Annex A

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Care Quality Commission Inspection: September 2018

Response to preliminary findings as at March 2019: Outstanding actions

A. Amber / Red = We either lack a plan or confidence in that plan

	CQC finding	Improvement action taken / planned to address the concern	RAG	Next Steps
1.	Mental Capacity Act – recording of capacity assessments were not available for some patients and DoLs were in place, so there was no assurance that processes were being followed. There was confusion/limited understanding amongst staff between the difference between a DoLs and a mental capacity assessment. *(The exception to this is Medicine at City Hospital where capacity processes were found to be in place.)*	• The Trust uses standard DNACPR forms and will review the format against best practice in other organisations, and introduce any agreed changes. • Forms to be read in conjunction with patient notes and records.	**A/R**	The Trust has worked with the CQC and with neighbouring Trusts and now has a proposal about what good looks like and what to do. An upcoming workshop with the CQC will be used to agree that if delivered this would constitute compliance. Implementation will proceed during Q1 and Q2 – ward by ward.
2.	Continued staff concerns with the quality and reliability of IT systems and support	The October Board established revised governance for IT having changed the management team. Performance data is widely published weekly across the organisation. • From January IT helpdesk tickets will only be	**A/R**	The digital MPA has oversight of work to improve IT reliability against uptime ambitions that exceed 99%. A sentinel users programme is being launched to hear employee feedback on improvement, whilst the Helpdesk SOP has been changed to ensure tickets are only closed with reporter agreement.

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		closed with employee confirmation and 100 'mystery' shoppers will advise the Board fortnightly on employee confidence in the revised systems. • The externally supported infrastructure programme will be implemented between October and December 2018. • Unity installation, which is cloud backed, will be take place during Q4 or Q1 of 2019. • Printer resolution team will visit each ward and department to close out remaining print issues. • Revision of password policy will enable Trust to reduce helpdesk tickets and waits by implementing meaningful self-service.		
3.	The specialist paediatric team did not work nights. Care overnight was delivered by non-specialist paediatric staff. There was no separate waiting area for children between the hours of 9.30pm to 9am, this could potentially compromise the safety of children.	The Trust is satisfied with the safety of children overnight, as waiting areas are observed. • Wait times for children are separately reported and the scale of staffing is being increased on weekday afternoons • Skills development is taking place to ensure	**A/R**	Whilst we do not share the CQC's perception of prevalent risk, we are working through two changes: • Additional training programmes for employees working in emergency care • Relocation of services within sites to reduce the staffing spread across areas

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		that nursing staff have the required competence and confidence to look after children. • The Trust is reviewing the interaction between its assessment units and its A&E department		Progress has been made on the latter and a project group is in place to achieve delivery in 2019. It is less clear that we have a delivery plan for the former, and the Matron for Emergency Care will be required to bring a plan for such to the Chief Nurse by the end of April. Outwith that we have agreed standards for APLS coverage in the Trust to be managed as part of mandatory training.
4.	We had concerns around nurse staffing levels. Particularly around high agency/bank staff numbers on OPAU	• Continued work to recruit and retain nursing staff across medicine • Cross directorate balancing work introduced to equalise gaps based on acuity • Revised Trust-wide approach to focused care and de-escalation	**A/R**	Daily 8.45 staffing huddle is being used to manage the routine risk of absence and to address red rated shifts. The Trust recruitment and retention strategy is being used to address underlying gaps. May performance reviews will be used to re-deploy staff on a six month basis into lowly staffed areas if there is not a reasonable prospect of organic resolution by June 30th.
5.	Ward managers do not have enough protected time to allow them to carry out their managerial roles.	Maternity, Neonatal Unit (NNU) & Paediatrics: Ongoing recruitment into current vacant posts to release ward managers to have rostered funded protected time.	**A/R**	We have funded changes to the nurse management structure of the Group to support a greater emphasis in these areas. Expectations for impact will be agreed with the Chief Executive and others in the May performance review cycle.
6.	Staffing was a concern across neonates and paediatrics. Multiple occasions of staffing not meeting patient acuity within neonates and D19.	• NNU: Increased funding secured through contract change to enable staffing to meet BAPM requirements • NNU: Escalation policy deployment; flow chart to indicate need and action to restrict	**A/R**	The Trust funded in early 2018-19 the relevant staffing for the neonatal unit. Work continues to deploy those new starters and to ensure intensive care training is sufficiently dispersed to provide coherent rotas. Changes within D19 will be made with a major shift intended in late 2019 to a single combined ED/AU facility.

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		activity. • D19: Ongoing utilisation of Paediatric Escalation Policy; flow chart to indicate need and action to restrict activity if required.		
7.	MCA DoLs. Improvements since last inspection, however using basic general checklist from patient assessment documentation as capacity assessments for decisions/MCA and for DoLs applications.	• Introduce MCA standard check into the Safety Plan reporting data. • Review MCA approach Trust-wide by reference to Black Country best practice and revise approach after CLE sigh-off.	**A/R**	The Trust has worked with the CQC and with neighbouring Trusts and now has a proposal about what good looks like and what to do. An upcoming workshop with the CQC will be used to agree that if delivered this would constitute compliance. Implementation will proceed during Q1 and Q2 – ward by ward.

29th March 2019

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B. Amber / Green = A clear plan for delivery completed.

CQC Inspection finding	Checks to test the issue has been addressed
CROSS-SITE ISSUES - MEDICINE AND EMERGENCY CARE	
1) Patient records, computer screens and boards had confidential patient information openly accessible, so potential for breaches of personal data 2) Some resuscitation trolleys were unsecure and not tamper proof. Some equipment on trolleys was out date despite signed checks by staff 3) Some IV fluids were not securely stored	• Information Governance observational visits: 04/2019 • Full trolley audit : 05/2019 • Observational audit: 04/2019
SANDWELL GENERAL HOSPITAL - URGENT AND EMERGENCY SERVICES	
1) Infection control and cleanliness of the department was a concern 2) Ambulance handover bay – There were concerns about the safety, privacy and dignity of patients	• Unannounced observational visits: 04/2019. Spot checks by Facilities Manager • Elicit patients views on privacy and dignity: 04/2019
SANDWELL GENERAL HOSPITAL - MEDICINE	
1) In AMU there was a policy to allowed mixed sex bays to be used. Whilst the policy states that this should be avoided if possible, bed configurations were not being optimised to reduce this. We have requested more information from you regarding mixed sex accommodation. We found the same concerns at City Hospital. 2) Staff had a limited understanding around duty of candour	• NHSI/E + CCG assurance visit: 03/2019. Gender breach escalation process through Capacity Office – COO decision in hours /Senior on-call manager OOH. • In-house inspections: 05/2019
CITY HOSPITAL – URGENT AND EMERGENCY SERVICES	
1) Concerns about paediatric care out of hours as was found at City 2) We saw large sharps bins full of needles and open to all by the paediatric department, staff told us they empty and re use sharps bins. These had no date or signatures were included as they were re-using them, so no audit trail was possible. 3) Safety/security concerns- doors were wide open, staff were concerned about safety so had doors open however, this had the potential for anyone to walk in the department. 4) The triage room door was wide open and everyone in the vicinity could hear/see patient during	• Monthly OOH observation visits by senior nursing teams • Audit of sharps bins: 04/2019 • Monthly OOH observation visits by senior nursing teams • As above

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an assessment	
CITY HOSPITAL – MEDICINE	
1) Concerns around mixed sex accommodation are highlighted (as documented under medicine at Sandwell) 2) Two staff were in tears when raising concerns and frustrations about staffing levels as they considered they could not always deliver the care patients deserved or needed 3) There were gaps in ward staff knowledge (Fire safety / DoLS) and planned training events were not always attended due to staff shortages	• NHSI/E + CCG assurance visit: 03/2019. Gender breach escalation process through Capacity Office – COO decision in hours /Senior on-call manager OOH. • Daily monitoring of rosters linked to patient acuity by the CN. Reported in Annex to monthly CEO report. • Mandatory training compliance.
SANDWELL GENERAL HOSPITAL - CHILDREN AND YOUNG PEOPLE	
1) There were ligature points in the rooms used by children with MH needs. Some information has been provided to us. 2) Resus trolleys were not locked/did not have tamper proof tags on Lyndon 1 or Lyndon ground. 3) Establishment Nurse staffing levels did not meet RCN guidelines. 4) Children were not being seen within 14 hours of admission and they did not have a 12 hour daily presence of consultant cover. 5) Out of date medicines including controlled drugs on Lyndon 1.	• CAMHS room compliance visits by UHCWT and NHSI – assurance gained. • Full trolley audit : 05/2019 • Daily monitoring of rosters by the Chief Nurse. Reported in Annex to monthly CEO report. • Compliance audit: 04/2019 • Controlled drugs compliance monitoring by Pharmacy
CITY HOSPITAL – MATERNITY SERVICES	
1) Reduced staffing levels on occasions, particularly in the Serenity Midwifery birth centre made some staff feel anxious and vulnerable about providing sufficient levels of care to women at the centre. 2) Staffing levels sometimes impacted on staff being unable to take breaks and attend mandatory training sessions.	• Daily monitoring of rosters linked to clinical priority. Reported in Annex to monthly CEO report. • Mandatory training compliance

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CQC Inspection finding	Checks to test the issue has been addressed
CITY HOSPITAL – CHILDREN AND YOUNG PEOPLE'S SERVICES: NEONATES	
1) Isolation Rooms - two babies were being cared for in isolation rooms with the door wedged open due to lack of staffing to provide one to one care. 2) Safe care and treatment - two members of staff disclosed they have felt pressure to do IV checks whilst not signed as competent; one refused and the other complied.	• Implementation of the neonatal improvement plan • Individual staff competency records review
CITY HOSPITAL – CHILDREN AND YOUNG PEOPLE'S SERVICES: CHILDREN'S WARDS	
1) Notes room - the door was not fully closed. Notes were potentially accessible to unauthorised individuals. 2) Dirty utility - the door was wedged open and there was access to chloro tabs and liquid cleaners albeit in wall mounted cupboards that 'older' children could potentially access. 3) Treatment room was open - there was access to syringes. Out of date drugs were found in the fridge. There was also a sharps bin in use that was full and contained a soup tin. 4) Out of date equipment - lubricating gel and paraffin, tubing, scissors all found to be out of date. A significant amount of stock was out of date. When asked about the process for disposal, staff said they didn't have time to do it but they would put them in the bin.	• Information Governance observational visits: 04/2019 • In-house inspections: 05/2019 • In-house inspections: 05/2019 • In-house inspections: 05/2019
COMMUNITY INPATIENTS & ROWLEY REGIS HOSPITAL: CONCERNS WHICH WERE FOUND ACROSS BOTH SITES AND CORE SERVICES	
1) Resus trolleys were not tamper proof.	• Full trolley audit : 05/2019
ROWLEY REGIS AND LEASOWES HOSPITALS	
1) DNACPR - tick boxes to describe ceilings of treatment. No narrative boxes, could easily be ticked after the form was signed. Some aspects weren't sufficiently explained, for example antibiotics did not state whether oral and IV antibiotics were not to be given. 2) Care plans – core care plans used – these had limited personalisation to describe the care needs in an individualised way. 3) NEWS – Where there are elevated scores the frequency and actions described are not always	• Records audit: 05/2019 • Records audit: 05/2019 • Case reviews: 05/2019

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CQC Inspection finding	Checks to test the issue has been addressed
being followed up.	
CRITICAL CARE SERVICES: SANDWELL GENERAL HOSPITAL	
1) Resus trolleys were not tamper proof.	• Full trolley audit : 05/2019

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