Walsall Council

Special Social Care and Health Overview & Scrutiny Committee

Meeting to be held on: Wednesday 14th July at 6.00 P.M.

Meeting to be held: Town Hall, Walsall Council House

Public access to meeting via: https://youtu.be/2og17FtUpBw

MEMBERSHIP:

Councillor Hussain	(Chair)
Councillor Cooper	(Vice-Chair)
Councillor Allen	
Councillor Coughlan	
Councillor Ditta	
Councillor Gandham	
Councillor Johal	
Councillor Murphy	
Councillor Pedley	
Councillor Sarohi	
Councillor Waters	

PORTFOLIO HOLDERS:

Health and Wellbeing	-	Councillor S. Craddock
Adult Social Care	-	Councillor R. Martin

Note: Walsall Council encourages the public to exercise their right to attend meetings of Council, Cabinet and Committees. Agendas and reports are available for inspection from the Council's Democratic Services Team at the Council House, Walsall (Telephone 01922 654767) or on our website www.walsall.gov.uk.

AGENDA

1.	**Apologies** To receive apologies for absence from Members of the Committee.	
2.	**Substitutions** To receive notice of any substitutions for a Member of the Committee for the duration of the meeting.	
3.	**Declarations of interest and party whip** To receive declarations of interest or the party whip from Members in respect of items on the agenda.	
4.	**Local Government (Access to Information) Act 1985 (as amended)** To agree that the public be excluded from the private session during consideration of the agenda items indicated for the reasons shown on the agenda (if applicable).	
5.	**Minutes of the previous meeting** To approve and sign the minutes of the meeting that took place on 8th April 2021.	Enclosed
	Scrutiny	
6.	**Planned Redevelopment of Bloxwich Hospital**	Enclosed
7.	**Walsall Healthcare Trust CQC inspection report**	Enclosed
8.	**Proposals for Acute Urology Services at Walsall and Wolverhampton**	Enclosed
	Overview	
9.	**Forward Plans** The forward plans for Walsall Council and the Black Country Executive Committee.	Enclosed
10.	**Date of next meeting** 23rd September 2021, 6p.m.	

The Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Specified pecuniary interests

The pecuniary interests which are specified for the purposes of Chapter 7 of Part 1 of the Localism Act 2011 are the interests specified in the second column of the following:

Subject	**Prescribed description**
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by a member in carrying out duties as a member, or towards the election expenses of a member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Regulations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority: (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to a member's knowledge): (a) the landlord is the relevant authority; (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where: (a) that body (to a member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either: (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Schedule 12A to the Local Government Act 1972 (as amended)

Access to information: Exempt information

Part 1

Descriptions of exempt information: England

1. Information relating to any individual.

2. Information which is likely to reveal the identity of an individual.

3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).

4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.

5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.

6. Information which reveals that the authority proposes:

   (a) to give any enactment a notice under or by virtue of which requirements are imposed on a person; or

   (b) to make an order or direction under any enactment.

7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

8. Information being disclosed during a meeting of a Scrutiny and Performance Panel when considering flood risk management functions which:

   (a) Constitutes a trades secret;

   (b) Its disclosure would, or would be likely to, prejudice the commercial interests of any person (including the risk management authority);

   (c) It was obtained by a risk management authority from any other person and its disclosure to the public by the risk management authority would constitute a breach of confidence actionable by that other person.

Social Care and Health Overview and Scrutiny Committee

Thursday 8th April 2021 at. 6.00 p.m.

Virtual meeting via Microsoft Teams

Held in accordance with the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020; and conducted according to the Councils Standing Orders for Remote Meetings and those set out in the Council's Constitution.

Present:

Councillor Hussain (Chair)
Councillor Ali
Councillor G. Clarke
Councillor Coughlan
Councillor S. Ditta
Councillor Rasab
Councillor Robertson
Councillor Sarohi
Councillor Waters

Portfolio Holders Present

Councillor S. Craddock – Health and Well Being
Councillor R. Martin – Adult Social Care

Officers

Kerrie Allward	Executive Director Social Care for Adults
Matthew Dodd	Acting Director of Integration for Walsall Together
Alison Stone	Joint Clinical Lead for Specialist Rehabilitation
David Brown	The Senior Commissioning Manager (Public Health) NHS England
Nikki Gough	Democratic Services Officer, Walsall Council
Aileen Farrer	Healthwatch Walsall representative

Welcome

At this point in the meeting, the Chair opened the meeting by welcoming everyone, and explaining the rules of procedure and legal context in which the meeting was being held. He also directed members of the public viewing the meeting to the papers, which could be found on the Council's Committee Management Information system (CMIS) webpage. Members confirmed that they could both see and hear the proceedings.

31/20 **Apologies**

There were no apologies received for the duration of the meeting.

32/20 **Substitutions**

There were no substitutions for the duration of the meeting.

33/20 **Declarations of Interest and party whip**

There were no declarations of interest.

34/20 **Minutes of the previous meeting**

The minutes of the meeting that took place on 28th January 2021 were discussed.

Resolved (by roll call)

That the minutes of the meeting held 28th January 2021, were agreed as a true and accurate record of the meeting.

35/20 **Walsall Together Update**

The Acting Director (of Integration for Walsall Together) presented the report (annexed) and highlighted the salient points. The report provided an update on the development of Walsall Together and an overview of the work undertaken since the previous report was received in January 2020. Key priorities for the partnership over the next financial year were also included.

Members were advised that the recent focus, of Walsall Together, had been the response to the Covid-19 pandemic. This had highlighted the benefits of integrated working and the Partnership was now refocusing on the reset of services. The impact of interventions were described and the impact of focusing on population need. The wider determinants of health and wellbeing were fed in through the work of 'Resilient Communities' and this built on the value added by the volunteer response to the pandemic. The workforce and development stream was described to explain the ideals of Walsall Together. A significant amount

of work had taken place, through the partnership, to ensure that the vaccination programme was a success. The future focus for the partnership would be on preventing individuals from needing health and social care.

A Member expressed disappointment that the 'Walsall Together' branding was not used in Walsall vaccination centres. It was acknowledged that NHS branding had been used, however, this was being reviewed.

It was suggested that there should be a housing representative sitting on the Walsall Together Board, due to the impact that housing had on individual's health and wellbeing. The Executive Director (Adult Social Care) explained that Walsall Housing Group and Public Health were involved with the Walsall Together Partnership and although there was further work to do, housing was on the agenda. In response a Member stated that the condition of housing in Walsall needed improving.

The importance of patients attending the right place for care was stressed. The Acting Director stated that there was a focus on removing duplication to avoid this and an opportunity to get care navigation right to ensure people were able to access the correct part of the healthcare system.

A Member queried if individuals were accessing mental health services before they reached crisis point. The Committee were informed that the IAPT mental health service signposted individuals to access the correct service. A discussion ensued on the vaccination of individuals who were not able to leave their home. Members were assured that individuals were able to access the support they needed.

Resolved

That the Walsall Together Update was noted.

36/20 **Community Stroke Rehabilitation Service Update**

The Acting Director presented the report (annexed) and highlighted the salient points. The Committee were informed that the report provided an update on the development of community stroke rehabilitation services in Walsall since the last report to the Committee in January 2020.

The background to the stroke reconfiguration at Walsall Healthcare Trust was described, and that the proposals saw the acute and hyper-acute patients being treated at Royal Wolverhampton Hospital from April 2018 with rehabilitation services provided from Walsall Healthcare Trust. The pandemic had accelerated the service transfer to Holly Bank House in April 2020. It was stressed that quality of service was always at the

forefront of service change and partnership support had assisted the relocation to be a success. The Committee were assured that the workforce had been enhanced to support the service change.

Performance information was described which demonstrated that patient outcomes had improved as a result of the service reconfiguration.

In the future a Member asked for the patient experience to be included in reports to provide a holistic view of the service. The Healthwatch representative suggested that the patient experience of individuals at Holly bank House had been put forward as a future work programme item within the patient engagement programme of Healthwatch.

Resolved

That the Community Stroke Rehabilitation Service update was noted.

37/20 **Diabetic Eye Screening Procurement – Birmingham, Solihull and Black Country**

The Senior Commissioning Manager (Public Health) presented the report and highlighted the salient points. Members were informed that the current contract was being re-procured and this meant that the service model may change to tackle the backlogs created as a result of the pandemic. It was noted that the current procurement exercise was paused, pending the patient engagement exercise. Members were assured that the input of diabetes UK in relation to the service had been sought. The Healthwatch representative stated that Healthwatch had been commissioned to provide service user engagement, through Walsall Together, and as part of this a diabetes service user group had been established. It was suggested that this group could be involved in future patient engagement exercises.

Resolved that:

1. That the Diabetic Eye Screening Procurement was noted

2. The Social Care and Health Overview and Scrutiny Committee requested to be involved in future patient engagement exercises.

38/20 **Forward Plans**

The Forward plans were considered.

Resolved

That the Forward plans were noted.

39/20 **Date of the next meeting**

The date of the next meeting would be agreed at annual Council.

Termination of Meeting

The meeting terminated at 7.30 p.m.

Social Care and Health Overview and Scrutiny Committee	**Agenda Item No.**
14th July, 2021	**6**

Planned Redevelopment of Bloxwich Hospital

Ward(s): All

Portfolios: Health and Wellbeing

1. Aim

To redevelop older peoples' mental health inpatient services in Walsall, currently provided at Bloxwich Hospital.

2. Recommendations

The Committee is asked to consider, support and give feedback on these proposals. In particular, the Committee is asked to support the stakeholder engagement plan.

3. Report detail

3.1 Bloxwich Hospital provides mental health inpatient services to older people in Walsall. It sits adjacent to the High Street immediately opposite Asda supermarket. It consists of two inpatient wards, other clinical space, a range of accommodation for non-clinical staff and a car park.

3.2 It has been recognised for some time that the facilities at Bloxwich Hospital are not fit for purpose for a range of reasons, including:

- Bloxwich Hospital was not purpose built - it was constructed in 1850 as a private residence and later became a maternity hospital. Compared to the modern healthcare facilities elsewhere in the borough, the building is old and not appropriate for delivering high quality care.
- The layout of the building is inflexible and can't provide the right type of space for good patient care.
- Due to the infrastructure of the building, teams often struggle to meet clinical standards, for example:
    - There are some mixed gender areas;
    - Infection prevention and control standards are difficult to maintain due to the age and condition of the environment;
    - Not all patient bedrooms are single occupancy; some bathroom areas are shared;

    - Large sections of the building are not accessible to people with mobility challenges.
- As a result, the maintenance and upkeep of the building is very costly and the opportunity for significant improvement is limited.

3.3 All partners, including the Care Quality Commission (CQC) have agreed that this needs to be addressed and the Trust has been developing plans for an alternative solution. Until recently however, appropriate funding for the redevelopment of the hospital has not been available.

3.4 Earlier in 2021, the NHS announced that national capital funding was available to support the 'Elimination of Dormitory Wards' in mental health (that is, ensuring that inpatient facilities provide high quality, single room accommodation). Black Country Healthcare made a successful bid against this financial allocation and secured funding to redevelop Bloxwich Hospital. The Trust has now embarked on the programme of work to finalise the full business case to support this investment and to develop plans to build new, high quality facilities for older people in Walsall.

3.5 Although the timescale for developing this full business case is extremely tight, the Trust has carefully considered a number of options for the future provision of older peoples' mental health inpatient services. The preferred option is to build a new, purpose built facility at the rear of Dorothy Pattison Hospital site (adjacent to Walsall Manor Hospital).

3.6 There are a number of reasons why this option is felt to be the best alternative to deliver high quality care, as follows:

- It will deliver modern, purpose built accommodation, ensuring that patients and their families have a much high quality experience of care.
- Being adjacent to the Manor and Dorothy Pattison hospitals, it will ensure that patients have easier access to other relevant healthcare services whilst they are in hospital.
- It will enable the delivery of the highest quality care and clinical standards.
- Staff and patients will benefit from greater access to facilities at Dorothy Pattison Hospital site – gym, canteen etc
- Good car parking and public transport access.
- Minimal disruption for patients, staff and residents – critically, patients will not have to experience the inconvenience of being temporarily decanted to another site.

3.7 The Trust has already undertaken extensive engagement work with staff, patients, their families and local residents in respect of these plans. Post-purdah, this programme of engagement has now restarted (described in further detail to the committee in the presentation which will accompany this paper).

3.8 Next steps will be:
- Continue with the programme of engagement with internal and external stakeholders.
- Complete the full business case to support this investment and seek approval via NHS mechanisms.
- Work with staff and patients to finalise the design details of the new facilities.
- Assuming all approvals are secured, begin construction in spring 2022.

- Discussions with partners in the borough regarding potential future plans for the Bloxwich Hospital site.

4. Financial information

The capital investment associated with the redevelopment of Bloxwich Hospital is c£21 million. The plans will be described in a detailed full business case which will need to be approved by NHS Improvement (NHSI/E). There will be no additional revenue consequences as a result of this development.

5. Reducing Inequalities

There is a significant evidence base to demonstrate that mental health problems are a key factor in health inequalities. People with severe mental ill health are known to experience worse health outcomes, have lower life expectancy and poorer access to physical health care.

This plan for investment into mental health services in Walsall is a significant opportunity to contribute positively to addressing these issues.

6. Decide

N/A

7. Respond

All feedback from the Committee will be incorporated into further planning and development work.

8. Review

The Trust will report progress to the Committee at regular intervals.

Author

Marsha Foster
Director of Partnerships, Black Country Healthcare NHS FT
✉ marsha.foster@nhs.net

Social Care and Health Overview and Scrutiny Committee	**Agenda Item No.**
14th July 2021	**7**

Assurance Report regarding Walsall Healthcare Care Quality Commission (CQC) Inspection of March 2021

Ward(s): All

Portfolios: Health and Wellbeing

1. Aim

To assure the committee on the actions taken by Walsall Healthcare Trust in response to the Care Quality Commission (CQC) unannounced inspection in March 2021 and the subsequent Section 29a notice and requirement notices.

2. Recommendations

To review the Trusts response to CQC findings, Section 29a notice and requirement notices and mechanisms for ongoing oversight and assurance.

3. Report detail

The CQC carried out an unannounced focused inspection of Walsall Healthcare Trust on 9 March 2021 following receipt of information of concern about the safety and quality of the services, specifically within the medical wards.

During the inspection the CQC visited five wards and spoke with staff, including service leads, matrons, nurses, medical staff, healthcare support workers and student nurses. They reviewed patient records including records with a Recommended Summary Plan for Emergency Treatment (ReSPECT) form and observed staff providing care and treatment to patients.

Following this inspection, the CQC issued a Section 29a warning notice to the Trust as significant improvement was required to the nurse staffing of the service, the governance of the service and how the Trust provided patients with a safe discharge. The Section 29a notice gave the Trust three months to rectify the significant improvements identified. The CQC also identified other breaches of regulation for which they issued the Trust with requirement notices.

The CQC rating of services went down as it was rated as inadequate. The reasons for this rating were:

- The service did not have enough staff to care for patients and keep them safe. There was an inconsistent approach and understanding on how to protect patients from abuse. The service did not always control infection risk well.
- There were no robust arrangements in place to provide assurance of safe and effective patient discharges. This meant patients were not always discharged safely with appropriate care and treatment.
- Staff had not been trained in the use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms which resulted in patients not receiving individualised plans of care for their end of life care.
- There was an inconsistent approach to how leaders ran services. Staff did not always feel respected, supported and valued. Leaders did not operate an effective governance process to continually improve the quality of the service and safeguard the standards of care.

The CQC did recognise good practice and the report highlighted the following:

- Staff managed medicine administration well and staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment and gave patients enough to eat and drink
- Staff remained focused on the needs of patients receiving care and provided kind and compassionate care to patients.
- Most staff were aware of how to meet the individual needs of patients, especially those where English was not their first language.

Current position:

All actions required by the Section 29a notice have been completed. The Trust wrote to the CQC on 29 June 2021 confirming the actions taken to meet the notice and the ongoing monitoring arrangements that are in place through a weekly CQC review meeting chaired by the Director of Nursing or Deputy Director of Nursing.

The Trust submitted action plans to the CQC in response to the requirement notices on 29 June 2021. The action plans are embedded in the background documents section of this paper and detail all actions taken to date to ensure compliance, ongoing actions and dates for completion and the ongoing monitoring arrangements through a weekly CQC review meeting chaired by the Director of Nursing or Deputy Director of Nursing.

In addition to the divisional action plans and monitoring there has been shared learning across the Trust through Matrons and Divisional Director of Nursing forums and the Trust wide Quality, Patient Experience and Safety Committee.

4. ***Financial information***

None applicable

5. Reducing Inequalities

Not applicable

6. Decide

Not applicable

7. Respond

Not applicable

8. Review

The on-going monitoring of continued compliance and assurance in response to the CQC notices is through the weekly CQC oversight meetings chaired by the Director of Nursing or Deputy Director of Nursing.

Background papers

Walsall Healthcare Trust CQC Inspection

Author

Lisa Carroll
Interim Deputy Director of Nursing
☎
✉ Lisa.Carroll@walsallhealthcare.nhs.uk

Walsall Healthcare NHS Trust

Manor Hospital

Inspection report

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

Date of inspection visit: 09 March 2021
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Manor Hospital

Requires Improvement 

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust serves a population of around 270,000. Acute hospital services are provided from one site, Walsall Manor Hospital. Walsall Manor Hospital has 429 acute beds. The medical services provide care and treatment to patients across seven specialities, these include general medicine, acute older adult, cardiology, frail elderly medicine, diabetes renal and haematology, gastroenterology and respiratory medicine. Across the division there were 190 beds located within 10 wards.

We carried out this unannounced focused inspection because we had received information of concern about the safety and quality of the services, specifically within the medicine wards at the Manor Hospital. The information of concern related to the following areas:

- Safeguarding.
- Assessing and responding to risk.
- Infection prevention and control.
- Records.
- Medicine administration.
- Staffing levels (and the ability to provide safe, dignified care for patients).
- ReSPECT forms and the decision-making process around Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR).
- Meeting the individual needs of patients (specifically around translation and interpretation services).
- Discharge process for patients.
- Leadership.
- Culture.
- Governance systems.

During our inspection we visited five wards (Ward 1, Ward 2, Ward 3, Ward 16 and Ward 17). We spoke with 28 staff, including service leads, matrons, nurses, medical staff, healthcare support workers and student nurses. We reviewed 14 complete sets of patient records including 10 Recommended Summary Plan for Emergency Treatment (ReSPECT) forms and three additional sets of patient clinical observations records. We also observed staff providing care and treatment to patients and spoken with one relative.

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

Our findings

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Following this inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to the nurse staffing of the service, the governance of the service and how they provided patients with a safe discharge. The section 29a notice has given the trust three months to rectify the significant improvements we identified. We also identified other breaches of regulation for which we issued the trust with requirement notices for.

Our rating of services went down. We rated them as inadequate because:

- The service did not have enough staff to care for patients and keep them safe. There was an inconsistent approach and understanding on how to protect patients from abuse. The service did not always control infection risk well.
- There were no robust arrangements in place to provide assurance of safe and effective patient discharges. This meant patients were not always discharged safely with appropriate care and treatment.
- Staff had not been trained in the use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms which resulted in patients not receiving individualised plans of care for their end of life care.
- There was an inconsistent approach to how leaders ran services. Staff did not always feel respected, supported and valued. Leaders did not operate an effective governance process to continually improve the quality of the service and safeguard the standards of care.

However:

- Staff managed medicine administration well and staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink
- Staff remained focused on the needs of patients receiving care and provided kind and compassionate care to patients.
- Most staff were aware of how to meet the individual needs of patients, especially those where English was not their first language.

Medical care (including older people's care)

Inadequate

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

Safeguarding

We were not assured all staff understood how to protect patients from abuse and the service did not always work well with other agencies to do so. Staff had training on how to recognise and report abuse however not all staff knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff told us training was completed through an electronic learning system. Qualified staff were required to complete level three training whilst non-qualified staff completed level two. Training information shared by the trust showed:

- Ward 1 had achieved the trust training target of 90% compliance for safeguarding children level two, safeguarding adults levels one and two. However, they were currently below the trusts target for safeguarding adults level three with a compliance of 79% of staff trained.
- Ward 2 had achieved the trust training target of 90% compliance for safeguarding children level two, safeguarding adults level one and three. However, they were currently below the trusts target for safeguarding adults level two with a compliance of 88%.
- Ward 3 had achieved the trust training target of 90% compliance for all mandatory safeguarding training, including safeguarding children level two and three and safeguarding adults level two and three.
- Ward 16 had achieved 100% compliance with safeguarding adults level one and three training. However, they were currently below the trusts target of 90% for safeguarding children two and safeguarding adults level two. The trust information also showed staff were required to complete safeguarding children level three training. At the time on our inspection, information showed no staff had completed this training.
- Ward 17 had achieved the trust training target of 90% compliance for all mandatory safeguarding training, including safeguarding children level two and three and safeguarding adults level one, two and three.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff we spoke with were confident in their safeguarding knowledge and would feel confident in reporting concerns if they identified them.

Staff did not always know how to identify adults and children at risk of, or suffering, significant harm and therefore did not always alert other agencies to risks. Despite having training around safeguarding children and vulnerable adults, staff were not always able to put the theory into practice. Staff discussed their examples of where they raised safeguarding concerns. Some staff were able to give a variety of examples, including both physical and psychological signs which may indicate abuse and harm to patients. One staff member was able to discuss an example where a patient had unexplained bruising and how they manged this concern which included alerting the safeguarding team.

However, there were staff who linked safeguarding with medicine errors on the ward, deprivation of liberty and patients lacking mental capacity and raising concerns around pressure ulcers. No additional information was discussed around the wider issues of safeguarding and the signs which may be present when a patient is admitted. This supported several concerns raised to the Care Quality Commission (CQC) by members of the public and an anonymous reporter. One concern, the complainant raised concerns about a family member who had been trying to seek help and assistance from staff for personal hygiene reasons. They reported being told to clean themselves as it was not the job a staff member and was then left for a further period before staff finally attended to the patient. This had not been reported as an incident or a safeguarding concern, despite appearing to fit the category of neglect.

In another example, an anonymous reporter identified staff were not helping patients with personal needs or attending to other needs of patients but were documenting they had provided aspects of care and treatment. In addition, patients were not having vital medication administered despite recording this was administered. This had also not been raised as a concern internally. In another concern raised to the CQC, a patient had been exposed to theft whilst on the ward which was neither highlighted as an incident or a safeguarding at the time by staff on the ward. Once this was highlighted to the trust by the relationship owner from the CQC, the trust implemented a full review of the incident.

Some staff knew how to make a safeguarding referral and who to inform if they had concerns. Some staff were knowledgeable about the safeguarding team and had previously used them for advice on concerns. They spoke positive about their experiences with the team and how they dealt with the concerns raised. We saw on one ward a notice board which had been completed about safeguarding and important information for staff to follow. However, there were staff who were unsure about the referral process and were not aware of the safeguarding team as they were not visible. Some staff told us they would raise it first to their line manager as they were unsure on how they would raise it beyond their manager. Some staff told us they were reluctant to contact the safeguarding team at the trust as they had previously had poor experiences when raising safeguarding concerns to the team. Some staff felt the team “always found things wrong with the ward” with another staff member feeling like the team were “against us”. This had been raised as a concern within the division and meetings held to address the concerns.

Information received by the trust indicated safeguarding champions had been implemented in the ward areas to raise the awareness of safeguarding and improve practice within their areas. The information showed they were also key to increasing awareness around the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. During our inspection, staff were not aware of any champions within their area. One member of staff told us that due to the pressures of the pandemic, champions were not embedded in their ward however this was something they were keen to implement again.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always implement control measures to protect patients, themselves and others from infection. However, at the time of our inspection equipment and the premises were visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw domestic staff regularly cleaning within the ward areas to ensure they were compliant with recent modifications to the cleaning recommendations. We also observed domestic staff responding promptly to a request for a deep clean of a room following a patient transfer. Audit information received from the trust for February 2021 showed Wards 1, 2, 3 and 17 were scored good on the maintenance of the estates and environment. However, Ward 16 was deemed non-compliant due to issues with cleanliness and clutter around the ward.

Medical care (including older people's care)

The service performed well for cleanliness. We observed several wards displaying 100% compliance for recent cleanliness audits on their quality and safety information boards.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff told us there were plentiful supplies of all PPE for them to use. We observed most staff wearing PPE appropriately and changing their PPE after their tasks. Staff followed this up with a hand hygiene moment. The only exception we saw to this were non-clinical staff who did not change their PPE following escorting a patient back to their wards. Senior managers had recognised this to be a concern and had previously escalated this to the managers of the workers.

Despite no concerns being observed with PPE, some staff told us they had received little or no training for the 'donning and doffing' procedure when putting full PPE on in preparation for caring for COVID-19 positive patients. Donning and doffing refers to the safe process for putting on and taking off PPE. Staff were unaware of these processes which are important to ensuring both patients and staff are protected from possible transmission of infection. Information received from the trust showed wards 1, 2, 3 and 17 were all compliant with IPC level one training at the time of our inspection (trust target for compliance was 90%). Wards 2 and 17 were also compliant with level two IPC training, however wards 1 and 3 were below the 90% target. Wards 1, 2, and 17 were also compliant with their mandatory hand hygiene training, however ward 3 were currently at 84% compliance. We had also requested training data for ward 16 however we did not receive this information for the ward. In addition to the mandatory training provided to staff, additional resources (videos of IPC practices) and posters were also provided to aide staff. We were also informed by the trust of one to one and group training provided to ward staff by the IPC team. However, staff we spoke with had not participated in any of the local ward training by the IPC team.

We observed staff allowing relatives of some patients in to assist with personal care and nutritional support. Staff helped relatives to put PPE on to enable them to maintain the safety of the patient as well as themselves and the staff members.

We observed alcohol hand gel near the entrance for staff, patients and visitors to use, as well as alcohol hand gel being available at point of care, whether this was by patients' beds or carried by staff. We observed good hand hygiene during our visits to the ward, with staff adhering to the five moments for hand hygiene (World Health Organisation). These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Audit information shared with us for February 2021 showed Wards 2, 3, 16 and 17 were all demonstrating good compliance with hand hygiene standards and Ward 1 demonstrated full compliance with standards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff had access to appropriate cleaning materials to ensure the correct cleaning of equipment after use. We observed green 'I am clean' stickers in place for equipment that was clean and ready for reuse. Information provided by the trust showed some areas had previously had difficulties with cleanliness of equipment during the February 2021 audit. Wards 3, 16 and 17 recorded a good score on the audit with Ward 1 demonstrating full compliance with the cleanliness of equipment. However, Ward 2 recorded a poor compliance with cleanliness of equipment due to auditors finding blood on equipment, no equipment with 'I am clean' sticks and staff reporting they did not always clean beds down once patients discharged/transferred.

Since the COVID-19 pandemic, there had been regular updates in the guidance required for healthcare establishments to comply with. Part of the recommendations were around ensuring rooms such as doctors' offices and staff rooms were risk assessed, and where necessary limits on the numbers of people allowed in the rooms at one time placed upon them. This was to ensure staff within these rooms were able to comply with other measures such as social distancing.

We found during our inspection, where rooms had been assessed and limits of people allowed in there at one time were placed on them, staff did not comply with these limits. On one ward we observed seven people in one room where a maximum of three was allowed. We also noted some corridors leading to the ward areas were not always clutter free. This impacted on the ability to socially distance when walking down the corridors.

Staff told us they had recently raised concerns over patients being admitted into the wrong pathway (patients who were COVID-19 negative being allocated to a COVID-19 positive bay). Staff told us this had resulted in patients testing positive later for COVID-19. During our inspection, we were aware of a near miss where a patient who was COVID-19 positive was due to be moved into a bay area with confirmed negative patients due to an error in communication about their current status. We requested information following the inspection and found there had been no incidents to support the concerns which staff raised, and what we witnessed during our inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff had access to an electronic tool which recorded patient observations. This automatically calculated a NEWS (national early warning score) score for a patient and identified the level of risk associated. Staff remained responsible for escalating any high-risk patients for further review by medical staff. The early warning scoring system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. We reviewed the observations of 17 patients and found there were no patients with an outstanding NEWS score which had not been escalated. We did however find there were eight patients spread across the wards we visited who were overdue their next observations, three of these were patients who had previously scored a three or four on their NEWS score. This meant there could have been patients who were deteriorating and who may not have been identified and escalated for further treatment in a timely manner.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 14 sets of notes containing risk assessments for patients including (but not limited to) skin integrity, nutritional risks, falls and manual handling assessment. Risk assessments were conducted on admission and we found evidence of reassessment when there had been a change in circumstances or on a routine weekly basis. Managers spot checked admission risk assessments to ensure staff were completing them within six hours of admission, which they usually did. They had previously found some issues regarding quick transfers where a risk assessment had just been conducted therefore staff did not complete their own on transfer. However, the managers did not accept this response and had completed work to ensure all patients had new assessments completed when admitted to the wards.

Most staff knew about and dealt with any specific risk issues. Staff we spoke with were knowledgeable about the risk of sepsis and would immediately escalate a patient who was a potential sepsis risk to the medical staff. Staff were confident in the response they received when escalating patients at risk of deterioration, especially those with potential sepsis. Staff told us, medical staff were quick to respond and provide the required treatment when necessary. At the time of our inspection, there were no patients who were suspected as at risk of developing sepsis.

Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe. Staff used handover templates to ensure important details were always handed over to an oncoming shift. We observed these handover documents and they appeared comprehensive. We also saw additional updates being handed over to staff following ward rounds.

Prior to our inspection, concerns were raised to the CQC about some of the discharges from the wards we visited. Concerns had been centred on patients being discharged with cannulas still in place (tubes into a vein where medication and fluids can be administered) and medicines not accompanying patients. In one incident, a patient required readmitting due to the delays in receiving medicines. We found all patients had a discharge checklist located in their nursing documentation, however none of these were completed. Staff told us it was rare for them to use these checklists, despite having important checks on there to ensure a safe discharge occurred. Ward managers were not aware of any checklists in place to provide reassurance of a patient's safe discharge, although some told us there would be some checks in place for a complex discharge. Information received after the inspection showed a situation, background assessment and recommendation (SBAR) tool had been added to the new electronic patient record system. No additional information was included about how this was being used to ensure patients were discharged in a safe manner or any audits on the effectiveness of this tool. Staff did not appear aware of this new tool either as there was no mention of this tool when we asked staff about how they ensured patients were discharged safely.

Prior to our inspection, concerns were raised around the ongoing assessment of patients for needs including support with elimination, repositioning to prevent pressure damage and hydration. We found all wards used the intentional rounding/comfort rounds to support their regular assessments of patient needs. Intentional rounding/comfort rounds are a structured process whereby staff carry out regular checks, with individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items. All wards aimed to review patients on a two hourly basis regardless of any specific needs. We found during the night shift staff were generally completing the reviews as scheduled and documented their actions. However, after 6am, the reviews became sporadic with some reviews completed four hourly or more. Most of the documents we reviewed evidenced patients being reviewed between two to three hours. Some of the concerns raised to us was around staff completing documentation to state checks had been completed when they had physically not completed any checks. We did not see any evidence of this during our inspection.

During the most recent surge in COVID-19 cases, there was a demand for more non-invasive ventilation. Non-invasive ventilation (NIV or ‘mask ventilation’) is a way of helping a person to breathe more deeply by blowing extra air into the lungs via a mask when they breathe in. Ward 17 was a respiratory ward and had previously had patients admitted requiring NIV. The decision was made to create a specialised bay for patients requiring this intervention. Only patients who were COVID-19 positive were allocated to this bay for intervention. Whilst developing the bay, staff from critical care and outreach supported the ward staff when delivering care and treatment until all staff had successfully completed their competencies to enable them to provide care and treatment. The staffing of the bay had been carefully considered by senior staff who developed the bay to ensure it met national standards and guidance.

Staffing

We were not assured the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Agency staff were not always provided with a local induction of the areas they worked in. However staffing levels and skill mix were reviewed throughout the day and where support could be provided, it was.

Medical care (including older people's care)

At the time of the inspection the trust were 12 months into the pandemic response to COVID-19, although the number of COVID-19 inpatients had significantly reduced when we visited.

The service did not have enough nursing and support staff to keep patients safe. All wards we visited identified staffing as the main risk. The concerns raised were a mixture of not having enough staff (due to vacancies or sickness) as well as not enough substantive staff on the shift. On one ward, staff voiced their concerns over the development of a non-invasive ventilation bay which required strict staffing to maintain safe standards. Staff told us the staffing for the ward had already been low prior to this specialist bay opening. Since this bay opened, the staffing has been diluted even further and there were regularly reduced numbers of staff on each shift. Staff from all wards discussed the difficulties which the COVID-19 pandemic had on the staffing of their wards.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance when completing the off duty. However, we found oversight of staff changes was not always maintained leading to concerns with staffing numbers and skill mix. All off duties (staff rosters) were completed electronically. Ward managers were responsible for completing these, with each matron having oversight of the off duties to ensure correct numbers and skill mix for each shift. These were completed a month in advance ensuring any shortages were covered well in advance. However, staff told us there had been times when continuous oversight hadn't been maintained which led to shifts being inadequately manned. We saw information in the incident data which supported these concerns. In one incident dated 20 January 2021, a staff member escalated concerns when due to finish their night shift due to inadequate staffing numbers and no trained staff present to manage the specific needs of a patient on the ward at the time.

The ward manager could adjust staffing levels daily according to the needs of patients. Safe care checks (also known as acuity scores) were required to be completed twice per day. Patient acuity refers to the needs/requirements of a patient, this may change in relation to their reason for admission and length of stay. Staff told us where the acuity of the ward heightened, additional staff were not always allocated. During the inspection, we observed an incident where a patient was deemed to require one to one care. However, despite staff requesting this, an additional member of staff was not allocated to the ward for this purpose. This was escalated to a senior member of the trust executive team at the time of inspection due to the risk this presented within the ward and to the patient. Members of the senior leadership informed us after the inspection this had been actioned immediately to ensure the patient was kept safe.

The number of nurses and healthcare assistants did not always match the planned numbers. All wards we visited displayed their planned and actual staffing numbers. We found all wards were demonstrating shortages in their actual staffing numbers compared to their planned staffing. Of those where staffing fell below their planned numbers, one ward had a member of staff allocated to them from a different ward. One staff member told us they rarely had a day where they had all staff on the shift which they had planned for.

We reviewed information about staffing for the wards we inspected between 15 January and 11 March 2021. We found all wards had more staffing shortages on day shifts than they did on night shifts. We also found there were fewer staffing shortages during weekend shifts than there were on weekday shifts. The information received did not contain details of shifts for 16th, 17th, 23rd and 24th of January 2021.

- Ward 1 recorded more non-registered staff shortages during this period (72 out of 156 shifts were short of at least one non-registered staff member). The ward recorded two days where there were no staff shortages.
- Ward 2 recorded slightly more registered staff shortages during this period (60 out of 156 shifts). The ward recorded eight days where there were no staff shortages.

- Ward 3 recorded more non-registered staff shortages during this period (61 out of 156 shifts). However, they also recorded a significant number of overfilling shifts with registered staff with 50 out of 156 shifts having at least one more registered member of staff. The ward also recorded 11 days where there were no staff shortages.
- Ward 16 recorded more non-registered staff shortages during this period (69 out of 156 shifts). However, they were the only ward that recorded staffing shortages for all shifts for both registered and non-registered staff on one day. The ward did record nine days where there were no staffing shortages.
- Ward 17 had the most staffing shortages recorded for any group of staff. The ward recorded there were 77 out of 156 shifts which were short of at least one registered staff member. The ward recorded nine days where there were no staff shortages.

The service had significant staff vacancy rates. All wards we visited had a number of staff vacancies which the senior managers were trying to recruit into. Staff told us there were recruitment events on-going to improve the staffing for the medical services. Staffing vacancies was a risk which was on the Care Group's risk register which was graded as a high at the time of the inspection. Information shared with us by the trust showed all wards we visited had vacancies within their staffing establishments.

- Ward 1 had both registered nurse and unqualified staffing vacancies. Registered nurse vacancies were recorded as 3.56 whole time equivalent (WTE) vacancies and unqualified staff recorded as 1.38 WTE vacancies.
- Ward 2 had the largest registered nurse vacancies which was recorded at 5.16 WTE. There were no unqualified staff vacancies on this ward.
- Ward 3 recorded a registered nurse vacancy of 3.78 WTE. There were no unqualified staff vacancies on this ward.
- Ward 16 had both registered nurse and unqualified staffing vacancies. Registered nurse vacancies were recorded as 0.42 WTE vacancies and unqualified staff recorded as 2.33 WTE vacancies.
- Ward 17 had both registered nurse and unqualified staffing vacancies. Registered nurse vacancies were recorded as 1.02 WTE vacancies and unqualified staff recorded as 2.86 WTE vacancies.

Staff told us there had been a recruitment drive to improve the staffing numbers within the medical division. Overseas recruitment had taken place to reduce some of the vacancies across the medical directorate, although staff told us they were mindful not to overwhelm areas with overseas nurses due to the supervision they required. One senior member of staff had also told us about additional external recruitment events which they had been able to access which had a good response.

The service had significant sickness rates in some wards which was impacting on staffing requirements. Staff from all wards told us about the impact of staff sickness during the most recent surge in COVID-19 cases. On one ward, there was a number of staff who were currently off on long term sickness as well as short term sickness. This was having a significant impact on the staff which were still working. Staff from other wards told us staff sickness had been difficult to manage due to the already low numbers of staff.

The service used bank and agency nurses across all of the wards. Managers tried to limit their use of bank and agency staff and requested staff familiar with the service. To try and ensure consistency within areas where there was reliance on agency staff, some managers made block bookings for agency staff. However, this was not always possible. Staff told us there was significant usage of bank and agency staff within the wards due to the recent surge in COVID-19 cases. In the earlier stage of the pandemic, there had been an uplift in staffing in the wards due to redeployed staff from within the trust. However, during the most recent surge in cases, redeployment of staff was lower in numbers due to many of the departments continuing to provide a service. This meant more reliance on bank and agency staff. On one ward, staff

members expressed concerns around the numbers of agency staff completing shifts. On one shift a member of staff was the only substantive member of staff which had caused considerable anxiety. The member of staff had escalated this incident to senior members of staff. We also reviewed incident data for the wards which we visited and saw incidents supporting the concerns raised by staff about the reliance of agency and bank staff. In one incident dated 30 January 2021, we saw information reporting there being no members of 'the regular staff' being present on a shift, only bank and agency staff were present to cover the ward.

We were not assured managers made sure all bank and agency staff had a full induction and understood the service. Bank staff completed online training and virtual induction prior to commencing work in the trust. Agency staff supplied under the 'agency framework' underwent internal checks on their training and general competencies and were only supplied to trusts if this was in order, as required under the framework agreement. Agency staff supplied 'off framework' underwent checks by their employers as part of their ongoing governance processes. Senior staff told us local inductions of agency staff were required on each shift they completed. This should have included important information about fire safety, resuscitation equipment, donning and doffing areas and staff comfort areas. However, not all staff within the ward areas were aware of this requirement and were not aware there was a document for staff to complete when this was done. Senior staff told us they did not perform checks of these local inductions to ensure they were performed. There was also no local checking of agency staffs competency for specific skills. Staff told us of an incident where an agency member of staff was allocated to a ward area where specific skills and competencies were required. However, the individual did not have these skills and competencies, and this resulted in the staff member completing a task they were no competent for and risked the safety of a patient. We escalated this incident to the senior leadership team for investigation at the end of our inspection. Following our inspection, the trust provided us with three completed local induction check sheets for agency staff. One of the forms was completed in 2019 and the most recent was February 2021, both of which were for wards we did not visit. The third did not have any details of time, date or ward. All three forms have areas which had not been ticked off as completed on the local induction.

There were two comprehensive staffing meetings which occurred each day. All ward managers/nurse in charge were required to complete safe care checks (acuity checks) on the patients on the ward and submit to inform the staffing meeting. In addition to this staff were required to raise a 'red flag' to identify the risks associated with staffing. The risks included (but were not limited to) less than 50% substantive staffing on a shift, understaffed and unable to meet one to one care requirements for patients. Information provided by the trust showed all wards had reported red flag staffing incidents between 4 January and 11 March 2021. Ward 1 reported 36 red flag staffing incidents, which was the largest number reported. Ward 2 reported seven incidents, Ward 3 reported 26 incidents, Ward 16 reported 12 incidents and Ward 17 reported three incidents. Staff from Ward 17 told us they didn't always report staffing concerns (through red flags or the trust incident reporting system) because they felt this did not achieve anything. During an interview with a member of staff, comments were made around staff inappropriately raising incident reports about staffing concerns within the wards. This raised concerns around the culture for raising incidents within the trust, not just in relation to staffing but raising incidents and concerns in general.

Information shared with us by the trust showed ward staffing reviews had occurred for Wards 1, 2 and 3 (Ward 1 21/10/20, Wards 2 & 3 02/11/2020). However, no information was submitted for Ward 16 and Ward 17 which meant we could not be assured the wards had undergone a review recently to ensure staffing was adequate for the requirements and demands of the ward. During a recent interview with a senior member of staff, they told us there was currently a review going on of all the staffing for the division with a view to stabilising staffing requirements now the most recent surge in COVID-19 had started to resolve.

Medical staffing

Medical care (including older people's care)

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Staff we spoke with told us there were enough medical staff to ensure patients were kept safe. Staff felt even during the most recent surge in COVID-19 patients, there was always enough medical staff to keep patients safe. Staff on one ward told us there use to be an issue with medical staffing and the cover provided, however this has changed and now they are well staffed from a medical staff perspective.

The medical staff matched the planned number. All wards we visited reported no concerns with medical staffing on that day. Staff told us there had been occasional times when there was only one registrar at night covering all medical areas, however staff still felt this was safe and had not raised concerns about this formally.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staff were positive about the skill mix of medical staff. Even during the height of the pandemic, staff felt there was a good skill mix amongst the medical teams. Staff told us there would always be a minimum of two junior doctors (foundation year one).

The service always had a consultant on call during evenings and weekends. Staff told us there was access to a consultant seven days a week. When the consultant was not physically present in the hospital, medical staff had access to a consultant who would attend if required. Admitting areas had physical consultant cover seven days a week. Consultant ward rounds were conducted six days each week, with no consultant ward round occurring on a Sunday. Out of hours, staff had access to the on-call team who would review a patient first before deciding on whether consultant presence was required. Advanced Care Practitioners (ACPs) were also part of the on-call team, staff told us they were always accessible and experts on the deteriorating patient pathway.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed 14 sets of complete notes and found most notes were comprehensive and met the professional standards set by the General Medical Council and Nursing and Midwifery Council. Notes were clear, thorough and had evidence of plans for the patients. Staff dated, signed and printed their details on most entries. Nurses documented in separate notes to medical and allied health professional staff, however this did not impact on the ability to receive an accurate update of the patients care and treatment. On one ward, the ward manager had identified a previous concern with the quality of documentation and had devised a prompt list for staff to complete. This was devised based on important headings which cover the care and treatment provided to patients. Staff from this ward were all positive about this change and the improvement in quality of the documentation.

We requested information on documentation and records audits after the inspection due to some concerns around documentation standards prior to the inspection. The information received showed results from October 2020 to January 2021. Ward 16 had consistently flagged as being below the standard expected, whilst Ward 2 and Ward 17 were achieving the expected standard for these months (except for October 2020 for Ward 17 who did not appear to have a score recorded). There were no specific details around what standards were looked at specifically for this audit. An action plan was submitted with the audit information to demonstrate how managers were driving improvements within this ward. During our inspection we found documentation standards on Ward 16 were in line with professional standards.

Medical care (including older people's care)

When patients transferred to a new team, there were no delays in staff accessing their records. No concerns were raised by staff about the lack or delay in records for patients in their care. Staff felt they had all the relevant records for them to deliver safe care and treatment to their patients.

The service had access to the patient administration system which recorded where patients were located within the hospital and contained any flags which staff needed to be aware of, for example safeguarding flags, patients with learning disabilities, infection control risk patients to name a few.

Records were stored securely. Medical notes were stored in the doctor's office in trolley's, whilst the nursing notes were either kept at the end of the patients' bed or outside of the bay. Where a bay was designated as a red COVID-19 bay, the nursing notes were kept inside the bay where staff were always present.

Medicines

The service had systems and processes in place to safely prescribe, administer and record medicines and staff mainly conformed to these.

Staff mainly followed systems and processes when safely prescribing, administering and recording medicines. We reviewed 14 medicines administration charts and found patients mainly had their medicines administered as prescribed. We found some minor issues in relation to staff not specifying which route a medicine was administered when a prescription indicated it may be given in more than one route. We also found staff had no available space to indicate the reason/follow up when a patient refused a medicine (only a code could be entered).

During our inspection, we observed staff completing medicines rounds. Staff wore red tabards to ensure staff knew they were completing a medicines round to prevent unnecessary interruptions. We did not observe any medicines left by patient's beds waiting to be taken, patients where necessary were helped to take them as soon as they were handed to them.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff told us they had regular pharmacy cover throughout the day who reviewed all medicines charts to ensure patients were receiving medicines as prescribed. Where necessary, pharmacy staff would discuss any specific medicine queries with the team caring for the patient or the patient themselves. Pharmacy staff would also help with pharmacy related incidents.

Staff stored and managed prescribing documents in line with the provider's policy. Medicine administration charts were paper based documents which were stored in the patient's bedside folder.

Is the service effective?

Inspected but not rated

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed staff distributing meals at lunch time. All staff were involved if not included in other essential tasks and staff provided support and assistance to patients who required it.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 10 fluid charts and found they were generally well documented with staff completing a total and a balance at the end of the day. There were a few entries on one chart where staff had entered 'PU (passed urine) in toilet' which meant it was impossible to complete an accurate balance, however this was not a common practice. Staff from Ward 16 said there had been a drive within the ward to improve the documentation and fluid balance charts had been one of them.

We also reviewed eight food charts and found these to be well completed and evidence of additional steps taken by staff to improve a patient's nutritional intake.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In all 14 sets of notes we reviewed, all patients had evidence of an initial malnutrition risk assessment with additional reassessments undertaken depending on changes to the patient's status or due to length of time admitted. Where indicated, we saw follow up action (referral to dietitian) and an individualised care plan to support ongoing care for the patient.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff referred patients for additional support if risk assessments highlighted they were at risk.

Competent staff

The service did not always make sure staff were competent for their roles.

Managers did not always give new staff a full induction tailored to their role before they started work. Staff told us during the pandemic, new starters did not always attend a trust induction within a timely manner. Local inductions had been key to ensuring staff felt comfortable and confident in their roles. One staff member told us they were newly qualified and had received no induction or preceptorship since starting in December 2020. They had however been given a lot of support by their ward manager to help them settle into their new role. They had now received information about their preceptorship which was due to start imminently including competencies which they were required to get signed off.

Managers did not always make sure staff received any specialist training for their role. The trust had recently implemented the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms to support patients who were within the last year of life or who had specific advanced directives about the care and treatment they wanted in an emergency situation. These forms also replaced the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms at the trust as this was contained within these forms. Staff from all wards told us they had received no formal training on these forms. This had meant staff were not completing the forms accurately to reflect the wishes of patients. As staff had not had formal training on the forms, they had substituted the old DNACPR forms for the new ReSPECT forms and only completed this section on the form with the exception of one which had very minimal information recorded about the patient wishes. In addition to this, the patient leaflet which accompanies the ReSPECT forms were found contained in the patient recorded in nine out of the ten sets of notes we reviewed of patients who had a ReSPECT form in place. Information received from the trust following the inspection identified there had been on-line training provided for staff to complete and they had ensured staff had completed the training. However, there was no supporting evidence around compliance with this training provide with this information.

On Ward 17 (respiratory ward), a non-invasive ventilation bay was set up due to the increase in demand for this procedure throughout the trust. Senior staff told us patients requiring this type of intervention had previously been cared for on the ward prior to this. However, this was in lower numbers and staff who already had the competencies would be allocated to the patient. To ensure the new way of working would be safe, staff were required to complete a range of electronic (online) learning modules to introduce them to providing patients with non-invasive ventilation (NIV) including relevant anatomy and physiology. They also completed educational modules about the equipment being used. Staff completed competency packages and shadowed critical care and outreach nurses during shifts in the NIV bay. In addition to the support from critical care and outreach staff, the matron for the ward and respiratory consultants completed clinical shifts to support the staff working in the bay. Staff were not required to care for NIV patients independently until they had successfully completed their competencies. At the time of our inspection 89% of eligible staff had completed the competency packages and were signed off by the practice development nurse. Despite the work which had been put into opening the NIV bay in a safe manner, staff had concerns about the speed in which this was opened and the expectations placed upon them to achieve their competencies in a small amount of time. Staff who had not provided care and treatment for patients receiving NIV previously, felt rushed to complete their competencies. Staff acknowledged there was support during their shadowing shifts, however felt anxious about working in the bay without that support. We raised this with the senior leadership team at the end of our inspection due to the anxiety and concerns raised by staff. The Interim Chief Executive informed us after the inspection they had made the decision to close the NIV bay due to the demand for this intervention reducing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to discuss with us situations when patients may require a formal capacity assessment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Prior to our inspection, we had six concerns raised with us about the practices around staff at the trust placing a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on their relatives without any discussion taking place with the patient and/or their relatives. During this inspection, we reviewed ReSPECT forms for evidence of discussion and agreement with the patient. We found five out of 10 forms which indicated the patient had capacity, had evidence of a discussion with the patient themselves which also included evidence of the patient agreeing to no advanced attempts at resuscitation documented in their medical records. Staff and the patient came to a mutual agreement about the level of care which was to be provided to the patient in the event of their health deteriorating. For the remaining five patients who did not have capacity, we found evidence in four patients records of discussions with family members taking place around the decision of whether resuscitation attempts should be made. For the one patient where we could not locate a discussion with the patients family, staff had indicated they had wanted to discuss this with the patients family however they had no family in this country and had no contact details provided for them. Due to the patient's current medical status and underlying health conditions which would not improve, a decision had been made by the patients' medical team to not attempt resuscitation should the patient go into cardiac arrest. Following our inspection, we have received a further two complaints about staff completing these decisions without engaging with the family or the patient. In one of these complaints, the incident pre-dated the date of our inspection.

Medical care (including older people's care)

Following our inspection, we requested information from the service around auditing of their DNACPR completion and also completion of the ReSPECT forms. Information received highlighted auditing of ReSPECT forms only commenced in February 2021 due to the recent roll out of the forms. The audit showed there were 38 ReSPECT forms completed for the wards we visited during this inspection. Of these 38 forms, 14 had evidence of family involvement in the decision-making process for end of life care. However, there was no supporting information to identify the circumstances of the ReSPECT forms and whether the family should have been included in all of the decision-making processes. It was therefore difficult to form a conclusion on the performance in relation to ReSPECT forms. Actions identified by the auditor indicated further awareness was required across the service with the recommendation for promotional campaigns to be ran to improve completion and compliance. The next ReSPECT audit was due to be completed in April 2021.

Additional audit information received was in relation to the decision to record a DNACPR request for patients who were deemed not to have capacity to make the decision themselves. The information was presented for the complete medical division and therefore could not separate into ward specific data. The audit identified staff were still challenged in completing formal MCA assessments for patients who lacked capacity to make the decision around resuscitation with only 46% of the forms identified as requiring a formal MCA, completed. During our inspection, we did not see any concerns around the lack of a formal MCA for patients who had been deemed as not having the capacity to make decisions about their resuscitation status. The audit results for February 21 also showed there had been a decrease in the involvement of relatives in the decision making process around resuscitation with only 73% recording relative involvement. In January 21, this figure had been higher at 81%. Although on inspection we did not see any concerns around the lack of family involvement, this result was in line with the concerns which were raised to the relationship owner of the trust.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. Staff gained informed consent from patients for clinical procedures and used appropriate consent forms where required. Staff would ask patients if it was okay to complete interventions including (but not limited to) measuring observations and physiotherapy. We saw evidence of consent being recorded within the patients' medical and nursing documentation.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff told us they were required to complete training as this was part of their mandatory training. Information requested by the trust showed all wards we visited had met the trust target of 90% for their Mental Capacity Act (MCA) (2005) training and all wards we visited had met the trust target of 90% for their Deprivation of Liberty Safeguards training.

We were not assured around the oversight of the use of Deprivation of Liberty Safeguards and who made sure staff knew how to complete them. Information received from staff varied across the wards around the oversight of Deprivation of Liberty Safeguards applications and MCA assessments. Senior staff told us there were specially trained staff within ward areas to complete both Deprivation of Liberty Safeguards applications and MCA assessments. However, within the ward areas, staff told us they would either complete the information themselves or would request support from the safeguarding lead. Some managers would monitor the assessments and applications locally, in some areas this was not specified, and staff looked towards the safeguarding team for this oversight. A senior member of staff added to this by telling us the safeguarding team completed regular audits of MCA assessments and Deprivation of Liberty Safeguards.

During our inspection, we did not observe any patients who had a Deprivation of Liberty Safeguards in place and were therefore unable to confirm what local oversight was in place for patients with this in place.

Medical care (including older people's care)

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. All staff we discussed MCA and Deprivation of Liberty Safeguards with said they would approach the safeguarding team if they had concerns or questions about the process. In addition to this, the mental health team were also able to advise staff on MCA and Deprivation of Liberty Safeguards.

Is the service caring?

Inspected but not rated

During this inspection, our focuses were on other aspects of the core service where concerns had been raised. However, we observed staff providing patients with care, which was kind and compassionate, as well as respectful and dignified. Call bells were answered in a timely manner in all wards we visited. Staff ensured any personal care was conducted behind closed curtains to maintain a patient's dignity. Patients had access to drinks and staff regularly offered them drinks. We did however observe in some areas, patients call bells had fallen out of reach of the patient which meant if a patient required staff attention, this would be delayed and could have a negative impact on the patients' experience.

During our inspection, a relative of a patient wanted to speak with us to feedback their observations they had since being allowed to visit their loved one. They found all staff (nursing, doctors, allied health professionals) were excellent and nothing was too much trouble. Staff were very attentive and always checking to ensure patients were alright and had what they wanted.

Staff told us they endeavoured to maintain contact with relatives throughout the pandemic and had purchased additional technology to enable them to do this. This enabled them to involve those close to the patient in their care and treatment, especially when making important decisions.

Is the service responsive?

Inadequate ↓↓

Our rating of responsive went down. We rated it as inadequate because:

Meeting people's individual needs

Whilst the service had systems in place take account of patients' individual needs and preferences, robust arrangements were not always in place to provide assurance of safe and effective patient discharge. Most staff were able to implement reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were aware of the need to meet the individual needs of people living with complex needs, however COVID-19 had provided challenges at times on how they achieved this. The specialist nurses for both dementia and learning disabilities completed some of their work off site which had meant there was a small delay in

them reviewing patients. Managers told us that they used their discretion around relatives accompanying patients, those with cognitive impairments and learning disabilities (as well as end of life care patients) would usually be allowed one relative to accompany them. Staff told us this was important to enable them to provide care that met their needs and would usually have a calming effect on them at times of significant distress.

Staff still had access to distraction boxes for patients living with dementia which included items like twiddlemuffs and puzzles which they had used. Dementia champions were in place on all wards prior to the pandemic, however in some area's champions were not able to deliver their roles effectively.

Wards were designed to meet the needs of patients living with dementia. Staff on some wards told us their wards had previously been reconfigured to improve the environment for patients living with dementia.

The service had information leaflets available in languages spoken by the patients and local community. Staff had access to information leaflets in alternative languages if required for their patients. We also saw some posters displayed in the ward areas in different languages, languages which were relevant to the local community which the hospital served.

Managers did not always make sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they were usually able to order interpreters for patients whose first language was not English. Staff on one ward told us about a recent experience of ordering an interpreter. They had experienced a short delay in the interpreter arriving to the hospital, however in the interim staff were able to use an alternative method of interpretation using a telephone. Another example staff gave us was for a language which was difficult to source an interpreter for. Staff on that ward were able to use a member of staff from the hospital to help in the short term for interpretation of key information. However, on the day of inspection, we observed staff on one ward using their personal mobile phone for interpretation purposes. Senior staff were not aware of these challenges at the time and were unable to provide a rationale for using personal mobile phones for this purpose. They told us they would review this to establish if there were any difficulties at the time with the usual interpretation services.

We requested information after the inspection to evidence how staff had used the interpretation services within the medical services. Information provided was for the whole trust over a year long timeframe. This showed there had been 6,770 bookings for interpretation services since 2 March 2020. Of these bookings, 59% had been provided by telephone, 38% were provided face-to-face and 3% provided through on demand video calls. No information was provided in relation to any challenges or delays in providing these services, however the trust did provide a satisfaction score of 4.8 out of a maximum of 5 demonstrating patient satisfaction with the interpretation service they had received.

Information provided by the trust showed there had been concerns raised about the lack of support for patients who had a hearing impairment. As a result of this, the trust had purchased six mobile digital interpreting services to promote bedside British Sign Language (BSL) interpretation. During our inspection, staff did not refer to any provision of interpretation services for patients with a hearing impairment, the focus had been on the interpretation requirements for those patients whose first language was not English. Information provided after the inspection showed BSL was one of the top ten requirements from staff over the last year. There were 160 requests from staff for BSL interpretation out of the 6,770 requests made from 2 March 2020.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us there had been no changes to the food and drink provision for patients. They were able to meet the cultural, religious and personal preferences of patients.

Staff had access to communication aids to help patients become partners in their care and treatment. However, not all staff were aware of alternative aids. Some staff told us they had access to a range of supportive communication aids to use with patients which included pictorial cards and electronic devices to support communication.

Access and flow

People could access the service when they needed it and received the care promptly. Waiting times from decision to discharge to actual discharge of patients was minimal, however discharge planning was not always completed proactively for patients.

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior managers were proud of their low delayed discharges from hospital. Prior to the pandemic, the trust had a medically fit for discharge ward where patients who were ready for discharge would be admitted whilst awaiting packages of care to be finalised. Senior staff told us they no longer required this as there had been significant work completed on the discharge pathways which had resulted in very few patients waiting for long periods for discharge.

When patients were identified as medically fit for discharge, capacity managers would review the individuals to identify who was suitable to move to the discharge lounge. Once a patient was identified, staff told us the patient would need to be ready to move straightaway as it was usually a swift process to transfer them to the discharge lounge.

Information received from the trust also identified the trust had completed work with local partners to reduce the delays experienced by patients waiting for a care home placement. A local care home had been identified to receive patients from the hospital who were COVID-19 positive as an interim measure prior to transfer to their designated care home. This had a positive impact on the number of delayed discharges.

We were not assured that managers and staff worked to make sure that they started discharge planning as early as possible. Although the number of patients awaiting discharge was low at the trust, we found there was inconsistent practices for preparing a patient for discharge. We reviewed 14 complete sets of notes and two additional sets of notes of patients who were confirmed for discharge the day of the inspection, looking for evidence of discharge planning. There was no evidence of discharge planning in 11 of the 16 sets of notes, including the two additional sets of notes of patients who had been identified as medically fit for discharge. For the remaining five sets of notes, one of these had identified a difficulty with communication with the next of kin as they were living in a different country, it was clear to see there were arrangements being completed for rehabilitation after discharge. The other four sets of notes had a small amount of information contained around the discharge requirements for the patient however this was brief.

Discharge coordinators planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge coordinators were responsible for facilitating discharges. Details of expected discharges were shared with the team early in the morning and a member of the team would attend the ward to take details of any outstanding issues. The team were able to facilitate a discharge the same day for patients with a straightforward discharge, however they may be delayed if the discharge was more complex. A member of the discharge team told us they were able to put additional 'wrap around care' in place for patients who were going home on discharge to support them, especially if there were concerns around how the patient may cope. This wrap around care could be in place for up to 72 hours during which additional assessment was taking place for any additional measures required after this period was up. This had been very successful in enabling patients to remain in their own home and reduce the risk of readmission.

Medical care (including older people's care)

The pandemic had sometimes impacted the patients who were due to go home on discharge due to families having concerns about the possibility of passing COVID-19 on to other members of the family who may also live with them. However, staff told us about examples of discharges where they had managed to provide additional care and support and rearrange a room so that it was designated to the patient to reduce the risk of transmission to other family members. This was well received by the families where this occurred.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

Leadership

We were not assured all leaders had the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. However, most of the leaders supported staff to develop their skills and take on more senior roles.

The division was led by a divisional medical director, divisional general manager and a director of nursing. They linked to the executive team for the trust and had oversight of medical services across the trust. The individual care groups comprising the various medical wards were led by matrons. The triumvirate met weekly to discuss the service level issues, however these meetings were not minuted and therefore we could not identify if there was a set agenda for these meetings. The divisional director of nursing told us they worked well as a triumvirate team. Feedback from staff was that the divisional director of nursing was very visible and supportive to staff of all levels. However, we had concerns around how the leadership managed priorities and concerns within the service. Following the previous inspection, the service was given a requirement notice around staffing concerns. We found concerns with staffing was still a large proportion of risk and concern on this inspection and staff were able to give examples of harm and near misses. Although we acknowledged the pandemic had impacted staffing within the service, we were aware of the challenges the service faced around staffing prior to the pandemic. We also found concerns around discharge planning for patients and the potential risk this involved. During our interviews with senior leaders, they were not sighted on these issues and were unaware of the lack of documentation to support patients experiencing a safe discharge.

Most of the staff told us they had felt supported by the senior leadership team, especially during the height of the pandemic. In particular staff identified the visibility and support that came from the chief nurse and interim chief executive.

There was a mixed response from front line staff about the leadership across the service. Most staff were extremely complimentary about their ward leaders and felt they were highly visible and supportive, with staff from one ward believing their manager was too modest and had been instrumental in the improvements made to ward. On one ward staff could not be more complimentary about the support they received from their manager and the investment in them to develop their skills and confidence. Staff told us it had been quite a daunting time over the past few months due to the pandemic, but with the leadership and management from their immediate leaders, they had gotten through it together as a team. However, some staff spoke about the challenges experienced due to absent ward managers. Although in some cases, this was due to circumstances beyond their managers control, this had still impacted the leadership and standards within the ward.

There was also a mixed perception on the leadership from the matrons. Some staff had commented on how they rarely saw the matron responsible for their area and they had seen them more on the day of our inspection than they had for months. Staff told us they felt some matrons were not always sighted on the issues faced in their areas of responsibility. However, staff mainly found the matrons for their areas to be visible, supportive and prioritised the right issues within their areas of responsibility.

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. However, some staff on wards where there had been significant changes did not feel supported by senior managers and specialist teams.

With the exception of one ward, staff told us they generally felt well respected, supported and valued by all members of their team, leaders and senior leadership team. Staff referred to themselves as 'one big family' within one ward area where they could approach any member of their team if they needed help. On another ward, staff spoke about the way in which they had all been there for each other during the 'hardest times of their career' and had picked each other up on days when they were down. There was an open-door approach to most local leaders and staff told us they would feel comfortable approaching them with concerns.

Managers on most wards told us morale despite the challenges of the pandemic was mainly high within their areas. However, they were concerned about the potential for some challenges appearing once staff had time to process what they had been through and the situations they had faced. Managers had tried to implement debriefing sessions but this had been hard so they had to modify how these sessions were presented. One manager had implemented 'chippy Tuesday' and 'pizza Friday' where food was provided for staff in the staff room and they were able to come along and where they felt it appropriate to do so, they could share their stories and concerns. So far this had gone well with staff and the manager was keen for this to continue. On another ward, the manager had implemented 'Thursday tea parties' for the staff.

On one ward staff were feeling undervalued, unsupported and not listened to. There were significant challenges within the ward from a staffing perspective and the pressures that came with the service. Despite approaching leaders and other individuals for support, staff did not feel they were listened to and the concerns they had went unresolved. Staff told us this had impacted a number of staff with short- and long-term sickness increasing. Due to the lack of support received, they now believed there was a disconnect between them and the leaders of the ward, and many felt they were at 'breaking point'. From a leaders point of view, they believed they had tried to listen and remedy any of the concerns staff had by implementing different ways of working and approaching staff external to the ward to facilitate some listening and supportive sessions, but unfortunately these were not taken up by staff. One of the opportunities provided for staff was for a psychologist to provide support to staff, but unfortunately no one accessed this support. We raised the concerns with the senior leadership team at the end of the inspection who took this on board and reviewed the situation immediately. The interim chief executive contacted the CQC shortly after this with an update of actions they had taken to support the staff in the area. In addition to this, an interview with the divisional director of nursing also provided further information around this situation around what additional support they were putting in place and the feedback from staff had been positive.

All staff we spoke with told us the needs and experiences of the patients came first and their safety was paramount. However, staff identified they were not consistently given feedback to enable them to continue to provide the high quality, safe care they were focused on delivering. If changes/improvements were required, staff did not always receive this information.

The trust had an appointed 'Freedom to Speak Up Guardians' which most staff were aware of. There was a mixed response from staff we spoke with about speaking up in the organisation. Some staff said they would feel confident about raising concerns and speaking with their manager if they had a problem or concern, however there were staff who had no confidence in raising concerns, mainly because they felt no action would be taken. Some staff had used the freedom to speak up guardian during our inspection and told us although the guardian was supportive and understanding, however they felt not a lot had changed by going to them.

Although there were no members of staff who directly told us they would not raise a concern due to fear of reprisals by senior managers, information provided by one ward indicated there had been concerns about reprisal if they raised concerns prior to our inspection. Following an incident on one ward, some targeted work had been completed with staff to raise awareness and knowledge about safeguarding. An anonymous survey was conducted in November 2020 which identified there had been staff who had seen poor care and treatment but had not raised this due to fearing "they would be trouble" for doing so. In addition to this, they also indicated that "it depended on who you were reporting as providing poor care as to whether any actions would be taken". Some staff had raised concerns on how this was managed at the time, with some staff reporting concerns about the survey not actually being anonymous and staffing being in trouble for the comments made within the report. This had impacted on the culture for raising concerns within this ward. On another ward, the reporting culture had been significantly impacted because of the lack of action. We had concerns on the messages which senior staff were sending out about the reporting culture. Feedback was rarely given to staff which did not encourage staff to continue reporting. We were also concerned by a comment made by a senior nurse around staff 'inappropriately reporting' incidents, for example staffing incidents.

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

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. At the time of our inspection some staff were unaware of any incidents which met the formal criteria to fully implement the duty of candour. However, matrons were able to recall incidents which they had completed the formal duty of candour process for. All staff were aware of the requirements for being open and honest with patients when errors had occurred.

Governance

Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

Senior staff including matrons and the divisional director of nursing were able to discuss the governance structure for the medicine service. Staff told us the majority of the significant meetings continued to go ahead, however these may have been scaled down in terms of attendance. The safety huddle was one meeting which had been identified as a key meeting which needed to continue, and we saw evidence of these meetings continuing throughout the pandemic. These were monthly meetings which reviewed serious incidents and complaints at a divisional level. Where learning and action had been taken as a result of the incident or complaint, this was logged on the document. However, we were not assured that information from these meetings was cascaded down to relevant departments for staff to learn from.

Medical care (including older people's care)

Quarterly care group meetings had continued throughout the pandemic and evidence of these were shared with us. Within these minutes, there was evidence of areas of concern and risk identified for escalation to the senior leadership team. However, we were unable to triangulate these risks and concerns had been escalated due to minimal information and minutes being shared with us by the trust about formal governance meetings.

During our previous inspection, we found matron meetings were in place where important governance issues would be discussed including incidents, complaints and staffing. During the current inspection, we found the feedback around these meetings inconsistent and were not assured these meetings were effective. We asked the trust for more information about the matron meetings to identify the structure behind them. However, the documents returned were not in relation to the meetings we had requested. The documents received were for a trust wide 'Nursing, Midwifery, Allied Health Professionals Advisory Forum' and did not appear to have attendance from any matrons. We therefore had concerns that a vital part of the governance chain within the division was not taking place and this impacted on the passage of information up the chain and downwards, back to staff within the ward areas.

At the time of our inspection, there was an inconsistent approach to team meetings amongst the wards we visited. In some areas, formal team meetings had been suspended due to the challenges related to the pandemic as well as the need to adhere to hospital and national policy around social distancing. As part of our inspection we requested evidence of each wards last three team meetings. One of the wards submitted minutes from November 2019 as one of their most recent formal team meetings. In other areas, managers were utilising other methods for communicating internal issues with staff including social media groups and newsletters. These were informal methods for communicating with staff and had no set agenda for information included. The inconsistent way governance issues were communicated with staff had impacted on the information they received around learning from incidents and complaints and other important governance related information. Staff were unable to tell us about any recent learning that had been cascaded down to them. Staff were also unaware of any recent (significant) complaints or incidents raised about the ward. Staff rarely received any feedback from any incidents which they themselves raised.

There were low numbers of audits conducted by the service. Where audits were conducted, there was minimal evidence of feedback to staff within the medical services and few formal action plans for driving improvements. Staff including the senior leaders of the service identified audit practice was low. This was a result of the pressures experienced during the pandemic. Some staff told us the audit programme had not really restarted yet after the most recent surge in COVID-19 cases and the pressure associated with this. However, some matrons had completed a small number of audits in relation to the perfect ward system. Where audits had been completed, we did not always see evidence of action plans to support practice change or improvements. After our inspection, the trust informed us of the wider audit activity which had been completed, including participation in 15 national audits and 12 completed local audits over the last year. However, staff on the wards we visited did not refer to any of these audits or the outcomes when discussing audit activity and quality improvement.

During our inspection we had concerns around the lack of effective governance processes to identify some of the risks, concerns and challenges which we came across. Examples of where the lack of an effective governance system was in place locally was around the oversight of assuring bank and agency staff had the right skills and competencies to work within a designated ward. In addition to this, we found senior members of staff had no assurance bank and agency staff were given local inductions of the areas they were working in which is not in line with trust policy. Another example we came across was the confusion over who had oversight of Deprivation of Liberty Safeguards. Staff gave inconsistent information about who completed the paperwork to apply for a Deprivation of Liberty Safeguards as well as who had the oversight to ensure those identified as requiring an application had one completed.

Management of risk, issues and performance

Medical care (including older people's care)

The division had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we were not assured all risks were regularly being reviewed and mitigated.

The wards we visited each had a risk register which were reviewed periodically, with some risk registers having risks on them which had no updated date for review documented since 2019. For risks which were deemed high by the service managers, these were escalated to care group and divisional risk registers and where necessary trust level risk registers. At the time of our inspection, all managers told us their main risk was staffing and this appeared to reflect their risk registers with the exception of Ward 17 which had no recorded staffing related risks recorded. We found variable amounts of information contained on the risk registers detailing the mitigating action in place. We also found some risks had no details of mitigation documented against it. It was difficult to establish which was the longest running risk on the register as there were some risks entered without dates of entry recorded.

Despite the compounding information presented to inspection staff about the risks of staffing within each ward, the highest risk on the care group risk register (reflecting those areas we inspected) was in relation to falls. Although some areas had identified a concern with falls, this was not an area of concern communicated to the level identified within the risk register. We therefore had concerns that the risk register did not accurately reflect the current risks which the wards we inspected presented.

Senior staff informed us they had implemented a system called 'perfect ward' which gave them oversight for some key areas of performance. Areas for monitoring included (but was not limited to) fluid balance audits, skin integrity audits, missed dose audits, individualised end of life care audits, complaints, staffing and infection prevention and control performance (hand hygiene, ward cleanliness and catheter care). We found some wards had displayed the information on their performance on the perfect ward and discussed areas of concern during safety huddles and actions required to address performance. However, we were informed staff had suspended the use of the perfect ward in some areas due to the pressures of the most recent surge of COVID-19. We therefore raised our concerns around how managers and senior staff had oversight of important areas of patient care and staff performance, and what currently was driving staff improvements.

Areas for improvement

MUSTS

The provider must:

- The trust must ensure that all staff are competent in the use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms. **Regulation 12 Safe care and treatment.**
- The trust must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSPECT forms. **Regulation 9 Person-centred care.**
- The trust must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing patients to the risk of harm. **Regulation 18 Staffing.**
- The trust must ensure systems are put in place to ensure that staff are suitably qualified, skilled and competent to care for and meet the needs of patients within all areas of the medical services. **Regulation 18 Staffing**.

Medical care (including older people's care)

- The trust must ensure effective risk and governance systems are embedded that supports safe, quality care. **Regulation 17 Good governance**.
- The trust must ensure systems and processes are established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The trust must ensure all staff adhere to policies and procedures to ensure patients are kept safe from avoidable harm of infection. **Regulation 12 Safe care and treatment.**
- The trust must ensure staff are documenting that discharge planning is taking place and discharge checklists are used to ensure a safe discharge. **Regulation 12 Safe care and treatment.**

SHOULDS

The provider should:

- The trust should consider adapting the intentional rounding timings so that they are individualised to the patient and meets the needs of the patient.
- The trust should consider how they assure themselves patients' observations are completed within the specified timeframe.
- The trust should consider improving the awareness and knowledge amongst all staff in the use of alternative communication aides when meeting the individual needs of patients.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager and two CQC inspectors, one of whom was an infection control nurse specialist. The inspection was overseen by Fiona Allinson Interim Deputy Chief Inspector.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Account number	RBK
Our reference	RGP1-10637124648
Location name	Walsall Healthcare NHS Trust

Regulated activity	**Regulation**
Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment.**
	How the regulation was not being met:
	The trust must ensure that all staff are competent in the use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms.

Please clearly describe the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- ReSPECT audits continued routinely to monitor compliance.
- Discharge checklist pilot has been implemented on all Medical wards, this includes prompt for ReSPECT (DNACPR). Audit results on completion of the Discharge checklist show marked increased compliance with completion since post inspection.
- MLTC training for ReSPECT programme continues and compliance is monitored
- The number and percentage of complaints that relate to ReSPECT (DNACPR) has reduced since March 2021. There have been no further complaints since the inspection.
- Ensure all staff who require training are able to access training supported by the Trust
- Prioritise staff who have received no training and then ensure all staff have accessed refresher training
- All staff who have received training to also have had a competency assessment.
- Raise awareness of the Division's palliative care lead who can
    - advice and support on ReSPECT at local level
    - Ensure all staff remain competent at local level by identifying and resolving issues and providing local support

The Trust End of Life Care Steering Group will:
Lead the implementation of the ReSPECT programme across the Trust which includes training, competency and monitoring.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

ReSPECT Audit is audited continuously.

Who is responsible?	End of Life Care Steering Group

What resources (if any) are needed to implement the change(s) and are these resources available?

Within current resources.	
Date actions will be completed:	MLTC actions are complete. This date refers to the Trust implementation plan. 30th September 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring will support this.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment.**
	How the regulation was not being met:
	The trust must ensure all staff adhere to policies and procedures to ensure patients are kept safe from avoidable harm of infection.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken;

- IPC policy requirements communicated to all staff. IPC audits continue and compliance is monitored.
- Donning and Doffing terminology clarified with all Medical wards.
- Video training around Donning and Doffing rolled out across all wards in MLTC.
- Divisional Director of Nursing walk around has 'tested' knowledge of terminology and IPC requirements and promoted ownership at ward level this has demonstrated improvement.
- Donning & Doffing poster are in MLTC wards.
- All senior staff challenge non-compliance.
- Make all IPC policies accessible to staff and raise awareness of all the IPC policies
- Ensure all staff who require training are able to access training and monitor uptake
- Prioritise staff who have received no training and then ensure all staff have accessed refresher training
- Ensure all required resources e.g. PPE are available and accessible to staff
- Incorporate IPC policies, procedures and implementation into the local induction processes within MLTC
- Identify IPC Lead on each ward to
    - be a resource for advice and support on IPC at local level
    - monitor compliance and audit IPC at local level

The Trust will;

Monitor policy adherence and implement improvement plans via the Trust IPC Committee and Director of Infection Prevention and Control (DIPC). This will include audits, training and communication of policy requirements.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monitoring of IPC policies and procedures via the IPC Committee.	
Who is responsible?	Director of Infection Prevention and Control (DIPC)

What resources (if any) are needed to implement the change(s) and are these resources available?

Within current resources.	
Date actions will be completed:	MLTC actions are complete. This date refers to the Trust action. 30th September 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring will support this.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment.**
	How the regulation was not being met:
	The trust must ensure staff are documenting that discharge planning is taking place and discharge checklists are used to ensure a safe discharge.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- MLTC have revised the Discharge Planning checklist and implemented across all medical wards.
- Compliance with SBAR tool for safe transfer to a care home setting forms part of the Discharge Planning Checklist audit
- Completion of the revised Discharge Planning checklist has been audited - 96% compliance demonstrated. Audits continuing.
- Evaluation of checklist completion undertaken by discharge lounge – who have fed back positively noting improvement.
- Staff report they have improved the completion and quality of discharge, highlighting the benefit of starting discharge planning from admission.
- Promote safe discharge planning on each ward
- Add ReSPECT Form onto discharge checklist
- Add Situation Background Assessment and Recommendation (SBAR) to discharge check list for patients transferred into a Care Home setting.
- Body maps are to be included on the checklist.
- Relaunch the use of the discharge planning checklist across all MLTC wards
- The discharge planning checklist is included in the documentation audit, which also includes whether discharge planning is documented on admission and on each care plan review, and this is included in the Perfect Ward Audit

The Trust Nursing Midwifery Action Forum will:

- Ensure systems and processes are in place around safe discharge and monitor compliance with the same.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Discharge checklist audits will continue; completion and action taken will form part of the monthly.

Who is responsible?	Trust Lead – Nursing Midwifery Action Forum

What resources (if any) are needed to implement the change(s) and are these

resources available?	
Within Current resources.	
Date actions will be completed:	MLTC actions are complete. This date refers to the Trust action. 31st July 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring will support this.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 18 Staffing**
	How the regulation was not being met:
	The trust must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing patients to the risk of harm

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- Twice daily staffing review in staffing hub looking at gaps, with reference to the 'safe care; acuity tool which uses red flags to alert when safe patient care may be compromised.
- Escalation SOP for use of Bank/Agency staffing is in place
- Action is taken to mitigate patient safety risks due to staffing and this is recorded on the daily SITREP and 'Safe Care' and reported to the workforce
- Ensure all staff aware of process for reviewing safe staffing across all wards and identifying issues/ escalation of staffing issues to staffing hub
- All staffing issues are recorded along with resolution.
- All wards discuss staffing issues within safety huddles at least twice daily and by exception
- Process for reviewing and communicating the need for 1:1 assessment implemented. Any enhanced staffing requested is recorded in the safety hub and managed by Matrons. The onsite manager – an experienced Band 7 Nurse/Matron provides support out of hours and an onsite report is shared with all divisions.
- Work is being undertaken with Older People's mental health team to promote the use of personalised care plans to promote de-escalation for patients with a mental health condition of cognitive impairment.
- Divisional Roster Confirm and Challenge meetings have been reintroduced.
- Staffing included on ward patient safety boards

The Trust Quality Patient Experience and Safety Committee will:
Monitor safety of staffing levels and receive escalation and exception reporting.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monitored by Safer Staffing reporting to People Organisation Development Committee.

Who is responsible?	Trust Lead – Quality Patient Experience and Staffing Committee

What resources (if any) are needed to implement the change(s) and are these resources available?

Within current resources.	
Date actions will be completed:	MLTC actions are complete. This date refers to the Trust action. 31st July 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring will support this.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 18 Staffing.**
	How the regulation was not being met:
	The trust must ensure systems are put in place to ensure that staff are suitably qualified, skilled and competent to care for and meet the needs of patients within all areas of the medical services

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken place:

- A full review of the nursing establishment and skill mix in MLTC was completed in May 2021. A Trust Board paper is to be presented for approval as a joint paper with the Surgery Division.
- Locally work has commenced on implementing the recommendations of the MLTC nurse staffing establishment review, including a 60% qualified to 40% unqualified skill mix including recruiting to vacancies.
- Staffing and skill mix has been raised on the Divisional risk register
- There has been an improvement in sickness statistics, indicating that staff are feeling supported to work competently
- Concerns raised on Ward 17 to the Freedom to Speak Up Guardian (F2SUG) regarding staffing both Ward 17 and the Non-Invasive Ventilation (NIV) unit were fully addressed immediately by the division and no further staffing concerns have been raised by Ward 17.
- Staff have reported an improvement in safety on Ward 17 with the pastoral support provided by the Matron positively received.
- All training competencies for NIV will be completed by 30th July 2021
- NIV business case approved to support the safe opening of a NIV unit. NIV specific training will be provided for the staff on this unit in conjunction with the Medical Devices trainers.
- Monitoring of competency in using NIV is monitored by Matron of NIV Ward
- Review recruitment processes (Job Descriptions and person specifications) for MLTC
- Ensure all staff access induction; training and appraisal
- Appraisals and Personal development planning continues in MLTC with assurance provided via the Executive Performance Review panel
-

The Trust People Organisation Development Committee will:
Monitor compliance and implement improvement plans.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Staff feedback. Qualifications, skills and competency will be monitored via workforce systems

e.g. recruitment, appraisals, reflective practice and validation, supervision and personal development planning.	
Who is responsible?	Trust Lead: People Organisation Development Committee
What resources (if any) are needed to implement the change(s) and are these resources available?	
Additional staff required, with a plan to recruit subject to the Nursing establishment review recommendations being approved.	
Date actions will be completed:	Current assurance by 30th September 2021 Sustainability by 31st March 2022

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring via the risk register process.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 13 Safeguarding service users from abuse and improper treatment**
	How the regulation was not being met:
	The trust must ensure systems and processes are established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- All care groups in Medicine will have Safeguarding escalation reports outlining:
  - Safeguarding training compliance for all staff groups in MLTC
  - Review of incidents and complaints relating to safeguarding and themes for improvement
- Divisional Safeguarding escalation/assurance reports to Trust Safeguarding Committee
- CCG Safeguarding committee reviews the level of Trust adult safeguarding referrals.
- The safeguarding team monitor that Safeguarding incidents or concerns have been dealt within 2 days from Ulysses Safeguard system.
- Standardised nursing staff handover includes any potential safeguarding concerns.
- Safeguarding concerns are discussed at MLTC's daily safety huddles
- Safeguarding Boards are on all the wards - The ReSPECT form is highlighted on the board. The options for ReSPECT are on the board.
- Bespoke training for Matrons/ divisional leads/ ward managers on identification of safeguarding issues and cascaded to teams
- All staff will have access to regular and routine safeguarding supervision by September 2021.
- Deprivation of Liberty (DoLs) referrals reported to Local Authority and a clinical incident is raised
- Local teaching sessions by the safeguarding team completed on all medical wards focussing on safeguarding in practice
- Complaints proforma now includes prompt for considering safeguarding reporting.
- Monthly matron escalation report includes information/action around safeguarding/ incidents
- CEO/Deputy Chief Nurse/Director of Governance (Support Team) currently have oversight of incidents at moderate level and above to provide a safety net in the short term.
- Safeguarding audits completed and reported via the Perfect Ward.
- Increase in appropriate safeguarding referrals since March 2021.
- Make all Safeguarding policies accessible to staff and raise awareness of all the safeguarding policies
- Ensure all staff who require training are able to access training and monitor uptake
- All staff make a safeguarding referral at point of concern to Adult Safeguarding team or directly to Local Authority Safeguarding.
- Prioritise staff who have received no training and then ensure all staff have accessed refresher training

- Identify Safeguarding Champion on each ward to raise awareness and understanding of the importance of Safeguarding vulnerable people and support staff

The Trust :
Safeguarding Committee will lead on the strengthening of the safeguarding policies and practices across the Trust, which includes training, competency and monitoring

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing Medicine and long-term condition Divisional Director Medicine and long-term condition Divisional Operational Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
We will ensure that staff are trained and competent and therefore the incidents of safeguarding referrals will increase. All safeguarding activity is monitored through the Safeguarding Committee in line with Local Adult Safeguarding Board requirements.

Who is responsible?	Trust Safeguarding Lead

What resources (if any) are needed to implement the change(s) and are these resources available?
Within current resources

Date actions will be completed:	MLTC immediate actions completed. Sustainability by November 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is mitigated with the actions taken and further monitoring via the risk register process.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 9 Person-centred care**
	How the regulation was not being met:
	The trust must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSPECT forms

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- Individualised person-centred information included in the care plan which is available at the bedside.
- What Matters to me information boards introduced in wards at bedside
- Detailed comprehensive handover on each shift, both at team level and between allocated healthcare professionals

This information is safely shared as;

- The MLTC have adopted the SBAR tool to support safe discharge of patients to a Care Home setting and this would include the personalised information.
- Ensure complete and accurate records are updated in real-time (Matrons and Ward Managers)
- Ensure all responsible staff are supported to access the individualised and person-centred information available to them (Matrons and Ward Managers)
- Review the current Trust Documentation Audit tool to ensure that all patient centred information is available – to include care records, what matters to me boards and handover (Director of Nursing)
- Every care team (e.g. ward) to undertake 10 sets of documentation audit. (Ward Manager)
- Discuss the results of documentation audits and the subsequent actions being taken both at ward level and care group level. (Matrons and Ward Managers)
- Ensure real-time information is transferred safely e.g. using handovers, safety huddles, (Matrons and Ward Managers)
- The Trust has implemented the Perfect Ward Audit tool which includes documentation audit and includes the information methods above, the Discharge Checklist and the ReSPECT forms. The MLTC have fully engaged in this activity and implemented across the division.

The Trust Nursing Midwifery Action Forum will:

- Monitor compliance with quality audits and identify areas for improvement.

Who is responsible for the action?	Medicine and long-term condition Divisional Director of Nursing

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Audits will be reviewed at various forums and actions for improvements identified and

implemented.	
Who is responsible?	Trust lead: Nursing Midwifery Action Forum
What resources (if any) are needed to implement the change(s) and are these resources available?	
Within current resource.	
Date actions will be completed:	MLTC Actions complete Trust Actions: 30th September 2021.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The immediate actions taken by MLTC have mitigated the risk.

Regulated activities	Regulation
Treatment of disease, disorder or injury	**Regulation 17 Good governance**
	How the regulation was not being met:
	The trust must ensure effective risk and governance systems are embedded that supports safe, quality care

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The immediate action the Medicines, Long Term Conditions Division (MLTC) have taken:

- Governance Safety Huddles are held weekly to enact incident management. All Care Teams within MLTC are represented. The incidents on the standardised extract are discussed - this includes
  - Confirming the level of harm
  - reviewing the 72 hour reports
  - reviewing actions and outstanding actions
  - reviewing and monitoring timeframes for completion
  - identifying and disseminating immediate learning
- The MLTC standardised extract is also used as an action tracker and is updated both during and immediately after the weekly Huddle and then disseminated to all Huddle Members. The MLTC Governance Facilitator follows up with action chasing activities in between weekly huddles and updates Ulysses Safeguard and therefore the MLTC Standardised extract in readiness for the next meeting.
- MLTC Divisional Director reports the outcomes of the MLTC Governance Safety Huddles at the Clinical Effectiveness, Quality Assurance and Board meetings by exception.
- The MLTC Team of Three (senior team) and MLTC Governance Team meet in between the MLTC Governance Safety Huddles to follow up progress on outstanding priority actions to be chased against incident deadlines
- A separate Serious Incident meeting is held weekly with attendance from the CCG which focusses on monitoring serious incidents which are STEIS reported.

The Trust Well-led improvement group is reviewing the governance framework across the Trust to strengthen systems and processes.

The Trust will

- Progress the work of the Trust Well-Led Improvement Group which will include review, monitoring, compliance and assurance.

Who is responsible for the action?	Director of Governance

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The Well-Led Improvement programme is reported to the Board and are within the Board assurance Framework.

Who is responsible?	Director of Governance

What resources (if any) are needed to implement the change(s) and are these

resources available?	
The Well-Led Improvement Programme is supported by the Trust Board and resources have been made available for this work.	
Date actions will be completed:	MLTC immediate actions have been completed. This date relates to Trust actions 31st December 2021

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a risk that care will not improve if learning is not translated into improved practice

Dr Matthew Lewis
Medical Director

Dr Hesham Abdalla
Director of Medical Education

Walsall Healthcare NHS Trust

Office of the Postgraduate Dean
St Chads Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

Sent via email

9th April 2021

Dear Both,

Re: Outcomes from HEE meeting with postgraduate medical trainees in Acute and General Medicine – 1st April 2021

As you will be aware the Postgraduate School of Medicine recently undertook a meeting with trainees in acute and general medicine following the emergence of concerns in December 2020 and subsequent assurances provided by the Trust. Outlined below are the key findings from our discussions with trainees:

1. Patient safety issues
2. Areas of concern
3. Good practice points

1. Patient Safety Issues

- Prioritisation of patients: The priority required by the nursing team and management team appears to differ from the medical staff, in that patients are prioritised based on their arrival time and not as clinical need. This can also cause friction and difficult interaction in the department.
- Transfer of patients from ED to AMU: It would appear that patients are being transferred from ED to AMU without any conversation or interaction with the medical team taking place, resulting in patients arriving without pre-notification. A number of transfers from ED appear inappropriate, with a lack of investigation into the patient conditions being carried out within

the ED. This also leads to some patients being seen in AMU who could have been pre-discharged.

- Post-take ward round: Trainees described having to "hunt for a consultant", to undertake the post-take ward round, which in itself could lead to difficult and avoidable situations.

In the first instance, please can we request a Trust response against the Patient Safety concerns identified, to be submitted to QAMedical.wm@hee.nhs.uk by Friday 16th April 2021.

2. Areas of Concern

- Workload: Medical staffing appears a significant issue, with particular aspects being discussed. It appears there is a struggle to cover the second registrar and trainees reported that there is often a pulling of doctors away from the acute team to cover ward work. Trainees were not aware of non-medical staff being considered as a possible solution to such issues.
- Educational opportunities: Trainees reported that the post-take ward round is not used as an opportunity for teaching and feedback.
- Handover: It is understood that there is a Handover protocol in place, which is commendable, however it unfortunately appears that it is not followed. Trainees raised concerns over the effectiveness of handover, with the morning handover being described as "shabby". Consultant attendance seems to be by exception despite it being an expectation according to the protocol. Often behaviour during handover is less than desirable with staff talking over each other and making the handover less effective.
- Patient record: The use of the electronic patient handover system 'fusion' was described as being unreliable and requires attention as well as needing to be embedded more within working practices.
- Annual leave: Trainees reported that despite requesting annual leave weeks in advance, they are not hearing back on their request without several prompts, causing some distress.
- Environment: Trainees raised concerns in relation to the poor behaviours of some of the staffing within AMU, having repercussions on their ability to work effectively together, particularly from some members of the nursing staff.
- Clinics: Despite some trainees reporting being able to access clinic, others reported having difficulties in accessing clinics particularly Internal Medicine stage 1 trainees.

- Training post: No General Practice or Foundation trainees would recommend the post as a place to train and only half of the registrar's trainees would recommend the post as a place to train.

Please can we request a Trust update against the 'Areas of Concern' in 6 weeks, due Friday 21st May 2021, to be submitted to QAMedical.wm@hee.nhs.uk.

3. Areas of Good Practice

- Access to Clinics: Certain speciality trainees reported being able to access clinics, specifically respiratory and gastroenterology.
- Teaching: In general teaching appears to have been maintained. Trainees reported that teaching has been maintained for foundation and general practice despite COVID challenges.
- Senior support: Trainees reported some good learning opportunities when consultants were involved.
- Educational Governance: The Educational team are aware of many of the issues discussed and improvement plans are in place. This is acknowledged and applauded although concerns have been raised for some time and changes are only now being implemented.

We are currently triangulating the concerns identified with our wider intelligence and will be in touch shortly to advise on the planned next steps in relation to the concerns that have been identified, however in the meantime should you wish to discuss any of these details further then please contact Andy Whallett (Andy.Whallett@hee.nhs.uk) who will be able to assist. We look forward to receiving the Trust response against the patient safety concerns by Friday 16th April 2021 and an update to the 'Areas of Concern' by Friday 21st May.

Yours sincerely,

Professor Russell Smith

Regional Postgraduate Dean, Midlands

Cc. Dr Andy Whallett, Deputy Postgraduate Dean, West Midlands

Cc. Leanne Clews, Head of Quality and Commissioning, Midlands

Cc. Kelly Smith, Senior Quality Lead, Midlands

Cc. Dr Phil Bright, Head of West Midlands Postgraduate School of Medicine, HEE

Cc. Dr Anthony Choules, Foundation School Director West Midlands North, HEE

Social Care and Health Overview and Scrutiny Committee | **Agenda Item No.**

14 July 2021 | **8.**

Proposals for Acute Urology Services at Walsall and Wolverhampton

Ward(s): All

Portfolios:

1. Aim

1.1 The aim of these proposals is to ensure safer, and more responsive acute care provision to the residents of Walsall by merging elements of urological emergency and elective (inpatient) procedures from Walsall Healthcare NHS Trust's (WHT's) Manor Hospital to The Royal Wolverhampton's (RWT's) New Cross Hospital site, while increasing the number of low complexity urological day case procedures at Walsall.

1.4 Outpatient procedures and follow-up consultations will continue to be undertaken in Walsall.

1.2 The proposed service model between WHT and RWT will facilitate:

- Walsall residents receiving safer, higher quality and more responsive acute care for urological conditions 24/7/365.
- A focus on health inequalities and actions that can address inequalities in access to, and standards of care.
- A focus on high volume, low complexity urology procedures (the majority of procedures) being undertaken at Walsall Manor Hospital, thus freeing up capacity and theatre space at the Royal Wolverhampton NHS Trust's hospital sites for more specialist/complex cases.
- A reduction in the time patients need to be in hospital.
- Driving continuous improvement in outcomes, with greater opportunities for participation in research, and for combined investment in service developments to deliver care closer to home.
- Maintaining elective throughput to highest possible levels throughout the coming winter period by creating facilities and pathways that are as protected as possible from urgent and emergency care pressures on beds, staff, and theatres.

2. Recommendations

2.1 Members of the Committee are asked to SUPPORT THE implementation of the proposals outlined in this Paper, namely:

2.2 One urology department operating across Walsall and Wolverhampton dedicated to delivering safe, responsive, high quality care.

2.3 Reduce the times patients wait for procedures, and the length of time they need to remain in hospital by further developing high volume low complexity procedures (the bulk of the demand from Walsall residents), at the Manor Hospital.

2.4 All urological emergency and inpatient procedures to be undertaken at the Royal Wolverhampton NHS Trust's specialist site. This will ensure that patients with an emergency episode will have access to a specialist urology consultant 24/7/365.

2.5 Outpatient procedures and follow-up consultations will continue to be undertaken in Walsall.

3. Report Detail

3.1 With only four consultants, the urology service at Walsall Manor Hospital predominantly focuses on high volume low complexity (HVLC) conditions, relevant to the demands of the communities it serves.

3.2 National guidance suggests that circa 85% of urological procedures can be, or are being performed in this way. In 2019/20, 55% of elective urology cases were performed as day cases at WHT. With improvements in pathways and the additional specialist resources in place, the number of hospital admissions required, and the lengths of stay for Walsall residents can be reduced.

3.2 The low numbers of complex urology cases received at WHT are referred on to specialist sites such as Birmingham, Stoke and Wolverhampton. This has impacted the trust's ability to recruit urology consultants, and registrars, many of whom prefer to work and train in larger specialised units.

3.3 Internal and external (Getting It Right First Time - GIRFT) reviews of the urology service identified that the small team at Walsall struggles to safely meet demand and recommended that the trust reaches out for support from neighbouring organisations.[1] This is an action mirrored by national recommendations for a network approach to urology service delivery, and in particular, a focus on a HVLC model of day case procedures. A Urology Area Network is being developed across the four Black Country and West Birmingham NHS Trusts.

3.4 In 2019/20 there were a total of 639 emergency admissions to Walsall Manor Hospital for emergency urological conditions and 432 admissions for elective interventions.

3.5 Both the Walsall Clinical Commission Group, and West Midlands Ambulance Service (WMAS) have confirmed their support to this proposal, identifying the need for improvements in the sustainable delivery of safe urological care.

[1] Getting it Right First Time – Walsall HealthCare NHS Trust Review (2018).

WMAS has provided assurance that the emergency conveyance of urology patients to Wolverhampton is safe and appropriate.

4. *Financial information*

4.1 There are no intended or perceived commercial gains or losses relevant to these proposals. The priority is the delivery of safe and responsive care to residents.

5. Reducing Inequalities

5.1 The proposals will improve the safety and care of patients by providing an on call consultant out of hours. Further, they will improve patient outcomes, including reducing the number of residents that need to be admitted to hospital, and reducing the lengths of stay for those patients that are admitted.

5.2 As one urology service across both areas, residents of Walsall will have better access to state of the art technology for urological procedures and greater opportunities to participate in regional and national research programmes.

6. Decide

6.1 WHT has attempted to recruit additional urologists, however, as indicated, the larger specialist centres such as Wolverhampton present a more attractive proposition. Sub-contracting consultant care from an agency would not provide sustainable care, and would not resolve the out of hours access.

6.2 The option of transferring only emergency patients to RWT and retaining the inpatient elective cases at Walsall has been considered in detail. However, specialist clinicians have concluded, that the safe option would be to have all emergency and elective inpatients under one roof so that they have access to consultant care 24/7.

6.3 As a previously stated, complex care is already referred to Wolverhampton, or other specialist centres.

7. Respond

7.1 Both trusts stress that these changes are brought about by the need to provide sustainably safe and responsive urological care for the residents of Walsall. Patient engagement has commenced, and will be presented to the Committee.

7.2 With the potential of a further surge of Covid-19 in the winter months, both NHS Trusts ask for the Committee's support to complete phase 1 – the transfer of emergency care patients as soon as possible, and to commence arrangements for the transfer of elective patients within this financial year.

8. Review

These proposals form part of WHT's Improvement Programme and reports monthly to the Improvement Programme Board, which in turn reports by

exception to the trust's Board. The trust's Board meetings are open to the public and details of how to join are published on the trust's website at www.walsallhealthcare.nhs.uk

Following the implementation of the proposals a "Closure Report" will be completed. Both trusts will be happy to share the Report with Committee.

Author

Roseanne Crossey
Head of Planning
☎ 01922 721 172
✉ bdp@walsallhealthcare.nhs.uk

BLACK COUNTRY EXECUTIVE JOINT COMMITTEE
FORWARD PLAN OF KEY DECISIONS
Published up to November 2021 (for publication 05/07/2021)

Date first entered into the plan	Project Name	Key Decision to be considered (to provide adequate details for those both in and outside of the Council)	Background papers (if any) and Contact Officer	Main consultees	Date Item to be considered
06/04/2021	Local Growth Fund (LGF) Programme changes Dudley Advanced Construction Centre	Approval for the Accountable Body for the Growth Deal (Walsall Council) to proceed to amending the Grant Agreement with Dudley College, to deliver the Local Growth Fund (LGF) funded elements of the Dudley Advanced Construction Centre project with delivery to continue in the 2021/22 financial year.	Papers TBC – Simon Neilson Simon.Neilson@walsall.gov.uk	Walsall Council	29/09/2021
05/07/2021	Local Growth Fund – Growth Deal Programme Approval of the 2020/21 Programme Spend Ruskin Mill Land Trust - Glasshouse Development Phase 3	Approval of the year end position of the Growth Deal Projects, reflecting all changes to the Programme (Funding and Outputs) throughout the year and, to maximise the 2020/21 Growth Deal allocation expenditure, requests approval for various changes detailed in Attachment 1 of the report. Approves the Accountable Body for the Growth Deal (Walsall Council) to proceed to amending the Grant Agreement with Ruskin Mill Land Trust, to complete the Local Growth Fund (LGF) funded elements of the Ruskin Mill Land Trust - Glasshouse Development Phase 3 project to conclude the delivery of the project outputs. Note that change request relates to the reduction in the Learner Assist output target.	Papers TBC – Simon Neilson Simon.Neilson@walsall.gov.uk	Walsall Council	29/09/2021

BLACK COUNTRY EXECUTIVE JOINT COMMITTEE
FORWARD PLAN OF KEY DECISIONS
Published up to November 2021 (for publication 05/07/2021)

Date first entered into the plan	Project Name	Key Decision to be considered (to provide adequate details for those both in and outside of the Council)	Background papers (if any) and Contact Officer	Main consultees	Date Item to be considered
	Advanced Manufacturing Training Centre	Approves the Accountable Body for the Growth Deal (Walsall Council) to proceed to amending the Grant Agreement with Incomm, to complete the Local Growth Fund (LGF) funded elements of the Advanced Manufacturing Training Centre project with delivery to continue in the 2021/22 financial year. Note that change request relates to a change in outputs.			
	Hub to Home Transport Innovation Centre and Test Track Project: Very Light Rail and Autonomous Technologies – Test Track 1 Project	Approval for the Accountable Body for the Growth Deal (Walsall Council) to proceed to amending the Grant Agreement with Dudley Council to deliver the Local Growth Fund (LGF) funded elements of the Hub to Home Transport Innovation Centre and Test Track Project: Very Light Rail and Autonomous Technologies – Test Track 1 project with delivery to continue in the 2021/22 financial year.			

BLACK COUNTRY EXECUTIVE JOINT COMMITTEE
FORWARD PLAN OF KEY DECISIONS
Published up to November 2021 (for publication 05/07/2021)

Date first entered into the plan	Project Name	Key Decision to be considered (to provide adequate details for those both in and outside of the Council)	Background papers (if any) and Contact Officer	Main consultees	Date Item to be considered
	Bilston Urban Village	Approval for the Accountable Body for the Growth Deal (Walsall Council) to proceed to amending the Grant Agreement with Wolverhampton City Council, to deliver the Local Growth Fund (LGF) funded elements of the Bilston Urban Village project with delivery to continue in the 2021/22 financial year.			
05/07/2021	Land and Property Investment Fund Programme Approval of the 2020/21 Programme Spend	Approval of the current position of the Land and Property Investment Fund Projects, reflecting all changes to the Land and Property Investment Fund Programme (Funding and Outputs) throughout the year and, to maximise the 2020/21 allocation.	Papers TBC – Simon Neilson Simon.Neilson@walsall.gov.uk	Walsall Council	29/09/2021

Walsall Council

FORWARD PLAN OF KEY DECISIONS

Council House,
Lichfield Street,
Walsall, WS1 1TW
www.walsall.gov.uk

7 June 2021

FORWARD PLAN

The forward plan sets out decisions that are termed as “key decisions” at least 28 calendar days before they are due to be taken by the Executive (Cabinet). Also included on the plan are other decisions to be taken by the Cabinet (“non-key decisions”). Preparation of the forward plan helps the Council to programme its work. The purpose of the forward plan is to give plenty of notice and an opportunity for consultation on the issues to be discussed. The plan is updated each month with the period of the plan being rolled forward by one month and republished. Copies of the plan can be obtained from Democratic Services, Walsall MBC, Council House, Walsall, WS1 1TW helen.owen@walsall.gov.uk and can also be accessed from the Council’s website at www.walsall.gov.uk. The Cabinet is allowed to make urgent decisions which do not appear in the forward plan, however, a notice will be included on the agenda for the relevant Cabinet meeting which explains the reasons why.

Please note that the decision dates are indicative and are subject to change. Please contact the above addressee if you wish to check the date for a particular item.

The Cabinet agenda and reports are available for inspection by the public 7 days prior to the meeting of the Cabinet on the Council’s website. Background papers are listed on each report submitted to the Cabinet and members of the public are entitled to see these documents unless they are confidential. The report also contains the name and telephone number of a contact officer. These details can also be found in the forward plan.

Meetings of the Cabinet are open to the public. Occasionally there are items included on the agenda which are confidential and for those items the public will be asked to leave the meeting. The forward plan will show where this is intended and the reason why the reports are confidential. Enquiries regarding these reasons should be directed to Democratic Services (helen.owen@walsall.gov.uk).

“Key decisions” are those decisions which have a significant effect within the community or which involve considerable expenditure or savings. With regard to key decisions the Council’s Constitution states:

(1) A key decision is:

(i) any decision in relation to an executive function which results in the Council incurring expenditure which is, or the

making of savings which are, significant, having regard to the Council's budget for the service or function to which the decision relates or

(ii) any decision that is likely to have significant impact on two or more wards within the borough.

(2) The threshold for "significant" expenditure/savings is £250,000.

(3) A decision taker may only make a key decision in accordance with the requirements of the Executive Procedure Rules set out in Part 4 of this Constitution.

FORWARD PLAN OF KEY DECISIONS
JULY to OCTOBER 2021 (7.6.21)

1	2	3	4	5	6	7
Reference No./ Date first entered in Plan	**Decision to be considered** (to provide adequate details for those both in and outside the Council)	**Decision maker**	**Background papers (if any) and Contact Officer**	**Main consultees**	**Contact Member** (All Members can be written to at Civic Centre, Walsall)	**Date item to be considered**
32/21 (10.5.21)	**Black Country Plan** – to seek approval for Black Country Plan 8 week consultation between August-September 2021	Cabinet Key Decision	Alison Ives 07385 348298 alison.ives@walsall.gov.uk	Public Internal Services	Councillor Andrew	Special meeting 7 July 2021
23/21 (8.3.21)	**Corporate Financial Performance 2021/22, Covid-19 update and Budget Framework 2022/23 to 2024/25** – To report the financial position based on 2 months to May 2021, impact of Covid-19, and the budget framework for 2022/23 to	Cabinet Non-key decision	Vicky Buckley 01922 652326 Vicky.buckley@walsall.gov.uk	Internal services	Councillor Bird	21 July 2021

	2024/25.					
36/21 (7.6.21)	**Refreshed Performance Management Framework:** The report presents the refreshed Performance Management Framework which is part of the Council's governance arrangements along with feedback from Audit Committee following their consideration of the robustness of the framework	Cabinet Non key decision	Helen Dudson Helen.dudson@walsall.gov.uk	Internal Services	Councillor Bird	21 July 2021
13/21 (8.3.21)	**Restart Scheme**: To note an overview of the new government Restart scheme and accept a sub-contract with the approved DWP Tier 1 Prime Provider for the Central West region.	Cabinet Key decision	Jane Kaur-Gill Jane.kaur-gill@walsall.gov.uk	Internal services	Councillor Andrew	21 July 2021
14/21 (8.3.21)	**Willenhall Masterplan: Strategic Land Acquisitions** – in principle approval for the use of Compulsory Purchase Order powers. *Contains information relating to the financial or business affairs of a particular person*	Cabinet Key decision- Private session	Willenhall Masterplan: Strategic Land Acquisitions. Joel.maybury@walsall.gov.uk	Internal services	Councillor Andrew	21 July 2021
24/21 (8.3.21)	**Phoenix 10 Project** To seek authority for the award of a contract for Environmental Impairment Liability Insurance to support delivery of the project. *Contains commercially sensitive information*	Cabinet Key decision private session	Joel Maybury Joel.maybury@walsall.gov.uk	Internal services	Councillor Andrew	21 July 2021

33/21 (10.5.21)	**Civil Traffic Enforcement contract** To recommend and award the Civil Traffic Enforcement Contract following the completion of the procurement process.	Cabinet Key decision	Glynnis Jeavons Glynnis.jeavons@walsall.gov.uk	Internal Services	Councillor Andrew	21 July 2021
34/21 (10.5.21)	**Northgate Revenues and Benefits Processing system contract renewal -** Approve the extension of the contract with Northgate to provide a Revenues and Benefits Software Service.	Cabinet Key decision	Jeanette Hitchcock Jeanette.hitchcock@walsall.gov.uk	Internal Services	Councillor Andrew	21 July 2021
37/21 (7.6.21)	**Sale of Council land in Blakenall:** To seek approval to the freehold disposal of Council land in Blakenall *Contains commercially sensitive information.*	Cabinet Key Decision Private session	Nick Ford, Team Leader – Asset Management Nick.ford@walsall.gov.uk	Internal Services	Councillor Andrew	21 July 2021
43/21	**Local Authority Delivery Scheme (LADS) Housing Retro-fit**: To appoint a contractor for this service.	Cabinet Key decision	David Lockwood David.lockwood@walsall.gov.uk	Internal Services	Councillor Butler	21 July 2021
38/21 (7.6.21)	**Liquid fuel supply Contract:** To approve the award of a contract for the Council's vehicle fuel and heating oil supply *Contains commercially sensitive information.*	Cabinet Key Decision Private Session	Den Edwards Den.edwards@walsall.gov.uk Alan Bowley Alan.bowley@walsall.gov.uk	Internal Services	Councillor Butler	21 July 2021
42/21 7.6.21	**Shared Lives payment remodelling:** To update members on the outcomes	Cabinet	Jeanette Knapper Jeanette.knapper@wals	Shared Lives Carers, Service	Councillor Martin	21 July 2021

	from Consultation and seek approval to proceed based on the outcomes and other supporting information	Key Decision	all.gov.uk Kirpal Bilkhu Kirpal.bilkhu@walsall.gov.uk Nigel Imber Nigel.imber@walsall.gov.uk	users and families Internal services		
39/21 (7.6.21)	**Walsall Domestic Abuse Strategy:** To agree the Strategy 2021 to comply with the new domestic Abuse Act 2020	Cabinet Key Decision	Domestic Abuse Strategy 2021 Domestic Abuse Need Assessment 2021 Domestic Abuse Act 2020 Ian Billham Community Safety Ian.billham@walsall.gov.uk	Safer Walsall Partnership Internal Services	Councillor Perry	21 July 2021
28/21 (10.5.21)	**Domestic Abuse:** To approve the new service delivery model and accordingly agree to a procurement exercise to enable the provision of • effective support to victims of domestic abuse and their children • Sufficient and effective safe accommodation to victims of Domestic Abuse as per the Councils' duty as outlined in the Domestic Abuse Bill and need identified through the Walsall Safer partnership	Cabinet Key decision	Domestic Abuse Needs Analysis Neil Hollyhead Neil.hollyhead@walsall.gov.uk Isabel Vanderheeren Isabel.vanderheeren@walsall.gov.uk	Safer Walsall Partnership Internal Services	Councillor Andrew Councillor Wilson	21 July 2021

	Domestic Abuse Strategic Needs Assessment.					
40/21 (7.6.21)	**Agreed Syllabus for Religious Education**: There is a legal requirement to review/revise the Agreed Syllabus every five years. Cabinet is asked to endorse the Agreed Syllabus to ensure that the teaching of RE in schools is relevant and appropriate and recommend the Syllabus to Council for approval.	Cabinet Non-Key Council	Nick Perks Nick.perks@walsall.gov.uk	Internal Services Standing Advisory Council for Religious Education	Councillor Towe	21 July 2021
35/21 (10.5.21)	**Corporate Plan 2021/22 - Quarter 1 Performance:** To note the approach to the five priorities	Cabinet Non key	Stephen Gunther Stephen.gunther@walsall.gov.uk	Internal – Directors' Group	Councillor Bird	8 September 2021
22/21 (8.3.21)	**Walsall Council Housing Allocations Policy:** To update the policy which sets the principles for the allocation of affordable housing	Cabinet Key decision	Neil Hollyhead 07943 500394 Neil.hollyhead@walsall.gov.uk	Public, Housing Associations, Internal Services	Councillor Andrew	8 September 2021
41/21 (7.6.21)	**Intermediate Care Service (ICS) Review**: to receive the outcome of the review and approve the Extension of the existing Transitional Bed contract	Cabinet Key decision	Tracy Simcox Tracy.simcox@walsall.gov.uk	Internal Services	Councillor Martin	20 October 2021