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

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