurses, doctors and members of the multidisciplinary team
- Met with service manager, clinical lead and matron

The paediatric service was last inspected in October 2014 and was rated as requires improvement overall including safe, responsive and well led. It was rated as good for effective and caring.

We looked at the changes the service had made to improve the service during this inspection.

Services for children and younger people at Sandwell Hospital were as follows:

- Ward Lyndon ground: Paediatric assessment unit and adolescent inpatient area consisting of 17 beds (in winter) and 14 beds (in summer)
- Ward Lyndon 1: Paediatric inpatient area consisting of 22 beds (in winter) including 2 high dependency beds and 18 beds (in summer)
- Priory ground: Paediatric elective surgical day case unit consisting of six beds located within side room

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

Staff within paediatrics worked at both the City Hospital and Sandwell Hospital sites. One group of staff were required to work as required within:

- Priory Ground at Sandwell Hospital: Open 7.30am to 6pm on Mondays, Tuesdays, Thursdays and Fridays, on a planned basis to accommodate day surgery activity
- Paediatric outpatients located at Sandwell Hospital
- Paediatric outpatients at the Birmingham Treatment Centre located at City Hospital
- Medical day unit at the Birmingham Treatment Centre located at City Hospital is opened

on a planned basis to accommodate medical day case activity
- Ward D6 at City Hospital: Open 7.30am to 8.30pm on Tuesdays, Wednesdays and Thursdays, on a planned basis to accommodate day surgery activity

A second group of staff worked as required within:

- Lyndon Ground located at Sandwell Hospital
- Ward D19 located at City Hospital consisting of 11 beds in winter and eight beds in summer

A third group of staff primarily worked on Lyndon 1 but could be moved to cover staff shortages.

Acute paediatrics services are a 24/7 service accepting 7,500 admissions through the paediatric assessment units on both the City and Sandwell sites with inpatient admissions on the Sandwell site into 14 beds (which include the High Dependency Unit) and the six-bedded adolescent facility.

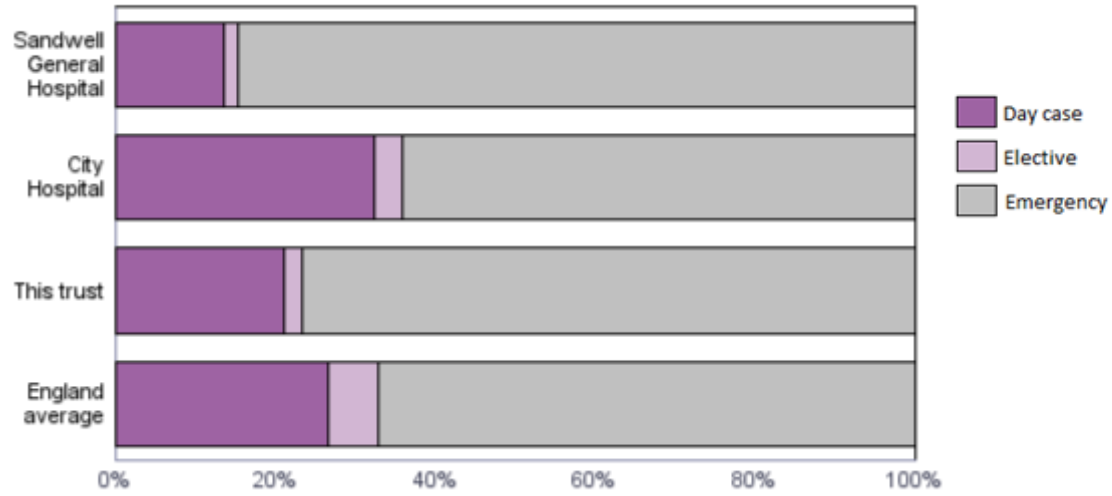
The paediatric service offers the full range of outpatient paediatric specialties delivering 12,000 outpatient attendances annually.

*(Source: Routine Provider Information Request (RPIR) – Context acute)*

The trust had 10,901 spells from April 2017 to March 2018.

Emergency spells accounted for 77% (8,350 spells), 21% (2,282 spells) were day case spells, and the remaining 2% (269 spells) were elective.

**Percentage of spells in children's services by type of appointment and site, from April 2017 to March 2018, Sandwell and West Birmingham Hospitals NHS Trust**




**Total number of children's spells by site, Sandwell and West Birmingham Hospitals NHS Trust**

| Site name | Total spells |
|---|---|
| Sandwell General Hospital | 6,595 |
| City Hospital | 4,306 |
| **This trust** | **10,901** |
| **England total** | **1,114,797** |

*(Source: Hospital Episode statistics)*

# Is the service safe?

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

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

## Mandatory training

**Arrangements in place to provide annual mandatory training to all members of staff were not effective. The service did not meet the Royal college of Nursing guidelines in relation to staff training in advanced paediatric life support.**

There was a structured induction programme for all staff to complete when they commenced employment. Staff we spoke with had received this induction and spoke highly of the induction programme.

The trust has a monthly half day where all elective activity was cancelled to provide clinical teams with protected learning time. These were known as Quality Improvement Half Days (QIHD). Each month there was a shared learning topic which all teams have to view and discuss, with some specific questions posed.

Mandatory training for all staff was a mixture of face-to-face and online learning with modules such as equality and diversity, information governance, fire training, infection control and manual handling. The trust used an electronic staff record (ESR) system which alerted staff by an automatic email when their training was due for renewal to remind them to book a session.

During our previous inspection in October 2014 we found only one nurse trained in advanced paediatric life support level (APLS) which was not in line with Royal College of Nursing guidelines. During this inspection the trust again did not supply this data as part of their routine provider information request or as part of an additional data request. Staff we spoke with said that not all shifts were covered by an APLS trained nurse. This could put children and young people at risk because the trust was unaware of how many staff were suitably qualified.

Sepsis training was included in the basic life support module including the use of sepsis screening tools and use of sepsis care bundles. But when asked about the sepsis training, most staff could not recall the training.

Nursing staff working on the wards told us they did not receive any training in mental health conditions, learning disabilities or autism.

### Mandatory training completion rates

The trust set a target of 95% for the completion of mandatory training.

### Nursing staff

A breakdown of compliance for mandatory training courses as at July 2018 for qualified nursing staff in services for children and young people at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Equality & diversity | 64 | 65 | 98.5% | 95% | Yes |
| Medical devices competency form | 64 | 65 | 98.5% | 95% | Yes |
| Information governance: introduction to information governance | 33 | 34 | 97.1% | 95% | Yes |
| Harassment & bullying level 1 | 63 | 65 | 96.9% | 95% | Yes |
| Conflict resolution initial training | 63 | 65 | 96.9% | 95% | Yes |
| Health & safety | 62 | 64 | 96.9% | 95% | Yes |
| Fire safety - workplace training | 59 | 61 | 96.7% | 95% | Yes |
| Blood collection | 10 | 11 | 90.9% | 95% | No |
| Conflict resolution update | 38 | 42 | 90.5% | 95% | No |
| Infection control | 58 | 65 | 89.2% | 95% | No |
| Moving and handling - patient handling | 57 | 65 | 87.7% | 95% | No |
| Transfusion | 35 | 40 | 87.5% | 95% | No |
| Medical devices training | 56 | 64 | 87.5% | 95% | No |
| Medicines management | 56 | 65 | 86.2% | 95% | No |
| Resuscitation: basic life support | 54 | 65 | 83.1% | 95% | No |
| Information governance: information governance refresher module | 24 | 31 | 77.4% | 95% | No |
| Fire safety warden or refresher training | 3 | 4 | 75.0% | 95% | No |

Within services for children and young people at Sandwell General Hospital, the 95% target was met for seven of the 17 mandatory training modules for which qualified nursing staff were eligible. The lowest completion rate was for the fire safety warden or refresher training module, which had a rate of 75.0%.

**Medical and dental staff**

The trust did not provide any mandatory training data for medical staff working in services for children and young people specifically at Sandwell Hospital. A breakdown of compliance for mandatory training courses as at July 2018 at trust level for medical and dental staff in services for children and young people is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Harassment & bullying level 1 | 49 | 54 | 90.7% | 95% | No |
| Consent - basic consent | 25 | 28 | 89.3% | 95% | No |
| Resuscitation: basic life support | 47 | 54 | 87.0% | 95% | No |
| Moving and handling - medical staff | 42 | 51 | 82.4% | 95% | No |
| Conflict resolution update | 12 | 15 | 80.0% | 95% | No |
| Medical devices competency form | 42 | 54 | 77.8% | 95% | No |
| Infection control | 40 | 54 | 74.1% | 95% | No |
| Equality & diversity | 40 | 54 | 74.1% | 95% | No |
| Fire safety - workplace training | 38 | 54 | 70.4% | 95% | No |
| Resuscitation: resuscitation of newborn | 11 | 16 | 68.8% | 95% | No |
| Introduction to information governance | 30 | 45 | 66.7% | 95% | No |
| Information governance refresher module | 6 | 9 | 66.7% | 95% | No |

| | | | | | |
|---|---|---|---|---|---|
| Medical devices training | 31 | 49 | 63.3% | 95% | No |
| Conflict resolution initial training | 30 | 54 | 55.6% | 95% | No |
| Medicines management | 29 | 54 | 53.7% | 95% | No |
| Health & safety | 27 | 54 | 50.0% | 95% | No |
| Transfusion | 27 | 54 | 50.0% | 95% | No |

In services for children and young people at the trust, the 95% completion target was not met for any of the 17 mandatory training modules for which medical and dental staff were eligible. The lowest completion rates were for the health and safety and transfusion modules, which both had a rate of 50.0%.

The medical staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

The General Medical Council (GMC) National Training Survey 2018

Every year the GMC surveyed all doctors in training and trainers for their views. This helped them make sure doctors in training receive high quality training in a safe and effective clinical environment, and trainers are well supported in their role.

Paediatrics generated a red flag in the area of clinical supervision. This meant that the department was substantially below its peer group in this this area. The concerns raised related to large volume of new admissions on ward and inadequate number of registrar's or consultants to review them in a timely manner and inadequate nursing staff.

*(Source: Trust data: DR522)*

## Safeguarding

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

There was an identifiable named doctor with lead responsibility for co-ordinating communication for children at risk of safeguarding issues. Staff we spoke to were aware of them and felt comfortable to go to them for any concerns or queries. During the inspection staff told us about steps they had taken to keep a child safe and to ensure there was a plan in place to keep them safe in the future.

The trust also had a safeguarding team based in Sandwell. Referrals to the children's safeguarding team were available by telephone Monday to Friday between 9am to 5pm. The trust safeguarding children policy contained guidance for staff who need to make a referral out of hours.

We saw posters and leaflets detailing CSE, FGM, domestic violence and safeguarding. All of which contained details of different agencies and their contact details. We also saw trust computer screen savers detailing the same information.

Senior staff had access to an online system which highlighted individual child protection plans or concerns. The trust had a CSE screening tool which gave staff a system to understand what degree of risk the child was at. The electronic system flagged up children who were at risk and senior staff could access interagency information. In the year before our inspection there had been no local safeguarding or serious case reviews.

Each ward area had locked doors, with entry access by a key pad or swipe card access. This ensured that patients were kept secure on ward and access from the outside was limited.

Staff we spoke with were not able to explain the Mental Health Act S5(2) nurse's holding power nor did they know when and how they can be used.

Staff had access to hospital safeguarding policies and procedures. The trust had a safeguarding policy implemented in August 2018, this policy did not mention child sexual exploitation (CSE) or Female Genital Mutilation (FGM). However the trust had a child protection policy which did contain information on CSE and FGM. The safeguarding policy contained contact information for the local safeguarding team.

Staff we spoke with were able to identify the different types of abuse and knew how to respond to safeguarding concerns and allegations of abuse. They felt confident in identifying potential abuse. Staff knew and understood what steps to take and who to contact when they identified concerns. referrals were made through an electronic form to the local authority safeguarding team, urgent or out of hours referrals could be made by the telephone. Staff did not have access to the local safeguarding team at the weekend, so this could lead to delays in staff gathering the necessary history on children and therefore delay putting procedures in place to protect children and young people. However, staff did have access to seek advice from the consultant on call to seek advice or guidance regarding appropriate care management, escalation or referral.

The trust met the statutory requirements in relation to Disclosure and Barring Service checks (DBS) checks. All staff employed at the trust undergo an enhanced DBS check before commencing employment.

At the time of our inspection staff could not tell us about any peer review processes for Doctors or safeguarding supervision in place for nurses. This is a core competency as outlined by the requirements of level three safeguarding training: 'Undertakes regular documented reviews of own (and/or team) safeguarding/child protection practice as appropriate to role (in various ways, such as through audit, case discussion, peer review, and supervision and as a component of refresher training).' The trust's named doctor for safeguarding identified the lack of peer review for doctors and lack of safeguarding supervision for nurses as a risk and had plans to improve this in the future.

The trust had a policy for restraint, this included specific details for the restraint of children. This policy was in line with national guidelines and suggests de-escalation techniques. No staff on the ward are trained in restraint or de-escalation and said they would have to get security if a child required restraining. The service had no incidents of restraint in the year before our inspection.

Nursing staff throughout children's services were not aware of the child absconsion policy and how to respond in the event of a child leaving the ward area without authorisation.

Staff were not trained to appropriate level set out in the intercollegiate document Safeguarding Children and Young People: Roles and competencies for Health Care Staff published in March 2014. All staff who are trained to level 3 safeguarding children should complete level 2 first. Following the inspection, we asked the trust to provide us with data on Safeguarding children level 2 course for staff, the trust failed to provide this evidence.

**Safeguarding training completion rates**

During our previous inspection in October 2014 we found there to be a shortfall in level 3 safeguarding children training. The trust set a target of 95% for the completion of safeguarding training.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in services for children and young people at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 65 | 65 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 65 | 65 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 56 | 65 | 86.2% | 95% | No |
| Safeguarding adults level 2 | 5 | 6 | 83.3% | 95% | No |

In services for children and young people at Sandwell General Hospital, the 95% completion target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible, with both courses achieving a 100% completion rate. The safeguarding adults level 2 course had the lowest completion rate, at 83.3%, however this equated to only one of the six eligible staff members not having completed this module.

**Medical and dental staff**

The trust did not provide any mandatory training data for medical staff working in services for children and young people specifically at Sandwell Hospital. All the staff were included in the 'other' site category, indicating that they worked across multiple sites. The analysis of this data can be found in the trust level analysis section shown below.

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in services for children and young people is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 53 | 54 | 98.1% | 95% | Yes |
| Safeguarding children level 1 | 53 | 54 | 98.1% | 95% | Yes |
| Safeguarding children level 3 | 19 | 22 | 86.4% | 95% | No |
| Safeguarding children level 2 | 26 | 32 | 81.3% | 95% | No |

In services for children and young people trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which medical and dental staff were eligible. The safeguarding adults level 2 module achieved a 100% completion rate; however, this was based on only two eligible members of medical staff. The safeguarding children level 2 module had the lowest completion rate, at 81.3%.

The medical staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

## Cleanliness, infection control and hygiene

**Staff followed the trust's infection prevention and control policy and procedures. However the children and young people's service could not assure itself of its equipment cleanliness.**

Staff followed the trust's infection prevention and control policy and procedures. There were adequate hand washing facilities in all clinical areas and we observed that staff washed their hands or used hand cleansing gel appropriately. The cleansing gel bottles we used during the course of our inspection were all functioning. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed that staff used them appropriately. All staff we saw had 'arms bare below the elbow' in clinical areas, in line with national guidance.

Patients with infections were nursed in single rooms (when available) and the necessary precautions were clearly displayed on the doors. This was to reduce the risk of spread of infection from infectious patients or to protect patients with altered immune systems. We saw evidence of this during our inspection and staff were aware of the precautions to take in order to reduce the spread of infections.

During our previous inspection in October 2014 we found that cleanliness in some clinical areas could be improved. However during this inspection we found all ward areas to be visibly clean. We also observed a deep clean taking place on Lyndon 1 following the discharge of some infectious patients.

However, the children's and young people service could not assure itself of its equipment cleaning standards. Whilst all wards appeared to be clean, they did not use 'I am clean' stickers; these stickers provided the date the equipment was last cleaned. Staff we spoke with said that if equipment was set up in full it would indicate it had been cleaned and that they would wipe all equipment again to be sure. Staff could not explain how the cleaning was audited. This meant staff were unable to provide assurance that all equipment was fully cleaned and sterilised.

Hand hygiene audits were carried out to assess staff compliance with hand washing in a number of situations. Submissions were not always consistent on ward Lyndon 1:

| Monthly Hand Hygiene Audits (% compliance) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 |
| Lyndon Ground | 100 | 99 | 99 | 100 | 99 | 99 | 98 | 100 | 100 | 99 | 99 | 100 |
| Lyndon 1 | 100 | | 96 | | 100 | | | 100 | 77 | 71 | 100 | 100 |

**CQC Children and Young People's Survey 2016**

In the CQC Children and Young People's Survey 2016 the trust scored 8.59 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Environment and equipment

**The children and young people's services were provided in an environment that was suitable for the services provided.**

The outpatients department was next to the paediatric assessment unit. The wards and outpatients department were clearly signposted and accessible to visitors with impaired mobility. People entered the wards using an intercom system controlled by reception staff who screened all visitors on arrival. People visiting the wards also had to be let off the wards using the intercom system.

We saw paediatric resuscitation trollies were present in easily accessible areas within the wards. On our previous inspection in October 2014 we found resus equipment that was out of date. However, on this inspection we saw the trollies were checked daily. Equipment contained within these trollies was in date and complied with national standards.

In theatres there was a dedicated recovery area for children. This has appropriate screening to protect children's privacy and dignity and to keep them separate from adult patients. This is in line with the guidelines for the provision of anaesthetic services (GPAS 2015).

There were limited facilities for children with sensory, behavioural or mental health needs. The hospital did not have a sensory room. Staff we spoke with said there were two play specialist staff who worked cross site who they could contact for assistance. The play specialists could provide sensory equipment to place on ward.

During our previous inspection in October 2014 we highlighted that there were ligature risks in the areas used to care for children and adolescents with mental health issues. During this inspection we were told about four ligature free rooms in Lyndon ground. These rooms were not ligature free and would be a risk for patients at risk of ligaturing. The trust had a risk assessment for patients who might deliberately self harm or vulnerable patients however this does not take into account all of the ligature risks we found in the room during our inspection. We also found low hanging blind chords in the assessment waiting area on Lyndon ground which could also be a ligature risk for small children playing in the area. Following the inspection, the trust had implemented some building work to address some of the risks and provided photographic evidence of the work.

## Assessing and responding to patient risk

**The children's wards recorded and appropriately actioned patient risk levels. The ward had good links with child and adolescent mental health services (CAMHS) to see patients with mental health needs.**

The children's wards routinely used a paediatric early warning score (PEWS) to enable the nurses in recognising and responding to signs of deterioration, thereby preventing serious adverse events. Records we look at showed this was completed and scores that required an action were acted upon.

The children's wards completed a sepsis algorithm for all children admitted onto the ward, this identified children who required the initiation of a sepsis bundle. We requested a copy of the trust's sepsis policy and the trust submitted a physiological observation, monitoring and escalation policy. This could be accessed by the intranet. However, we found that the policy referred staff to the sepsis pathway, sepsis screening tool and sepsis six treatment Following the inspection the

We reviewed nine paediatric early warning score observation charts and found these were completed in detail by members of the nursing team and appropriate actions were taken.

The Royal College of Nursing recommend at least one member of qualified staff on the children's unit has an advance paediatric life support qualification (APLS). Staff we spoke with said that not

every shift was staffed by a member with APLS. Evidence the trust provided us showed that only one nurse across the paediatric services was trained in APLS.

We were told of good links with child and adolescent mental health services (CAMHS). CAMHS staff would call the children's ward on a daily basis for verbal referrals of overnight admissions; they would then visit the ward if required. This service was available seven days per week across both Lyndon Ground and Lyndon 1.

### CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 7.72 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

The trust scored 9.46 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was also about the same as other trusts.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Nurse staffing

**The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment, in line with the Royal College of Nursing 2013 guidelines.**

One team of staff were split between five wards located at both sites:

- Sandwell Hospital: Priory Ground, paediatric outpatients
- City Hospital: ward D6, paediatric outpatients, medical day unit

The team reported to a band 6 sister who had stepped up to cover the band 7 ward manager role which had been vacated due to retirement, this was a temporary role until a new ward manager could be appointed and was supported by the matron. The ward manager role oversaw all five areas and as such was challenged to provide direct staff support. In addition, due to staffing shortfalls the band 6 sister had to step back into a clinical role as well as complete their managerial duties.

The second team were based at either:

- City Hospital: ward 19
- Sandwell Hospital: Lyndon Ground

This team reported into a band 7 ward manager who was predominantly based at Sandwell Hospital. Again, this challenged the ability to provide direct staff support.

A third group of staff were primarily based in Lyndon 1, however, they could be called to support any of the above areas. This team was reported into a band 6 ward sister who had stepped up to cover the bank 7 manager role.

All ward managers had to cover clinical shifts in order to fill gaps in the rota. This is not in line with the Royal College of Nursing standards for defining staffing levels for children and young people's services 2013, which states that the shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff.

The trust submitted data which detailed dates where HDU patients were admitted to the assessment units. From June to August 2018, there were 28 occasions where at least one HDU patient was admitted to Lyndon 1. Based on their average patient numbers, before the HDU admission, Lyndon 1 did not have enough staff to meet a nurse patient ratio of 1:4 on nine occasions. However, the addition of the HDU patient on all 28 occasions would have led to the ward being short staffed.

On Lyndon 1 the trust planned to have 22 beds (including 2 HDU beds) open during winter, they planned to have 5 nurses (potentially including one band 4 following a skill mix exercise) and 2 HCAs, across all shifts. On Lyndon ground the trust planned to have 17 beds open during winter, they planned to have 3 nurses and 2 HCAs with 3 nurses and 1 HCA at night. These staffing plans do not meet the royal colleges of nursing guidelines that state that children aged over two years old should have one nurse to four patients.

During our previous inspection in October 2014 we raised concerns that unregistered band 4's were being used in registered staff roles. This continued to be the case at this inspection, band 4's were included in registered staff numbers for Lyndon 1. Staff raised this as a concern during the inspection due to the impact on staffing numbers and the increased pressures on registered nurses.

Staff told us that staff were leaving, with newcomers not staying very long. They felt that the reason behind this turnover was due to a lack of support from the leadership team.

Staff we spoke with said they followed the trust's escalation guidelines and reported staff shortages by the incident reporting system. We reviewed the escalation guidelines for paediatrics and neonates and found that the paediatric guidelines were currently review, having past their February 2017 review date.

We requested data detailing the number of times the escalation policy had been implemented and the number of times wards had closed. The trust response was that this would not be documented on an incident form as the escalation policy was used to ensure a plan is in place to support staff unless the escalation plan had failed to be delivered and or the intended output not achieved. Over the past 12 months, the unit has not closed to admissions.

Staff regularly worked over their hours to support their colleagues and often worked without breaks. Staff told us how they went to work even when they were ill in order to support their colleagues. Staff reported incidents of low staffing through the trust incident reporting system.

Paediatric staff we spoke with said that the service did not always feel safe and they felt under pressure to make up shortfalls in staffing. Staff were shared between the two hospital sites within two teams and were allocated as required.

Bank and agency staff did not always have appropriate paediatric training. Staff told us that sometimes when bank and agency staff were recruited to cover a shift they were not aware it was for paediatrics. This resulted in some staff not being able to cover the shift due to a lack of training or experience. The trust told us that due to a lack of paediatric staff there were occasions when adult nurses with additional training covered children's wards.

The trust reported the following nurse staffing numbers in services for children and young people both for April 2017 to March 2018 and, more recently, in April/May 2018:

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 51.6 | 57.1 | 90.4% | 47.5 | 57.1 | 83.3% |

Services for children and young people had a planned to actual nursing staffing level of 90.4% from April 2017 to March 2018. However, this dropped to 83.3% in April/May 2018 due to a decrease of 4.1 WTE nursing staff in post.

The trust was unable to provide this data broken down by site, indicating that the nursing staff worked at across multiple sites.

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

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 7.1% for nursing staff in services for children and young people at trust level, which was higher than the trust's target of 3%.

The trust could identify some staff working at Sandwell Hospital. However, for the remainder of the data, the trust was unable to specify a specific site, stating that these staff worked across multiple locations. A breakdown of vacancies at site level is provided below.

- Sandwell General Hospital: 2.8%
- Staff assigned to 'other' sites within services for children and young people: 11.1%

There was a high vacancy rate among staff assigned to 'other' sites, which exceeded the trust's target of 3%.

The trust noted that the discrepancy between their planned versus actual staffing data and their data for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded positions not recruited directly by them.

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

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 22.4% for nursing staff in services for children and young people at trust level, based on 28.6 WTE members of nursing staff leaving over the 12-month period, compared with an average substantive level of 127.8 WTE staff. There is no overall trust-wide turnover target, however there is a target of 10.5% for band 5 nurses.

The trust could identify some staff working at Sandwell Hospital. However, for the remainder of the data, the trust was unable to specify a specific site, stating that these staff worked across multiple locations. A breakdown of the turnover data at site level is provided below:

- Sandwell General Hospital: 23.5%
- Staff assigned to 'other' sites within services for children and young people: 21.3%

Neither location met the target of 10.5% for band 5 nurses.

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

**Sickness rates**

From June 2017 to May 2018, the trust reported an annual sickness rate of 5.2% for nursing staff in services for children and young people at trust level, which was higher than the trust target of 3%.

The trust was able to identify some staff working at Sandwell Hospital. However, for the remainder of the data, the trust was unable to specify a specific site, stating that these staff worked across multiple locations. A breakdown of the sickness data at site level is provided below:

- Sandwell General Hospital: 4.5%
- Staff assigned to 'other' sites within services for children and young people: 5.9%

The sickness rate at each location was also worse than the trust target.

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

**Bank and agency staff usage**

**Trust level**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts in all cases. Therefore, we have been unable to analysis bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in services for children and young people at trust level from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff.

For qualified nurses, 1,830 shifts were filled by bank staff and 1,535 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

For nursing assistants, 2,573 shifts were filled by bank staff and 52 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants.

| Bank/agency | Qualified nurses | Healthcare assistants | Total |
|---|---|---|---|
| Bank | 1,830 | 2,573 | 4,403 |
| Agency | 1,535 | 52 | 1,587 |

We were unable to provide a site-specific breakdown of nursing bank and agency usage in services for children and young people, due to the format of the data provided by the trust.

*(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)*

## Medical staffing

**Medical staffing levels did not meet the requirements of the Facing the Future: Standards for Acute General Paediatric Services.**

The trust had 11.75 whole time equivalents who worked across the two hospital sites. Consultants told us that they were having to 'act down' to cover junior shifts. At the time of the inspection clinics were still being maintained however, there was no capacity if there was an unexpected absence.

The trust did not provide paediatric consultant cover out of hours but did cover on call based from home. Consultants worked at City Hospital from 8.30am to 4.30am. This did not meet the Royal College of Paediatrics and Child Health Facing the Future standards which states that there should be a consultant paediatrician present and readily available in the hospital during times of peak activity, seven days a week. Staff we spoke with said that consultant staff would arrive within 20 minutes of being called were available over the telephone for advice. This was also raised as a concern at the previous 2014 inspection.

The trust worked to a consultant of the week model. Staff we spoke with were aware who the consultant was at the time of our inspection.

Staff we spoke with said that not every child admitted to a paediatric department with an acute medical problem was seen by a consultant paediatrician within 14 hours of admission.

Due to the inability to recruit a consultant, the trust created a fellowship post and were in the process of finalising recruitment into that post.

The trust reported the following medical and dental staffing numbers in services for children and young people both for April 2017 to March 2018 and, more recently, in April/May 2018.

| Site | April 2017 to March 2018 | | | April/May 2018 | | |
|---|---|---|---|---|---|---|
| | Actual WTE staff | Planned WTE staff | Fill rate | Actual WTE staff | Planned WTE staff | Fill rate |
| All sites | 45.2 | 48.0 | 94.2% | 46.1 | 48.0 | 96.1% |

The medical and dental staffing levels were similar in both time periods.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

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

**Vacancy rates**

From July 2017 to June 2018, the trust reported that medical and dental staff in services for children and young people at trust level were over-established by 2.0%, which was better than the trust's target of 3%.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

The trust noted that the discrepancy between their planned versus actual staffing data and that for vacancies might be due to differing exclusions. Their vacancy data only included posts which were recruited through their internal vacancy authorisation form (VAF) process and so excluded junior doctors and positions not recruited directly by them.

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

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 42.2% for medical and dental staff in services for children and young people at trust level. There is no overall trust-wide turnover target.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

It should be noted that trainee grades may have been included in the turnover data which would have impacted on the rate. This should be confirmed on inspection.

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

**Sickness rates**

From June 2017 to May 2018, the trust reported an annual sickness rate of 0.5% in services for children and young people at trust level, which was lower than the trust target of 3%. There is no overall trust-wide turnover target.

The trust was unable to provide this data broken down by site, indicating that the medical staff worked at across multiple locations.

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

**Bank and locum staff usage**

**Trust wide**

From June 2017 to May 2018, the trust reported that 681 shifts within services for children and young people trust-wide were filled by bank staff and 946 shifts were filled by locum staff. There were no shifts not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to break down the data by site. In addition, they could not provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

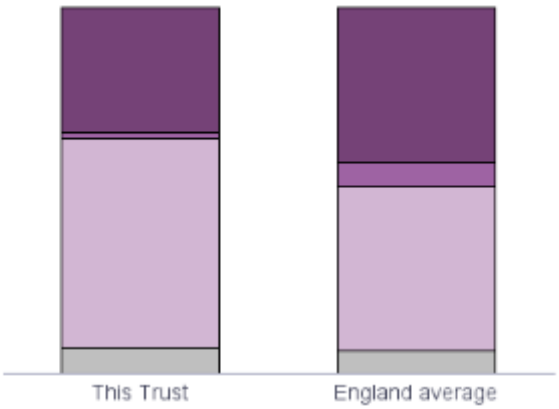
| Staffing type | Bank shifts | Locum shifts | Unfilled shifts | Total shifts (bank, locum and unfilled) |
|---|---|---|---|---|
| Consultant | 302 | 608 | 0 | 910 |
| Middle Grade | 303 | 281 | 0 | 584 |
| Doctor in Training | 76 | 57 | 0 | 133 |
| **Total** | **681** | **946** | **0** | **1,627** |

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

**Staffing skill mix**

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

**Staffing skill mix for the 56 whole time equivalent staff working in children's services at Sandwell and West Birmingham Hospitals NHS Trust**




| | This Trust | England average |
|---|---|---|
| Consultant | 34% | 42% |
| Middle career^ | 2% | 7% |
| Registrar Group~ | 57% | 44% |
| Junior* | 7% | 6% |

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

*(Source: NHS Digital Workforce Statistics)*

## Records

**Individual nursing and medical records were written and managed in a way that kept people safe.**

During the inspection we looked at 17 sets of records. Records in all areas were accurate, complete, legible and up-to-date. Patient records across the wards and in the outpatients department were paper records, the trust had plans to move to electronic records in the future.

Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and dietetic staff.

Paper documentation included a range of risk assessments, pain scores, paediatric early warning scores (PEWS), allergies and care plans for patients. We saw that staff consistently recorded PEWS scores.

When patients were transferred from the emergency department to the children's wards information was shared with the ward using a form which was transferred with the patient. The ward could also see if there had been a safeguarding referral made in the child's notes.

Test results were available using an electronic system. Staff told us these were available in a timely fashion and could be prioritised if necessary.

Discharge was communicated to GPs on discharge by nursing staff. Information on the patients history, treatment in hospital and follow up plans are given.

During the previous inspection in October 2014 we identified that patient records were not stored securely. During this inspection we found records were stored securely in lockable trolleys.

The trust conducted 13 records audits between May and July 2018. It found 100% of entries contemporaneous and that daily entries were made. However it also found that only 88% of allergies were recorded, the trust highlighted this as an area for improvement and put actions in place to improve this.

## Medicines

**There were out of date medicines (including controlled drugs) found during this inspection. Staff on Priory Ground only record fridge temperatures for the days the ward is open putting patients at risk of ineffective medicines. However, medicines were stored securely in locked cupboards.**

Prescription medicines were stored safely in locked cupboards which staff accessed using their keys. There was also a locked controlled drugs cupboard that staff only accessed when two staff were present.

During our previous inspection in October 2014 we found medication that had expired. During this inspection we also found out of date medication including controlled drugs, the inspector alerted the staff in that clinical area. This meant that these drugs were removed immediately to reduce the likelihood of a future medication incident from occurring.

There were fridges available for temperature sensitive drugs. Staff recorded temperature levels daily and these remained within an acceptable range. Staff in priory ground only recorded fridge temperatures for the days the ward was open. This could mean that medicines could be stored at a higher temperature on the others days which would make the medication ineffective and the staff would not be aware.

The trust conducted 13 records audits between May and July 2018. It found 100% of entries contemporaneous and that daily entries were made. However, it also found that only 88% of allergies were recorded, the trust highlighted this as an area for improvement and put actions in place to improve this. We reviewed four sets of records all records had the child's weight clearly recorded however only one out of the four records had the allergies documents.

The trust audited antimicrobial prescribing and had implemented an action plan to address any shortfalls such as incomplete allergy status.

## Incidents

**Incidents were reported by staff working in the service. Staff were more aware of incident investigation processes than they were at our last inspection**.

Staff we spoke with knew how to report incidents and were encouraged by leaders to do so. Incidents were logged using the trust-wide electronic reporting system.

During the previous inspection we were not assured that incident management was robust. During this inspection we found that all incidents were reviewed by the ward manager and escalated where necessary to senior staff. Serious incidents were reviewed by the service triumvirate and a 72-hour report, with initial investigation findings, completed. However there were no formal mortality and morbidity meetings held by the paediatric service.

The service had monthly risk meetings where any identified risks were discussed and appropriate actions and timelines put in place. These were then fed into the wider paediatric clinical governance group

During the previous inspection we were not assured that incident learning was robust. During this inspection we found that the paediatrics team received feedback from the paediatric lead for risk who led investigation review meetings. Learning from incidents was also a standing agenda item for the services quality improvement half days.

We requested the children and young people's service business continuity plan following the inspection, the trust did not make a submission.

**Never Events**

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

From July 2017 to June 2018, the trust reported no incidents classified as never events for children's' services.

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

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children's services at Sandwell Hospital which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

## Safety thermometer

**The service had one new pressure ulcer, no falls with harm and no new urinary tract infections from June 2017 to June 2018.**

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and no new urinary tract infections in patients with a catheter from June 2017 to June 2018 for children's services. The pressure ulcer occurred in June 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Sandwell and West Birmingham Hospitals NHS Trust**

1 Pressure ulcers levels 2, 3 and 4

*(Source: NHS Digital)*

# Is the service effective?

## Evidence-based care and treatment

**We saw that staff complied with evidence based practice within their work and completed audits to monitor the quality and efficiency of children and young people services at the trust.**

Treatment was delivered in line with NICE guidelines, for example the trust had guidelines for fluid management, sepsis and asthma. We observed that staff could access evidence based clinical guidelines easily and quickly using the trust's intranet system.

The trust had guidelines on physiological observation monitoring and escalation policy, which details the steps to take when patients observations hit different risk areas. This policy was due for review in July 2018 and does not reference up to date NICE guidelines (sepsis: recognition, diagnosis and early management, NG51). There was a sepsis flow chart was clearly displayed on the walls in the inpatient wards.

The trust's sepsis policy did not guide staff to additional information. We requested a copy of the trust's sepsis policy and the trust submitted a physiological observation, monitoring and escalation policy. This could be accessed via the intranet. However, we found that the policy referred staff to the sepsis pathway, sepsis screening tool and sepsis six treatment but could not see any details on how to access these nor any examples of them within the document.

At the time of our inspection Sandwell Children and young people's services were not approved by any national accreditation schemes. However, staff told us the wards had plans for the future to become Baby friendly (UNICEF).

The trust completed the national audits for Paediatric diabetes audit 2015/16. The trust also completed monthly local audits on infection control, paediatric asthma audit and paediatric indicator audit.

Staff we spoke with told us how they would make a referral to the CAMHS team if a child or young person was displaying signs of depression or thought to be at risk of suicide.

Ward staff did not receive any training in de-escalation or restraint and told us they would have to phone security to deal with any incidents of violence or aggression.

## Nutrition and hydration

**Patients nutrition and hydration needs were met on the ward.**

Patients had all meals provided and drinks and snacks were available throughout the day. We saw that vegetarian, vegans and patients with specific dietary requirements were catered for on the ward.

The service had access to five paediatric dieticians to review patients. There was also access to a speech and language team based in the community who could review patients when required.

Records we looked at showed that nutritional assessments and management plans were completed and took into consideration people's personal wishes.

During the previous inspection in October 2014 we found there was no nil by mouth policy which could have resulted in a risk to patients due to confusion in staff. We requested a copy of the current nil by mouth policy but no submission was made by the trust.

## Pain relief

**Patient's pain levels were recorded and managed appropriately.**

Staff assessed patients' pain as part of routine observations. We found pain scores well documented in patient records, and appropriate interventions. We observed staff giving pain relief to a child who was going to be fitted with a cast despite it delaying the fitting of the cast.

Staff could use a pictorial pain score to assess a child or adolescents pain if they were non-verbal. Staff told us how they would observe patients in order to assess their pain if they could not communicate.

We reviewed ten sets of patient records, all ten contained assessments of pain and appropriate responses.

## Patient outcomes

**The service monitored, and had low, re-admission rates.**

Ward managers completed a monthly programme of audits. These were reported through a ward dashboard.

At the time of our inspection the children and young people's service were not involved in any peer review programmes or research programmes.

The service conducted a monthly paediatric sepsis audit. The results showed that not all children requiring a sepsis screen were screened. This could put patients at risk of not receiving appropriately, timely treatment. The results for May to July 2018 can be found below:

| Month | Required screening | Were screened |
|---|---|---|
| May | 46 | 16 |
| June | 45 | 41 |
| July | 48 | 38 |

**Paediatric diabetes audit 2015/16**

In the 2015/16 Paediatric diabetes audit, the proportion of patients receiving all key care processes annually at Sandwell Hospital was 48.2%, which was better than expected. The national aggregate was 35.5%, while the hospital's score in the 2014/15 report was 66.1%.

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".

The mean average HbA1c value (adjusted by case-mix) for this hospital was 62.2 mmol/mol which was within the expected range. The national aggregate was 68.3 mmol/mol. The hospital performed within the expected range for this metric in the previous year's audit.

The median HbA1c value recorded amongst the 2015/16 sample for this hospital was 61.0 mmol/mol, which was not a clinically significant improvement from the previous year's median of 61.0 mmol/mol. The national aggregate was 65.0 mmol/mol.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

From February 2017 to January 2018, there were no specialties with six or more readmissions following an elective admission recorded for the under one or 1-17 age groups.

The tables below show the percentages of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that, from February 2017 to January 2018, a lower percentage of patients aged under one were readmitted following an emergency admission in paediatrics, compared to the England average.

| Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2017 to January 2018) | | | | |
|---|---|---|---|---|
| Specialty | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| Paediatrics | 2.2% | 2,240 | 50 | 3.3% |
| No other speciality at this trust had six or more readmissions. | | | | |

In addition, a lower proportion of the trust's patients aged 1-17 years old were readmitted following an emergency admission in paediatrics compared to the England average.

In contrast, a higher proportion of the trust's patients in this age group were readmitted following an emergency admission in paediatric surgery compared to the England average.

| Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2017 to January 2018) | | | | |
|---|---|---|---|---|
| Specialty | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| Paediatrics | 1.5% | 4,961 | 74 | 2.8% |
| Paediatric Surgery | 3.1% | 227 | 7 | 1.9% |
| No other speciality at this trust had six or more readmissions. | | | | |

*(Source: Hospital Episode Statistics, provided by CQC Outliers team)*

**Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes**

From March 2017 to February 2018, a similar proportion of the trust's patients aged from one to 17 years of age had two or more admissions for asthma. However, please note that this analysis was based on a small number of multiple admissions.

In contrast, higher proportions of the trust's patients aged from one to 17 years of age had two or more admissions for diabetes and epilepsy in comparison to the England rates.

| Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under one year and from one to 17 years) (March 2017 to February 2018) | | | | |
|---|---|---|---|---|
| Long term condition | Sandwell and West Birmingham Hospitals NHS Trust | | | England |
| | Multiple admission rate | At least one admission (n) | Two or more admissions (n) | Multiple admission rate |
| **Asthma** | | | | |
| Under 1 | - | - | - | 14.5% |
| 1 to 17 | 16.0% | 250 | 40 | 16.1% |
| **Diabetes** | | | | |
| Under 1 | - | - | - | 20.0% |
| 1 to 17 | 21.2% | 33 | 7 | 13.1% |
| **Epilepsy** | | | | |
| Under 1 | * | * | * | 34.0% |
| 1 to 17 | 36.4% | 55 | 20 | 27.0% |

Note: For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'. Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

*(Source: Hospital Episode Statistics, provided by CQC Outliers team)*

**National Neonatal Audit Programme**

Sandwell Hospital did not participate in the 2017 National Neonatal Audit as they do not provide a neonatal service.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

## Competent staff

**Acutely unwell patients have their needs, preferences and choices met by staff with the right skills and knowledge. However staff did not have the skills or training to competently care for CAMHS patients.**

Staff were encouraged and given opportunities to develop. Staff we spoke with spoke highly of the development opportunities available at the trust. Staff learning needs were identified through a learning needs analysis.

During our previous inspection in October 2014 we found only one nurse trained in advanced paediatric life support level (APLS) which was not in line with RCN guidelines. Evidence the trust provided us showed that only one nurse across the paediatric services was trained in APLS. Staff we spoke with said that not all shifts were covered by a APLS trained nurse. This could put

children and young people at risk because the trust was unaware of how many staff were suitably qualified.

The children and young people's service at Sandwell did not have any volunteers at the time of our inspection.

Theatre staff who covered the children's rota at Sandwell hospital had paediatric training in order to deliver effective care to children.

The trust had a policy which detailed the statutory, mandatory and risk management training needs and frequencies for staff. The trust also has a policy to detail the competencies needed for staff performing surgery on children and young people.

The children and young people's service had access to the opinion of a consultant paediatrician at all times through a rota on call system. Consultants could be called into the hospital to review patients out of hours if required. The service also ran a consultant of the week system which enabled staff to be clear on who they can contact for advice or for urgent reviews.

During our previous inspection in October 2014 we highlighted that staff did not feel confident to treat patients with mental health needs. At the time of this inspection staff did not receive any training in mental health conditions, learning disability or autism. Staff had mixed understanding of who would be responsible for providing extra observations. Some staff told us that if a patient required observations from a specialist mental health nurse then they would use an agency who specialised in mental health nurses. However other staff told us it would be whoever was available either from the children's ward or from another ward. While there was an effective working relationship with the CAMHS team the lack of staff training may mean staff may not recognise when a referral was required.

Staff who are new to the Lyndon ground have six months protected time in order to gain experience of the ward before they are rotated to D19. If October comes quicker than the six months is up then people will be rotated earlier than six months. Staff told us that this was a good initiative as it allowed them to embed into the ward before moving.

Staff we spoke with told us that they had yearly appraisals and they found them to be effective at highlighting areas for development. However, staff do not have regular one to ones.

**Trust level**

From April 2017 to December 2017, 75.7% of staff within services for children and young people at trust level received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| NHS infrastructure support | 3 | 3 | 100.0% |
| Qualified healthcare scientists | 1 | 1 | 100.0% |
| Support to ST&T staff | 29 | 31 | 93.5% |
| Support to doctors and nursing staff | 47 | 59 | 79.7% |
| Qualified nursing & health visiting staff | 113 | 157 | 72.0% |
| Medical & dental staff | 42 | 59 | 71.2% |
| Other non-medical staff | 2 | 3 | 66.7% |
| **Total** | **237** | **313** | **75.7%** |

From April 2017 to December 2017, 83.5% of staff within services for children and young people

at Sandwell General Hospital received an appraisal compared to a trust target of 100%. A breakdown by staff group is shown in the table below.

| Staff group | Appraisals completed | Appraisals required | Completion rate |
|---|---|---|---|
| NHS infrastructure support | 2 | 2 | 100.0% |
| Support to doctors and nursing staff | 39 | 44 | 88.6% |
| Qualified nursing & health visiting staff | 64 | 79 | 81.0% |
| Other non-medical staff | 1 | 2 | 50.0% |
| **Total** | **106** | **127** | **83.5%** |

The trust had a performance development review (PDR) programme known as Aspiring to Excellence PDR. Section D of the PDR contained the Future Aspirations and Personal Development Plan and encouraged individuals to discuss the aspirations and plans for next three years. This serves two purposes; purpose one to identify anyone who was looking to retire or leave their role in the next three years and purpose two to identify those employees who demonstrated high performance and potential.

To support the succession planning, those high performing and high potential employees would have access to a programme of talent management with opportunities including shadowing, exposure to meetings and forums that they previously would not have attended, coaching and mentoring and for appropriate posts, recruiting firstly within the organisation to enable employees to grow and have opportunities to stay working within the organisation.

*(Source: Routine Provider Information Request – Succession Planning)*

## Multidisciplinary working

**Necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.**

Staff described good multidisciplinary working between specialities on the wards. Records we reviewed showed that staff planned discharge in advance and that discussions were multi-disciplinary.

The trust employed two play specialists for both Sandwell and City sites. They covered all of the areas that children and young people would be seen and treated. They were not available seven days a week and staff told us that they were not always available when needed due to the number of different areas they covered.

The diabetes team did outreach into the community to follow up on children who had been discharged home to check how they were getting on.

For young people with complex health needs requiring transition to adult services, staff from the adult services would be invited to appointments with the child to aid the smooth transition.

We were told of good links with child and adolescent mental health services (CAMHS). The local CAMHS were used within the children's ward as necessary; and were provided by the local mental health trust. CAMHS staff would call the children's ward on a daily basis for verbal referrals of overnight admissions; they would then visit the ward if required. This service was available seven days per week.

There was a psychologist available to see children on the wards. Staff told us they would see patients who had been diagnosed with long term conditions, for example, diabetes.

Staff on the children's ward told us that they liaised with social services regularly but acknowledged that there were sometimes delays within social services to respond and that they would chase them when required.

**CQC Children and Young People's Survey 2016 – Q23**

In the CQC Children and Young People's Survey 2016 the trust scored 8.69 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts."

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Seven-day services

**Both inpatient wards operated a seven day service. Outpatients was run Monday to Friday.**

Lyndon ground and Lyndon 1 were open 24 hours, seven days a week. Priory ground was open 7.30am to 6pm Mondays, Tuesdays, Thursdays and Fridays Outpatients was run Monday to Friday with some consultants offering ad hoc clinics on Saturdays. However at the time of our inspection Priory Ground was not open on Tuesdays due to staffing shortages.

A consultant was available seven days a week with cover out of hours provided by an on-call consultant. All children and young people were reviewed by a consultant every day.

Staff could access diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) seven days a week.

## Health promotion

**The service encourages patients to manage their own health and national priorities to improve the populations health are supported.**

People who use services were encouraged to manage their own health. Staff gave patients and families training in using equipment needed to manage their health conditions. For example, children were trained in how to manage their diabetes in a child friendly way by the diabetes and they are then followed up post discharge to check how they are getting on.

National priorities to improve the populations health were supported for patients and those close to them. During our inspection we observed staff signposting a parent to support services for help with smoking cessation. We also observed a staff member discussing with a parent a referral to an alcohol support service.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff understood consent and sought consent from children and their families. However, we did not find any evidence of capacity assessments having being completed.**

The trust had a mental capacity act policy which includes information on assessing capacity in children and young people and when staff can or cannot use the act. During the inspection we found no evidence of capacity assessments documented.

The trust had a policy for restraint, this included specific details for the restraint of children. This policy was in line with national guidelines and suggests de-escalation techniques. No staff on the ward are trained in restraint or de-escalation and said they would have to get security if a child required restraining. The service had no incidents of restraint in the year before our inspection.

Staff we spoke with confirmed that a child's or their parent's consent would be appropriately sought before any procedures or tests being undertaken. For day case surgery consent would have to have been initially given before the day of the surgery and confirmed on the day or the surgery would be cancelled.

Parents were involved in decisions and discussions relating to their child's care. Parents and carers told us that they had been involved in decisions relating to the treatment offered.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust has reported that Mental Capacity Act and Deprivation of Liberty Safeguards training is included within safeguarding training. Therefore, the following section is a repetition of the safeguarding training data presented above.

The trust set a target of 95% for the completion of safeguarding training.

**Nursing staff**

A breakdown of compliance for safeguarding training courses as at July 2018 for qualified nursing staff in services for children and young people at Sandwell General Hospital is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 1 | 65 | 65 | 100.0% | 95% | Yes |
| Safeguarding children level 1 | 65 | 65 | 100.0% | 95% | Yes |
| Safeguarding children level 3 | 56 | 65 | 86.2% | 95% | No |
| Safeguarding adults level 2 | 5 | 6 | 83.3% | 95% | No |

In services for children and young people at Sandwell General Hospital, the 95% completion target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible, with both courses achieving a 100% completion rate. The safeguarding adults level 2 course had the lowest completion rate, at 83.3%, however this equated to only one of the six eligible staff members not having completed this module.

**Medical and dental staff**

The trust did not provide any mandatory training data for medical staff working in services for children and young people specifically at Sandwell Hospital. All the staff were included in the 'other' site category, indicating that they worked across multiple sites. The analysis of this data can be found in the trust level analysis section shown above.

A breakdown of compliance for safeguarding training courses as at July 2018 at trust level for medical and dental staff in services for children and young people is shown below:

| Name of course | Staff trained | Eligible staff | Completion rate | Trust Target | Met (Yes/No) |
|---|---|---|---|---|---|
| Safeguarding adults level 2 | 2 | 2 | 100.0% | 95% | Yes |
| Safeguarding adults level 1 | 53 | 54 | 98.1% | 95% | Yes |
| Safeguarding children level 1 | 53 | 54 | 98.1% | 95% | Yes |
| Safeguarding children level 3 | 19 | 22 | 86.4% | 95% | No |
| Safeguarding children level 2 | 26 | 32 | 81.3% | 95% | No |

In services for children and young people trust-wide, the 95% completion target was met for three of the five safeguarding training modules for which medical and dental staff were eligible. The safeguarding adults level 2 module achieved a 100% completion rate; however, this was based on only two eligible members of medical staff. The safeguarding children level 2 module had the lowest completion rate, at 81.3%.

The medical staff were not assigned to a specific site but rather to an 'other' site category, indicating that they worked across multiple sites.

**Other CQC Survey Data**

**CQC Children and Young People's Survey 2016 Data**

The trust performed about the same as other trusts for four questions relating to effectiveness in the CQC Children and Young People's Survey 2016. No score was available in relation to question 54 'Did hospital staff play with you or do any activities with you while you were in hospital?'

**CQC Children's Survey questions, effective domain, Sandwell and West Birmingham Hospitals NHS Trust**

| Question Number | Question | Age group | Trust score | RAG |
|---|---|---|---|---|
| 21 | Did you feel that staff looking after your child knew how to care for their individual or special needs? | 0-15 adults | 8.32 | About the same as other trusts |
| 9 | Did staff play with your child at all while they were in hospital? | 0-7 adults | 6.92 | About the same as other trusts |
| 19 | Did different staff give you conflicting information? | 0-7 adults | 7.21 | About the same as other trusts |
| 33 | During any operations or procedures, did staff play with your child or do anything to distract them? | 0-15 adults | 7.20 | About the same as other trusts |
| 54 | Did hospital staff play with you or do any activities with you while you were in hospital? | 8-15 children | No Score | No Score |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Is the service caring?

### Compassionate care

**Staff understand and respect the personal, cultural, social and religious needs of people and take these into account in the way they deliver care.**

During the inspection we observed staff taking the time to interact with people using the service and those close to them in a respectful and considerate way. Staff spoke to patients at a level that was appropriate for their development.

Patients and family we spoke with all highlighted the compassionate care provided by staff. We were told that staff took time to explain care and treatment and were approachable to speak with should family members have any questions.

Parents told us, and we saw, that privacy and dignity was maintained during outpatient appointments and inpatient consultations. Staff asked before entering private areas and respected patients' needs.

### CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

| Question Number | Question | Age group | Trust score | RAG |
|---|---|---|---|---|
| 10 | Did new members of staff treating your child introduce themselves? | 0-7 adults | 8.26 | About the same as other trusts |
| 14 | Did you have confidence and trust in the members of staff treating your child? | 0-15 adults | 8.51 | About the same as other trusts |
| 22 | Were members of staff available when your child needed attention? | 0-15 adults | 8.02 | About the same as other trusts |
| 42 | Do you feel that the people looking after your child were friendly? | 0-7 adults | 8.91 | About the same as other trusts |
| 43 | Do you feel that your child was well looked after by the hospital staff? | 0-7 adults | 8.90 | About the same as other trusts |
| 44 | Do you feel that you (the parent/carer) were well looked after by hospital staff? | 0-15 adults | 7.68 | About the same as other trusts |
| 58 | Was it quiet enough for you to sleep when needed in the hospital? | 8-15 children | 7.15 | About the same as other trusts |
| 64 | If you had any worries, did a member of staff talk with you about them? | 8-15 children | 8.14 | About the same as other trusts |
| 74 | Do you feel that the people looking after you were friendly? | 8-15 children | 9.26 | About the same as other trusts |
| 75 | Overall, how well do you think you were looked after in hospital? | 8-15 children | 8.60 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Emotional support

**Patients, their families and carers were given emotional support during their hospital admission.**

Parents we spoke with told us they felt confident leaving the ward and their child's care with the staff on the ward.

Psychological services were involved with supporting children and young people on the wards. They were used to support children and young people with long term conditions.

Staff were aware of the trusts bereavement team and told us they would refer families to them when required.

Play specialists were available to provide distraction therapy for children on the ward. Staff we spoke with told us how valuable they were.

Internet access was not available for children and young people to keep in touch with family and friends when in hospital for long periods of time.

**CQC Children and Young People's Survey 2016**

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People's Survey 2016.

**CQC Children and Young People's Survey 2016 questions, emotional support, Sandwell and West Birmingham Hospitals NHS Trust**

| Question Number | Question | Age group | Trust score | RAG |
|---|---|---|---|---|
| 7 | Was your child given enough privacy when receiving care and treatment? | 0-7 adults | 9.09 | About the same as other trusts |
| 29 | If your child felt pain while they were at the hospital, do you think staff did everything they could to help them? | 0-15 adults | 7.92 | About the same as other trusts |
| 45 | Were you treated with dignity and respect by the people looking after your child? | 0-7 adults | 9.00 | About the same as other trusts |
| 65 | Were you given enough privacy when you were receiving care and treatment? | 8-15 children | 9.04 | About the same as other trusts |
| 67 | If you felt pain while you were at the hospital, do you think staff did everything they could to help you? | 8-15 children | 8.40 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

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

**Staff communicated with people so that they understand their care, treatment and condition and any advice given.**

Children, young people and their families were given the opportunity to speak with staff, to ask questions and were kept informed of what was happening.

Interpreters were available to aid communication with people who spoke a different language to staff on the ward. Staff told us that they can also request people who can translate to British sign language. Information leaflets were available on the staff intranet in a variety of languages.

Staff involved people who use services and their families in making decisions about their care. Parents told us they felt listened to during their period of care. During the inspection we saw where staff had supported parents to get their child discharged home.

### CQC Children and Young People's Survey 2016

The trust performed worse than other trusts for one question and about the same as other trusts for 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016. No score was available in relation to question 66 'If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?'

### CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Sandwell and West Birmingham Hospitals NHS Trust

| Question Number | Question | Age group | Trust score | RAG |
|---|---|---|---|---|
| 11 | Did members of staff treating your child give you information about their care and treatment in a way that you could understand? | 0-15 adults | 9.06 | About the same as other trusts |
| 12 | Did members of staff treating your child communicate with them in a way that your child could understand? | 0-7 adults | 7.06 | Worse than other trusts |
| 13 | Did a member of staff agree a plan for your child's care with you? | 0-15 adults | 9.10 | About the same as other trusts |
| 15 | Did staff involve you in decisions about your child's care and treatment? | 0-15 adults | 8.51 | About the same as other trusts |
| 16 | Were you given enough information to be involved in decisions about your child's care and treatment? | 0-15 adults | 8.60 | About the same as other trusts |
| 17 | Did hospital staff keep you informed about what was happening whilst your child was in hospital? | 0-15 adults | 8.37 | About the same as other trusts |
| 18 | Were you able to ask staff any questions you had about your child's care? | 0-15 adults | 8.77 | About the same as other trusts |
| 31 | Before your child had any operations or procedures did a member of staff explain to you what would be done? | 0-15 adults | 9.34 | About the same as other trusts |
| 32 | Before the operations or procedures, did a member of staff answer your questions in a way you could understand? | 0-15 adults | 9.28 | About the same as other trusts |
| 34 | Afterwards, did staff explain to you how the operations or procedures had gone? | 0-15 adults | 9.12 | About the same as other trusts |
| 39 | When you left hospital, did you know what was going to happen next with your child's care? | 0-15 adults | 8.23 | About the same as other trusts |
| 41 | Do you feel that the people looking after your child listened to you? | 0-7 adults | 8.58 | About the same as other trusts |
| 59 | Did hospital staff talk with you about how they were going to care for you? | 8-15 children | 8.91 | About the same as other trusts |
| 60 | When the hospital staff spoke with you, did you understand what they said? | 8-15 children | 8.78 | About the same as other trusts |
| 61 | Did you feel able to ask staff questions? | 8-15 children | 9.03 | About the same as other trusts |

| | | | | |
|---|---|---|---|---|
| 62 | Did the hospital staff answer your questions? | 8-15 children | 9.79 | About the same as other trusts |
| 63 | Were you involved in decisions about your care and treatment? | 8-15 children | 6.55 | About the same as other trusts |
| 66 | If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there? | 12-15 children | No Score | No Score |
| 69 | Before the operations or procedures, did hospital staff explain to you what would be done? | 8-15 children | 9.75 | About the same as other trusts |
| 70 | Afterwards, did staff explain to you how the operations or procedures had gone? | 8-15 children | 8.81 | About the same as other trusts |
| 72 | When you left hospital, did you know what was going to happen next with your care? | 8-15 children | 7.77 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.
0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12-15 children = asked of children aged from 12 to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

# Is the service responsive?

## Service delivery to meet the needs of local people

**The environment was designed to meet the needs of the people who used it.**

The wards had single rooms available for teenagers and the ward environment was configured in such a way that adolescents had separate sleeping areas than young children. There was also space in the adolescent area outside of the rooms for relaxing and socialising. However due to demand on services, babies could be cared for in areas with adolescent rooms.

The children's outpatient department provided a supportive age appropriate environment offering a range of activities for children and young people to access while they waiting for their appointment.

The service has not had any engagement or involvement of children and young people and their families in the design and running of the service.

Lyndon ground has an adolescent area in which children who are 16-18 years old can be seen and treated. Young people who are 16 to 18 years old and their families are given the choice whether they are seen in the adolescent area or on adult wards.

One parent is permitted to stay overnight with children and young people next to the patients bed in a fold down bed or reclining chair. Both Lyndon 1 and Lyndon Ground each have a family room with a kitchen and seating for families. Families are given breakfast on the ward and have to purchase or bring in their own lunch and dinner. Drinks making facilities are also in the family room.

The service had magnetic stickers for use above the beds to act as a reminder to aid the delivery of care to patients, for example the sticker symbolise nil by mouth, risk of falls, vulnerable adults amongst other things.

Sandwell hospital was the regional allergy centre and had a specialist allergy team who treated patients from the region.

**CQC Children and Young People's Survey 2016**

The trust performed about the same as other trusts for all 17 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

**CQC Children and Young People's Survey 2016 questions, responsive domain, Sandwell and West Birmingham Hospitals NHS Trust**

| Question Number | Question | Age group | Trust score | RAG |
|---|---|---|---|---|
| 4 | For most of their stay in hospital what type of ward did your child stay on? | 0-15 adults | 9.83 | About the same as other trusts |
| 5 | Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs? | 0-15 adults | 8.45 | About the same as other trusts |
| 25 | Did you have access to hot drinks facilities in the hospital? | 0-15 adults | 8.08 | About the same as other trusts |
| 26 | Were you able to prepare food in the hospital if you wanted to? | 0-15 adults | 3.68 | About the same as other trusts |
| 28 | How would you rate the facilities for parents or carers staying overnight? | 0-15 adults | 7.22 | About the same as other trusts |
| 55 | Was the ward suitable for someone of your age? | 12-15 children | 7.65 | About the same as other trusts |
| 8 | Were there enough things for your child to do in the hospital? | 0-7 adults | 7.02 | About the same as other trusts |
| 24 | Did your child like the hospital food provided? | 0-7 adults | 5.98 | About the same as other trusts |
| 37 | Did a staff member give you advice about caring for your child after you went home? | 0-15 adults | 8.38 | About the same as other trusts |
| 38 | Did a member of staff tell you who to talk to if you were worried about your child when you got home? | 0-7 adults | 8.06 | About the same as other trusts |
| 40 | Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you? | 0-15 adults | 7.79 | About the same as other trusts |
| 56 | Were there enough things for you to do in the hospital? | 8-15 children | 6.14 | About the same as other trusts |
| 57 | Did you like the hospital food? | 8-15 children | 7.76 | About the same as other trusts |
| 71 | Did a member of staff tell you who to talk to if you were worried about anything when you got home? | 8-15 children | 7.76 | About the same as other trusts |
| 73 | Did a member of staff give you advice on how to look after yourself after you went home? | 8-15 children | 8.13 | About the same as other trusts |
| 2 | Did the hospital give you a choice of admission dates? | 0-7 adults | 3.10 | About the same as other trusts |
| 3 | Did the hospital change your child's admission date at all? | 0-7 adults | 9.54 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age.

0-15 adults = asked of parents and carers of children up to 15 years of age.
8-15 children = asked of children aged from eight to 15 years of age.
12 to 15 children = asked of children aged from 12 to 15 years of age.

*(Source: CQC Children and Young People's Survey 2016, RCPCH)*

## Meeting people's individual needs

**Staff within the children and young people's service were responsive to the individual needs of the patients and their families and carers. However, staff were not trained to support children or young people with mental health needs if their mental health deteriorated.**

During our previous inspection of the service in October 2014 we found there was no formal agreement with the local children and adolescent mental health services. This continued to be the case during this inspection, however there were good links in place with the CAMHS team.

Children with mental health needs or children awaiting a bed in a mental health unit could be cared for on the ward. Staff told us that they did not have any training in caring for people with a mental health condition, learning disability or autism. Staff told us that if a child required extra observations from staff then this would be delivered by a HCA or nurse on the ward or from elsewhere in the hospital. This could put the child at extra risk by not having someone who is suitably experienced or trained to conduct their observations.

A variety of equipment was available on the children's ward including beds and cots in a variety of sizes, and different chairs including those that converted to beds for parents wishing to stay with their child.

All wards and the outpatients department was accessible for people using a wheelchair. There was equipment on the ward available for assisting with moving and handling of patients when required.

We spoke with, and observed the play specialist working with children and young people. The trust did not have a multisensory room; however they did have multisensory toys available for children with a variety of cognitive and physical disabilities. The play team have access to a range of toys however due to the lack of play hours they could not always be available for all children.

There was a large variety of play equipment available to accommodate a variety of ages and needs in both inpatient and outpatient areas. Toys could be provided at the bedside as well as games and books.

Transitional arrangements were in place for adolescents. Staff told us they were especially proud of their young people's diabetes service, allergy management and the way acutely ill children were cared for. Staff told us that when young people were 15 or 16 staff from adult services would attend appointments to facilitate the smooth transfer to adult services.

Staff described how they could arrange translation services for patients whose first language was not English. Staff also told us how they could access information leaflets on the intranet in languages other than English if required.

## Access and flow

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

The admitting pathway through the children and young people's service was through the paediatric assessment unit located in Lyndon Ground. Children can be referred in through accident and emergency at the hospital, through outpatient appointments or through their GPs. If children need admitting they are admitted to either Lyndon 1 or the adolescent area on Lyndon Ground. There is access to next day clinics in outpatient should patients require them.

Surgery and outpatient clinics are rarely cancelled with less than 24 hours notice. Surgery has only been cancelled twice from June to September 2018 with less than 24 hours notice on the Sandwell site. Four clinics have been cancelled with less than 24 hours notice between June to September 2018.

The trust monitors the number of did not attend figures and collects data on the outcome. There are three possible outcomes, discharged, another appointment given or appointment to be made at a later date. The trust has a patient access policy, it states that adults do not attend are discharged from the service back to their GP but children who do not attend are reviewed on a case by case basis. The number of did not attend figures for June to September can be found below:

| Month | Sandwell |
|---|---|
| Jun-18 | 319 |
| Jul-18 | 427 |
| Aug-18 | 365 |
| Sep-18 | 187 |
| **Total** | **1298** |

*(Source- DR631)*

Most children admitted to the paediatric department with an acute medical problem were seen by a healthcare professional on the tier two (middle grade) paediatric rota within four hours of admission. In June 78% of children were reviewed by a registrar, 95% in July and 95% in August. This is in line with Facing the Future standards 2015.

Every child who is admitted to a paediatric department with an acute medical problem was not seen by a consultant paediatrician within 14 hours of admission. This is not in line with Facing the Future standards 2015.

Staff told us they have to overbook their outpatient clinics in order to fit all the required patients in due to staff shortages, clinical need and lack of availability of adequate numbers of follow up appointment slots.

The ward reduced and increased bed stock in summer and winter to support the needs of children. During periods of increased admissions or staff shortages the service could move patients or staff to ensure children and young people were cared for in a safe environment. Over the past 12 months the wards have not closed to any admissions.

Children aged 16-18 have the choice of the adolescent ward area or to be in an adult ward in a different part of the hospital. The expectations are explained to children and their families so they can make an informed decision.

The service promoted an app for patients' phones for management of diabetes to enable them to manage their diabetes. Staff told us how this was a benefit to children because it facilitated them to be able to manage their condition whilst also eating out.

Not all patients received treatment within the 18 weeks referral to treatment time. The average maximum wait for services was 27.1 weeks. All speciality data can be found in the table below:

The table below shows the referral to treatment time:

| Speciality | Minimum RTT | Maximum RTT | Average RTT |
|---|---|---|---|
| Anaesthetics | 1 | 1 | 1 |
| Chemical Pathology | 0 | 21 | 10.7 |
| Dermatology | 0 | 20 | 8.43 |
| Endocrinology | 8 | 8 | 8 |
| ENT | 0 | 46 | 11.19 |
| Gastroenterology | 1 | 16 | 8.28 |
| General Medicine | 0 | 41 | 7.71 |
| General Surgery | 0 | 48 | 5.08 |
| Gynaecology | 0 | 12 | 4.16 |
| Haematology (Clinical) | 0 | 37 | 15.03 |
| Immune pathology | 0 | 30 | 8.55 |
| Medical Oncology | 4 | 4 | 4 |
| Neurology- Acute | 10 | 10 | 10 |
| Ophthalmology | 0 | 31 | 8.77 |
| Oral Surgery | 0 | 21 | 0.58 |
| Paediatric Cardiology | 20 | 31 | 26.17 |
| Paediatric Neuro-disability | 0 | 46 | 10.46 |
| Paediatric Neurology | 0 | 25 | 9.24 |
| Paediatric surgery | 1 | 22 | 8.87 |
| Paediatrics | 0 | 43 | 6.4 |
| Pain Management | 7 | 9 | 7.67 |
| Plastic surgery | 0 | 52 | 13.73 |
| Radiology | 0 | 3 | 1.25 |
| Respiratory medicine | 0 | 40 | 8.48 |
| Rheumatology | 0 | 14 | 7.53 |
| Trauma and orthopaedics | 0 | 42 | 3.29 |
| Urology | 0 | 45 | 13.96 |
| Urology-paediatric | 2 | 41 | 17.37 |
| Average: | 1.9 | 27.1 | 8.8 |

*(Source- DR528)*

## Learning from complaints and concerns

**Complaints were handled in a timely and sensitive manner.**

Staff told us how they recognised when a parent or visitor was unhappy with care provided, and made effort to manage these situations promptly. Staff and patients we spoke with were aware of the complaints procedures to follow within the trust. However, staff were not aware how they

routinely received learning from complaints. The trust also has a purple phone system where members of the public can use one of the phones situated around the hospital to raise matters of concern with the trust.

We reviewed the trusts response to five complaints relating to children and young people's services at Sandwell Hospital. They all communicated in a sensitive way how the complaint had been investigated, the outcome of the complaint and any learning that had been put in place following the complaint. However, there was no formal process for learning from complaints to be fed back to staff.

There is a child friendly inpatient survey in a way that is accessible to younger children through a smiley face scale and tick boxes. These were available on all of the wards. The unit also conducts the 'Friends and Family' test.

From April 2017 to March 2018, there were 16 complaints about services for children and young people at Sandwell General Hospital. The hospital took an average of 29.5 days to investigate and close complaints. This is in line with their complaints policy, which states all complaints should be investigated and closed within 30 days.

Staff told us how they recognised when a parent or visitor was unhappy with care provided, and made effort to manage these situations promptly. Staff we spoke with were aware of the complaints procedures to follow within the trust.

The table below shows the complaints broken down by subject:

| Subject of complaint | Number | Percentage |
|---|---|---|
| Integrated care (including delayed discharge due to the absence of a care package) | 8 | 50.0% |
| Patient care | 2 | 12.5% |
| Staff values & behaviours | 2 | 12.5% |
| Privacy, dignity & well being | 1 | 6.3% |
| Appointments | 1 | 6.3% |
| Admissions and discharges (excluding delayed discharge due to absence of care package) | 1 | 6.3% |
| Access to treatment or drugs | 1 | 6.3% |
| Total | 16 | 100% |

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

**Number of compliments made to the trust**

From January to June 2018, there were no compliments recorded for services for children and young people at the trust.

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

# Is the service well-led?

## Leadership

**Leaders did not have protected time to carry out their managerial duties. However, ward managers were visible and approachable.**

We saw ward managers of the children and young people's service were visible and approachable to staff. During the inspection, we spoke to variety of staff of different grades. All told us they felt confident to raise issues and concerns with their direct line managers and local leadership team.

At the time of our inspection there was an acting ward manager in post on Lyndon one who was being supported by the matron to develop in this role**.** Leaders told us they felt, at times, unsupported by their managers. Ward managers did not have protected time assigned to their managerial duties and as a result struggled to complete their managerial duties.

The trust holds monthly quality improvement half days, this is an afternoon a month where staff from across paediatrics meet to discuss a variety of topics. This was held on the Sandwell site which meant that staff from the wards could rotate in and out for the afternoon. Outpatient clinics and routine operations were not booked for this time to allow maximum staff to attend. Staff told us they were required to attend a minimum of two meetings a year and could choose which ones they attended based on the topics available. However, staff we spoke with were not always aware about ward team meetings or when they had last attended one.

## Vision and strategy

**There was no children's strategy at the time of our inspection and inadequate support for business planning.**

Trust vision is to become renowned as the best integrated care organisation in the NHS. The trust had nine values they described as care standard promises to; "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". During the inspection we observed staff displaying these values.

During our previous inspection in October 2014 we found there was no children's strategy. During this inspection we asked staff if there was a strategy. No staff we interviewed could tell us about the strategy whilst we were on site. Leaders, when interviewed, could not provide an overview of the strategy. Following the inspection, we requested a copy of the trusts children's strategy, the trust did not submit this.

The service demonstrated a lack of support for business planning. Staff told us how they had previously put in a business case for consultants to be on site until 10pm at night and this had not been approved. They were in the process of making another application.

## Culture

**Staff wellbeing was a concern due to staff shortages. Staff worked excessive hours and when they had physical ailments. However, ward staff worked effectively as a team and felt supported by their ward managers.**

During our previous inspection of the children and young people's service in October 2014 we found low staff morale. During this inspection due to the shortage of staff there were staff wellbeing concerns and the team culture was to cope and be resilient. However, it was strongly felt

that the situation was not sustainable and staff raised concerns about the services ability to cope during winter.

Staff told us about, and we saw, effective teamwork within areas which focussed upon children and young people. We observed a supportive environment whereby staff of all grades aided each other to care for patients. We were told about more senior nursing staff regularly providing clinical care to cover staff shortages.

Staff we spoke with told us they felt supported, respected and valued by their ward managers. Some staff did not feel supported by management above ward manager level. Staff working on the wards all described how committed they were to the teams they worked with, they all gave examples of working extra shifts to cover gaps in the rota. Staff welfare was not a priority with staff working excessive hours and staff told us they continued to work when they had physical ailments.

Staff across Lyndon ground and D19 at City hospital worked cross site. Staff in outpatients and Priory ground also worked in outpatients and D6 at City hospital. Staff all described how they worked across wards and sites when needed to cover for staffing shortages.

## Governance

**The service has a clear governance structure for paediatrics.**

The trust holds a monthly children and young people's board. This board was established to provide assurance regarding services across the trust provided to patient below the age of 18. These meetings were minuted and were attended by the heads of service.

The children and young people's service at the trust partook in monthly paediatric risk meetings and a separate clinical effectiveness meeting attended by the speciality leads. This then feeds into the directorate risk and governance meeting which is held monthly. This then feeds information up through the governance structure to the board.

The children and young people's service also had a monthly safeguarding meeting in which has standard agenda items to discuss maternity service, health visiting service, paediatric service, serious case reviews, domestic violence update, safeguarding children training, prevent, quality assurance and performance and audits. We reviewed three sets of minutes the paediatric service didn't provide any updates during any of the meetings.

The paediatric service did not hold separate mortality and morbidity meetings to discuss patient deaths. However, we saw a trust wide learning from deaths committee was in place. This committee discussed deaths across the trust and had action points to be completed with clear review dates documented. In addition, paediatric and neonatal deaths were clearly discussed and documented within clinical governance meetings. The service had a child death lead paediatric consultant who convened learning investigation meetings in the event of a child death or incidence of morbidity.

Staff we spoke with could not tell us if there was an Executive or NED lead for the service. This meant staff were not aware of board oversight of the monitoring of quality and safety in the service.

## Management of risk, issues and performance

**The trusts risk register was not complete and we could not be assured what actions were being taken to mitigate risks.**

The trust had a performance and capability policy in place which detailed how to manage poor or variable staff performance. Leaders could tell us a number of ways that poor staff performance could be highlighted and the steps that would be taken in order to address this.

We saw the trust risk register for paediatrics. It contained 32 risks relating to Lyndon ground, Lyndon 1, paediatrics, paediatric outpatients, D19 and Priory Ground. The risk register did not contain any dates for when the risks were added and there were dates missing for the target date and next review date. This meant that the trust would not be aware of how long risks had been on the risk register or when the risks would need to be reviewed. There was only one risk out of 27 that had a review date of in the future from when the risk register was provided to us, this meant that we were not assured risks were being reviewed and updated. The risk register did not always contain information on the risk, action details of who was responsible for the risk. This meant that we could not be assured that appropriate actions were being taken to mitigate the risks.

Staff we spoke to were aware of the risks to the service, however they were not always aware if the risks for the service were on the risk register.

We saw the overall trust risk register. This contained the risk in relation to Lyndon Ground on it.

There were two risks rated as red which is the highest risk category:

| Department | Title |
|---|---|
| Not completed therefore unknown. | Potential risk to patient safety and clinical care due to gaps in middle grade rota, and subsequent effect on consultant workload following stepping down and the effect this has on quality of care, e.g. cancellation of clinics. |
| Lyndon ground | Children-Young people with mental health conditions are being admitted to the paediatric ward due to lack of Tier 4 bed facilities. Therefore, therapeutic care is compromised and there can be an impact on other children and parents. |

*(Source: Trust data: DR504)*

The trust operated on a summer and winter bed capacity plan. The summer operated from April to September and winter from October to March. The wards had more beds open in winter to meet the increase in demand. However, staff told us they felt that October was too late to open the extra beds and that the demand increased in September due to children going back to school. The trust had an escalation policy that directed staff to the process to follow in the event of an increase in activity. This included increasing capacity by opening additional beds, with increased staffing and approval at executive level.

## Information management

**Ward management were responsible for cascading information upwards to the trust management team and downwards to the clinicians and other staff on the front line.**

The children and young people's service did not complete the information boards outside of the ward areas. These boards should have staffing figures, hand hygiene audit results and friends and family test result. These provided patients and visitors with an overview of the ward.

An electronic patient safety reporting system was in place to ensure that incidents were escalated to and reviewed by appropriate clinicians and managers ensuring that incidents were followed up and feedback sent to the reporter.

Computer stations were available so that staff could access the intranet and internet on the children and young people's wards. Staff we spoke with said there were issues with the information technology (IT) policies blocking their access to the internet. This meant they could not always access work-related tools such as the child sexual exploitation screening tool. They had raised this with the IT department but it had yet to be resolved.

We saw staff treating patient identifiable information in line with General Data Protection Regulations (GDPR). Patient identifiable information was stored securely in locked trolled in the outpatients and ward areas.

## Engagement

**There was minimal engagement with patients, their families or carers.**

Leaders could not identify any formal engagement methods with patients or their families and carers. They identified this as an area that they needed to focus on in the future. We were told that in the past there had been a session with matron and clinical director in the play areas on the ward but this was not taking place at the time of our inspection.

The service collected patient and family feedback using the paper feedback forms which were child and young people friendly. Staff told us how they had listened to the feedback and had redecorated the play areas on the wards as a result.

Staff told us they did not feel actively involved in change in the organisation. For example, they were aware of the new electronic patient record system however were awaiting the revised implementation date which was not yet available across the Trust. Team meetings were not occurring regularly or at all and said they did not have access to minutes.

## Learning, continuous improvement and innovation

**The trust held Quality Improvement Half Days where learning was shared. The diabetes team had developed an innovative diabetes bag for children being discharged from the service home.**

The trust had a monthly half day where all elective activity was cancelled to provide clinical teams with protected learning time. These were known as Quality Improvement Half Days (QIHD). Each month there was a shared learning topic which all teams have to view and discuss, with some specific questions posed. Staff were required to attend two meetings a year.

Staff working within the diabetes team had developed a diabetes bag. These were bags given to children with diabetes before discharge. They contained information suitable for a variety of ages, equipment to manage their condition and a teddy which they could practice injecting on.

The trust did not demonstrate significant improvements made following the previous inspection in October 2014. The trust had not improved on a number of concerns we previously raised such as nurse staffing, staff training and medicines management.

# Trust Wide Well-led

## Evidence appendix

Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B71 4HJ

Tel: 0121 553 1831
www.swbh.nhs.uk

Date of inspection visit:
4 to September 2018

Date of publication:
5 April 2019

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

## Facts and data about this trust

**Acute hospital sites at the trust**

A list of the acute hospitals at the trust is below.

| Name of acute hospital site | Address | Details of any specialist services provided at the site |
|---|---|---|
| City Hospital | Dudley Road, Birmingham, B18 7QH | • Assessment or medical treatment for persons detained under the 1983 Act<br>• Diagnostic and screening procedures<br>• Family planning services |

| | | |
|---|---|---|
| | | • Maternity and midwifery services<br>• Nursing care<br>• Personal care<br>• Services for everyone<br>• Surgical procedures<br>• Treatment of disease, disorder or injury<br>• Caring for adults under 65 years<br>• Caring for adults over 65 years |
| Halcyon Birth Centre | Oldbury Road, Smethwick, B66 1JA | • Maternity and midwifery services<br>• Caring for children (0 - 18yrs)<br>• Caring for adults under 65 years<br>• Caring for adults over 65 years |
| Rowley Regis Hospital | Moor Lane, Rowley Regis, B65 8DA | • Diagnostic and screening procedures<br>• Services for everyone<br>• Treatment of disease, disorder or injury |
| Sandwell General Hospital | Lyndon, West Bromwich, B71 4HJ | • Assessment or medical treatment for persons detained under the 1983 Act<br>• Diagnostic and screening procedures<br>• Services for everyone<br>• Surgical procedures<br>• Treatment of disease, disorder or injury<br>• Caring for adults under 65 years<br>• Caring for adults over 65 years |

*(Source: Trust Website)*

**Background to the trust**

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.

The trust also includes the Birmingham and Midland Eye Centre (BMEC) a supra-regional eye hospital, as well as the Pan-Birmingham Gynae-Cancer Centre, a Sickle Cell and Thalassaemia centre, and the regional base for the National Poisons information service, all based at the City site.

There is also a midwifery led maternity unit at the City Hospital site, named Serenity.

The Trust consists of multiple acute and community sites:

**Acute**
Sandwell General Hospital
Birmingham City Hospital
Birmingham and Midlands Eye Centre (BMEC)

**Community**
Rowley Regis Hospital
Leasowes Intermediate Care Centre

**Facts and data about the trust**

**Patient numbers**

611 beds, 62 maternity beds, 27 critical care beds as of June 18

- 5,912 staff
- Inpatient admissions 97,431
- A&E attendances 224,954 → (all figures for the period June 17 – May 2018)
- Number of deaths 1,547
- Number of deliveries 5,438

# Is this organisation well-led?

**Leadership**

**Not all leaders had the necessary experience, knowledge or capability to lead effectively. Leaders were not always visible.**

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

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

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

The trust board consisted of:

- The Chair, appointed April 2012.
- Chief Executive Officer (CEO), appointed April 2013.
- Chief Operating Officer, appointed July 2011.
- Medical Director, appointed in February 2018.
- Director of Nursing and patient support services, appointed March 2018.
- Finance Director, appointed in January 2014.
- Director of People & Organisation Development, appointed November 2015.
- Director of Governance, appointed February 2008.
- Five non-executive directors.

Since our last inspection two new appointments had been made to board. The medical director and the director of nursing and patient services had both joined the board in 2018. All board members had a development programme in place.

Both the medical director and director of nursing were well-respected and spoken of positively by staff at all levels.

We found occasions where there had been a lack of capability to influence from some directors to effect change. We were unable to establish there was robust processes in place to have oversight of patient safety and well-being. For example, we had concerns about mixed sex accommodation breaches and experienced some delay to securing assurance of a plan for sustained improvements. We also found that concerns we had raised during our previous inspection had not been addressed. These included clinical practices in line with the mental capacity act and deprivation of liberty standards and the appropriate storage of emergency resuscitation equipment.

The chair was well respected and had been with the trust since 2012.The NEDs had joined the trust at a variety of dates between 2010 to 2017 and offered a variety of relevant experience to the board. The executive and non-executive leaders were positive about the cohesiveness of trust leadership felt there was a board culture of constructive and respectful challenge. All board members could provide examples of when challenge had been well received and positive as a means of ensuring the right direction and decisions for the trust. One NED told us that they 'didn't always get it right', but that they recognised and addressed concerns well.
There were regular board development sessions and all board members spoke positively of the impact of these.

The board met monthly in both public and private. The public session covered as much detail as possible. The private session was limited to issues which were commercially sensitive only. We observed two board meetings and found they were effectively chaired. At each board meeting a patient story was presented by the patient or their relative. This gave the board insight into the experience of patients and families accessing services.

After each board meeting all Board members visited clinical and non-clinical areas on an unannounced basis. Additionally, weekend and 4am visits to clinical areas were completed. The schedule of visits was planned to cover all areas. This provided an opportunity for the board to hear from staff and patients directly. We heard some very positive messages from staff about the approachability of the executive directors. However not all staff felt that board members were visible or accessible. We heard an example from staff where board members visited departments and observed but did not interact or engage with staff to establish what was happening in the department.

Clinical leadership at the trust was provided by six clinical care groups:

- Primary Care, Community and Therapies (PCCT)
- Women's and Child Health (WCH)
- Medicine and Emergency Care (MEC)
- Surgical Services
- Pathology
- Imaging

Each clinical group was led by group director and director of operations. Group leadership teams for PCCT, WCH, MEC and Surgery also included a director of nursing. The clinical groups were responsible for 25 clinical directorates across the trust.

The Deputy Director of Finance had been acting up to the Director of Finance role for three months. Although the deputy director post had not been backfilled as this was part of succession planning, there were no other vacancies in the finance team. All senior members of the finance team were well qualified and had worked with the trust for number of years.

There was a focus on succession planning. All trust employees had an 'aspiring to excellence' performance development review. This served two purposes; to identify anyone who was looking to retire or leave their role in the next three years and to identify those employees who demonstrated high performance and potential. To support the succession planning, those high performing and high potential employees were given access to a programme of talent management with additional opportunities.

An ongoing leadership programme had been implemented which delivered five modules of training to 770 staff in the past year. The modules included: sickness management, unconscious bias, governance, financial management and performance development reviews. This was designed to be a rolling programme with additional modules being completed in subsequent years. Year two was to focus on coaching/mentoring and having difficult conversations. It was planned that the course would lead to a 'manager passport' being achieved. Staff told us of the benefit of this development for their practice.

The trust does not provide specific budget holder training but had an accredited manager's training programme which includes a financial module delivered by the Acting Director of Finance.

**Board Members**

Of the executive board members at the trust, 14% were British Minority Ethnic (BME) and 57% were female.

Of the non-executive board members 28% were BME and 42% were female.

| Staff group | BME % | Female % |
|---|---|---|
| Executive directors | 14% | 57% |
| Non-executive directors | 28% | 42% |
| All board members | 21% | 50% |

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

**Fit and Proper Persons**

**Fit and Proper Person checks were not in place.**

NHS providers must take proper steps to ensure that their executive and non-executive directors, or equivalent, are fit and proper for the role in accordance with regulation 5 of the Health and Social Care Act. This regulation ensures that directors are of good character and have the right qualifications and experiences to carry out their role.

The trust had a fit and proper persons process in place. The process involved a number of checks on appointment and subsequent ongoing checks and declarations.

We reviewed the files of three executive directors and three non-executive directors to determine if the trust had completed the necessary fit and proper person checks. Information was missing from all the six profiles we reviewed. All files had up to date annual self-declaration forms within them in line with FPPR. However, there were no associated assessment forms in line with trust policy.
We found that one of the profiles had not had a DBS check since January 2013.
There was insufficient information in any of the files to demonstrate the recruitment process was robust and five of the six profiles had no evidence of qualifications being checked. Where

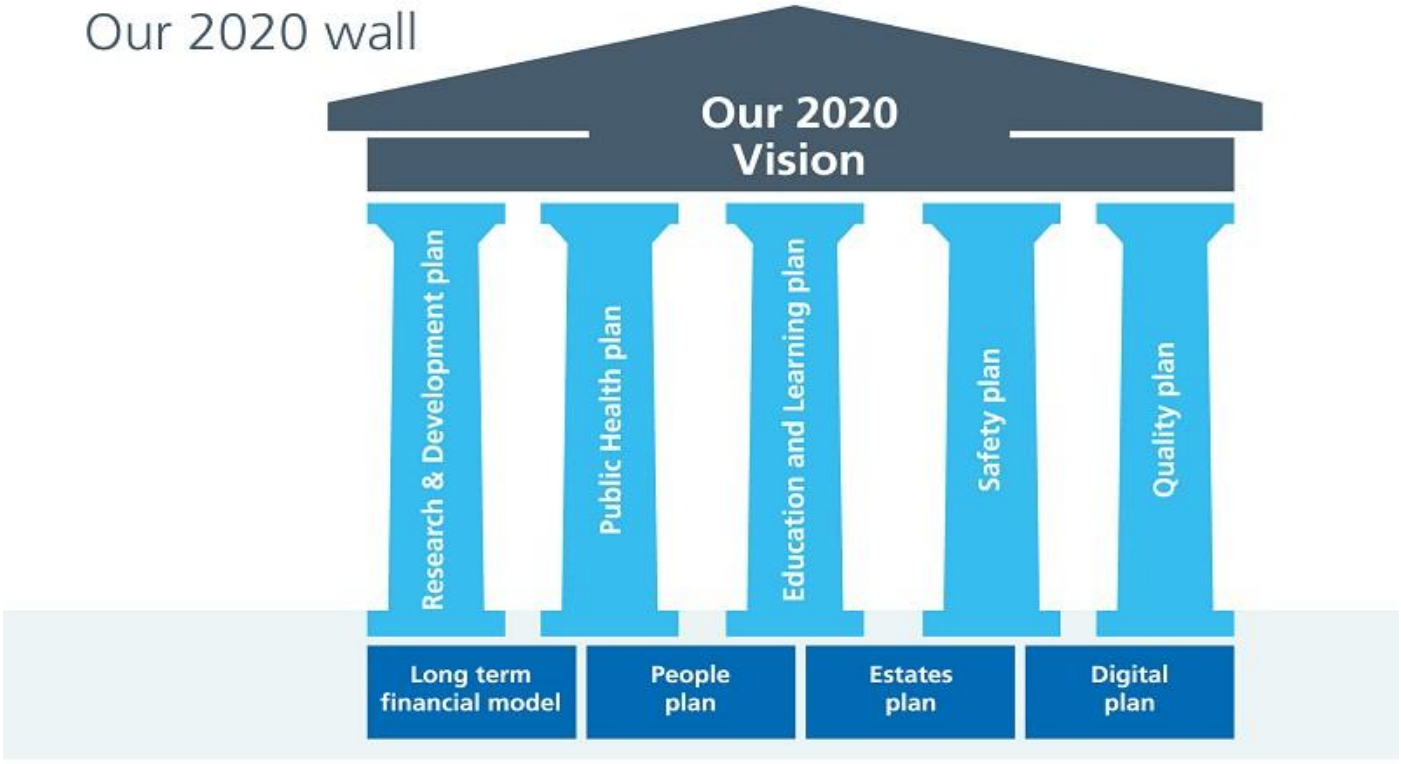
qualifications were listed on a curriculum vitae, only one profile included copies of qualification certificates.
There was no evidence of fitness checked in two of the executive files and occupational health assessments were missing in four of the six profiles.

We discussed the gaps within the director profiles with the director of governance to give them the opportunity to provide the missing information. We received some additional information for one of the staff profiles but gaps remained for the other five files. At our previous inspection in March 2017 we also found gaps and all the requirements of FPPR were not met. This had not been addressed.

## Vision and strategy

**The trust had a clear vision and strategy for what it wanted to achieve as a local systems leader and workable plans developed to turn it in to action. The vision, values and strategy had been developed in collaboration with people who used services, staff and external partners.**

The trust vision was to become renowned as the best integrated care organisation in the NHS. This was underpinned by nine key strategic plans, these are displayed below.




Each of the nine plans was well connected to the overarching strategic vision. The plans set out the approach and milestones towards delivery. It was not always clear how the trust board was assured of performance and progress against the plans.

## Values

The trust values were nine care promises, developed by staff across the organisation:

1. I will… make you feel welcome

2.I will… make time to listen to you

3.I will… be polite, courteous and respectful

4.I will… keep you informed and explain what is happening

5.I will… admit to mistakes and do all I can to put them right

6.I will… value your point of view

7.I will… be caring and kind

8.I will… keep you involved

9.I will… go the extra mile

We found that the promises were well known by staff across the trust.

The overall vision for pharmacy was to make sure that there were assurances and processes in place for the safe management of medicines. The key priorities were to get the basics right from the procurement of medicines to the patient receiving the right medicine at the right time.

The medicines optimisation strategy was aligned with the trust strategy which had been shared with the Directors of Nursing, Medicine and Governance. Feedback on progress would be undertaken through a new Medicine Management and Safety Oversight Group which would link directly into the Executive Quality Committee.

The development and implementation of a new pharmacy workforce strategy was in place to improve succession planning however although good progress was being made it was still in its early days.

There was no formal strategy in place to support the trust freedom to speak up function and we also noted that the strategy to promote the care and experiences of those with dementia was out of date.

## Culture

**Leaders did not ensure the promotion of a positive culture across the trust. Staff did not always feel supported and valued.**

Staff satisfaction was mixed and we heard inconsistent views of morale and engagement. Not all staff felt able to raise concerns. The trust had appointed Freedom to Speak Up Guardians, however they were not provided with sufficient resources and support to help staff to raise concerns. Equality and diversity was not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Some staff felt there was positive discrimination towards black and minority ethnicity (BME) staff. At group level work was ongoing to promote inclusion and representation, however further sensitive work needed to be done to ensure there was consistency across the trust.

During our inspection we held a number of focus groups across most hospital sites with staff. These included consultants, nurses, allied health professionals, heads of nursing, clinical directors and support staff. Most focus groups were poorly attended.

Staff gave mixed opinions on the openness of the culture within the trust. Whilst most staff felt they could speak up, some reported a fear to raise concerns. of bullying and harassment. We also heard examples of where concerns had been escalated and no action had been taken.

Although many staff told us they recognised the work of the leadership team to be supportive, approachable and inclusive, we also heard some examples of staff experiencing bullying and harassment. We spoke to two of the trusts equality networks, and to the Freedom to Speak Up Guardians (FTSUG). The equality networks and the FTSUG told us that black and minority ethnic (BME) staff felt singled out because of their race.

Morale among junior doctors was variable with some high-pressure areas such as medicine experiencing lower morale.

Changes had been introduced to ensure all pharmacy staff had the same core objectives with additional individual objectives. However, there was still some work to do to ensure staff were directly involved in career development discussions. Pharmacy staff appraisals were completed and up to date.

Staff Diversity

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

| Ethnic group | Medical and dental staff (% of all trust staff) | Nursing and midwifery staff (% of all trust staff) |
|---|---|---|
| White | 3.9% | 17.2% |
| Mixed | 0.3% | 1.0% |
| Asian | 5.1% | 4.8% |
| Black | 0.6% | 5.7% |
| Chinese | 0.5% | 0.1% |
| Other | 0.5% | 0.9% |
| Unknown / Not Stated | 0.5% | 1.8% |

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

The trust was proud to be in the top ten most diverse employers in the UK.

Some staff focus groups felt that those with particular protected characteristics under the Equality Act were promoted or supported more positively, so perceived they were not treated equitably.

The human resources director was aware that some staff felt staff of protected characteristics were being promoted above other staff. It was acknowledged that there was subtle branding was used to try attract staff from a BME background on some occasions. We heard of one example where we were told a staff member from a BME background was preferred for a post that was currently being advertised.

## NHS Staff Survey 2017 – results better than average of acute trusts

The trust has 13 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

| Key Finding | Trust Score | Average (median) for combined acute and community trusts |
|---|---|---|
| KF11. % appraised in last 12 months | 92 | 86 |
| KF13. Quality of non-mandatory training, learning or development | 4.07 | 4.07 |
| KF15. % satisfied with the opportunities for flexible working patterns | 52 | 51 |
| KF7. % able to contribute towards improvements at work | 73 | 70 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.91 | 3.89 |
| KF9. Effective team working | 3.75 | 3.73 |
| KF6. % reporting good communication between senior management and staff | 36 | 33 |
| KF10. Support from immediate managers | 3.78 | 3.77 |
| KF2. Staff satisfaction with the quality of work and care they are able to deliver | 3.97 | 3.91 |
| KF3. % agreeing that their role makes a difference to patients / service users | 93 | 90 |
| KF22. % experiencing physical violence from patients, relatives or the public in last 12 months | 10 | 14 |
| KF24. % reporting most recent experience of violence | 81 | 68 |

| | | |
|---|---|---|
| KF26. % experiencing harassment, bullying or abuse from staff in last 12 months | 23 | 24 |

## NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has nine key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

| Key Finding | Trust Score | Average (median) for combined acute and community trusts |
|---|---|---|
| KF12. Quality of appraisals | 2.98 | 3.10 |
| KF20. % experiencing discrimination at work in last 12 months | 15 | 10 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 79 | 85 |
| KF29. % reporting errors, near misses or incidents witnessed in last months | 86 | 91 |
| KF17. % feeling unwell due to work related stress in last 12 months | 43 | 37 |
| KF18. % attending work in last 3 months despite feeling unwell because they felt pressure | 58 | 53 |
| KF19. Organisation and management interest in and action on health and wellbeing | 3.55 | 3.62 |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.52 | 3.75 |
| KF32. Effective use of patient / service user feedback | 3.62 | 3.69 |

*(Source: NHS Staff Survey 2017)*

The overall indicator for staff engagement was just below average (a score of 3.74 out of 5) compared to trusts of a similar type.

Following the results of the survey, senior managers were asked to reflect on the findings and together with their teams discuss the actions they would take within their teams to improve engagement.

Teams were asked to consider the following questions:

1. What are your ideas for continuing to improve Sandwell and West Birmingham Hospitals NHS Trust as a place to work?
2. How can you improve on communication within your team, directorate and group?
3. How can you involve colleagues in important decisions?

There were a number of themes which emerged from the staff survey. These included:

- IT issues
- improved communication and higher management to listen to concerns and act upon them providing appropriate feedback, especially staff with patient contact
- Closer working relationships and better recognition for the work done by community services
- Making mandatory training relevant to the role
- The Quality Improvement Half Days were well received by staff and there was suggestions on how to build on these.

The trust carried out a staff survey every quarterly called 'Your Voice'. This included the staff friends and family test. Your Voice was a survey to measure staff engagement. It also asked bespoke questions each time to gauge staff opinion on topical issues.

Between 27 July and 31 August 2018 questionnaires were sent out to 7 different Team groups. Of the 6,682 questionnaires sent out in July, 1,438 responses were received so a response rate of 21.5% a slight increase on the previous quarter. The focus of questions in this survey was about knowledge and involvement in the new electronic patient record which was being introduced.

## Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

| | | | Your Trust in 2017 | Average (median) for combined acute and community trusts | Your Trust in 2016 |
|---|---|---|---|---|---|
| KF25 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | White | 24% | 26% | 26% |
| | | BME | 32% | 27% | 12% |
| KF26 | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 25% | 23% | 22% |
| | | BME | 22% | 29% | 19% |
| KF21 | Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | White | 87% | 88% | 85% |
| | | BME | 72% | 73% | 84% |
| Q17b | In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues? | White | 9% | 6% | 5% |
| | | BME | 5% | 15% | 7% |

Of the four questions above, no questions showed a statistically significant difference in score between White and BME staff.

*(Source: NHS Staff Survey 2017)*

A WRES action plan was in place. This included to increase the number of BME leaders as the current level was not representative of the local population.

The trust had three staff equality networks and plans were underway to establish a fourth. The active networks were: lesbian, gay, bisexual and trans network, disability network and black and minority ethnic (BME) network. Each network had an executive sponsor. The Director of Governance was the sponsor for disability and long-term conditions, The Director of People and OD sponsored LGBT group, and the Chief Executive was the sponsor for BME.

During the inspection we spoke with the chairs of the equality networks. We found that lesbian, gay, bisexual and trans (LGBT) staff were supported within the trust and the LGBT network felt positive steps had been taken around inclusion and equality. The trust participated in events associated with the LGBT community, for example Birmingham Pride and LGBT history month. The network did not voice any concerns about bullying or discrimination on the grounds of gender or sexuality across the trust.

The disability network told us they felt staff with a disability were supported, for example making reasonable adjustments to allow staff to continue at work. The disability network did not voice any concerns during the inspection about the inclusion of disabled staff within the trust. However, both the LGBT and disability networks felt a lack of representation amongst staff at senior levels within the organisation.

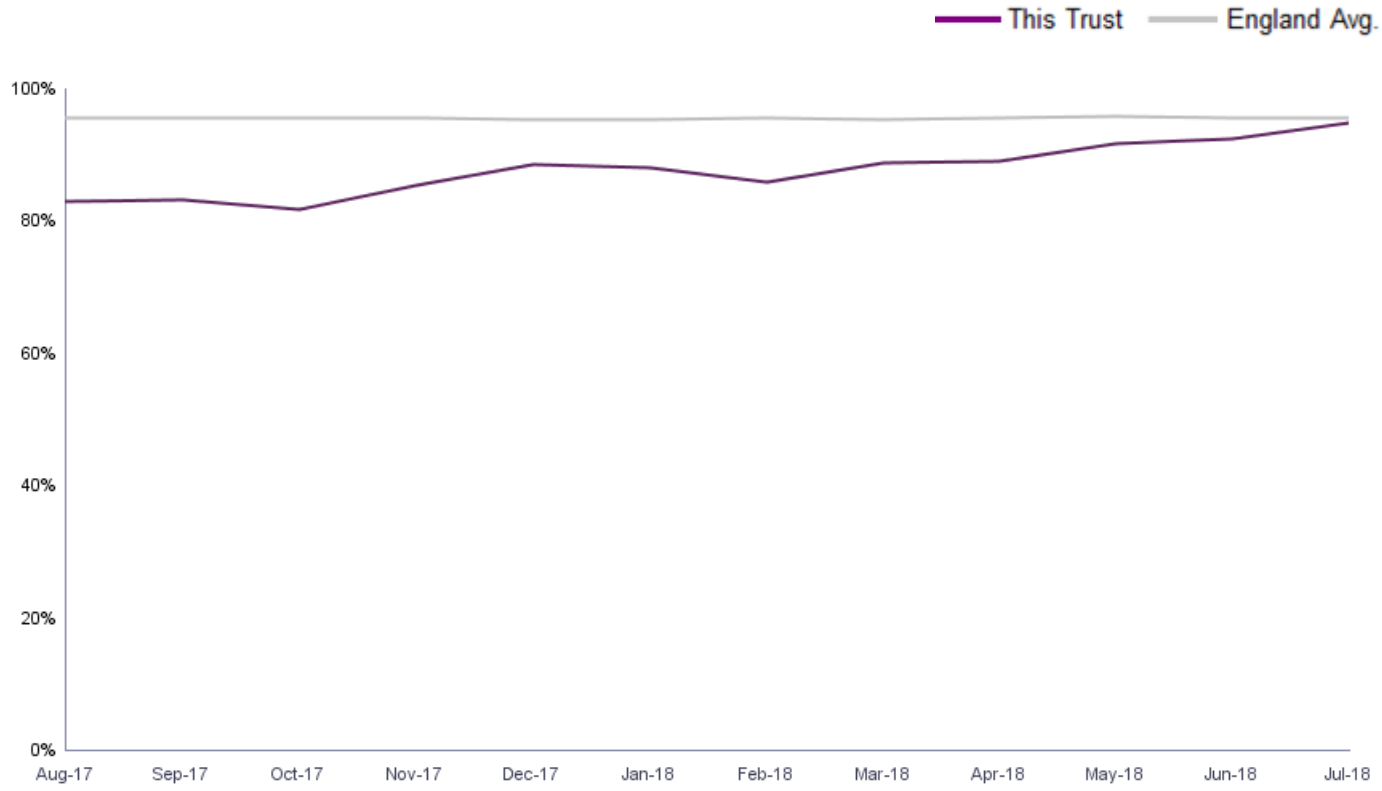
The BME network told us they felt visible across the organisation, with representation at all levels throughout the organisation. However, the BME network and the Freedom to Speak Up Guardians (FTSUG) both voiced concerns about the recruitment process currently used at the trust. The network and the FTSUG told us that all interview panels must have at least one BME interviewer on it. Although the network and the FTSUG told us this was a positive step, they both raised concerns that staff were being targeted due to their background. One member of staff told us they felt targeted and on the interview panel simply because they were from a BME background, rather than for their skills. We were told of an occasion when a senior clinician was interviewed and a non-clinical junior member of staff was on the panel because they were from a BME background; despite their skill set not being suitable to interview a senior clinician.

The equality networks and the FTSUG expressed concern that this was only extended to BME staff, rather than to ensure a member of staff who identified as a ‘minority characteristic’ (e.g. from the LGBT community, disabled or BME background) were part of the panel. The FTSUG raised concerns that staff could sign up if they wanted to be a BME interview panellist; however, staff that had not signed up were being approached due to their perceived BME status.

<u>Friends and Family test</u>

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

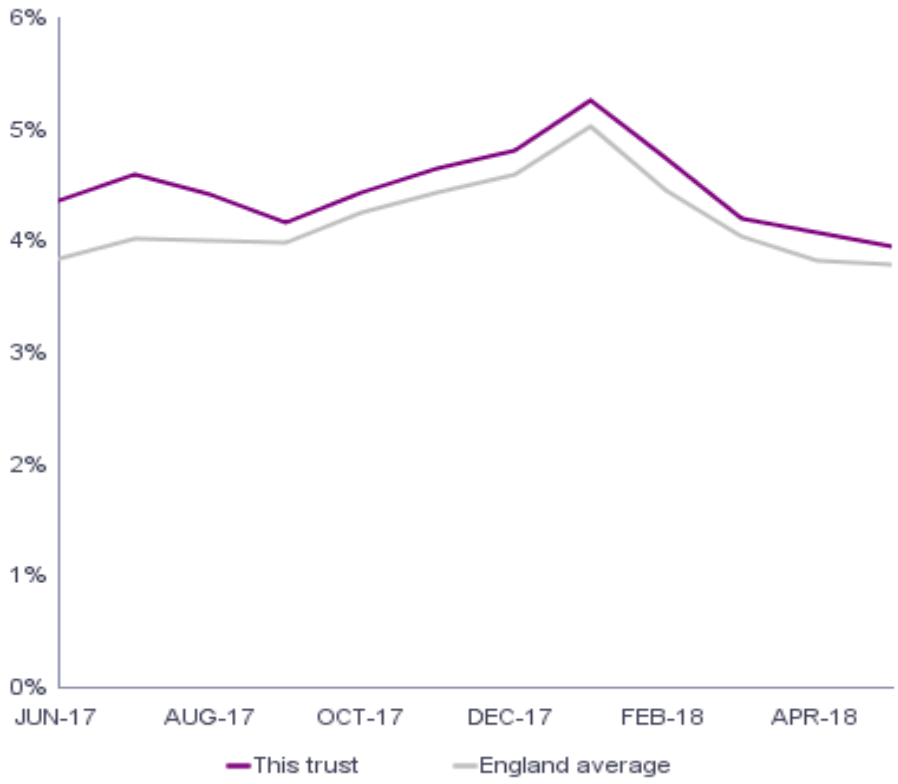
The trust scored below the England average for recommending the trust as a place to receive care from August 2017 to July 2018.




*(Source: Friends and Family Test)*

Sickness absence rates

The trust's sickness absence levels from June 2017 to May 2018 were similar to the England average.




*(Source: NHS Digital)*

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Training Scheme Survey the trust performed the same as expected for all questions.

Better than expected  Same as expected  Worse than expected

**General Medical Council – National Training Scheme Survey**

| Survey Area | This Trust |
|---|---|
| Overall satisfaction | ○ |
| Clinical Supervision | ○ |
| Clinical Supervision out of hours | ○ |
| Handover | ○ |
| Induction | ○ |
| Adequate Experience | ○ |
| Supportive environment | ○ |
| Work Load | ○ |
| Educational Supervision | ○ |
| Feedback | ○ |
| Local Teaching | ○ |
| Regional Teaching | ○ |
| Study Leave | ○ |

*(Source: General Medical Council National Training Scheme Survey)*

The trust had three guardian of safe working (GOSW). The GOSW had been introduced to protect patients and doctors by making sure doctors aren't working unsafe hours**.** The Guardian is required to produce a quarterly and an annual report to the Board in order to provide reassurance that trainees are working safely under the new contract and highlighting any safety issues, if necessary**.** In the October 2018 report there was a total of 172 exception reports. Reports for each quarter varied and there were efforts being made to improve the reporting culture.

Freedom to Speak Up Guardian

The trust had appointed Freedom to Speak Up Guardians (FTSUG) but not provided them with sufficient resources and support to help staff to raise concerns. Feedback as to the effectiveness of the freedom to speak up function was varied

The Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS in 2015, whistleblowing policy to help normalise the raising of concerns.

The trust had eight FTSUG representing different grades of staff from different departments and directorates. Two 'Speak up' days had been held and a third was planned. The aim of these was to promote openness and awareness of the role of the guardians.

We found a culture amongst the Guardians of wanting to make a difference and support staff within the trust. However, the Guardian function did not have a formal strategy in place. None of the FTSUG had protected time to undertake the role and fitted the duties associated with the role around their day jobs. The Guardians told us this made it difficult sometimes to arrange times to meet staff and discuss concerns.

The Guardians did not feel supported by the trust executive team. The Guardians told us they had infrequent meetings with a senior member of the executive team. In the past year, they have had two meetings, one with the chief executive and one with the director of governance, this does not meet national guidance. The freedom to speak up guardian's report directly to the chief executive and a report goes to the board. The last report to board was in June 2018, this was written by the trust's governance lead. The report highlights the 'tiny' number of approaches made across the year and indicates the need for a better understanding of why staff are not contacting them. The report did not include the detail of how many staff had contacted the FTSU guardians or collate any trends or themes. Therefore, there was a lost opportunity to promote learning and the board were not fully informed on the themes or concerns staff were raising.

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 reasonable support to the person.

The trust had a 'Being open following a patient safety incident policy', this was overdue for review as of December 2016 however this provided a clear steer for staff on standards and expectations.

The majority of staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. The majority of senior staff were aware of the trust's policy and their requirement to apply duty of candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when Duty of Candour processes were triggered.

We looked at four serious incident reports to see how the trust applied duty of candour. There was a serious incident which was in date. The policy referred to a number of other documents and policies, there was no links or summaries of these to enable staff easy access to information.

Lessons were sometimes embedded in the reports but not drawn out separately to enable learning and changes in practice and it was not clear what remedial actions had been taken to prevent reoccurrences. Sometimes delays were evident in reporting which did not give assurances of actions being taken to prevent further occurrence.

There were different report formats being used in different clinical teams, this did not ensure a consistency of approach across the trust.

It was not always clear in reports if feedback or opinion was sought from family members or individuals or if they had been consulted on the terms of reference for the investigations. However, staff understood their duty of candour so patients would receive full and detailed explanations if things went wrong.

## Governance

**The arrangements for governance were well established. However, we were not assured that the approach and the flow of information was always effective.** There had been a review of the arrangements in 2017. We found leaders were not always clear of how the levels of governance interacted with each other or their individual accountabilities.

The trust board met regularly and provided an opportunity for scrutiny to members of the public as well as internally. Meetings were held in two parts, the first being in public. The board then met in private to deal with confidential business, typically consisting of personal information and/or information which were commercially sensitive.

Clinical care group directors were invited to board. This was to ensure that the clinical voice was heard and also allow an opportunity for NEDs to apply scrutiny and challenge directly.

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

Quality and Safety Committee
Finance and Investment Committee
Remuneration and TCS Committee
People and OD Committee
Audit and Risk Management Committee
Public Health, Community Development and Equality Committee
Charitable Funds Committee

The clinical care groups reported to the clinical leadership executive (CLE). CLE was chaired by CEO. The interface between the sub board committees and CLE was not always clear. We were not assured that board always had oversight of key operational issues. Examples included that board had not been made aware of included the extent and impact of mixed sex wards, and the environmental risk to children with mental health needs.

We found that the established governance system was difficult to navigate. Directors, executives and board members also provided inconsistent explanation of the mechanics to ensure the dual flow of information.

Board Assurance Framework

The trusts 2017/19 board assurance framework (BAF) was last updated in August 2018 and was discussed at each board meeting. The BAF detailed 14 strategic risk statements.

We found the BAF presented to the inspection team to lack clarity and coherence. This included lack of dates of entry, actions needed to address gaps in controls and regularity of review. Whilst the actions in place to mitigate the risks were rated, the identified risks were not. The direction of travel was also unclear. We were not assured the board was fully sighted of the strategic risks to service delivery and the links to the corporate risk register were weak.

Following the inspection and initial feedback the trust submitted an alternate fuller version of the BAF that had not been shared with the team during inspection. However, entry dates of risks and oversight of the BAF at board level remained unclear.

| ID | Description |
|---|---|
| **BAF1** | There is a risk that our infrastructure does not support 365 day 24/7 uptime for key systems, resulting in a resort to paper back up, and a loss of confidence by users. This then reduces use and data completeness militating against the quality and efficiency gains we are seeking. |
| **BAF2** | There is a risk that we are unable to deliver consistent safety checks inside the first 24 hours because staff turnover and temporary staffing use mean that our wards are not staffed by individuals sufficiently familiar with our ‘approach’. This exposes patients to risk of sub optimal care. |
| **BAF3** | There is a risk that the Trust is unable to reduce amenable mortality to the timescale set out in our plans because we do not identify interventions of sufficient heft to alter outcomes. |
| **BAF4** | The first-time CQC inspection may deem that BMEC is not fit to continue to provide a safe, high quality care in its current form, particularly to children on an emergency basis, leading to the Trust losing 20% of its outpatient income thus putting at risk the financial viability of SWBH. |
| **BAF5** | There is a risk that our necessary level of cost reduction plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects. |

| | |
|---|---|
| **BAF6** | There is a risk that our necessary level of cash remediation plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects. |
| **BAF8** | There is a risk that labour supply does not match our demand for high quality staff, because of low training numbers or overseas options for students, and therefore we are unable to sustain key services at satisfactory staffing levels resulting in poorer outcomes, delayed delivery or service closures. |
| **BAF9** | There is a risk that we do not invest precisely enough to improve sufficiently the skill base of our staff and as a result our altering staffing levels may not be appropriate for the care we are trying to provide. |
| **BAF10** | There is a risk that we are unable to deliver the full change programme by July 2019 resulting in stranded services and stranded costs for disused but not yet decommissioned estate. This would compromise our ability to deliver seven day multi professional services because locational alignment is not achieved concurrently. |
| **BAF11** | There is a risk that confusion over the governance of key decisions in West Birmingham compromises the redesign of services on a 'Midland Met' footprint resulting in operational dysfunction of the opening of the New Hospital. |
| **BAF12** | There is a risk that we are unable to achieve our qualitative and quantitative goals for research because we do not broaden the specialties that are research active, principally because we are unable to recruit personnel with the time and inclination for research. |
| **BAF13** | There is a risk that we do not deliver improved mental health and wellbeing across our workforce because our interventions do not work or are poorly targeted, or because the drivers of ill health grow through organisational and societal change and churn. |
| **BAF15** | There is a risk that difficulties in recruiting and retaining local GPs leads to unwarranted variation in patterns of care resulting in excess secondary care demand. |
| **BAF16** | Collapse in local care home provision arising from commercial pressures and immigration policy increases SWBH admissions and reduces patterns of discharge creating pressure on acute hospital beds. |

*(Source: Trust's Board Assurance Framework – Aug 2018)*

There was regular reporting of financial information to key committees and operational management. Core areas of financial information were presented, including income and expenditure position, cost improvement programme delivery and cash and balance sheet reporting, with some of the financial risks discussed in the narrative. The financial position and areas of focus were however, not immediately obvious and financial risks were not given prominence in the report.

Quantified financial risks and mitigation were not clearly articulated with reference to their potential impact on forecast position. When included, these represent the best likely and worst-case scenarios.

The Medicine Management Group ensured all medicine audits and storage of medicine audits were completed. A Medicine Prescribing Effectiveness Group ensured all relevant policies and

procedures trust wide were up to date and implemented. A Formulary and Therapeutics Group ensured the trust formulary was up to date and reviewed the introduction of any new medicines.

The implementation of a new Medicine Management and Safety Oversight Group had been introduced which would report to the Executive Quality Committee. This was to ensure medicine safety was integrated directly into the trusts governance structure and improve the reporting lines for medicine safety; however, this group had not yet had a meeting.

**The trust did not have clear strategies for meeting the needs of patients with a mental health, or dementia diagnosis**. **Appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance.**

The Mental Health Act lead was identified in policies and procedures as the safeguarding lead; however, they told us they did not consider they had the knowledge and training to fulfil this role and it was under review. The mental health act policy was overdue for review as of October 2017. The named person referred to for further queries had left the trust. Therefore, we could not be assured that staff could access timely advice. Processes were in place for a local NHS trust to check administration systems relating to Mental Health Act administration functions; however, this was informal and no formal reports or quality measures were monitored. There was no named executive lead for mental health at board level, and no board reports submitted or oversight maintained of how the trust fulfilled its functions under the Mental Health Act 1983.

We asked the trust for their dementia strategy. The trust provided a 'dementia/delirium – improving patient experience action plan', this was not a dementia strategy, this was last updated July 2018 (original plan 2014/15). This was reported through the Safeguarding Steering Group. Whilst progress of the action plan had been updated there were some aspects which remained ongoing, recorded as being on track but had not met deadlines.

## Management of risk, issues and performance

**Systems to identify and reduce or eliminate risks were not always effective. Risks and issues were not always dealt with quickly enough. Oversight and assurance of mitigation at board level was not always evident and there was an inconsistent approach to audit processes**.

Finances Overview

The trust's strategy to secure financial sustainability had been delayed by factors beyond its control. The trust was working to refresh its medium term financial plans to address the impact of slippages and had strengthened its annual planning process.

The 2018/19 financial plan had an ambitious efficiency requirement of £37m which covered recovery of the underlying position (£26m deficit), and delivery of the annual cost improvement requirement. There was currently a gap of circa £9m unidentified efficiencies which the trust planned to cover with in-year contingencies.

Cost reduction was recognised as a key strategic risk identified by the board and was monitored by the Finance and Investment Committee.

| | Historical data | | Projections | |
|---|---|---|---|---|
| **Financial metrics** | **Previous Financial Year (2016/17)** | **Last Financial Year (2017/18)** | **This Financial Year (2018/19)** | **Next Financial Year (2019/20)** |
| Income | £460m | £494m | £494m | £497m |
| Surplus (deficit) | (£12m) | £22m | £3.5m | £3.5m |
| Full Costs | (£472m) | (£472m) | (£490m) | (£493m) |
| Budget (or budget deficit) | (£463m) | (£475m) | (£490m) | (£493m) |

*(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)*

Trust organisation risk register

The trust risk register served to ensure board oversight of the higher-level risks of the clinical groups. There were 19 risks on the register at the time of inspection. However, we could not trace all the high scoring clinical group risks to the trust risk register and so were not assured that board had appropriate oversight or assurance of risk management systems.

Risks were being reported through the clinical leadership groups, as these did not feed directly into committees there was no assurance that the board had oversight of significant risks. As risks were included at the discretion of the clinical leadership groups it could not be assured that there was a consistent approach to escalation.

The flow and escalation of risk within the trust was not reliable or consistent to ensure robust oversight. For example, the risk registers for children's services did contain some risks and did not demonstrate robust flow as some risks were not escalated to a higher level, or staff were unaware and there it was not documented where some risks were identified at a higher level

Risks were not always being considered fully for example the risk register entry identified possible risks to children from the hospital providing care to children with mental health needs. However, the risk register did not identify that there were risks to children with mental health needs for example environmental risks.

The trust policy for risk assessment and risk register was out of date and should have been reviewed by June 2017.

Lessons from serious incidents were sometimes embedded in the reports but not drawn out separately to enable learning and changes in practice.

Some aspects we highlighted as requiring improvement from our last inspection remained unaddressed. This included ensuring resus trolleys were tamperproof, and lawful administration and application of the Mental Capacity Act 2005

There was good management of medicine safety alerts within the trust. Action and learning from any medicine errors was undertaken and shared across the trust.

The 'pharmacy risk' register was separate from the 'medicines risk' register. However, it was hoped that the two registers would be combined into one joint risk register. High risk areas had been identified and action plans were in place which were reviewed regularly. This also included areas of concern that had been identified by the inspection process.

## Information management

**Access to data was inhibited by the poor reliability of IT systems. Staff did not have access to the IT equipment and systems needed to do their work. Analysis and interpretation of available data to board was weak. The trust had recognised the information technology system was not fit for purpose.**

We heard repeatedly from all levels of staff at the trust that information technology (IT) presented significant challenges and affected the day to day working for staff. This was strongly recognised at board level and action had been taken to improve the stability and infrastructure of the system.

Staff sometimes had to resort to using paper based systems when IT systems failed. This occurred during our visit and it was regarded as a major incident. Most patient records were paper based so this did not impact on the delivery of care. A new electronic patient record system was planned; however, this was not being introduced until the reliability of the IT network could be assured.

There was general confidence in the quality of data being collected as nationally recognised 'off the shelf' systems and tools were in place, however challenges around the hardware and accessibility of the IT system, this often-affected accessibility to data and systems. Analysis of data was not always collated or used to drive improvements.

A new Informatics officer had recently been appointed, they were currently writing the IT plan which was to be put forward for agreement in October 2018. They reported directly to the chief executive so there was good oversight of the challenges and progress. Reports were given to the board directly at the last meeting to update them on the current situation.

Continuity of service provision priorities were on stabilising the system and having recovery plans in place. Some staff had reported some improvements within a short space of time although major work was required still.

The trust was supported by NHS Improvement to maintain cyber security. There had not been any breaches of security through unauthorised access to systems. There was currently a vacancy for a cyber security lead officer.

Staff accessed policies and procedures on the trust internet. The instability of the network meant that these were not always accessible. We reviewed a number of policies and procedures and

found that they had not been reviewed in a timely manner and were not always up to date and accurate.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation's information governance practices through the provision of evidence of around 45 individual requirements. The self-assessment must be submitted to NHS Digital, with all evidence uploaded by 31 March 2017The summary Information Governance (IG) report for 2017 – 18 showed a score of 93% which was graded as satisfactory compliance.

**Information governance systems were not robust and the confidentiality of patient records was not assured. There was a lack of oversight of the management of patient information.**

The trust had a named Caldicott guardian, The Caldicott Guardian acts as the "conscience" of the organisation for management of patient information and is a focal point, providing advice on patient confidentiality and information sharing issues.

The role and responsibilities of the Caldicott Guardian were not being fulfilled. Concerns had been fed back during our inspection to the trust regarding the lack of confidentiality of patient data, this had not been shared with the Caldicott Guardian.

The Risk Management Committee (RMC) was the executive committee which oversaw the Information Governance Group. During our inspection despite a number of requests we had difficulty accessing a range of documents and reports. Often these were provided late and timescales were not met.

Electronic Prescribing and Medication Administration (EPMA) has long been recognised to enhance patient care by providing digital support of prescribing and medicine administration as well as being part of the Carter Review. However, there was no EPMA within the trust because the current IT infrastructure would not be able to support its use.

A Prescription Tracking System had been installed to support and inform staff and patients where prescriptions were within the dispensing process.

The information governance policy was overdue for review as of October 2017.

Our review of board papers highlighted that where large volumes of data was available, there was often limited interpretation and analysis of the information to inform board oversight.

## Engagement

**There was a range of strategies in place to engage with staff, however the trust did not have a structured and systematic approach to engaging with people who use services, those close to them and their representatives.**

There was no overall patient engagement strategy or mechanisms to monitor effectiveness of patient engagement in place. This does not ensure there is a robust plan, strategy or monitoring of the effectiveness of patient engagement.

There were communication systems such as the intranet and newsletters were in place to engage with staff, patients and carers to plan and manage trust services. People had access to up to date information about the work of the trust and its services.

The trust was striving to develop innovative services and opportunities to meet the needs of the local population.

Staff engagement

A six-monthly pulse check staff survey named 'Your Voice' was undertaken to sense check staff engagement. Trends and themes were monitored and fed back through team performance reviews to look at improvement. We were given an example of where there had been a lack of engagement in one team, support had been offered and the team progressed to be one of the highest level engaged teams.

Junior doctors felt supported in their role however the overall level of engagement was variable. They did not always feel their concerns were being listed to.

The trust had a guardian for safe working (GoSW). This role was introduced alongside the new junior doctor's contract in 2016/17. All organisations employing or hosting 10 or more doctors in training are required to appoint a guardian to oversee the trust management of safe working hours.

The GoSW reported to the workforce committee. Four hours each work was allowed to fulfil the duties of the role. The Guardian attended all induction sessions with junior doctors to introduce themselves.

In October 2017 a survey of 370 junior doctors was conducted, 62 responses were received, the results were fed back to the Deanery and other national groups. The majority of junior doctors said they mostly or always felt supported and they were happy with the level of education they received.

Junior doctor's forums were held quarterly but these were poorly attended. The trust was trying to understand the reasons for poor attendance and planned initiatives such as whatsapp reminders to encourage doctors to attend.

Junior doctors were encouraged to report where they worked excessively long hours or were not supported with training. Whilst there had been some barriers to reports the number of reports was increasing but was variable according to specialty. Junior doctors were asked the reasons for a lack of reporting in the annual survey, responses were varied. Strategies were recorded to try to improve reporting. Where there were clusters of reports for an area these were escalated to specialty leads. There was no formal system in place to close down the reports when they had been made so all remained open. An annual report was presented to board each October from the guardian of safe working hours, this ensured board oversight.

Junior doctors we spoke with told us about gaps on rotas and expressed that they did not always feel their concerns were listened to when they raised them. Frustrations with changing rotas and errors on rotas were also shared.

Some engagement took place with staff regarding changes and policy reviews. For example, the sickness absence policy was under review. This was being consulted on with staff side representatives and managers. This then went to the people and operational delivery group and clinical groups.

Staff side representatives reported good engagement with the trust although they considered communication was not always good. Staff had access to support for their own physical and emotional health needs through occupational health.

The trust had a range of employee benefits and wellbeing programmes available. These included discounts for shopping, yoga, advice on financial matters and a cycle to work scheme. There was also an app available to inform staff what was available. There was a staff counselling service in place that staff could access confidentially.

Each year a staff awards ceremony was held. Private sponsorship took place to fund this. Each month there were nominations put forward for staff to receive awards. All shortlisted nominees were invited to the annual ceremony.

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

Patient engagement

We asked the trust for their patient engagement strategy but were advised that there was no formal strategy in place but that the trust engaged in an ongoing way. This does not ensure there is a robust plan, strategy or monitoring of the effectiveness of patient engagement.

The pharmacy team interacted and engaged with patients every day. This included using the diversity within the team to engage with patients about their individual medicines requirements.

The communications team reviewed the NHS Choices website daily to assess what patients were feeding back about the service. Responses were given and we told the chief executive sometimes responded personally to tweets and other aspects in the media.

Patient groups had been taken on site to the proposed new Midland Met Hospital. They had been involved in some planning and design decisions and consulted re signage. Accessibility to the new hospital was also been considered to ensure there was sufficient parking and public travel options available to the public.

The trust had a Charitable Fund which was managed by a committee chaired by a non- executive director. Board members were trustees of the charity. The committee provided assurances to the board regarding the use and monitoring the use of charitable funds and the benefit gained. The aim of the charity was to provide the opportunity for local groups to apply for funds to set up or continue projects. The type of projects supported linked in with the promotion of healthcare and well-being in the community.

An example of this is the Sandwell CARES group which are a local organisation that was set up to support carers in Sandwell. Through the charity, money was awarded to them to further engage relatives and carers of our patients.

The trust had some health promotion initiatives in place to reach hard to reach patient groups. This included a midwifery service provided at a refugee centre and a health visitor dedicated to working with the travelling community. There was also a specialist GP and nurse who worked to develop the care pathway for homeless patients. They looked at providing support into hostel accommodation.

The trust was part of the The Black Country and West Birmingham sustainability and transformation partnership (STP). The Midland Met Hospital which is being built is a part of the STP plan for the future of healthcare provision for the local community.

## Learning, continuous improvement and innovation

**The trust had some systems in place to ensure learning from incidents, complaints and safeguarding alerts and make improvements. However, the focus on continuous learning was inconsistent and learning was not always shared effectively across the organisation.**

The trusts long term future for promoting quality healthcare was based on moving to a new hospital, the Midland Met. There had been a delay to the move as the building constructor went into administration. The original planned move date of October 2018 had been re-set to 2022 This had resulted in a requirement for the trust to consider how service provision could be maintained across the current estates.

The pharmacy team encouraged innovation amongst themselves. There was a strong drive to continually make improvements in systems delivery with particular emphasis in reducing waiting times for dispensing medicines.

**Complaints process overview**

Oversight and responses to complaints was managed by the corporate governance function of the trust and a new head of complaints had recently been appointed. Complaints were overseen according to a three-tiered approach as; purple phones, informal and formal.

The ‘purple phones’ phoneline was available across the acute sites and allowed patients and families to raise concerns immediately whilst on-site. Calls were managed via a call centre and targets were to resolve issues within 48 hours. The phones were answered by staff who had access to translation services. The aim of the immediate access was that where possible resolution to concerns could be actioned quickly to avoid escalation of complaints and dissatisfaction.

The siting of some of the phones afforded little privacy to users as they were in corridors and immediately outside ward areas where people passed by frequently. The height of some phones made it difficult for wheelchairs users to use them comfortably.

Informal complaints were typically dealt with within 48 hours to 20 days. For formal complaints. There was a three-day key performance indicator for acknowledgment and a 30-day target for providing a final formal response.

Informal and formal complaints were either lead by a member of the complaints team or by the service in which the complaint originated with the support of a complaints team manager. There was a low threshold for partially upholding complaints and learning was directly shared with the services involved.

The trust analysed themes and trends of complaints and the explicit learning was clearly identified on the system. The head of complaints recognised that there was implicit learning that they could utilise further. Staff told us learning from complaints was a key priority. They recognised that the system was not utilised to its full potential and wanted to improve this to ensure learning points and associated actions were clearer.

The complaints department produced a quarterly report for the board and the Equality and Diversity committee, which informed the annual report. The April 2017 to March 2018 annual report for the trust showed that the number of complaints had reduced from the previous year. The three services that received the most complaints were medical care, urgent and emergency care and surgery services. The top three themes for complaints were aspects of clinical treatment, appointment delays and staff attitude.

The complaints team met weekly with the mortality team, the serious incidents team and the legal team. During this meeting, the teams discussed cases and documented them on Venn diagrams to show cross over and to determine the appropriate team to lead the investigation.

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

| **Question** | **In days** | **Current performance / Date Range** |
|---|---|---|
| What is your internal target for responding to complaints? | 3 | 100% |
| What is your target for completing a complaint | 30 | 98.5% |
| If you have a slightly longer target for complex complaints please indicate what that is here | As negotiated with the complainant dependant on complexity, and within the defined target of the Complaints Regulations, of six months. | 98.5% |
| Number of complaints resolved without formal process in the last 12 months? | See below | N/A |
| Informal (PALS) | 2242 | April 2017-March 2018 |

| | | |
|---|---|---|
| Local resolution (purple point service) | 79 | 28 February 2018 – 19 June 2018 |

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

**Number of complaints made to the trust**

The trust received 976 complaints from April 2017 to March 2018. The medical care core service received the most complaints with 243.

| Core Service | Number of complaints | Percentage of total |
|---|---|---|
| Medical care (including older people's care) | 243 | 25% |
| Urgent and emergency services | 187 | 19% |
| Surgery | 143 | 15% |
| Outpatients | 141 | 14% |
| 'Other' | 91 | 9% |
| Maternity | 48 | 5% |
| Gynaecology | 32 | 3% |
| Diagnostics | 28 | 3% |
| Services for children and young people | 22 | 2% |
| CHS - Community Inpatients | 17 | 2% |
| CHS - Adults Community | 11 | 1% |
| CHS - Children, Young People and Families | 5 | 1% |
| Critical care | 4 | >1% |
| CHS - Sexual Health | 4 | >1% |

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

Compliments

From January 2018 to June 2018, the trust received a total of 34 compliments. A breakdown by core service can be seen in the table below:

| Core service | Number of compliments |
|---|---|
| Medical care (including older people's care) | 11 |
| Urgent and emergency services | 8 |
| Outpatients | 4 |

| | |
|---|---|
| Surgery | 3 |
| 'Other' | 3 |
| Maternity | 2 |
| CHS - Community Inpatients | 2 |
| Gynaecology | 1 |

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

**Learning from deaths**

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

The executive lead for mortality acknowledged that improvements were required to the systems and efficiencies for ensuring investigations and learning from deaths.
The Learning from Deaths (LfD) Committee (which was a sub of the Executive Quality Committee who in turn reported to the Quality and Safety Committee) met monthly. The trust had a named mortality lead. The trust target was to review 100% of deaths in line with national guidance. Trust performance against this target at the time of inspection was a review rate of 30% of deaths. The trust identified on the board assurance framework (BAF) that there was a risk that the trust may not reduce the number of deaths because sufficient numbers of deaths were not reviewed to inform learning and affect outcomes.

The learning from deaths policy, implemented February 2018, had a detailed approach to investigating deaths. This included those that required a structured judgement review (SJR) or a specialist mortality review (SMR), for example those deaths involving a patient with a learning disability, a child or a maternal death.

The trust provided us with access to five records of patients that had died at the trust within the last six months. Each death had been reviewed using the trust review process.
we found records were not always completed in full and we were unable to establish if the full mortality review process had been undertaken in line with the learning from deaths policy. The records of patient one stated that the death was preventable; however, the narrative given by the reviewer stated that the death was not preventable. The information documented was contradictory. Patient one's records also stated that lessons could be learnt; however, the narrative box to state what these lessons were was left blank. Patient two's records stated a 'do not attempt resuscitation' form was in place at the time of death; however, the question "was the DNACPR decision reasonable" was left blank. The records also stated that a coroner's inquest had happened, but no further details, and the lessons learnt box was blank despite the reviewer documenting that lessons could be learnt.

We found the same concerns regarding DNACPR form on the third set of records; however, the rest of the record was completed in full. The records for patient four stated that lessons could be learnt; however, these were not documented. The records also show that the DNACPR form was not discussed with the patient as they were "deaf and blind". The fifth and final set of records looked at were completed in full.

Following the inspection, we requested further evidence to show that the above five patients had been reviewed in accordance with the learning from deaths policy. The trust did not provide this information, but did resubmit a copy of the records already reviewed during the inspection. We were unable to establish the effectiveness of the learning from deaths process. We were not assured that lessons were learnt and shared following deaths due to the inconsistent documentation within electronic records

The trust had a mortality reduction plan (May 2018). This had defined responsibilities and dates for actions for actions to be taken. One of the trust's quality plan initiatives was to reduce the number of avoidable deaths and for the trust to be in the top 20% in the country.

The current Hospital Standardised Mortality Ratio (HSMR) higher than expected when compared with trusts nationally and projections for the trust were that this would continue. This included the Hospital Standardised Mortality Ratio weekend statistic. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

For the 12-month period from April 2017 - March 2018, HSMR was higher than expected with a value of 119.22 (compared to 100 for England).

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

For the 12-month period from April 2017 - March 2018, SHMI was as expected with a value of 1.14 (compared to 1.0 for England), the trend since October 2017 was this was increasing.

We reviewed a sample of completed serious incidents reports. The quality and content of the reports was variable, some reports had key information such as the patients date of birth missing, and did not evidence how the patient and family were engaged in the investigation process.

Accreditations

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

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

| Accreditation scheme name | Service accredited |
|---|---|
| Joint Advisory Group on Endoscopy (JAG) | Endoscopy |

| | |
|---|---|
| Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189 | Trust assessed between February & April 2017 and final evidence was sent to UKAS in January 2018. Awaiting their decision. |

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