Walsall Healthcare NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas and the trust serves a population of around 260,000. Acute hospital services are provided from one site, Walsall Manor Hospital which has 606 inpatient beds made up of 536 acute and general beds, 57 maternity beds and 13 critical care adult beds. There is a separate midwifery-led birthing unit and a specialist palliative care centre in the community.

We carried out this announced comprehensive inspection on 8 to 10 September 2015. We held two public listening events in the week preceding the inspection visit and met with individuals and groups of local people and analysed data we already held about the trust to inform our inspection planning. Teams, which included CQC inspectors and clinical experts, visited Walsall Manor Hospital and inspected eight core services: emergency department, medical services, surgery services, critical care services, maternity services, children and young people services, end of life services and outpatients and diagnostic services. We also inspected three out of four community services: adult services, children, young people and families and end of life care services. We did not inspect community inpatient services as this service was registered with the local authority. We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

We have rated this trust as 'inadequate'. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. We rated the key questions for safety, effective and well led as 'inadequate'. We rated the key questions, for caring and responsive as 'requires improvement'.

Our key findings were as follows:

- Maternity services had multiple issues with staffing, delivery of care and treatment and people were at high risk of avoidable harm. The service had limited capacity and staffing resources which impacted negatively on patient experience and compromised patient safety.
- The latest MBRRACE report presented results for still births, neonatal mortality and extended perinatal mortality rates for 2013. Standardised results for Walsall were slightly higher than their comparator group. MBRRACE recommended that Walsall should consider a local review to better understand factors that may contribute to these results. In response to this the trust with its partners in the CCG and Public Health had participated in a detailed local study and agreed an action plan both of which have been shared with the Trust Board in public following our inspection.
- The Emergency Department (ED) triage process was ineffective, there was a shortage of qualified paediatric nurses and no paediatric consultant based in ED. There were regular delays with patient handover from ambulance to ED. The trust had been consistently performing worse (5 to 9 minutes) than the England average (median 3 to 6 minutes) for the time to initial assessment of patients between January 2013 and April 2015.
- The percentage of patients seen within the national four hour target to see, treat and admit or discharge 95%, was worse than the standard or national average for almost all of the period between April 2014 and May 2015. We saw the percentage of emergency hospital admissions waiting four to twelve hours from the decision to admit until being admitted (18 to 50%) was consistently above the England average of 5 to 15% between April 2014 and April 2015.
- Incident reporting, particularly feedback to staff was variable across the trust. There was a mixed approach to incident reporting which differed between services. The trust promoted incident feedback to staff through various methods. However, this was dependent upon individual service managers to disseminate lessons learned and staff's capacity to engage.
- Previous concerns relating to the trust's management of duty of candour had improved. We

Summary of findings

looked at several serious incident records which demonstrated the trust had adopted a more open and rigorous approach to the duty of candour regulation and its process.

- Staff were caring and compassionate towards patients and their relatives. We did however see that in both ED and Maternity the excessive workload led to the standards of caring falling below that we would expect. Patient's dignity and privacy was largely ensured and we saw many examples of good care across the trust from staff at all levels.
- Community services for Adults, Children, Young people and Families and End of Life Care, were rated as good overall. Governance structure and risk management were well embedded and general leadership of community teams was supportive and nurturing.
- The trust took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme, where national guidance was audited and local priorities for audit were identified.
- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die. It was recognised that the SHMI for Walsall Manor Hospital had increased over an extended period of time, March 2015 was 107.41, April 2015 was 110.54 and May was 102.64. This represented a risk to patient safety.
- The trust was still seeing the effects of implementation of the new electronic patient administration system nearly 18 months previous. Improvements had been made however, the trust was still struggling with simple tasks, (e.g. making patient appointments) as well as experiencing difficulties in gathering accurate information for decision making and performance management.
- The culture of the trust was described by many staff as poor. Morale was low across many wards and departments and we heard examples of senior managers and in some cases executive members taking a heavy handed approach to problem solving. Despite 'low morale' staff demonstrated a positive approach to patient care and a genuine compassion to deliver the best care possible.
- Divisional and corporate risk registers did not accurately reflect identified risks trust wide.
- The trust had failed to implement the new checks and tests necessary to fulfil the requirement for all directors to be 'fit and proper' persons. This statutory requirement came into effect in November 2014. We saw no checks had been carried out for any directors within the trust and there was no Fit and Proper Person Policy in place. Following the announced inspection, the trust had taken remedial action to satisfy statutory requirements which demonstrated compliance with the Fit and Proper Person Regulation before the inspection period ended.
- The Trust described to us what they referred to as a "perfect storm" in 2014 as a result of significant increases in emergency and obstetric activity and problems following the replacement of the patient administration system. The Trust Board recognised that the organisation faced significant quality and performance challenges in 2015 and had launched an Improvement Plan ("Improving for Patients; Improving for Colleagues; Improving for the Long-Term"). The plan included a programme of work to develop the two to five year strategy for the Trust and its services. The plan had been launched in June and as in its early stages at the time of our inspection in September 2015.

Importantly, the trust must:

- Improve the governance of incident reporting systems to ensure that processes are embedded across the Trust.
- Improve duty of candour training to ensure staff have a clear understanding of the process.
- Implement systematic training for complaints investigation,improve the RCA process and dissemination of lessons learned to front line staff and their managers.

Summary of findings

- Ensure there are adequate numbers of qualified staff across all services, particularly in: maternity services, emergency department and medical services to meet the needs of patients to protect them from abuse and avoidable harm.
- The trust must ensure there is an adequate supply of equipment in good working order and fit for purpose across all services. Any mitigation to replace equipment must have clear reasons, regular review and an up –to-date action plan clearly demonstrating alternative options and timescales to support actions.
- The trust must ensure equipment is stored appropriately; all fire exits must be kept free without compromising patient and staff safety and staff can access equipment when required.
- Mental Capacity Assessments (MCA), Deprivation of Liberty Safeguards (DoLS) and Do Not Attempt CPR (DNACPR) assessments to be carried out in a timely manner and supported by appropriate documentation.
- Review the patient administration system to minimise problems associated with missed patient appointments. Ensure data is accurate and the system is a reliable resource for staff to use which meets the need of patients using the service.
- Ensure health records are completed appropriately and patient data is confidentially managed. Patient confidentiality is maintained at all times across all service.

After the inspection period ended, the Care Quality Commission issued the trust with a Section 29a warning notice outlining there was significant improvement required. This set out the points of concern and timescales to address this. The trust has responded to this with a detailed plan for remedial action.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Walsall Healthcare NHS Trust

- The health of people in Walsall is generally worse than the England average. Walsall ranks 30th out of 326 local authorities for deprivation (with 1st being the most deprived). Deprivation and childhood poverty is worse than the England average with high infant mortality rates. Walsall has high rates of obesity, smoking, diabetes, coronary heart disease and alcohol related hospital admissions. Disease and poor health indicators in Walsall saw five out of eight were worse than the national average. Life expectancy and causes of death showed the trust scored worse than the national average for six out of nine indicators.

  At the time of inspection the trust board had seen three new appointments. The director of nursing had been in post for approximately one year, the director of finance had been in post a matter of weeks and the trust had appointed a new director of OD and HR who started the week of the inspection. There were six non-executive directors. The Chair was appointed in June 2004 and the Chief Executive Officer joined the Trust in May 2011supported by executive directors.

  Walsall Healthcare NHS trust has seen an increased demand due to growth in hospital activity from Walsall and Staffordshire following changes at the former Mid-Staffordshire Foundation Trust. This (in part) resulted in a 23% increase in emergency admissions between 2012/13 and 2014/15.

Our inspection team

Our inspection team was led by: Chair: **Professor Juliet Beale, CQC National Nursing Advisor**.

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

The inspection team comprised 21 members of CQC staff, 30 specialist advisors and two experts by experience who have experience of, or who care for people using healthcare services. CQC members included the head of hospitals inspection, an inspection manager, a pharmacy inspector and 14 inspectors. Our specialist advisers included: an NHS chief executive, director of quality governance, consultant general surgeon and medical director, specialist nurses, medical consultants, consultant in intensive care medicine and anaesthesia, consultant midwife, speciality doctor in palliative medicine, specialist nurses, allied health professionals and clinical managers. In total, the inspection team collectively had over 1,000 years of healthcare experience.

How we carried out this inspection

To get to the heart of the patient care experience, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Group, Trust Development Authority, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch. We carried out an announced inspection visit from 8 to 10 September 2015 and three unannounced visits on 13, 20 and 24 September 2015. We inspected the one location, Walsall Manor Hospital and three community services: Adult Services, Children,

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Young People and Families Services and End of Life Services. There were no community inpatient services registered with the trust. We held focus groups with a range of staff, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually and talked with patients and staff from support services, ward areas, and outpatient services. We observed how people were being cared for, talked with patients, carers, visitors and relatives and reviewed patient records of personal care and treatment.

What people who use the trust's services say

The Friends and Family Test (inpatient) for the period March 2014 to December 2015 showed the trust scored worse than the England average for that period. There was a significant rise in January 2015, followed by a decline from February 2015 onwards.

The CQC adult inpatient survey for 2013, found the trust comparable with other trusts on all questions, except for 'did you feel doctors talked about you as if you weren't there?' which was worse than other trusts.

From direct patient feedback prior to the inspection and information from Healthwatch colleagues, we received mixed feedback about the hospitals and the services provided by the trust.

We used all of this information to help direct the inspection team and focus the inspection on areas important to all service users.

Facts and data about this trust

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas and the trust serves a population of approximately 260,000. Acute hospital services are provided from one site, Walsall Manor Hospital, which has 606 inpatient beds made up of 536 acute and general beds, 57 maternity beds and 13 critical care adult beds. There is a separate midwifery led birthing unit and a specialist palliative care centre in the community.

Between 2014/2015 there were 116,003 attendances to the emergency department and 69,039 admissions. Emergency admissions amounted to 39,619 and elective admissions were 29,348.

Between January and December 2014 there were 358,543 outpatient appointments of which approximately 136,813 were first attendances and 221,730 were follow up. The trust also provides care to people in community settings; patients' own homes and from a number of clinics and health centres, GP surgeries and schools. The trust employs 4370 staff. This includes 380 doctors and 1150 nurses.

The trust has an annual turnover (2014/15) of £239.4m and in 2014/15 saw a deficit of £12.9m.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Inadequate

Summary

Patient safety incidents are not always identified and reported and the inconsistent approach between services to learn from incidents serve to increase the risk of repeat occurrences or more serious harm in the future.

Duty of candour process had improved but further training to front line staff is required. Systematic training for complaints investigation is required as the root cause analysis (RCA) process is inconsistent and lacks structure.

Staffing levels show substantial and frequent shortages in maternity services which led to significant concerns regarding the service's ability to provide safe care and treatment to prenatal and post-natal women and their babies. The Trust was recruiting additional midwives but these staff were not yet in place at the time of the inspection.

Concerns were raised in ED regarding insufficient numbers of qualified paediatric nurses available 24 hours a day and no paediatrician based in ED may compromise safety of patients who use the service.

There was an overreliance on agency staff which created risks to safety.

Care and treatment in ED was largely delivered reactively and was not risk based.

The trust did not give sufficient attention to ensuring the safety of patients and visitors to ensure fire doors and exits were free and access to restricted areas such as hospital kitchens were locked at all times.

Duty of Candour

- The trust was aware of its role in relation to the duty of candour regulation that was introduced in November 2014. The intention of this regulation is to ensure providers are open and transparent when things have gone wrong. It sets out specific requirements providers must follow which includes an apology to patients.

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- The trust's current policy on 'Being Open' was revised in response to the regulatory obligations of the duty of candour requirements.
- As well as setting out the duties and processes, the policy sets out how the trust will monitor compliance. The policy details the way in which the trust will ensure openness with patients when patient safety incidents occur.
- We met with a number of patients and relatives of patients before our inspection who told us of their previous experiences with the trust when things went wrong. They felt the trust had not been open with them and communications had been difficult.
- Historically, the trust's approach to duty of candour lacked rigour and openness.
- We looked at investigation reports of three serious incidents that had taken place since the duty of candour regulation came into force. We carried out an extensive review of all related documents which detailed complexity of each case. Complaints and contact with the families were transparent and each file contained written evidence of apologies to the families concerned.
- The trust recognised failings from the previous complaints process and had taken action to address this. However, the trust needs to implement systematic training for complaints investigation as the root cause analysis (RCA) process was inconsistent and lacked structure.
- Further work was required around staff training with duty of candour as understanding among many front line staff was unclear.

Safeguarding

- Staff knew how to report safeguarding issues and the process of safeguarding was understood and followed.
- Safeguarding training was generally well attended however, further work was required to improve training figures acrossthe emergency department and throughout medical services. The trusts overall training figures for Children's safeguarding levels 1, 2 and 3 was 85.4%. The highest score was the Women's, Children's and Clinical Support Services division with 92.1% and the lowest figure was in the Medicine and Long-Term Conditions division at 61.2%. Safeguarding adults training trust wide was 79.6%.

Incidents

- There was an inconsistent approach to incident reporting across the trust. Incident reporting and sharing lessons learned

varied from service to service. There was a low incident reporting and staff feedback in ED and maternity services due to normalisation of reportable incidents and a general lack of staff.

- Between May 2014 and April 2015 there were 123 serious incidents, including one 'never event'. The most common incident type was grade 3 pressure ulcers (There were 12 incidents each for slips trips and falls, ward closures and hospital transfer issues. Maternity services reported nine incidents of intrauterine deaths.
- Between October 2014 and September 2015, the trust reported a total of 11,073 incidents. Of these, 7,307 were categorised as no harm and 3,450 were categorised as low harm.
- Incident feedback and learning from lessons varied between services. There was a mixed approach to incident reporting which differed between services. The trust promoted incident feedback to staff through various methods. However, this was dependent upon individual service managers to disseminate lessons learned and staff's capacity to engage.
- Due to the inconsistency of incident feedback the trust was losing valuable opportunities to learn from these incidents and improve patient care.

Staffing

- The trust staffing establishment was funded for 4055.18 WTE, in May 2015 the actual WTE in post was 3734.03, this showed a deficit of 321.15. The staff group with the largest deficit was nursing and midwifery staff, band 7 and below, which had a shortfall of 110.9 WTE.
- Trust usage of bank and agency staff were significantly higher than the England average accounting for nearly 8% of staffing costs.
- Maternity, emergency department and medical services did not have sufficient staff to meet the needs of patients all of the time. Significant concerns were raised particularly with staffing levels in maternity services and we were not assured women assessed as 'high risk' were protected from abuse and avoidable harm.
- The corporate risk register highlighted nursing and midwifery staffing levels as a focus for concern during periods of excessive demand and pressure since 2011.
- The trust had mitigated against this risk by recruiting more than 80 oversees nurses, who were being inducted during the time of our inspection.

Summary of findings

- The skills mix of the emergency department staff showed there were insufficient qualified paediatric nurses available 24 hours a day and no paediatric consultant based in ED.
- During the announced inspection 8 to 10 September 2015, we were concerned about leadership and governance arrangements in maternity services in particular, management of staffing levels. We were not assured pregnant and postnatal woman were protected against the risk of abuse and avoidable harm. The trust assessed that one to one care was required to manage the risks to women who were in active labour, or assessed as being at 'high risk,' we saw multiple incidents where this was not achieved.
- We carried out two unannounced visits on 13 and 24 September 2015 and saw the trust's maternity escalation policy was invoked on both days to bring the staffing levels up to the trust's establishment of nine midwives per shift.
- On all four inspection visits to the labour ward, on 9,10,13 and 24 September 2015, we identified the staffing levels of nine midwives per shift was insufficient and did not meet the needs of women receiving care and treatment in the service. The system to assess monitor and mitigate the risk to women assessed as being at high risk was ineffective.
- We observed midwives caring for several women assessed as high risk at the same time when women should have been receiving one to one care. Midwives were also caring for several women at the same time who were in active labour and should have received one to one care.
- We reviewed the Walsall Maternity Coordinator's record and saw on 17 September 2015 six high risk inductions of labour had been delayed; on 19 September 2015 there were delays to two patients in the induction of labour. These ladies did not have their waters broken which places risks on women and babies and indicates poor planning.On 21 September 2015 there was a 90 minute delay in suturing, which increased the risk of infection and on 24 September 2015 there was a delay in the start of three planned caesarean sections. In an incident of a category one caesarean section (which identified the procedure needed to be undertaken within 30 minutes under national guidance) this woman waited 91 minutes from the decision to operate to when the baby was born.
- During our inspection, we saw the birth to midwife ratio of 1:37 far exceeded the national recommendations of 1:28. The recruitment of extra midwives had commenced earlier in the year to improve the ratio to 1:33. These staff were not yet in post at the time of our inspection.

- There was a failure to manage the risks relating to patient information as well as patient confidentiality. During all four inspection visits on 9,10,13 and 24 September 2015, women's confidential informationincluding their name, dates of birth and past medical history was openly displayed on a white board in the labour ward. Staff failed to use the lockable doors which were in place to conceal the white board and secure women's confidential information. Therefore, there is a risk to the integrity and security of information which could be tampered with when left unsecured. On 10 September 2015 at the Midwifery-Led Unit we found the birthing register was left on display on top of a filing cabinet.
- The trust's current position is as sent to us on 16 October 2015 following a detailed internal review and the request of CQC in a document entitled 'Maternity Staffing, Overview and Summary'. This indicates there are an additional 19 whole time equivalent overseas midwives due to commence employment at Walsall Maternity services, 14 of whom are due to commence employment within four weeks of 16 October 2015. We are aware through several interviews which took place during our inspection between 8-10 September 2015 with senior managers at the trust that there will be a delay before the midwives are available to work independently, due to a period of training and assessment of their competencies. The forthcoming introduction of the cohort of midwives therefore does not mitigate against the current risks in the maternity services.
- During the CQC inspection from 8 September to 10 September 2015, poor workforce planning by Walsall Healthcare NHS trust resulted in a lack of suitably qualified children's nurses available in the Emergency Department over a 24 hour period. There was no paediatric consultant working in the Emergency Department. To mitigate against the risk to children all emergency department staff were trained in paediatric life support and a paediatric consultant may be called to assist from other areas in the hospital. However, the lack of qualified paediatric nurses or a paediatric consultant based in the emergency department increased the risk that cchildren with deteriorating health conditions.

Medicines

- In maternity services, during the period of 23 to 24 September 2015, there were delays in antibiotic administration for several transitional care babies on the postnatal ward. This ward was understaffed during this time as midwives had moved to work on the labour ward because the labour ward was short staffed and the trust's Maternity Escalation Policy had been invoked.

- During the inspection on 8 to 10 September 2015 in the emergency department, pain relief records were not completed for all patients, and staff were unsure what pain relief patients had received or at what time. This increased the risk that patients' needs would not be met and their pain relief would be delayed or left untreated.
- Between 8 to 10 September 2015 in when staff administered bolus doses which was additional to the prescribed infusion rate, these bolus doses were not documented on the prescription chart. This was also not documented on the fluid chart. There was no record to indicate medication administration.

Mandatory Training

- Mandatory training of staff was below target in some areas for example, figures dated May 2015 showed the Medicines and Long term Condition Division achieved 80% attendance for fire safety and 79% for patient handling. The Surgery Division achieved 77% for fire safety and 71% for patient handling and Woman, Children and Clinical Support services achieved 88% for fire safety and 89% for patient handling. This was set against a mandatory training target of 90%.

Assessing and Responding to Risk

- On 9 September 2015 in the emergency department (ED) we found that a process was in place to assess and triage patients but emergency department management did not ensure the process was always followed by staff. This increased the risk of patients not being streamed in a timely way. Care and treatment was delivered reactively and was not risk based.
- On 9 September 2015 in the emergency department, three patient records did not contain a triage category and it was unclear to nursing staff whether these patients had been triaged at all. This increased the risk of delayed care and treatment to those patients.
- On 10 September 2015 in the emergency department two out of the three patients' notes we looked at for patients admitted through the ED and admitted to wards, had no triage score recorded. This increased the risk patients injuries would not be assessed and treated in a timely way.
- During a visit to the discharge lounge on 10 September 2015, we saw the entrance to the fire escape and the corridor leading to another fire door was blocked with more than 10 items of equipment, ranging from a motorised scooter awaiting repair,

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walking frames and hoists. Within the same corridor there were multiple boxes of confidential patient files stored on shelves, the doors to which were unlocked. This was escalated to the director of nursing who took remedial action.

- During a visit to the catering department and kitchens on 10 September 2015, the double doors tothe kitchen were unlocked and wedged open. This provided access to unlocked fridges containing patient food items and access to catering equipment. Open access to these areas should be restricted to catering personal to prevent tampering of food and protect patients and visitors from avoidable harm. The inspection team escalated this to the facilities manager whotook remedial action.

Are services at this trust effective?

Inadequate

There was a lack of an effective system in place to assess, monitor and mitigate the risk of patients who were receiving end of life care and who required completion of a DNACPR form and patients who required a Mental Capacity Assessment.

Care and treatment was not always planned and delivered in line with current evidence-based guidance and standards and further improvements are required to complete clinical audits and achieve better patient outcome results.

Multi-disciplinary working was effective and care was coordinated; staff work collaboratively to deliver effective care.

Evidence based care and treatment

- We asked how the trust could be certain clinical areas were following the correct policies. We were told one way of measuring this was through senior managers and non-executive directors carrying out quality walks.
- The ED performed worse than other trusts in two of the three CQC 2014 national ED survey questions for effectiveness. The ED performed poorly in the national 2013/14 severe sepsis and septic shock royal college of emergency medicine (RCEM) audit with scores on most aspects well below the RCEM standard for example, the timeliness of pain relief.
- The Intensive Care Society guidelines were implemented within Critical Care services to determine the treatment provided and Critical Care pathways and protocols were in use. For example, staff followed the unit's sedation break protocol.

- Critical care was not fully meeting the requirements of NICE (guidance 83) which identified a need for an individualised, structured rehabilitation programme. Patients were seen by the critical care outreach team within 24 hours of transfer to the wards.
- Critical care audits were carried out locally for example, on critical care bundles, aseptic non-touch technique for IV therapy (ANTT) and completion of critical care notes, however, there were no action plans in place to support areas for improvement.
- The care of women using the maternity services was not in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development and facilities.
- Trust policies were available for staff to access and were based on NICE guidance. In children, young people and families acute services for example, we reviewed the local guidelines for head injury in paediatrics and this was clearly linked to the NICE guidance.
- Joint Advisory Group (JAG) accreditation of the endoscopy unit had yet to be achieved. It had been deferred for six months due to staff vacancies impacting on capacity. OPD clinics were in line with best practice and NICE guidelines in relation to appropriate referral, availability of information and completion of checklists.
- In radiology, interventions and patient outcomes were submitted into the national database for outcome comparisons and these were measured against those trusts undertaking similar procedures. It is a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR) (ME R) for audits to be carried out to ensure safe exposure and practice. Examination audits had been completed to comply with IR(MER) safety policy.

Patient outcomes

- The trust took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- The outcomes for patients across a range of specialties varied, when compared with similar services. For example, The

Sentinel Stroke National Audit Programme (SSNAP) measures the effectiveness of care and treatment provided for stroke patients at hospitals in England, Wales and Northern Ireland. The report published in 2014, showed Walsall Manor Hospital had a performance level of 'D' for acute care organisation on the scale used by SSNAP, where 'A' represents the best performance and 'E' the worst.

- The trust saw an elevated risk for Myocardial Ischaemia National Audit Project (MINAP) which is the proportion of patients who received all the secondary preventive medications for which they were eligible. This was 52% against the expected figure of 88% for 2013/14.
- The trusts results for the National Bowel Cancer Audit for 2014 indicated all patients in this category were discussed at multi-disciplinary meetings. 77% of patients were seen by a clinical nurse specialist, which was slightly worse than the England average of 87.8%.
- Hip fracture audit results for 2014 indicated that the location performed worse on four of the indicators in comparison to the England average. For example, 32.6% of patients were seen by a senior geriatrician within 72 hours of admission, against England average of 51.6% and 20.7% of patients were admitted to orthopaedic care within four hours, against the England average of 48.3%. However, they did perform better on patients developing a pressure ulcer, 0.7% against England average of 3% and patients having a falls assessment 99.3% against England average of 96.8%.
- The National Neonatal Audit Programme 2013 did not meet any of the standards.

Multidisciplinary working

- We observed and were told about good multi-disciplinary working across all core service areas.A multi-disciplinary approach was actively encouraged and we saw many examples of co-ordinated care as a result of this.
- Effective team working between ward and theatre staff was observed with interactions and interventions seen.
- We saw good MDT working between nurses, occupational therapists and physiotherapists across many medical wards.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We saw there was a general lack of understanding across many areas of the trust with the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS).

Summary of findings

- Where patients lacked the capacity to consent, staff did not always act in a timely manner to follow appropriate processes to complete MCA assessments and/or document best interest decisions in patients' records.
- There was a lack of an effective system in place to assess, monitor and mitigate the risk of patients who were receiving end of life care and who required completion of a DNACPR form and patients who required a Mental Capacity Assessment. In April 2015 Walsall Healthcare trust conducted an audit of 117 DNACPR forms and found on average 93.5 % were completed appropriately.
- On 9, 10 and 20 September 2015 the CQCinspection team reviewed 25 DNACPR forms and found on wards 3, 11, 15, 17 and 29three were not completed appropriately, two were not signed or dated and the other lacked rationale for the decision. This rendered the forms invalid and increased the riskstaff who cared for and treated these patients would not be clear as to the correct DNACPR status of those patients, such that they may receive inappropriate treatment.
- On 9, 10 and 20 September 2015 we looked at 25 DNACPR forms on wards 3, 11, 15, 17 and 29. All 25 forms were ticked to indicate the patient did not have mental capacity to make the required decisions and provide consent.Out of 25 forms, 17 forms did not contain either a completed Mental Capacity Assessment or documented evidence in their medical records to indicate a two stage test had been carried out. There was no record in their notes to evidence a best interest decision had been made. This increased the risk patients may receive care and treatment that was inappropriate to their needs.
- Trust wide MCA training figures for 2014/2015 was 69.6% and DoLS training figures was 69.6%.

Are services at this trust caring?

Requires improvement

Feedback from patients and relatives was largely positive about how the staff treated them.

We found people were largely treated with dignity, respect and kindness during their interactions with staff and they felt emotionally supported.

We saw examples in both ED and in Maternity where this was not the case. We saw where activity was not matched by sufficient staff, the standards of caring for individual patients fell below what we would expect.

Compassionate care

Summary of findings

- We saw good care provided across the trust in many areas.
- The majority of patients commented positively on their care and on the staff providing it. However, during a visit to ward 29 on 8 September 2015 we saw two patients were distressed and calling out for the toilet; one patient was in a bay of four people and one patient was in a side room. The inspection team informed the nurse in charge.
- During a visit to the ED we saw two patients' pain relief was delayed and both patients were distressed; one was a young child and the other patient had learning disabilities. The inspection team informed the nurse in charge.
- During 2014, a questionnaire was sent to 850 people who had attended an NHS accident and emergency department (A&E) during January, February or March 2014. Responses were received from 267 patients at Walsall Healthcare NHS Trust. We saw in seven out of eight areas surveyed, Walsall Manor Hospital scored 'about the same' as other trusts.
- The exception was for care and treatment, where the hospital scored 'worse' in areas of 'time to receive pain relief' and 'pain control'.

Understanding and involvement of patients and those close to them

- Patients reported being involved in their care across the majority of services, more work was required in maternity services and the emergency department because with increased activity there was a decline in patient involvement.
- Services were able to describe the processes they used to involve patients.
- The Patient-Led Assessments of the Care Environment (PLACE) audit results 2014, showed cleanliness, food and facilities were similar to the national average. However, the trust scored worse than the national average for privacy, dignity and well-being.

Emotional support

- The trust provided support for patients and their families where required, despite some services feeling the strain of staff shortages.

Are services at this trust responsive?

Services were not consistently delivered in a way that responded to people's needs, particularly with the implementation of the new patient administration system which adversely affected planning and delivery of appointments and accurate trust wide data gathering.

Requires improvement

Summary of findings

Performance against national targets for waiting times and access to treatment was a mixed picture.

The needs of patients living with dementia and people with learning disabilities was satisfactory however, dementia training requires improvement.

Service planning and delivery to meet the needs of local people

- Challenges caused by the implementation of a new electronic patient administration system meantoutpatient department (OPD) clinics were sometimes cancelled and patients had not been informed, or informed at very short notice. There was a lack of appropriate staff to meet people as they arrived for their appointments, or patients arrived for their appointment and found the clinic was running late or patient notes could not be located.
- In maternity, there was a continued failure of the trust to respond effectively to an increase in activity. On numerous occasions we saw elective caesareans and planned induction of labour cancelled on the same day which increased the fears and anxieties of the women it served.
- The trust had recognised a new critical care unit was required due to the current HDU not currently being fit for purpose. The HDU was geographically separate to the ITU and isolated from both theatres and ITU. There was too little space around each bed and the unit lacked facilities such as showers, toilets and isolation facilities. A business plan for a new integrated, 18 bedded critical care unit had been approved by the Trust Development Authority and was currently awaiting release of national capital.

Meeting people's individual needs

- Patients were not being seen for follow-up appointments within the timescale requested by their clinician due to existing problems experienced with implementation of the patient administration system. There were no alerting systems in place to warn staffpatients had not been seen for follow-up appointments in a timely manner.
- In maternity, the trust did not have midwives with role specific responsibilities. For example, there was not a midwife leading on teenage pregnancy, obesity or bereavement.
- Staff across the hospital sites demonstrated they knew how to care for people with learning disabilities and people living with dementia.

- Staff described how they would liaise closely with the patient's carers/family to ensure the patient's individual needs were met.
- There was no trust-wide process to access interpreters for patients whose first language was not English. Wards and departments used staff and relatives to translate. This is not considered good practice. In the community setting link workers were available to act as interpreters, they were recruited according to their ethnicity to aid engagement in the local population. Translation services could be booked for clinic appointments.

Dementia

- The trust had implemented 'butterfly bays' across several wards to identify patients who may need more support because they were living with dementia. However, more work was required to teach staff the meaning of this. For example, not all staff were aware of the meaning of the butterfly symbol; some thought it was to identify people at risk of 'falls' (this is indicated in the trust by a leaf symbol) and some staff thought it was purely for decoration.
- Each ward and department has a dementia champion. A dementia champion encourages others to make a positive difference to people living with dementia. They do this by giving them information about the personal impact of dementia, and what they can do to help.
- There was no formal agreed process in place in theatres, Emergency department or OPD and diagnostics to prioritise care for people living with dementia. However, staff acknowledged and respected the individual needs of this particular group and where closer support was needed, staff aimed to provide this.
- Trust wide dementia training figures for 2014/2015 was 75.7% against a target of 90%.

Access and flow

- Emergency department attendances resulting in admission was approximately 18.6% in 2014/15, which was better than 20% in 2013/14 and slightly better than the England average of 22.8%.
- The CQC survey of emergency department patients in 2014 showed the trust was similar to other trusts for all the questions relating to responsiveness.
- From January 2014 to December 2014, 2,110 people left the department without being seen or having refused treatment. However, this was below the England average.

Summary of findings

- The percentage of patients seen at the emergency department within the national four hour target to see, treat and admit of discharge 95%, was worse than the standard or national average for almost all of the period between April 2014 and May 2015.
- The percentage of people seen by a specialist within two weeks for all cancers was 96% which was in line with the England average from quarter one 2013/14 to quarter two 2014/15. Following this period, a reduction to between 85% and 90% was seen in quarter three and quarter four 2014/15 which was below the national standard.
- The trust saw improvements in referral to treatment times which showed patients waiting over 18 weeks was down from 13,000 in October 2014 to 6,600 in July 2015.
- The percentage of people waiting over six weeks between July 2013 and August 2014 was below the England average. From November 2014 onwards the percentage of people waiting over six weeks rose from 1% to 7% in February 2015.
- Between February and May 2015, 13 clinics were cancelled with reasons recorded such as annual leave or service redesign.

Learning from complaints and concerns

- Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of patient care. In 2013, the Patients Association published good practice standards for complaints handling, and all NHS organisations are expected to meet them. They provide guidance on how to investigate and respond to a complaint as well as how to manage complaints as an organisation.
- Rates of complaints for Walsall trust between 2010/11 and 2012/13 averaged 323 per year, increasing slightly to 354 in 2013/14.
- The trust have been working towards achieving 70% of all formal complaints having a completed response within 30 working days, which has been achieved in five out of the last six months. The overall average for this time period is 84%.
- The trust received 372 complaints 2014/2015, 102 had been upheld and resolved. 138 were partially upheld, 76 were not upheld by the trust, 27 complaints are currently on-going and eight complaints were withdrawn by the patient. The most complaints (208) related to clinical care assessment and treatment, followed by 37 complaints about appointments and 28 complaints related to poor staff attitude.
- Following a recent review of the standard the trust have agreed within their updated complaints policy (ratified in April 2015)

Summary of findings

that they will start to work on the following revised standards for responding to formal complaints: single issue complaints to be resolved within 20 working days, moderate harm or multi-issue complaints to be resolved within 30 working days. Resolution date for major or catastrophic or complex medical complaints should be agreed with the complainant, taking into consideration the timescale for an independent investigation.

Are services at this trust well-led?

Inadequate

The executive board had a clear vision and values but this was not universally shared across the organisation.

The Trust Board was aware that the organisation faced significant quality and performance challenges and had launched an Improvement Plan in June 2015 and had begun to address them.

Arrangements for governance and performance management was inadequate. The board was not always receiving clear and accurate evidence of assurance because of the way data was presented. We found evidence that actions from investigations into incidents were not completed appropriately.

The governance arrangements and the trusts purpose was unclear. There was no process in place to review key items such as the strategy or the governance framework. Senior managers were not all aware of fundamental trust documents to inform thinking, for example: The Board Governance Assurance Framework report dated March 2015 and the Quality and Safety Strategy dated June 2015. Divisional and corporate risk registers were inaccurate and did not reflect current risks trust wide.

There was a heavy reliance on external organisations for example, the CCG and TDA to lead on the direction and pace for recovery and provide solutions for long term sustainable improvements. The board had no long term strategy or plan to recover the financial position.

There are low levels of staff satisfaction, high levels of stress, work overload, and conflict within the organisation, particularly in maternity services, medicine and ED. Staff across many wards and departments do not feel respected, valued, supported, appreciated and cared for by senior managers and executive board members. We heard numerous examples of senior managers and on some occasions executive board members adopt a heavy handed and 'bullish' approach to leadership.

Vision and strategy

Summary of findings

- There was a trust vision which senior managers and executive team shared; this was to be a 'First class, integrated health services for the people we serve, in the right place and at the right time'. This involved six trust promises: 'welcomed, cared for, in safe hands, part of a team, appreciated and supported to meet our high standards'.
- However, this was a not a vision shared by staff and their line managers and it was not imbedded trust wide.
- The trust has recently formed the Black Country Alliance with Dudley and Sandwell & West Birmingham trusts as part of responding to some of the challenges they face. It is early days for this initiative but it is intended to allow the trust a critical mass to deliver services more sustainably. In its first year the Alliance is focusing on five priority projects including clinical service and "back office" services.

Governance, risk management and quality measurement

- We were not assured that clinical governance, risk and quality management was effective and were not confident that the governance, risk and quality boards influenced or impacted at an operational level. Our interviews with governance leads indicated "there was a lot to do" in the trust.
- There was no clear strategy to respond to the significant concerns raised in the Board Governance Assurance Framework (BGAF) report dated March 2015. During interviews with the interim company secretary and interim governance lead we were told they had not read the BGAF report and were not involved in any action plans to improve governance arrangements associated with the report's findings and were not able to articulate its contents.
- During interviews with several members of the executive team we were not assured they had good oversight of the trust's fundamental issues. For example, the Clinical Harm Group had not undertaken a comprehensive 'look back' exercise to establish if any wide-scale harm had taken place during implementation of the new patient administration system. This was a missed opportunity to learn from lessons and improve future performance and protect patients.
- The interim company secretary was busy administering corporate meetings and opportunities were lost to improve quality and governance.
- The implementation of a new patient administration system, more than 18 months ago was cited by the board as a major

challenge, creating obstacles to simple tasks. For example, making patient appointments as well as making it difficult to gather accurate information for decision making and performance management.

- The trust board were aware of the inherent difficulties with the implementation of the software system but had failed to be proactive and plan ahead in preparation. Instead the trust took a reactive approach which left staff confused, frustrated and fire-fighting problems on a daily basis.
- Divisional and corporate risk registers did not provide an accurate or comprehensive reflection of key risks.
- We saw maternity staffing levels had been placed on the corporate risk register since April 2014 and scored at 16 which is high risk. It had been RAG rated as red (high risk) for eight out of the following 12 months.
- The trust executive board lacked insight into the potential and actual risks present within maternity services. On the last day of the inspection, we provided feedback to the executive board and relayed our concerns around staffing levels in the maternity services. We carried out two unannounced inspections to the maternity services and we informed the trust of our continued concerns. We found the response from the trust to be defensive and provided no assurance that current staffing levels would be increased. It was not until we took enforcement action that the trust took action and increased staffing levels to meet the needs of women who used the service.
- Evidence provided by the NHS Litigation Authority showed clinical negligence claims had risen significantly in the last two years.

Leadership of the trust

- Staff reported feeling supported in their teams and by their immediate line managers and colleagues of a similar grade. However, staff told us they did not feel supported by middle management or executive leaders.
- We heard from some staff that some of the executive leadership in the hospital needed improvement. Staff highlighted lack of clear direction and a relaxed approach to leadership as being areas that concerned them.
- There was a mixed response from staff relating to visibility of executive leaders. Many staff stated they had never seen members of the executive team, particularly across community services.
- We heard non-executive directors were more visible however, not all staff knew who they were.

Summary of findings

- During the CQC inspection from 8 to 10 September 2015 we saw there was a lack of strategic planning for End of Life care services. Following the nationwide removal of the Liverpool Care Pathway in July 2014, trusts were required to provide a replacement end of life care plan. The new documentation to replace the Liverpool Care Pathway has not yet been implemented and remains in draft form. The absence of the End of Life plan led to no formalised document in operation to guide ward staff to support patients with end of life needs. This increased the risk that appropriate care, support and treatment would not be delivered in a timely way.
- The executive board had decided to not to discuss the risks associated with the patient administration system at the Quality and Safety forum but instead sees it as a finance and performance issue rather than a potential quality and safety issue. This meant missed opportunities to monitor, identify and manage risks.
- The Quality and Safety Strategy, June 2015 was not widely read or understood by all senior managers. This was validated by 10 staff who when asked, could not articulate it.
- We saw multiple examples of executives and non-executives being heavily involved in operational detail for example, the Quality and Safety Committee was reported to be a four hour long meeting with multiple papers, which did not enable focused scrutiny and debate.
- We saw a team of non-executive directors who chaired the boards and committees however, these had significant agendas with an large amount of papers which needed to be more succinct. They described the trust as 'getting back on track' following several years of becoming increasingly operational and reactive and in parts non-functional.
- One senior manager told us "there was too much time spent on 'rear view' focus looking back at what had happened rather than forward looking."
- Another senior manager explained board committee plans are inconsistent, assurances are deferred or significantly delayed and a 'refresh' is now urgently needed.
- During one to one interviews with board members, there was a unified agreement the trust had taken a reactive (rather than proactive) operational approach during the past 12 months, largely due to the challenge to deliver on the cost improvement programme (CIP). There was a limited strategic plan for finance going forward or to deal with the significant challenges caused with implementation of the patient administration system.
- There was no current strategy to recover the trusts' financial position.

Summary of findings

- We heard how the executive team have faith in their current clinical leaders and consider themselves to be on a wide-scale journey of improvement.
- The Trust Board was aware that the organisation faced significant quality and performance challenges and had launched an Improvement Plan in June 2015 and had begun to address them.

Culture within the trust

- We were contacted by staff before, during and after the inspection (some of whom were classified as whistleblowers) who told us they did not feel supported by middle and board level management. The themes identified related to how change was implemented, the quality of staff consultation or in some cases lack of consultation, low morale, heavy handed approach bordering on a bullying culture from senior management and in some cases at board management level.
- We were contacted by several staff members during the inspection who told us of instances of inappropriate behaviour by senior management and at executive board level by reprimanding staff in public and we were shown examples of reprimands via email. The style of communication employed was inappropriate in a professional arena.
- It was evident from the various methods used by staff to protect their anonymity when making initial contact with CQC, they were genuinely worried. This indicated there was an unhealthy culture which did not promote effective listening. Staff were reluctant to speak out for fear of reprisals from senior management.
- Whilst the trust demonstrated its efforts to engage staff, the majority of staff we talked with felt it was insufficient and ineffective.
- Despite 'low morale' across many wards and departments staff demonstrated a positive approach to patient care and a genuine compassion to deliver the best care possible.

Fit and Proper Persons

- The Fit and Proper Persons Requirement is a statutory requirement that came into effect in November 2014. It requires all those that hold a board level appointment to undergo certain checks to demonstrate they are able to hold that office. These include checks on whether they are declared bankrupt, previously been found guilty of serious misconduct and have the ability and qualifications to carry out their role.

Summary of findings

- We looked at a number of files of executive and non-executive directors. The trust had failed to implement the new checks and tests necessary to fulfil the requirement for all directors to be confirmed as 'fit and proper' persons.
- We saw no active checks had been carried out for any directors within the trust (self-declaration only), despite the appointment of new directors in the months leading up to our visit. There was no Fit and Proper Person policy in place.
- Following the announced inspection, the trust had taken prompt remedial action to satisfy statutory requirements which demonstrated compliance with the Fit and Proper Person Regulation.
- We sampled four directors files from the trust of our choosing during the unannounced visit. Of these, two were in post before the Fit and Proper Persons Requirement came into force, and two were appointed after the requirement. Some of these were different files from the previous sample. For all of these the appropriate checks had subsequently been done and the trust was now compliant with the regulations.
- The trust had developed a policy with external support and this had been presented to the trust board and had been fully signed off and accepted by the board.
- At the end of the formal inspection period the trust was compliant with the Fit and Proper Persons Requirement.
- The trust intended to apply the principles of the regulation to the next layer of management below the board. This is not a statutory requirement but demonstrates good management practice.

Public engagement

- The board heard a patient story at every meeting so that the executive and non-executive directors could have an understanding of patients' experiences. The trust executive directors acknowledged they had more work to do on public engagement.
- The Family and Friends Test during 2014/15 showed the most common words used by patients in free text comments in relation to our colleagues were: friendly, good and very good, helpful, caring, excellent, efficient and speedy with explanations provided.
- However, the response rate was low for example, ED response was 4.28%, inpatient response was 45.9% and maternity services was 10.9%.

Staff engagement

Summary of findings

- The trust promoted staff engagement through different methods for example: paper bulletins with updated information on issues and a calendar of governance events and meetings. The trust had a 'Quick Comms' which was a visit by members of the directorate team once a fortnight for 30 minutes for staff to speak with the senior team about what the staff are proud of and what was working well and staff were kept updated via monthly newsletters.
- 2014 NHS Staff Survey results scored better than most trusts in relation to two indicators relating to training. However, the trust scored worse in relation to 15 of these indicators. These include: bullying and harassment from patients/public, low motivation, job satisfaction, stress and work pressure.

Innovation, improvement and sustainability

- In Critical Care services we saw one of the consultants had produced a comprehensive induction booklet as an introduction to critical care for junior medical staff.
- The role of the advanced neonatal nurse practitioner (ANNP) had been developed and there were six ANNPs undertaking activities and roles previously allocated to medical staff. They also provided an outreach service to the babies receiving intermediate care on the maternity unit.
- In OPD and diagnostic services we saw an advanced practitioner now worked in the imaging department. The service implemented the use of three armed gowns for privacy purposes in x-ray. The overlap of the gown ensured the person's body was fully covered.
- £17,000 had been saved in OPD in gynaecology clinics by changing some of the service equipment during a supplier review.
- The trust held bi-annual trans- vaginal scan workshops for two days by the consultant in the gynaecology clinics. Approximately 150 women attend at each workshop to volunteer for a scan. Although this was a training session for staff, when any problems were identified the volunteer was referred for further consultation and treatment.

Overview of ratings

Our ratings for Walsall Manor Hospital

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

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Walsall Healthcare NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Improve the governance of incident reporting systems to ensure that processes are embedded across the Trust.
- Improve duty of candour training to ensure staff have a clear understanding of the process.
- Implement systematic training for complaints investigation and improve the RCA process and dissemination of lessons learned to front line staff and their managers.
- The trust must ensure equipment is stored appropriately; all fire exits must be kept free without compromising patient and staff safety and so staff can access equipment when required.
- MCA, DoLS and DNACPR assessments to be carried out in a timely manner and supported by appropriate documentation.
- Review the patient administration system to minimise problems associated with missed patient appointments. Ensure data is accurate and the system is a reliable resource for staff to use which meets the need of patients using the service.
- Ensure health records are completed appropriately and patient data is confidentially managed.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust did not ensure all Fire Exits were kept free from clutter. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15 (1) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that steps were taken to secure the contents of the treatment room on the children's ward which could pose a risk to children and young people who might self-harm. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (d)

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered provider did not ensure there were adequately qualified staff across all services to meet the needs of patients to protect them from abuse and avoidable harm, specifically in the Emergency Department and Maternity Services. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider did not ensure medication was stored, administered and recorded appropriately across all services, specifically in Maternity Services and Critical Care Services. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered provider did not ensure that patient confidentiality was maintained at all times across Maternity Services. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17 (1) (2) (c)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered provider did not ensure equipment was stored appropriately without compromising patient and staff safety and that staff and patients can access equipment when required, for example the birthing pool in maternity services. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15 (e)

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider did not ensure that appropriate systems were in place and being used for patients who lacked capacity in relation to completion of DNACPR records and implementing timely assessment and implementation of Deprivation of Liberty Safeguards. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (4)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care We have issued a Section29A Warning Notice to the Registered Provider, as the quality of health care provided for the regulated activities listed requires significant improvement.