CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

7 October 2015

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Board Room, Corporate Services Building (Building 12 on the attached map), New Cross Hospital, Wednesfield, Wolverhampton, WV10 0QP

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence (if any)** (Pages 5 - 6)

2 **Notification of substitute members (if any)**

3 **Declarations of interest (if any)**

4 **Minutes of the previous meeting** (Pages 7 - 10)
[To approve the minutes of the previous meeting (29 July 2015) as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 29 July 2015]

6 **Summary of outstanding matters** (Pages 11 - 14)
[To consider and comment on the summary of outstanding matters]

7 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 15 - 18)
[To consider and comment on the items listed on the Forward Plan]

8 **Infant Mortality Health Scrutiny Review** (Pages 19 - 90)
[To consider the recommendations of the Health Scrutiny Infant Mortality Review]
[Ros Jervis]

9 **Review of the Wolverhampton Joint Strategic Needs Assessment (JSNA) process** (Pages 91 - 96)
[To consider information from the review of the local and national Joint Strategic Needs assessment (JSNA) processes and an option for the development of an updated JSNA for Wolverhampton from 2016 onwards]
[Ros Jervis]

10 **Better Care Fund - Update** (Pages 97 - 108)
[To receive a report on the development and progress of the Better Care Fund, including financial risks and next steps and to secure the continuing support of the wholw Health and Social Care economy to facilitate the successful delivery of the Better Care Fund programme]
[Viv Griffin / Anthony Ivko / Steven Marshall]

11 **Royal Wolverhampton NHS Trust - Care Quality Commission (CQC) - Inspection Results** (Pages 109 - 266)

[To consider the results of the recent Care Quality Commission inspection into the Royal Wolverhampton NHS Trust]

[David Loughton]

12 **Wolverhampton Safeguarding Children's Board - Annual Report and Executive Summary 2014-15** (Pages 267 - 364)

[To consider the Safeguarding Children's Board Annual Report and Executive Summary 2014 - 15]

[Alan Coe]

13 **Wolverhampton Adults Safeguarding Board - Annual Report** (Pages 365 - 454)

[To consider the Safeguarding Adults Annual Report and Executive Summary for 2014 - 15]

[Alan Coe]

14 **Minutes from Sub Groups** (Pages 455 - 470)

[To receive feedback from the following Sub Groups]

(i) Children's Trust Board (Cllr Val Gibson)[TO FOLLOW]
(ii) Integrated Commissioning and Partnership Board (Linda Sanders)
(iii) Public Health Delivery Board (Ros Jervis)

15 **Exclusion of the Press and Public**

[To pass the following resolution:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information on the grounds shown below]

Part 2 – Matters not open to the press and public

16 **NHS Capital Programme** (Pages 471 - 474)

[To receive a report on the current position of the NHS Capital Programme insofar as it relates to Wolverhampton] [Dr Kiran Patel / David Johnson]	Information relating to the financial or business affairs of any particular person (including the authority holding that information) Para (3)

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Wards

Ward Name	Zone	Location Number	Floor Level
Acute Medical Unit	C	C21	Ground
Beynon Short Stay Ward	C	C39	Ground
Cardiology Day Ward	B	B15	3
Cardiology Ward	B	B14	3
Cardiothoracic Ward	B	B8	2
Catheter Suite	B	B15	3
Clinical Haematology Unit & Day Case	B	B11	3
Critical Care Unit (ICCU)	B	B9	2
Deanesly Ward	C	C35	1
Delivery Suite	D	D16	3
Gynaecology Ward	D	D7	1
Mary Jones Ward	A	A33	1
Maternity Ward	D	D10	2
Midwifery Led Unit (MLU)	D	D11	2
Neonatal Unit	D	D6	1
Stroke Unit	B	B12	3
Ward A10	A	A10	Ground
Ward A12	A	A12	1
Ward A14	A	A14	1
Ward A21 (Children's Ward)	A	A21	1
Ward A23	A	A23	2
Ward A5	A	A5	1
Ward A6	A	A6	1
Ward A7	A	A7	1
Ward A8	A	A8	1
Ward A9 (Surgical Assessment Unit)	A	A9	Ground
Ward B7	B	B7	2
Ward C15	C	C15	1
Ward C16	C	C16	1
Ward C17	C	C17	1
Ward C18	C	C18	1
Ward C19	C	C19	1
Ward C22	C	C22	Ground
Ward C24	C	C24	Ground
Ward C25	C	C25	Ground

Departments

Department Name	Zone	Location Number	Floor Level
24 hour Blood Pressure Monitoring Unit	C	C8	Ground
Acute Medical Unit	C	C21	Ground
Antenatal Clinic	D	D1	Ground
Appleby Suite	A	A16	Ground
Baby Clinic	D	D9	2
Beynon Day Case Unit	C	C40	Ground
Cancer Services	C	C27	2
Car Park Services	B	B20	1
Cardiac Investigations	B	B4	1
Cardiac Outpatient Department	B	B3	1
Cardiac Rehabilitation	B	B2	1
Cardiac Theatre	B	B10	2
Chapel / Prayer Room	C	C5	Ground
Chapel of Rest	B	B20	Ground
Chemotherapy Unit	C	C35	Ground
Children's Outpatient Department	A	A22	2
Chronic Kidney Disease Team	C	C7	Ground
Clinical Chemistry	C	C30	Ground
Clinical Illustration	C	C29	Ground
Colorectal Nursing	A	A37	Ground
Day Assessment Unit	D	D1	Ground
Deanesly Outpatient Department	C	C35	Ground
Dermatology Outpatient Department	A	A30	Ground
Diabetes Centre	C	C28	Ground
Discharge Lounge	C	C12	Ground
Discharge Lounge (Maternity)	D	D9	2
Durnall Unit	A	A24	3
Emergency Department		Emergency Department	Ground
Emergency Department X-Ray	A	A18	Ground
Endoscopy	C	C40	Ground
ENT/Maxillofacial Outpatient Department	A	A25	3
Eye Infirmary	A	A33	Ground
Eye Referral Unit	A	A34	Ground
Fetal Medicine	D	D1	Ground
Fracture & Orthopaedic Clinic	A	A26	Ground
General Office & Bereavement Suite	A	A11	Ground
Gynaecology Assessment Unit	D	D7	1
Gynaecology Outpatient Department	D	D18	Ground
Haematology Department & Blood Bank	C	C8	1
Haemodialysis Training Room	C	C8	Ground
Health Record Services	B	B19	Ground
Histopathology	C	C31	Ground
Macmillan Cancer Care Centre	C	C1	Ground
Main Theatres	A	A15	Ground
Maternity Triage Unit	D	D16	3
Microbiology	B	B16	Ground
Mortuary	B	B21	Ground
Multi-faith Prayer Room		Building 12	Ground
Neurophysiology	B	B5	1
Nutrition & Dietetics Services		Building 12	Ground
Orthodontics	A	A23	2
Orthotics	A	A28	Ground
Outpatient Department	A	A27	Ground
Paediatric Assessment Unit (PAU)	A	A21	1
Parents Education Suite	D	D9	2
Pathology Centre	C	C37	Ground
Patient Assessment / Treatment - Therapy Services	C	C14	1
Patient Information Centre	C	C2	Ground
Pharmacy	A	A3	Basement
Private Patient Office	C	C3	Ground
Radiology	A	A2	Ground
Radiotherapy	C	C35	Ground
Renal Unit & CAPD	C	C8	Ground
Research & Development	B	B18	Ground
Respiratory Centre	B	B1	Ground
Rheumatology Day Case Unit	A	A29	Ground
Rheumatology Outpatient Department	A	A29	Ground
Social Services		Building 14	Ground
TB Nursing Team		Building 9	Ground
The Fowler Centre for Sexual Health		Building 3	Ground
Therapy Services Outpatient Department	A	A36	Ground
Urology Outpatient Department	A	A31	Ground
Volunteer Office		Building 9	1
Wolverhampton Medical Institute		Building 11	Ground
Women's and Children's Ultrasound	D	D4	Ground

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 29 July 2015

Attendance

Members of the Health and Wellbeing Board

Cllr Sandra Samuels (Chair)	Cabinet Member for Health and Wellbeing
Ian Darch	Wolverhampton Voluntary Sector Council
Manjeet Garcha	Wolverhampton City Clinical Commissioning Group
Cllr Val Gibson	Cabinet Member for Children and Families
Ros Jervis	Director of Public Health
Cllr Roger Lawrence	Leader of the Council
Steven Marshall	Wolverhampton City Clinical Commissioning Group
Donald McIntosh	Wolverhampton Healthwatch
Linda Sanders	Strategic Director, People
Jeremy Vanes	Royal Wolverhampton NHS Trust

Council employees and representatives of partner organisations

Viv Griffin	Service Director - Disability and Mental Health
Sarah Fellows	Mental Health Commissioning Manager
Donald McIntosh	Chief Officer
Linda Banbury	Democratic Support Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence were submitted on behalf of Alan Coe (Independent Chair, Wolverhampton Safeguarding Children's Board), Simon Hyde (West Midlands Police), Linda Lang (University of Wolverhampton), David Loughton (Royal Wolverhampton NHS Trust), Kiran Patel (NHS England) and Councillor Paul Singh.

2 **Notification of substitute members (if any)**
No notifications of substitutes had been received.

3 **Declarations of interest (if any)**
There were no declarations of interest.

4 **Minutes of the previous meeting**
Resolved:
That the minutes of the meeting held on 3 June 2015 be confirmed as a correct record, subject to clarification in regard to paragraph 4 in that it related to the Better Care Fund.

5 **Matters arising**

With reference to minute 6, Ros Jervis, Director of Public Health, advised that Professor Kevin Fenton, National Director Health and Wellbeing PHE, had yet to visit the city. Donald McIntosh advised that the recruitment campaign for Chair of Wolverhampton Healthwatch was being repeated due to insufficient response.

6 **Summary of outstanding matters**

Resolved:

That the report which appraised the Board of the current position with a variety of matters considered at previous meetings be received and noted.

7 **Health and Wellbeing Board Forward Plan 2015/16**

Viv Griffin, Service Director Disability and Mental Health, presented a report which provided an update on items listed in the Forward Plan for the Board.

Resolved:

That the report be received and noted.

8 **Primary Care Co-Commissioning**

Steven Marshall, Director of Strategy & Transformation, presented a report which outlined the content of guidance received to date, assessed the opportunities and risk of each co-commissioning level and its preferred option of level 2 (joint commissioning) for Wolverhampton Clinical Commissioning Group (CCG).

With regard to table 2.5 (primary care functions), he advised that the financial balance target had now been reached and that the outcome of re-consideration for joint commissioning should be received in August.

Resolved:

That the report be noted and received.

9 **Update from the Wolverhampton Clinical Commissioning Group in response to the recommendations made by the Francis Inquiry**

Manjeet Garcha presented a report, which provided a further assurance that the CCG continued to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience. She advised that nursing staff and midwifery revalidation would commence in 2016, that senior leadership programmes had been strengthened and monthly oversight reports would be produced by all providers in terms of safety, effectiveness and experience.

Resolved:

That the report be received and a further update, including the findings of the recent and pending (Care Quality Commission) CQC inspections be presented in six months.

10 **Obesity Call to Action - Update and progress made towards developing an Action Plan to tackle obesity in Wolverhampton**

The Director of Public Health presented a report, which provided an update in relation progress made for the Obesity Call to Action on 15 March 2015. The report included an update on the development of a whole systems obesity action plan and associated governance arrangements, promoting an element of challenge to progress and stimulate ideas for contribution across the partnership. She indicated that nominations were still awaited from some partners in respect of the Programme

Board membership, adding that operational leads were needed to champion this cause. It was anticipated that the inaugural meeting of the Board would take place on 18 September 2015.
Resolved:
That the report be noted and received.

11 **Public Health Annual Report 2014/15**

The Director of Public Health made a presentation in regard to 'Lifestyle Choice – A Prevention Plan for Wolverhampton', which outlined information on the Prevention Plan Public Health Annual Report and requirements and measures, together with the prevention strategy. The presentation included statistical information drawn from qualitative studies in respect of smoking, obesity, physical inactivity, alcohol exposure, illegal drugs and poor mental health and lifestyle.

Resolved:

That the presentation be received and that a report be presented to a future meeting on the seventy recommendations being addressed by the partner organisations.

12 **Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014 - 16**

Sarah Fellows, Mental Health Commissioning Manager, presented a report which outlined recommendations in respect of a proposal to increase capacity within CAMHS Commissioning across NHS Wolverhampton Clinical Commissioning Group and City of Wolverhampton Council. This aimed to deliver a dedicated whole systems project across short, medium and longer term, deliver the key strategic drivers and ambitions of Future in Mind and transform the lives of the children and young people in the city. Close work would be undertaken in connection with schools, both in terms of curricular and extra-curricular activities, in order to deliver this agenda.

The Chair suggested that, in future, links be provided rather than producing lengthy documents for circulation with the agenda papers.

Responding to questions, the Service Director Disability and Mental Health advised that the GEM Centre focussed around special educational rather than mental health needs and that, as part of the Headstart programme, work was being undertaken with eighteen schools including special schools, adding that engagement with children, parents and carers was vital.
Resolved:
That the report be received and the recommendations regarding a proposal to increase capacity within CAMHS Commissioning across NHS Wolverhampton Clinical Commissioning Group and City of Wolverhampton Council be endorsed.

13 **Joint Strategy for Urgent Care - Equality Analysis**

The Director of Strategy & Transformation presented a report which provided information on action taken following the equality analysis report on the Joint Strategy for the Provision of Emergency and Urgent Care in Wolverhampton.
Resolved:

That the steps taken by the Clinical Commissioning Group to implement recommendations in the equality analysis document be noted and that a further update be presented in February 2016.

14 **Better Care Fund - Update**

The Director of Strategy and Transformation presented a report which briefed the Board on the development and progress of the Better Care Fund and, in particular, the Intermediate Care and Community Care workstreams. The report appraised the Board of next steps and sought continuing support from the whole Health and Social Care Economy to facilitate the successful delivery of the Better Care programme.
Resolved:

That the report be received and noted.

15 **Minutes from Sub Groups**

Councillor Gibson tabled a paper briefly detailing the work of the Children Trust Board April 2014 to March 2015 and, in so doing, apologised that the minutes of the last meeting had not been circulated with the agenda.

The Strategic Director, People presented the minutes of the Integrated Commissioning and Partnership Board held on 11 June 2015.
Resolved:

a) That the Annual Report of the Wolverhampton Children Trust Board be received.
b) That a full report be presented to a future meeting.
c) That the minutes of the Integrated Commissioning & Partnership Board held on 11 June 2015 be received.
d) That an update be presented to the next meeting on the mental health and dementia interface.

16 **Any other business**

Jeremy Vanes drew attention to the many changes in the provider sector and undertook to circulate relevant information form the Association of Foundation Trusts and Trusts (NHS Providers).

Agenda Item No. 6

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

7 October 2015

Report Title	Summary of outstanding matters	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Director	Viv Griffin – Service Director – Disability and Mental Health	
Originating service	Governance	
Accountable officer(s)	Carl Craney Tel Email	Democratic Services Officer 01902 55(5046) carl.craney@wolverhampton.gov.uk

Recommendations for noting:
The Health and Wellbeing Board is asked to consider and comment on the summary of outstanding matters

1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at previous meetings of the Health and Wellbeing Board.

2.0 Background

2.1 At previous meetings of the Board the following matters were considered and details of the current position is set out in the fourth column of the table.

DATE OF MEETING	SUBJECT	LEAD OFFICER	CURRENT POSITION
31 March 2014	Health and Well Being Strategy – Performance Monitoring	Helena Kucharczyk (WCC)	Quarterly reports (included with Better Care Fund updates)
31 March 2014	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Les Williams / Dr Kiran Patel (NHS England)	Quarterly reports
7 January 2015	Implementation of Action Plans following Francis Inquiry – Update	Six monthly updates	Reports to July 2015 and January 2016 meetings and six monthly thereafter
4 March 2015	Scoping the JSNA and analysing best exemplars nationally	Ros Jervis (WCC)	Report to a future meeting
3 June 2015	Integrated Commissioning	Roles and responsibilities of the various partner agencies involved in Integrated Commissioning	Report to a future meeting as part of a Better Care Fund – Update report.
29 July 2015	Joint Strategy for Urgent Care	Update on steps taken by the WCCCG to implement the recommendations	Report to the February 2016 meeting.

in the equality
analysis document

3.0 Financial implications

3.1 None arising directly from this report. The financial implications of each matter will be detailed in the report submitted to the Board.

4.0 Legal implications

4.1 None arising directly from this report. The legal implications of each matter will be detailed in the report submitted to the Board.

5.0 Equalities implications

5.1 None arising directly from this report. The equalities implications of each matter will be detailed in the reports submitted to the Board

6.0 Environmental implications

6.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report submitted to the Board.

7.0 Human resources implications

7.1 None arising directly from this report. The human resources implications of each matter will be detailed in the report submitted to the Board.

8.0 Corporate landlord implications

8.1 None arising directly from this report. The corporate landlord implications of each matter will be detailed in the report submitted to the Board.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the former Shadow Health and Well Being Board and associated reports and previous meetings of this Board and associated reports

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Agenda Item No. 7

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

7 October 2015

Report Title	Health And Wellbeing Board – Forward Plan 2015/16
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Director	Viv Griffin – Service Director – Disability and Mental Health
Originating service	Disability and Mental Health
Accountable officer(s)	Viv Griffin Service Director Tel 01902 55(5370) Email Vivienne.Griffin@wolverhampton.gov.uk

Recommendation
That the Board considers and comments on the items listed in the Forward Plan

PRIORITIES OF THE HEALTH AND WELLBEING BOARD (To be updated 7 October 2015)

The priorities of the Board are outlined in Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

- Wider Determinants of Health
- Alcohol and Drugs
- Dementia
- Mental Health
- Urgent Care

MEETING	TOPIC	LEAD OFFICER
7 October 2015	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (CoWC)
	Infant Mortality	Ros Jervis (CoWC)
	JSNA Options Appraisal	Ros Jervis (CoWC)
	Better Care Fund Update • Dementia • Mental Heath	Viv Griffin (CoWC) / Steven Marshall (WCCCG)
	Royal Wolverhampton NHS Trust – CQC Inspection	David Loughton (RWT)
	NHS Capital Programme – Update	Dr Kiran Patel (NHS England – Local Area Team)
	Wolverhampton Children's Trust Board - Report	Linda Sanders (CoWC)
	Update on the mental health and dementia interface	Tony Ivko (CoWC)
	Wolverhampton Children's Safeguarding Board - Annual Report	Alan Coe (Independent Chair)
	Wolverhampton Adults Safeguarding Board - Annual Report	Alan Coe (Independent Chair)
2 December 2015	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (CoWC)
	Better Care Fund Update • Intermediate Care • Primary and Community	Steven Marshall (WCCCG) / Viv Griffin (CoWC)

	Care	
	Updated Health and Wellbeing Board priorities (following away day 7 October)	Viv Griffin (CoWC) / Steven Marshall (WCCCG) / Ros Jervis (CoWC)
	CCG Commissioning Intentions 2016/17	Steven Marshall (WCCCG)
	Public Health Commissioning Intentions 2016/17	Ros Jervis (CoWC)
	National Transforming Care Policy	Kathy Roper (CoWC)
10 February 2016	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (CoWC)
	Better Care Fund Update • Dementia • Mental Health	Steven Marshall (WCCCG) / Viv Griffin (CoWC)
	NHS Capital Programme – Update	Dr Kiran Patel (NHS England – Local Area Team)
	Joint Strategy for Urgent Care – Equality Analysis –Update on implementation of recommendations	Steven Marshall (WCCCG)
	Update on progress with implementing recommendations from the Francis Inquiry	Dr Helen Hibbs (WCCCG)
	Update on Engagement / Consultation of Urgent Care Centre	Dee Harris (WCCCG)

	Update on the Children and Young People's Plan	Emma Bennett (WCC)
27 April 2016	Minutes from Sub Groups	Viv Griffin / Linda Sanders / Ros Jervis (WCC)

To be added at some appropriate point: Youth Offending Team input Joint Strategic Needs Assessment

Agenda Item No. 8

Health and Wellbeing Board

7 October 2015

Report title	Infant Mortality Health Scrutiny Review	
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Director Public Health
	Glenda Augustine	Consultant in Public Health
	Tel	01902 551372
	Email	ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team	1 June 2015
	Public Health Senior Management Team	18 June 2015
	Cabinet	22 July 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to approve:

- The recommendations proposed within the Health Scrutiny Infant Mortality Review

The Health and Wellbeing Board is recommended to note:

- The close alignment of the proposed recommendations to the Wolverhampton Infant Mortality Action Plan 2015 - 2018

1.0 Purpose

1.1 The purpose of this report is to present the recommendations of the Health Scrutiny Infant Mortality Review which was undertaken from July 2014 to March 2015 to gather evidence in relation to the issue of infant mortality in Wolverhampton.

2.0 Background

2.1 The National Child Health Profiles published in March 2014 indicated that Wolverhampton had the highest rate of infant mortality in England. The average rate of infant mortality between 2010 and 2012 was 7.7 deaths per 1,000 live births compared to the England average of 4.3 deaths per 1,000 live births.

2.2 This high rate of infant mortality raised concerns across health and social care organisations and resulted in the convening of a multi-agency infant mortality working group in May 2014.

2.3 A Health Scrutiny Review commenced in July 2014 to assess the effectiveness of current and future work aimed at addressing modifiable factors that are the main causes of infant mortality in Wolverhampton. The review group met on seven occasions to consider written and verbal evidence from local and regional organisational and professional representatives.

2.4 A key element of the scrutiny review was the city-wide Infant Mortality Action Plan that was presented to and approved by the Health & Wellbeing Board on the 4 March 2015.

3.0 Health Scrutiny Review Infant Mortality

3.1 The Scrutiny Review is a comprehensive summary of current services, policies and practices to address the high rate of infant mortality in Wolverhampton. There was in-depth discussion on the main causes of infant mortality and identification of gaps in service provision that could improve maternal and infant outcomes (see appendix one).

3.2 The detailed consideration of the evidence presented to the Review group resulted in the development of 12 recommendations outlined in the executive report that can be found at appendix two.

3.3 Primarily the recommendations highlight the:

- importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton
- need for a strategic and co-ordinated response to tackling the modifiable causes of infant mortality in Wolverhampton
- need to respond to challenge of poverty and deprivation

- importance of changing practice and policies alongside the application of learning based on reliable new evidence of impact and effectiveness

3.4 The Scrutiny Review recommendations endorse the Wolverhampton Infant Mortality Action Plan produced by the Infant Mortality Working Group (IMWG). The IMWG is chaired by the Director of Public Health who will also be responsible for co-ordinating progress reports on delivery/implementation of the Scrutiny Review recommendations.

3.5 On 22 July the Infant Mortality Scrutiny Review was presented to and approved by Cabinet.

4.0 Financial implications

4.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The initial funding allocation for Public Health for 2015/16 is £19.3 million, this is subject to a half year funding reduction for which consultation is currently in progress to determine the actual impact of the proposed announcement on the Council.

4.2 Public Health related recommendations will be contained within the Public Health ring-fenced grant.

[JF/24092015/E]

5.0 Legal implications

5.1 There are no anticipated legal implications to this report.RB/25092015/L

6.0 Equalities implications

6.1 The are no equalities implications related to this report .

7.0 Environmental implications

7.1 There are no environmental implications related to this report.

8.0 Human resources implications

8.1 There are no anticipated human resource implications related to this report.

9.0 Corporate landlord implications

9.1 This report does not have any implications for the Council's property portfolio.

10.0 Schedule of background papers

10.1	Draft Infant Mortality Action Plan – Health & wellbeing Board	4 March 2015
	Scrutiny Review of Infant Morality – Final Report & Executive Response - Cabinet	22 July 2015

Scrutiny Review of Infant Mortality

Final Report

21.5.15

1. Preface

The death of a child is a tragedy for the both family and the wider community.

It is important therefore to review and to challenge appropriately the impact of work being done across Wolverhampton by all key agencies to reduce the number of avoidable child deaths. In 2014 it was reported that Wolverhampton has the highest rate of infant mortality in England. The average rate of infant mortality between 2010 and 2012 in Wolverhampton was 7.7 deaths per 1,000 live births, compared to the England average of 4.3.

The review group wanted to understand the causes of infant mortality and also to review the work being done to reduce the numbers of babies dying in the first 12 months.

The causes of infant mortality are complex and it is clear from the evidence presented that no one single agency can successfully tackle them. It is clear from witness evidence provided that a sustained reduction in the number of avoidable child deaths in the first 12 months of life will require the long term commitment of commissioners, providers of services and crucially the public.

The review group has focused its work on those environmental or modifiable factors, which arise primarily because of unhealthy diet or lifestyle choices, and can be changed, for example by not smoking during pregnancy.

The review group was very impressed by the dedication and skills of staff at the neo natal unit at The Royal Wolverhampton NHS Trust and the work being done to increase survival rates of preterm babies and provide families with support and comfort at a very difficult time.

I would like to place formally on record my appreciation and thanks to the witnesses, review members and employees for their invaluable contributions. In particular, I would like to give special thanks to Ros Jervis, Service Director- Public Health and Wellbeing, and her team for their contributions during the review. The information and insights into the challenges facing key partners has helped to provide the review group with a much better understanding of the work being done to improve the situation. The information provided by all witnesses has also greatly helped in this process and in the drafting of the findings and recommendations.

As Chair of the review I fully commend this report and recommendations.

I hope the recommendations will help improve outcomes and have a positive impact on reducing the number of avoidable deaths of babies in Wolverhampton.

Cllr Claire Darke
Chair – Scrutiny Review of Infant Mortality

2. Summary of report

- The issue of infant mortality is an important indicator of the health of the local population and a key priority for action locally and nationally. For the purpose of the review the following definition of infant mortality will be used - the death of a live born baby within the first year of life.

- An increase in the rate of infant mortality has major implications for efforts aimed at improving the outcomes for babies born in Wolverhampton and also for reducing the inequalities that exist between local and national measures.

- The current high rate of child infant mortality in Wolverhampton will require a long term strategy that provides information that reaches the intended target audience, particularly those groups considered to be at risk, for example, births to mothers aged 40-44 years.

- A key aspect of the review was investigating the underlying factors behind the reported figures, and getting a clear understanding of the risks and the work being done by local and regional organisations to reduce the number of infant deaths within the first 12 months of life.

- The current rate of infant deaths is a significant issue in Wolverhampton which can be addressed through tackling the modifiable factors that are associated with an increased risk of infant death. Primarily, the promotion of smoking cessation and smoke free homes will have a substantial impact on the unborn infant with benefits realised not just in the first 12 months following birth, but throughout life for the child and their family and encouraging breastfeeding.

- The review group accept that a proportion of child deaths in Wolverhampton, while regrettable, are inevitable and will not be affected by changes in policies and practices. For example, child deaths due to severe congenital abnormalities or extremely preterm babies born at or after the threshold of viability at 24 weeks gestation, where the chance of survival is low. Generally the earlier the baby is born the higher the risk of health problems and reduced chances of long term survival.

- There is agreement among witnesses about the importance of using every contact with pregnant women and their families, particularly at points when they are likely to be more receptive to, and act on positive health messages.

- The challenge for the different organisations, working to reduce the rate of infant mortality, is how to create and support a culture of continuous learning and improvement that results in a sustained reduction in the number of avoidable deaths.

- The review findings are based on written and verbal evidence from expert witnesses with knowledge of the topic that could provide answers to the questions detailed in the terms of reference. The review group has considered evidence from representatives of organisations that have a responsibility for commissioning, delivering or reviewing antenatal or post natal services provided to pregnant women.

- In preparation for the review a detailed briefing was provided by Wolverhampton Public Health of analysis of data of the numbers of deaths, the causes of infant mortality and the local risk factors. As part of the review a short questionnaire was sent to members of Infant Mortality Working Group and also to representatives of local and national bodies to get evidence needed to answer questions detailed in the terms of reference. The review group held seven meetings to consider written and verbal evidence.

3. Introduction

- In 2014 it was reported that Wolverhampton has the highest rate of infant mortality in England.

- The average rate of infant mortality between 2010 and 2012 in Wolverhampton was 7.7 deaths per 1,000 live births, compared to the England average of 4.3. According to the Child Health Profile (March 2013) 3,661 live births were recorded in Wolverhampton in 2011.

- It is important therefore to review and to challenge appropriately the impact of work being done across Wolverhampton by all key agencies to reduce the number of avoidable child deaths.

- The overall aim of this review was to assess the effectiveness of current and future work aimed at addressing modifiable factors that are the main causes of infant mortality in Wolverhampton. (see Appendix 1 for a summary of terms of reference)

- The review group accept that there is no easy or quick solution to the challenge of reducing the rate of child infant mortality in Wolverhampton.

- The review group has considered evidence about infant deaths due to severe genetic abnormalities, which are included in the national figures, but are outside the scope of this review. The review group has focused its work on those environmental or modifiable factors, which arise primarily because of unhealthy diet or lifestyle choices, and can be changed, for example by not smoking during pregnancy or following safe sleeping advice.

The review group understands that levels of poverty and deprivation in Wolverhampton are important factors that contribute to the challenge faced by local partners in encouraging positive behaviour change.

- The review group wanted to understand the causes of infant mortality, the work being done to reduce the numbers of babies dying in the first 12 months by making changes to policies and practices.

- The review group welcome the willingness of witnesses to share their views and insights, based on their professional judgement, on the issue of infant mortality and suggestions of what more can be done to improve the situation. Evidence from witnesses has greatly helped to inform the findings and recommendations in this report.

- The review group acknowledge the excellent examples of partnership working and local initiatives aimed at reducing the rate of infant mortality in Wolverhampton; but support the view that more work is needed to achieve a sustained reduction in the number of babies dying within the first 12 months.

- It is clear from witness evidence that a sustained reduction in the number of avoidable deaths in the first 12 months of life will require the long term commitment of commissioners and providers of services. The success will also depend on efforts by health partners to engaging the public and raise awareness of the factors that increase the risk of infant deaths so that people make informed choices.

4. Context - overview of infant mortality in Wolverhampton

Wolverhampton – the local picture

- Wolverhampton now has the highest rate of infant mortality in England (National Child Health Profiles, March 2014). The figures for infant mortality include babies dying at The Royal Wolverhampton NHS Trust due to significant congenital abnormalities that are not compatible with life or preventable by folic acid.

- A detailed breakdown of the infant mortality data is summarised in Appendix 2.

- During the past 30 years there has been a 33.3 per cent reduction in the national infant mortality rate, but the rate of improvement has been much slower in Wolverhampton over the same period.

- Historically, Wolverhampton along with a majority of neighbouring authorities in the West Midlands has had the highest rates of infant mortality according to national figures. However, there are differences in results at the ward level between infant mortality rates which do not correspond to rates of deprivation.

For example, the results of an analysis by electoral ward show that Penn ward has rate 6.8 deaths per 1000, compared to East Park ward which has a rate of 2.8 per 1000.

- The levels of under 18 conceptions, smoking before and after delivery in Wolverhampton are above the England average. Breastfeeding rates are lower than the England average.

- The top four major modifiable local risk factors linked to the deaths of infants in Wolverhampton are:

    - exposure to environmental tobacco smoke which was recorded in 55% of cases;
    - co-sleeping environment (bed sharing/sofa sharing) which was recorded in 44% of cases;
    - alcohol use within the last 24 hours which was recorded in 35% of cases;
    - over-heating which was recorded in 32% of cases.

- The review group has considered different theories that may explain the variation in infant mortality rates in Wolverhampton at ward level and the impact of any 'protective' factors that might be at work. For example, variations in rates of infant mortality among different ethnic groups in Wolverhampton. The influence of 'protective' factors is difficult to determine as the actual numbers of babies dying are very small and figures are based on a three year rolling average of deaths, which adds to the challenge in finding a clear link.

- The widespread effects of poverty and deprivation in Wolverhampton have been highlighted by witnesses as a major barrier to reducing the rate of infant mortality and supporting the required behaviour changes. Witnesses have also highlighted the challenge in raising awareness about the risk factors during pregnancy. There is some anecdotal evidence to suggest that there is level of mistrust by local people in the advice given by professionals and lay health workers and as a result the service has to work against established family beliefs and practices. There is a much greater reliance on advice provided by older female relatives on known risks to a baby during and after pregnancy.

- The Royal Wolverhampton NHS Trust neonatal unit (NNU) is designated a level 3 [NICU] facility with capacity to cater for the sickest and smallest babies in the region. The NNU is part of the Staffordshire Shropshire and Black Country Newborn Maternity and Newborn network which is working to increase survival rates for preterm babies. (see Appendix 3 for details of the key functions of the network.)

- Dawn Lewis ,Matron Maternity, Antenatal/Postnatal Services, The Royal Wolverhampton NHS Trust explained that in response to more babies being admitted into the neo natal unit than expected changes have been introduced. In the past the service would have intervened when a mother was 12 -14 days past their due date. The practice is now that they will look to change the timing induction of labour and to intervene when the birth is more than 10 days late. This was based on audited evidence of hospital births.

- A range of interventions are used to stop smoking during pregnancy due to the strong links to low birth weight, prematurity and poorer perinatal outcomes. This includes education on foetal health status and pharmacotherapy, motivational support. The number of women referred to the stop smoking service and the take up rate is collected. There is data on the number of pregnant women setting quit date, and the number of women who have quit at four weeks. In the same data set there are numbers of people who set a quit date using nicotine replacement therapy.

  There are issues in getting reliable data on outcome of pregnant women referred to the stop smoking service for support. The percentage of mothers smoking at delivery is at highest levels in East Park, Bilston North and Bilston East and lowest in Tettenhall Wightwick, Tettenhall Regis and Penn.

- The issue of how sex and relationship teaching is delivered in schools has been highlighted as a concern by the review group. The review group support the view of witnesses about the challenge of getting a clear and consistent health messages to young people that support behaviour change and promote a healthy lifestyle. However, the autonomous position of schools means that local authorities have little influence on what is included as part of PHSE course or how it is delivered. In addition, parents can choose to withdraw their children from parts of sex and relationship education if they want.

- The Service Director, Public Health and Wellbeing, leads a multi-agency working group whose members includes the Maternity lead, Clinical Lead for Women and Children and the Executive Director for Nursing and Quality. The aim of the group is review existing practices to support changes that will lead to a reduction in the infant mortality rate.

- There are a number of organisations that are responsible for the commissioning and provision of services that contribute to reducing the rate of infant mortality in Wolverhampton. A summary is given below:

NHS England	Primary care (GPs) Vaccinations and Immunisations Antenatal and neonatal screening programmes
Public Health	Overall responsibility for population health and wellbeing Commissioning of healthy lifestyles programmes across the life course Mandated provision of public health advice to Wolverhampton Clinical Commissioning Group
Wolverhampton Clinical Commissioning Group	Maternity services Health care across the life course Enhanced services to promote healthy lifestyles
The Royal Wolverhampton NHS Trust	Acute midwifery services Obstetric care Neonatal care Community midwifery services Health visiting services Healthy lifestyles programme Acute and community paediatric care

Infant Mortality - national and regional initiatives

- The National Institute for Health and Care Excellence (NICE) has published a range of specific good practice guidance for the public, commissioners and service providers aimed at optimising the quality of care received and assist with improving outcomes for premature and very low birth weight babies. Examples of published guidance are listed below:

  - Pregnancy and complex social factors overview;
  - Quitting smoking in pregnancy and following childbirth;
  - Pregnancy and complex social factors;
  - Smoking cessation in secondary care: acute, maternity and mental health services.

- Data and evidence about infant mortality and stillbirth is published by the National Child and Maternal Health Intelligence Network (ChiMat) who are part of Public Health England. The network provides an analysis of the data which includes details about trends and variations, the causes and underlying risk factors and national policies. Data from ChiMat indicates that at a national level 71% of all infant deaths occur in the neonatal period i.e. the first 28 days of life.

The evidence also reported that at the national level the main risk factors are: smoking, low socioeconomic status, maternal obesity, maternal age, ethnicity, multiple births, diabetes and influenza.

- Responsibility for the delivery of the Healthy Child Programme (HCP) which covers 0- 5 services (see Appendix 4 for details of the services) will be transferred to Public Health, in October 2015. This will include the transfer for responsibility for commissioning of health visiting services. (In April 2013 local authorities were given a key role in improving the health of their local population, working in partnership with clinical commissioning groups, and others, through health and wellbeing boards in their localities.)

- National NHS priorities to reduce mortality and morbidity in perinatal care include the following:

    - Antenatal detection of Intra Uterine Growth Restriction(IUGR) (this is a condition where a baby's growth slows or ceases when it is in the uterus);
    - Reduction in postpartum haemorrhage (primary postpartum haemorrhage is loss of blood estimated to be more than 500 ml within 24 hours of delivery);
    - Reduction in caesarean rates without clinical indication pre 39 weeks gestation
    - Reduction in unexpected term (less than 39 weeks gestation) admissions to neonatal units.

- A national priority for Public Health England is ensuring every child has the best start in life. Reducing the rate of infant mortality is central to achieving this aim. Public Health England (West Midlands) has included infant mortality as one its priorities and has set up a number of working groups.

- West Midlands Strategic Clinical Networks exists to enable patients, professionals and organisations to work together, across the West Midlands, on large and lasting programmes of quality improvement in four areas of major healthcare challenge. The network aims to achieve the best outcomes for the population by bringing together the right people and expertise to help drive improvements.

- The West Midlands Maternity and Children's Strategic Clinical Network (SCN) was established on 1 April 2013. The Maternity and Children's SCN covers three specific areas – maternity, newborn and children. The aim of the group is to support the delivery of high quality healthcare for women during pregnancy, childbirth and the post natal period, babies, children, young people and their families across the West Midlands. There are currently a number of projects being undertaken within the West Midlands Maternity and Children's Strategic Clinical Network and Senate to achieve this.

- West Midlands Strategic Clinical Network for Maternity and Children produced a report on the findings of phase one maternity gap analysis. The objectives of the gap analysis were to:

  - Identify what data capturing tools are currently in use across the region maternity services;
  - Identify any variation or common areas of concern in line with national priority areas; both across the West Midlands region and nationally;
  - Identify any existing or future planned initiatives and service developments to tackle the national priority areas.

- The report made a number of specific recommendations aimed at supporting improved outcomes and contributing to the overriding aim of reducing stillbirth and neonatal loss; and to improve the experience for families. There are a number of short-term pieces of work that have been agreed for improvement in Phase 2 of the maternity gap analysis.

- A number of the recommendations relate directly to the issues highlighted during the review. For example, the need for more robust information for patients around the issues such as stillbirths/neonatal death, neonatal units and varying levels of care, recognising the signs of pre-eclampsia and monitoring of reduced fetal movement.

- There are national priorities, performance standards, staffing levels and targets aimed at reducing the rate of stillbirth and early neonatal loss which have been published by British Association of Perinatal Medicine (BAPM). The stated aim of BAPM is to support newborn babies and their families by providing services that help all those involved in perinatal practice to improve the standards of perinatal care in the British Isles.

- As part of universal antenatal care during the first visit to a midwife or GP a pregnant women will be given information about:

  - folic acid and vitamin D supplements;
  - nutrition, diet and food hygiene;
  - lifestyle factors that may affect a women’s health or the health of the baby, such as smoking, recreational drug use and drinking alcohol;

- In addition, information will be given on keeping healthy and discussion about whether there is a history complications or infections in a previous pregnancy or delivery, such as pre-eclampsia or premature birth, current treatment for chronic disease, such as diabetes or high blood pressure or family history of having a baby with an abnormality; such as spina bifida or an inherited disease, such as sickle cell or cystic fibrosis.

5. Summary of findings

The underlying causes of infant mortality in Wolverhampton

An analysis of deaths recorded at Royal Wolverhampton NHS Trust (RWT) from 2004 – 2012 was conducted in February 2014. This review relates to Wolverhampton residents and highlighted the following key issues:

- Smoking during pregnancy: there is a 54% increased risk of infant death for women who smoke during pregnancy, as recorded at the time of delivery, compared to women documented as non-smokers. This indicates a strong association between smoking in pregnancy and infant death. Smoking in pregnancy has a significant impact on avoidable mortality. It causes impaired foetal growth, low birth weight and pre-term birth as well as being associated with an increased risk of miscarriage, stillbirth, neonatal death and sudden infant death. Smoking in pregnancy is high in England at 12.7 % with tenfold variation between local areas. Smoking is most prevalent in young, white, expectant mothers from deprived communities, with low educational attainment.

  Health Visitors recommend to fathers and other family members that they should smoke outside the home to protect a baby from the health risks of second hand smoke. In addition, smokers are advised by health visitors not to hold a baby for at least 30 minutes to avoid exposure to the harmful substances in cigarettes. This is because when a person smokes, toxins can get into their clothes and hair and will remain there. In addition, a smoker will continue to exhale toxins such as carbon monoxide for several minutes after extinguishing their cigarette.

- Prematurity: prematurity is defined as birth after less than 37 completed weeks of pregnancy, which usually lasts 40 weeks. Whilst most premature births occur between 34 weeks and 37 weeks of pregnancy, a small proportion of babies are born under 34 weeks. Almost 65% of infant deaths occurred in babies born under 34 weeks of completed pregnancy, whereas premature infants were only 3% of all births. This indicates that prematurity is a high risk factor for infant death.

- Very Low birth weight: a birth weight under 1,500g is classified as a very low birth weight. 60% of infant deaths in Wolverhampton occurred in very low birth weight infants, whereas very low birth weight infants accounted for only 1.5% of all births. This indicates that a very low birth weight is a high risk factor for infant death.

- Maternal age: although the highest number of infant deaths occurred in mothers aged between 20 and 34 years, the proportion of deaths was similar to the proportion of births within these age groups. However, 7.9% of infant deaths occurred in babies born to mothers aged 40 to 44 years, whereas births to mother aged 40-44 years were only, 2.5% of all births. This indicates that later maternal age is a high risk factor for infant death.

- Ethnicity: the proportion of infant deaths compared to total births is broadly similar across ethnic groups with the exception of babies born to black mothers. 16.4% of infant deaths occurred in babies born to black mothers, whereas births to black

mothers were 9.8% of all births. Preliminary findings from the review suggest a link between ethnicity and prematurity, with higher proportion black mothers delivering premature babies, under 34 weeks. Overall, this indicates that black ethnicity is a higher risk factor for infant death than other ethnic groups.

- Deprivation: most of the infant deaths occurred amongst the 20% most deprived mothers within the City, a slightly higher proportion of 69.4% compared to total births to mothers in this group, 65.1%.
  This indicates that deprivation is a high risk factor for infant death. Socio-economic deprivation covers a number of issues, for example, poor housing, poor diet of women planning a pregnancy or during their pregnancy, the spacing of pregnancies, low income, language barriers, asylum seekers moved late in pregnancy, low educational attainment and unsupported single mothers.

Examples of modifiable or environmental risk factors

The following are examples of modifiable risk factors that potentially contribute to infant mortality recorded as 'sudden unexplained death in infancy' (SUDI) within the first year of life in Wolverhampton:

- Mother smoking before and during in pregnancy and exposing the baby to cigarette smoke;
- Bed sharing/not following safe sleeping advice;
- Low birth weight;
- Late booking for the first official antenatal appointment;
- Low breastfeeding rates;
- Drugs and alcohol misuse;
- Maternal obesity (babies of women with a pregnancy BMI (body mass index) ≥35 have an increased risk of perinatal mortality, being overweight or obese may double the odds of stillbirth)

There is agreement among witnesses that the causes of infant mortality are complex and often linked. Furthermore, that no one organisation can deliver the sustained changes in reducing the number of infant deaths reported annually.

Key risks in early pregnancy

It can be difficult to identify risks early in pregnancy, especially in first time pregnancies, as often little is known about the experience and abilities of the mother to be, and the characteristics of the child.

The following are examples of useful predictors of the risks during pregnancy highlighted in research published by NHS Scotland:

- young parenthood, which is linked to poor socio-economic and educational circumstances;

- educational problems – parents with few or no qualifications, non-attendance or learning difficulties;
- parents who are not in education, employment or training;
- families who are living in poverty;
- families who are living in unsatisfactory accommodation;
- parents with mental health problems;
- unstable partner relationships;
- intimate partner abuse;
- parents with a history of anti-social or offending behaviour;
- families with low social capital;
- ambivalence about becoming a parent;
- stress in pregnancy;
- low self-esteem or low self-reliance; and
- a history of abuse, mental illness or alcoholism in the mother's own family.

Reducing the risk factors

Witnesses provided a range of examples of work currently being done by their service and in the future to tackle the underlying causes of infant mortality. The work is being done as part of a strategic and co-ordinated response to the situation. The following are examples of this work that were presented as evidence:

- **Royal Wolverhampton NHS Trust**

    - Analysis of health visiting data regarding smoke free homes;
    - Stop smoking team to attend the neonatal unit three times a week ;
    - Daily presence of health trainers in the antenatal clinic started on 1 October 2014;
    - Auditing of 40 maternity notes in the postnatal period to be arranged with Public Health Support;
    - A marketing campaign is required to promote the prevention agenda.

- **Dr Helen Sullivan, Consultant Obstetrician and Guidelines Lead, Royal Wolverhampton NHS Trust**

    - All pregnant women in Wolverhampton are seen repeatedly by their community midwife, including at least once at home;
    - All smokers are referred to the smoking cessation service and have to actively opt out if they do not want referral;
    - Breastfeeding is promoted to all women;
    - All women are given advice about a healthy diet and the vast majority given multivitamin supplements. There is a challenge with mothers either not maintaining a proper healthy diet during their pregnancy and or who find it difficult to follow a diet that provides the necessary vitamins and nutrients.
    - Where possible the women are seen in children's centres to help the women become familiar with this resource;
    - There is a structured handover of care from midwifery to health visiting when the baby is about two weeks old;

- Where women are thought to be particularly vulnerable they receive enhanced care from a specialist midwife for pregnant teenagers and a specialist midwife for vulnerable women; principally those with problems with drugs and alcohol, domestic abuse and severe and enduring mental health problems.
- Recommended that the Council supports enhanced targeted interventions for high risk families with new babies. The families can be identified by maternity services. This could take many forms for example extended support from the midwives for vulnerable women and targeted work with Children's Centres' workers.

- **Dr Tilly Pillay, Neonatal Clinical Lead, SSBCNN Consultant, Royal Wolverhampton NHS Trust**

  - Developing a 'Reducing the Risk' Programme
    Parent advice and support for all babies leaving the NNU and a select geographical target area on:

    - Smoking cessation;
    - Advice on limiting sudden infant death;
    - Resuscitation and choking training for parents;
    - Breastfeeding support;
    - Advice on healthy diet and weaning.

  - Promoting breast feeding on discharge from the hospital and the setting up of a donor breast milk scheme. Donated breast milk is used to help save the lives of poorly and premature babies whose mothers are unable to provide their babies with enough of their own breast milk.

  - Breastfeeding women, who have established breastfeeding their own baby, must enrol as a donor before baby is 4 months old, and then can continue to donate until baby is 6 months old.

  - Developing appropriate newborn network pathways within our SSBC Newborn Network to ensure that the sickest and smallest babies in Wolverhampton are treated at the right neonatal intensive-care unit (NICU) at the right time, at the right place.

  - Participating in network wide neonatal nurse staffing review to define nursing workload on the Neonatal Unit so that optimal levels of nursing staff can be recruited to meet British Association of Perinatal Medicine standards of nursing workload, as nursing workload correlates with neonatal mortality.

  - Accurate and detailed mortality reviews with SSBC Newborn Network review, with lessons learnt being shared to augment uptake of modifiable clinical aspects of care.

  - Benchmarking neonatal outcomes against international standards.

- **Dr Helen Carter, Consultant in Public Health, Public Health England, West Midlands Centre**

    - The National Infant Mortality Support Team produced a report in December 2010\ about improving infant and maternal health outcomes. Many of the contents of this report are still very applicable today.

    - The report strongly linked infant mortality to deprivation and the wider social determinants of health with a strong focus upon the impacts of poor housing. Public Health England highlighted deprivation as being associated with increased risk of infant mortality. An analysis of data identified disadvantaged mothers as being more likely to have babies of low birth weight.

    - The report reviewed evidence and concluded that the following interventions would have the biggest impact upon reducing the infant mortality:

        - Reduce child poverty;
        - Reduce the prevalence of maternal obesity;
        - Reduce smoking in pregnancy;
        - Improve housing and reduce overcrowding;
        - Safe sleeping;
        - Reduce teenage pregnancy rates;
        - Improve breastfeeding rates.

- **Dr Angela Moore, Consultant Paediatrician. Designated Doctor for Safeguarding Children, Royal Wolverhampton NHS Trust (RWT)**

    - Safe sleep campaign in autumn/winter 13/14.
    - The CONI programme (Care Of Next Infant after a SUDI - support for families also includes near relatives and infants where there has been an Acute Life Threatening Event but not actual death) delivered by RWT - Health Visitors and Community Paediatrics.
    - Regular clinical post neonatal mortality reviews also take place.

Summary of witness evidence - main headlines

The following is a summary of the key messages from witnesses who submitted written and or verbal evidence to the review group:

- The modifiable risk factors in infant deaths in Wolverhampton were the subject of two published research papers which reviewed the causes of child infant mortality in Wolverhampton.

- The papers written by Dr Angela Moore highlighted the historical nature of the underlying causes of child infant mortality, the similarity in the causes of death, and the slow progress made in reducing the number of deaths when compared on an international basis. Dr Moore recommended that all schools in Wolverhampton should include mandatory child care in their PSHE for both boys and girls and include messages about smoking, breast feeding and prevention of SUDI (safe sleep).

- Dr Moore commented on the finding that all studies have shown increased risk of SUDI linked to sofa sharing, either parent smoking and smaller babies. The risks of SUDI increase significantly when there is a combination of modifiable factors, for example, smoking and co-sleeping. Dr Moore explained that if a parent smokes when a baby is six months or less, then they are eight times more of risk of SUDI. Dr Moore commented on the societal changes in respect of alcohol use during pregnancy.

- The risk of SUDI is higher for older mothers, but it compensated to some extent by the fact that they are likely to be financially better off and adopt a more cautious approach before and during their pregnancy.

- Poverty and deprivation were common themes contributing to poorer health outcomes and the deaths of babies. Higher rates of pre-term death were linked to people who are poor and also defects and smoking.

- The transfer of pregnant women by West Midlands Ambulance Service (WMAS) to the nearest hospital is not always appropriate. Evidence shows much better outcomes for preterm babies who are born at less than 26 weeks gestation, if they are delivered at a neonatal unit with Level 3 (NICU) capacity, rather than a lower designated unit and transferred in to a NICU. In such situations it is important for ambulances to transfer women to the most appropriate hospital with neonatal facilities that can cope with the birth and post natal support of the extremely preterm baby; which in the Black Country, would be RWT neonatal unit. There are on-going discussions within the SSBC Newborn and Maternity Networks, attempting to facilitate appropriate triage of women through creation of care pathways that will enable this.

- An audit provided evidence that 15% (90) of 600 births were to women considered to be vulnerable Evidence was presented of the challenge in persuading vulnerable women to consider contraception or the spacing of pregnancies following the birth to reduce risks linked to the death of infants and to improve outcomes.

- Community midwives ask questions about mental health and domestic abuse at the 'booking' appointment (first midwifery contact) and again at 28 weeks and at handover of care to the health visitor. Midwives notify Health Visitors at 24 weeks of pregnancy highlighting any particular issues or problems.

- Improving numbers of pregnant women for booking below 13 weeks of pregnancy. The national performance target is 12 weeks and 6 days for the first antenatal appointment.

- Evidence of the impact of debt and low income among mother's who may decide to prioritise other needs such as paying bills and give lower priority to attending clinical ante or post natal sessions with health professionals.

- Concerns expressed about the impact of the loss of funding for specialist midwives and the important resource in supporting pregnant women considered to be vulnerable or where there mental health issues.

- There is no 'single bullet' solution to the reducing the rate of infant mortality and cannot be the responsibility of anyone agency to achieve.

- Increased risk of sudden unexpected death in infancy (SUDI) associated with sofa sharing rises further if either parent smokes; the mother drinks alcohol or is obese. There is no risk from bed sharing if the mother stays awake. The safest place for a baby to sleep is in a cot in a room with parents for the first six months of life.

- Breastfeeding is protective for SUDI. Evidence presented that recently arrived migrants to Wolverhampton have a strong tradition of breastfeeding where it is considered to be the cultural norm. There is concern that this habit will change over time and more women will choose to bottle feed instead, which is more typical of the local population where breast feeding rates are low.

- 'The Baby Sleep Safe' was a successful campaign which gave advice about how to protect the baby when sleeping. There were no deaths due to co-sleeping in 2013 following the publicity campaign. An example of the campaign posted is give below:

Bed sharing increases the risk of a baby dying because of the following factors:

- Rebreathing;
- Over-heating (head covering) ;
- Soft surface (mattress, pillow) ;
- Suffocation (over-laying).

- The Pedi-Pod is a type of crib which can be placed in the parent's bed to give the baby its own space and prevent over-heating/overlaying. The Pedi-Pod crib was introduced in New Zealand by the Government. The crib is offered as a free gift a bed for new born babies to all mothers and encouraging the idea of separate sleeping arrangements. The programme was developed as a public health intervention aimed at more vulnerable babies. This is an example of the Pedi Pod sleep space bed.

- The review group discussed the feasibility of introducing a scheme similar to Finland where shortly before babies are born they are given a cardboard box filled with a range of useful things for the ffirst 8-12 months. The Finnish Baby Box includes necessities to help mothers to dress and take care of their newborn. The box is provided by the state.

- The Healthy Lifestyles Service is based at RWT. The service provides support as part of the stop smoking service. The staff support women and their families to undergo quit attempts and offer home visits to pregnant women. The service provides support for the full length of the pregnancy and also relapse prevention at any time during this period. Carbon monoxide checks are done at each antenatal visit and pregnant women are also asked about their smoking status.
  The staff undertake carbon monoxide checks to confirm a successful quitter but if this is not possible then this will be confirmed by telephone.

  The service provide advice and help to families to cook and eat healthy meals that support healthy weight gain during pregnancy and healthy weight loss post natal. The service is also able to offer support and weight management advice and help with breastfeeding problems.

- A witness from the Healthy Lifestyles Service commented that there is evidence of a lack of trust among women in the advice given by professionals and the staff have to work against beliefs and practices of older female family members about how to reduce modifiable risks.

- It is difficult to get reliable data about pregnant women setting quit smoking dates as the population profile changes during the period of assessment when Health Visitors currently identify smokers at each contact and offer cessation advice.

All health visiting staff are trained in motivational interviewing techniques to support pregnant women to stop smoking.

- Both Walsall and Dudley have successfully rolled out a quit smoking programme. The programme involves checking carbon monoxide levels using a monitor at every antenatal contact and actively working to link up events planned around National No Smoking Day and other quit smoking campaigns.(Carbon monoxide (CO) assessment is a non-invasive biochemical method for measuring CO from expired breath. It can detect exposure to CO which may come from tobacco smoke, traffic emissions or leaky gas appliances.)The service is delivered by a small team which adds to the challenge in supporting a change in behaviour.

  Estimates of the number of Wolverhampton women smoking in pregnancy at time of delivery is reported to public health.

- Pregnant women who smoke and also take illegal substances may be willing to stop smoking, but less willing to stop smoking illegal substances.

- There is a set list of questions used to identify signs of post natal depression and the subsequent risk to the mother and the health of the baby.

- Evidence presented about 'preventative' factors within different ethnic groups which may explain the lower rates. For example, the rates of infant deaths for Polish mothers were lower when compared to White British mothers at the time of delivery.

- The Child Death Overview Panel (CDOP) investigates the death of every child in Wolverhampton. The key purpose of reviewing all child deaths is to learn lessons and reduce child deaths in the future. The CDOP produce an annual report which is considered by Wolverhampton Safeguarding Children Board.

- The most recent report includes a summary of Wolverhampton child death statistics covering the period 1 April 2013 to 31 March 2014. The findings of the local safeguarding children boards (LSCBs) are collated and used to complete the annual child death data collection published by Department of Education for England.

- The review group were advised by the co-ordinator of the CDOP that over the past 18 months, following the departure of the post holder responsible for collating comparative statistics, Wolverhampton's performance compared to its regional neighbours, had not been available. As a result, the previous annual report 2013/14 and the current report do not include regional statistics. The issue is unlikely to be resolved in the short term.

The respective CDOPs within the region have already raised their concerns with NHS England about the situation and its impact on their work.

- Evidence of late booking and women not knowing they are pregnant. As a result the opportunity to give important antenatal health messages and have a range of important health checks done during the early stages of their pregnancy is missed.

- 'Early bird' clinics were introduced two years ago as an alternative option for women who do not want to see their GP for their antenatal check-up. The clinics are available to give early health education advice via Maternity Support Workers who work alongside the community midwives. In addition, representatives of the Healthy Lifestyles Service attend the sessions as part of a 'one stop-shop' for pregnant women.

- Representatives of the pregnancy and beyond service are also in attendance at the clinics to offer support to women who want to give up smoking.

- The service is actively promoted to local women to encourage them to seek advice and support at early stages of their pregnancy. Where possible, women are seen in Children's Centres to help the women become familiar with this resource. There is a structured handover of care from midwifery to health visiting when the baby is about two weeks old.

- The issue of language barriers for new migrants to Wolverhampton was highlighted. The use of interpreters is not ideal and there is concern about whether important health messages are being received and acted upon. Evidence presented about a peer support service provided by the refugee and migrant centre could be a better option for the future.

- The breastfeeding peer support network is delivered by a group of volunteers who provide part-time support and telephone advice to mothers. The scheme has an infant co-ordinator to promote the service. In addition, there are four paid support workers working part-time.

- The birth to midwife ratio is at a safe level. RWT has been reaccredited as meeting the Baby Friendly Initiative standards. The Family Nurse Partnership is an accredited programme aimed at improving outcomes for first time pregnant teenagers. The scheme has just begun and it is hoped that it will be successful.

- All women are given advice about a healthy diet and the vast majority given multivitamin supplements. Public Health is reviewing local delivery of the 'Healthy

Start Vitamins' scheme. The means-tested scheme is a Government initiative aimed at improving nutrition and reducing rates of infant mortality.

Pregnant women or someone with a child under four years old will be eligible to get vouchers to help buy some basic foods. In addition, women and children getting 'Healthy Start' food vouchers will also get vitamin coupons to swap for free 'Healthy Start' vitamins.

- All pregnant women in Wolverhampton have a scheduled programme of antenatal appointments with their named community midwife, including at least once at home. All smokers are referred to the smoking cessation service and have to actively opt out if they do not want referred to the service. The benefits of breastfeeding are promoted to all women.

- The issue of the quality and effectiveness of sex and relationship education in schools was highlighted as an issue, particularly for girls who are reaching puberty much earlier as result rising levels of obesity.

- There is national guidance published by NICE about the importance of weight management before, during and after pregnancy and the risks to the mother and baby. The guidance provides advice to help women in achieving and maintaining recommended weight and body mass index before, during and after pregnancy.

  The review group shared concerns about the variable quality of lessons at secondary schools and that parents can choose to exclude their children. Local authorities have no influence about how lessons are taught in schools and it is difficult to maintain quality of information and to check that key messages about health and wellbeing are shared in a consistent way.

- The importance of the role of fathers and other people with an interest in the health and wellbeing of the child, for example other family members and close friends was highlighted in offering support during and after.

- Following the Governments Call to Action – The Health Visiting Implementation Plan 2011 there are now 64 whole time equivalent health visitors for the Wolverhampton area. The number of health visitors allocated is based on the number of children aged 0 – 5 living in an area. The calculation of the number of health visitors does not take account of the impact of deprivation on an area.

- The average caseload size for a Wolverhampton health visitor is 368 children. Unite the Union/Community Practioners and Health Visitors Association (CPHVA) and the Royal College of Nursing recommend that individual caseloads should ideally be 250 children per whole time equivalent (WTE) health visitor.

In areas of deprivation this should be lowered to 200. In Scandinavia, where frequent health visiting is the norm, child mortality rates are much lower than in most of the rest of the world. The Maternal and Child Health service in Denmark gives each health visitor a caseload of only 150 children.

- Health visitors do health and development checks at set stages of a baby's life and will also visit where there are concerns. Health visitors work with all parents to assess the support they need and develop appropriate programmes to help give the child the best possible start in life. Health visitors support and educate families from pregnancy through to a child's fifth birthday.

- Evidence presented of the importance of using contacts with mothers to discuss issues such as smoking, alcohol and diet. Mothers are likely to be more open to suggestions of making behaviour changes, such as the benefits of not smoking before and during the pregnancy. Health visitors provide advice and support to encourage pregnant to stop smoking. This service is also offered to other family members living in the same household who smoke.

- The issue of Public Health accessing health data was highlighted as a major issue, following the transfer of the service to the local authority and new governance rules implemented in April 2013. A statistical analysis of infant deaths needs to consider deaths over a long period to provide meaningful information as the numbers involved are small.

- An analysis of child deaths reported that in 2013, 15 of the deaths that occurred were expected. The cause of deaths was extreme prematurity or congenital abnormality. Further analysis of deaths of babies born at RWT collected annually showed a number of deaths due to significant congenital abnormalities:

  2011 4/25 neonatal deaths had significant congenital abnormalities
  2012 5/31 neonatal deaths had significant congenital abnormalities
  2013 7/24 neonatal deaths had significant congenital abnormalities
  2014 2/17 neonatal deaths had significant congenital abnormalities (preliminary data only up to mid-October)

  (Not all of these abnormalities will have been detected before birth but some that were may not have led to death within the first 28 days of life but within the first year of life.)

- Evidence arguing for a shift in focus to more specialist support services and universal services aimed at vulnerable women which would have a have a major impact on Wolverhampton's infant mortality rate.

- A witness expressed concern about the significant deterioration in addiction support service and withdrawal of funding for a specialist midwife post following a change of provider. The service is provided jointly by Wolverhampton Integrated Substance Misuse Service (the key partners are NACRO and Black Country Partnership Foundation Trust). The issue of the addiction referral arrangements for pregnant women was highlighted. It was reported that an estimated 30-40 women are referred to the specialist support addiction service. The Service Director - Public Health and Wellbeing responded that the newly commissioned addiction service is focusing on risk triggers and supporting people to get better outcomes.

- The Service Director - Public Health and Wellbeing explained that the issue of post natal depression is considered during any investigation into a death of a child. The review will look at the child records. The Service Director commented on a pilot initiative to look at recognising the signs of mental health issues and also the challenge that many new mothers do not always have an established support network. This lack of support for new mothers can be a real issue where it involves a difficult birth, which can add to stress levels.

- There is need to establish an enhanced family planning service for vulnerable women to avoid early, repeat pregnancy and the spacing of pregnancy. It is important that the issue of contraception is discussed following the birth.

- Pregnancy and the period following birth can provide a number of psychological, psycho-social and physiological challenges for women and their families. The onset of pregnancy can have an impact on hormone levels which can affect mental health state leading to changes in eating habits and other physical changes which can affect a person's mental state and general wellbeing.

- There are specialist services available at RWT to support the pregnant women with mental health issues. There is also provision for pregnant women to be referred to either St George's Hospital (Stafford) or Birmingham and Solihull Mental Health NHS Trust for women experiencing mental health problems during pregnancy requiring hospitalisation. Both units allow the mother where possible to stay with their baby. Community mental health services in Wolverhampton are delivered by Black Country Partnership Foundation Trust.

- For women with pre-existing mental health conditions the confirmation of pregnancy may require a change in medication. For women experiencing severe post-partum mental health conditions there is evidence of the positive benefits of electroconvulsive therapy. The numbers of mothers needing specialist hospital care is about 1-3 annually. Women with pre-exiting mental health issues and also difficulties such as substance or alcohol misuse can be especially vulnerable. Community care pathways will be developed by Wolverhampton CCG to support pregnant women with this in mind.

- Current community care pathways are being reviewed. The Wolverhampton Clinical Commissioning Group will develop a written guide regarding perinatal mental health services. There are also discussions on-going about the development of an electronic tool that could be used to show the different treatment care pathways based on the circumstances and the services available to pregnant women.

6. Conclusions

The review has increased level of awareness and knowledge among Councillors about the work being done by key agencies to reduce levels of child infant mortality in Wolverhampton and a better understanding of the issue. The review has also provided evidence of the work being done by different local partners, individually and collectively, to reduce the rate of infant mortality in Wolverhampton.

It is clear from witness evidence presented that an important part of achieving the desired sustained reduction in the rate of infant mortality is supporting and promoting public awareness of the range of support available. In addition, this should be supported by improving existing practices and procedures and applying learning about what can be done to reduce the risks of a baby dying during the first 12 months.

A sustained reduction in infant mortality rate will require getting the right balance between the provision of enhanced universal services and specialist support services that will increase the likelihood of a successful pregnancy and address the modifiable causes of infant deaths in Wolverhampton.

There will need to be a targeted approach to meet the needs of specific groups such as mothers who smoke in pregnancy, older mothers, black mothers and mothers from the most deprived areas of the city. However, a universal approach is also required to deliver routine care and identify potential changes that may indicate an increased risk of infant mortality. The review has highlighted the opportunities for Councillors in their day to day meetings with the public to get important health messages to people when discussions arise about pregnancy and what practical steps they can take to reduce risks or simply to raise awareness about where to get advice and help if they have concerns.

The importance of making every contact by the service with a pregnant women count was highlighted.

Evidence presented of the impact of lower educational attainment among young mothers, leading to lack of aspirations and poor decision making in relation to the timing and spacing of births. The importance of giving mothers appropriate contraceptive advice following the birth was highlighted.

The review group shared the concerns of the Service Director - Public Health and Wellbeing about the amount of the budget that will follow the transfer of responsibility for delivering health visiting services to Public Health and meeting key performance targets. The new national health visiting service specifications will require an extra 300 contacts.

The review group welcomes the renewed commitment by representatives of key agencies to work together to improve practices and policies and make changes based on learning both locally and nationally, that has been used successfully to improve outcomes for babies.

7. Recommendations

The aim of these recommendations is to create and support a culture of continuous learning and improvement across all the organisations working to reduce the number of child deaths in Wolverhampton, by highlighting what works and what promotes good practice locally. The recommendations are intended to support improved performance and contribute to the achievement of a sustained reduction in the current rate of infant mortality in Wolverhampton.

The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton

1. The Service Director- Public Health and Wellbeing to be responsible for collating a coordinated response from the officers responsible for to the following recommendations listed below. The Service Director to and advising Scrutiny present a report to Scrutiny Board with details of progress in implementing all the accepted recommendations and necessary follow up action, as appropriate, where accepted recommendations have not been implemented. The Scrutiny Board report to be presented to the Infant Mortality Working Group for information and comment:

   a) Royal Wolverhampton NHS Trust to coordinate a response from the maternity, healthy lifestyles living and health visiting services which details specific actions aimed at reducing the percentage of pregnant women setting a smoking quit date, where the results are either not known or lost to follow up. The report to include details of the take-up rate of nicotine replacement therapy and the number who have set a quit date.

   b) Royal Wolverhampton NHS Trust to coordinate a report from maternity, healthy living lifestyles and health visiting services on progress in the use and results of carbon monoxide testing of pregnant women at every contact. The report to include feedback from pregnant women recorded as smoking and subsequently referred, about their experiences of the stop smoking service.

   c) Royal Wolverhampton NHS Trust to present a report on a review of effective interventions aimed at reducing the numbers of women smoking during and after pregnancy.

   d) The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

e) A report on the benefits of providing a Pepi-Pod crib or similar alternative cot in Wolverhampton. A report of the potential value of using a mobile phone app for parents and parents-to-be with personalised information and content approved by doctors and midwives that spans from pregnancy right through to the first six months after birth. The schemes, if introduced, should be initially targeted a vulnerable women and the findings published with recommendations about a possible future roll out across the City.

f) The Service Director – Public Health and Wellbeing to work with lead officers from key partners to for infant mortality at Wolverhampton CCG to detail proposals to discuss proposals to make best use of available local intelligence in order to help with the early identification better of identify vulnerable pregnant women mothers and provide appropriate targeted interventions that can support them. that will contribute to the overall aim of reducing the numbers of infant deaths. The findings to be shared with the Wolverhampton Health and Wellbeing Board, and Wolverhampton CCG Governing Body and the Infant Mortality Working Group.

g) To invite Directors of Public Health across the West Midlands region to share examples of best practice in respect of delivering an effective smoking cessation programme to pregnant women and to discuss further opportunities to promote the adoption of best practice across the region.

h) The Service Director – Public Health and Wellbeing and the Chair of the Child Death Overview Panel (CDOP) to jointly report on progress in recruiting staff to collate current and future statistics. Analysis of comparative data at a regional level to be included in future annual reports.

i) The Chair of the Child Death Overview Panel (CDOP) to publish the annual report for Wolverhampton to be published prominently on the Council's website and also the findings shared with key local agencies to promote good practice and improve the quality of local intelligence.

j) The Service Director- Public Health and Wellbeing to report on outcome of review of the national funding formula for 2016/17. (The formula is used to calculate the number of health visitors that an area needs to deliver safe and effective services.)

2. Wolverhampton Clinical Commissioning Group (CCG) and the Service Director - Public Health and Wellbeing to agree a programme of work that supports enhanced targeted interventions for high risk families or vulnerable mothers with new babies identified by maternity services; including advice on contraception to avoid unplanned early repeat pregnancy, and support pregnancy spacing. This should include post natal support in the first few weeks of life aimed at parent education and support to reduce the risk of infant death after discharge from the neonatal unit/post natal ward.

3. The Black Country clinical representative of West Midlands Maternity and Children's Strategic Clinical Network in discussion with representatives of SSBC Newborn and Maternity Networks to jointly present a report to the Infant Mortality Working Group regarding care pathways for anticipated extreme preterm births.

   The report to include an update on work towards improving survival rates for this cohort and also progress on the outcome of discussions with West Midlands Ambulance Services about improving care pathways for intrauterine transfers of pregnant women in preterm labour. The overall aim of the policy is for pregnant women in preterm labour to be taken to the most appropriate hospital for the safe delivery and on-going care of their baby.

A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation.

4. The review group endorse the recommendations of the Infant Mortality Working Group Action Plan 2015 – 2018. A joint report to be presented by the lead officer for infant mortality at Wolverhampton CCG and Public Health to the Wolverhampton Health and Wellbeing Board on a six monthly basis on progress and achievements against recommendations accepted in the Infant Mortality Action Plan.

   The Service Director - Public Health and Wellbeing to ensure the action plan is reviewed and updated to include emerging risks and further services changes. The findings to be shared with all key partner agencies.

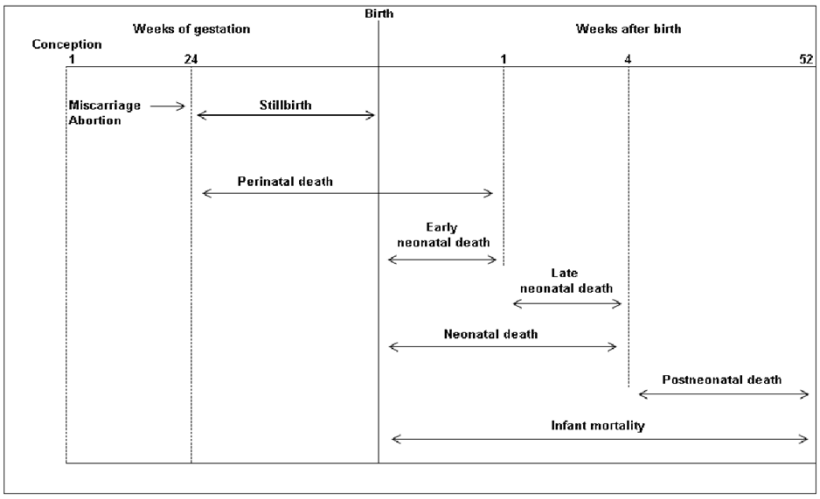
5. The findings and progress of the Infant Mortality Working Group to be shared with organisations with a special interest in reducing the number of child deaths, for example, the CDOP, SANDS, BLISS and the Lullaby Trust for comment.

   Representatives to be invited to comment on progress and invited to share learning locally and nationally on further improvements in the co-ordination of care from a neonatal setting, to home and whether there are any specific recommendations to build on good practice.

6. The Service Director – Public Health and Wellbeing to draft terms of reference and agree membership for a task and finish group to review vulnerable pregnant women's care pathway. Representatives of Wolverhampton Integrated Substance Misuse Service (Recovery Near You) need to participate in a review of the effectiveness of the current working arrangements for supporting women referred to the service; particularly those involving drugs, alcohol, domestic abuse or long term mental health issues. A report of the findings to be reported to the Health and Wellbeing Board and Scrutiny Board.

Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.
7. Royal Wolverhampton NHS Trust to provide a detailed response to the NICE published guidance that all NHS hospitals and clinics should become completely smoke-free zones and to set out detailed proposals for implementation and a timetable for achieving this to be presented to a meeting of the Health and Wellbeing Board.
8. The lead officer for infant mortality at Wolverhampton CCG to consider the availability of genetic screening and counselling support across Wolverhampton and to raise awareness generally of the service. The findings to be presented to the Health Scrutiny Board.
9. Service Director - Public Health and Wellbeing, to work with partner agencies to create a public resource document similar to Bradford's 'Every Baby Matters' which explains the risk factors and provides practical advice and support that can help reduce the numbers of avoidable deaths of babies. The resource should be built into any planned public awareness campaigns and include details of the impact of lifestyle behaviours, such as smoking and alcohol that increases the risks of child dying. The document should promote positive health messages and signpost families to sources of available support and useful information.
10. All newly elected Councillors to be given a briefing on the issue of infant mortality in Wolverhampton and the practical advice and information they can give when they meet people as part of their work. This should be presented as briefing of the key health messages and the main risks including sofa/bed-sharing, as well as smoking and alcohol in the lifestyle behaviours.
11. Service Director - Public Health and Wellbeing, to report on progress in resolving the issue of getting access to personal confidential health data needed to assess the effectiveness of changes introduced to reduce the infant mortality rate.
12. The scrutiny review of infant mortality report to be sent to Wolverhampton CCG, Royal Wolverhampton NHS Trust and CDOP for information and comment and they are invited to give comments on the findings and recommendations. A progress report on those recommendations accepted by the Cabinet is reported to the Wolverhampton Health and Wellbeing Board in 6 months. The report recommendations to be tracked and monitored by Scrutiny Board at the same time.

Definitions



Early neonatal: death occurring up to 7 days after a live birth
Late neonatal: death occurring from 7 days and up to 28 days after a live birth
Post neonatal: death occurring after 28 days following a live birth
Infant: death occurring in the first year of life following a live birth (includes all three time periods above)

Late booking - defined as booking an appointment with a GP or midwife after 13 weeks 6 days.

Successful Quitters - A person is counted as a 'self-reported 4-week quitter' if when assessed 4 weeks after the designated quit date, they declare that they have not smoked, even a single puff on a cigarette, in the past two weeks. Clients who self-report as having quit at the 4-week follow up are required to have their Carbon Monoxide (CO) levels monitored as a validation of their quit attempt (unless the intervention was by telephone).

Preterm birth is birth that occurs before 37 weeks of pregnancy. It usually follows spontaneous preterm labour, which may be preceded by preterm pre-labour rupture of membranes. However, around 25% of women have a planned preterm birth following iatrogenic intervention (induction of labour or planned caesarean section) to avoid continuing risk to the mother or baby from complications of pregnancy.

Councillors on the review

Councillor Claire Darke (Chair) (Lab)
Councillor Phil Bateman (Lab)
Councillor Ian Claymore (Lab)
Councillor Dr Michael Hardacre (Lab)
Councillor Rita Potter (Lab)
Councillor Judith Rowley (Lab)
Councillor Bert Turner (Lab)
Councillor Mrs Wendy Thompson (Con)
Councillor Pat Patten (Con)
Councillor Richard Whitehouse (LD)

Witnesses - Verbal evidence

- Ros Jervis, Service Director- Public Health and Wellbeing, Wolverhampton Council
- Glenda Augustine, Consultant in Public Health, Wolverhampton Council
- Debra Hickman, Head of Nursing and Midwifery, The Royal Wolverhampton NHS Trust
- Dr Angela Moore, Consultant Paediatrician. Designated Doctor for Safeguarding Children, The Royal Wolverhampton NHS Trust
- Sarah Brackwell, Health Visiting Service Manager, The Royal Wolverhampton NHS Trust
- Dr Tilly Pillay, Neonatal Clinical Lead, SSBCNN Consultant, The Royal Wolverhampton NHS Trust
- Dawn Lewis, Matron Maternity, Antenatal/Postnatal Services, The Royal Wolverhampton NHS Trust
- Anne Macleod, Manager, Healthy Lifestyles Department, The Royal Wolverhampton NHS Trust
- Dr Helen Carter, Consultant in Public Health, Public Health England, West Midlands Centre
- Dr Helen Sullivan, Consultant Obstetrician and Guidelines Lead, The Royal Wolverhampton NHS Trust
- Sarah Fellows, Mental Health Commissioning Manager, WCCG

Witnesses - Written evidence

- Hilary Osborne, Business Manager, National Child and Maternal (ChiMat) Health Intelligence Network
- Dr Rajcholan GP, Wolverhampton CCG board member women's health and paediatrics
- Jason Gwinnett, Principal Public Health Information Analyst, Wolverhampton Council
- Sharon Walton, Interim Senior Public Health Intelligence Analyst, Knowledge and Intelligence Team (West Midlands), Public Health England
- Sue McKie, Health Improvement Principal (NHS Facing), Wolverhampton Council
- Gill Hateley, Coordinator ,Child Death Overview Panel
- Clare Barratt, Development Manager, Wolverhampton CCG
- Laura Price PhD, Research and Information Officer, SANDS

Documentary Evidence

- Public Health Intelligence Briefing for the Health Scrutiny Review Panel: Infant Mortality in Wolverhampton, Public Health Wolverhampton (4.9.14)
- Final draft Wolverhampton Infant Mortality Action Plan 2015-2018
- Public Health England – Child and Maternal Health Knowledge Update 19 December 2014
- West Midlands Strategic Clinical Network for Maternity and Children. Maternity Gap Analysis Final Report (November 2014)
- Bradford Every Child Matters
- Child Health Profile Wolverhampton (March 2013)

Appendix 1: Terms of Reference – Summary

Key questions for the review:

1. What is the rate of infant mortality in Wolverhampton and how does this compare locally and nationally?
2. Are there any marked imbalances in infant mortality figures in Wolverhampton between localities and communities, and if so what are the causes of the imbalance?
3. What are the specific causes of infant mortality in Wolverhampton?
4. What is your understanding of the “underlying” causes of infant mortality in Wolverhampton?
5. Briefly describe the strategic approach that your organisation is taking to tackle the modifiable causes of infant mortality across Wolverhampton?
6. Briefly outline your evidence to show that you are making progress towards your organisational objectives aimed at reducing the number of infant deaths?
7. Briefly described evidence-based targeted actions being taken to reduce to reduce levels of child infant mortality. How effective have these actions been?
8. Do you have examples of best practice locally or nationally that can be shared with the review that will make a positive impact on reducing the infant mortality rate?
9. What more do you think can be done, now or in the future, to reduce the current rate of infant mortality in Wolverhampton?

Outcomes expected from conducting this work

1. An increased level of awareness and knowledge among Councillors about the work being done by key agencies to reduce levels of child infant mortality in Wolverhampton.

2. Evidence that local key partners are applying good practice, individually and collectively, to improve outcomes for children and families in Wolverhampton.

3. A set of practical evidence based recommendations that support improved performance and contribute to the achievement of a long and sustained reduction in the current rate of infant mortality in Wolverhampton.

4. Public reassurance that there is proper peer challenge among the key agencies involved to evidence that there is a shared commitment to reduce levels of infant mortality and there is the appropriate level of challenge and scrutiny

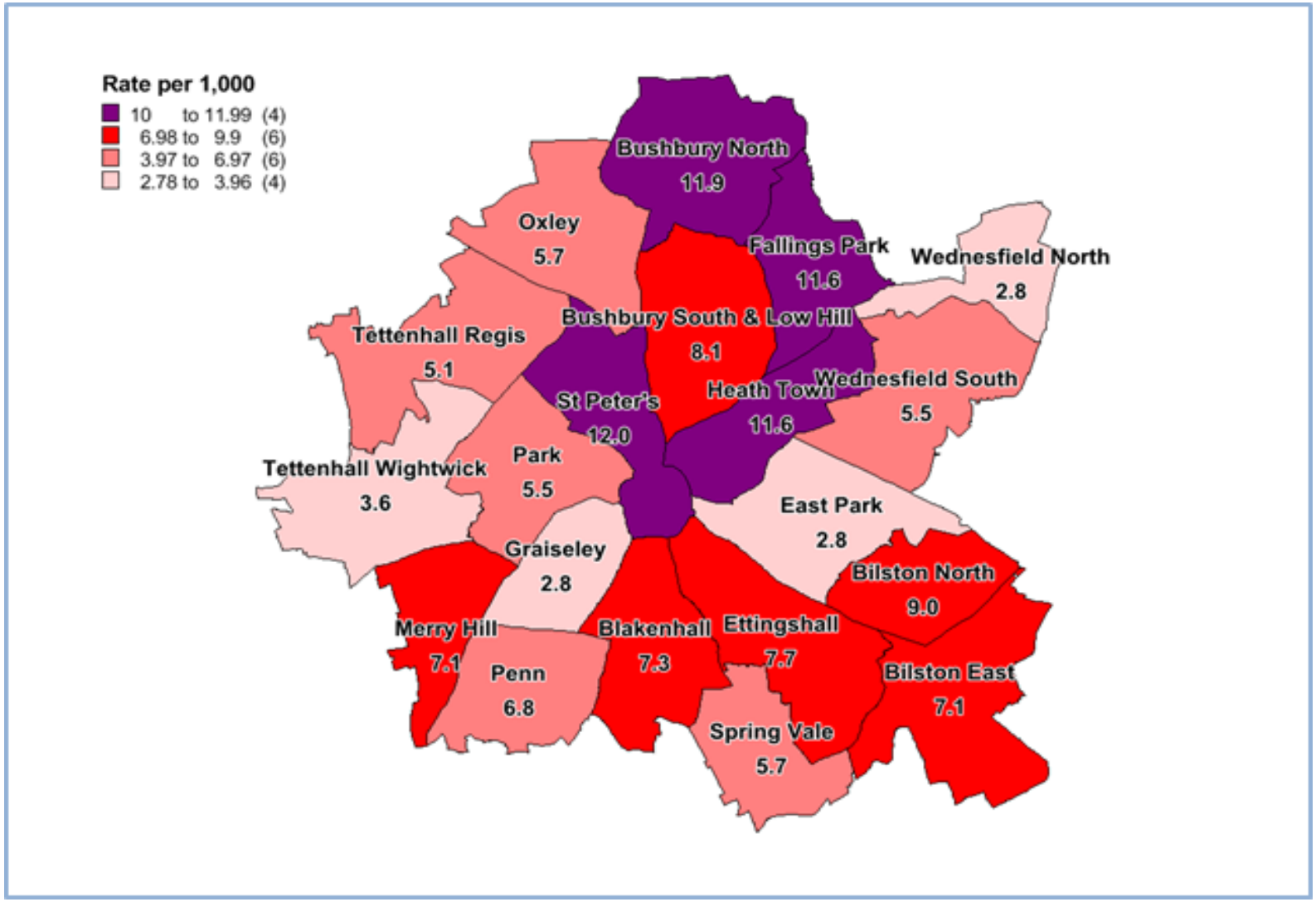
Appendix 2: Child Infant Mortality Data.

Historically, the rate of infant mortality in Wolverhampton has been almost double the national rate, with an average of 14 deaths per 1,000 live births between 1987 and 1989. However, when the National Child Health Profiles was published in March 2014 it was reported that Wolverhampton now has the highest rate of infant mortality in England at 7.7/1000 compared to the England average of 4.3/1000. The following figures for neighbouring authorities provide a comparison of local performance

- Walsall 7.6/1000
- Birmingham 7.2/1000
- Sandwell 7.1 /1000
- Dudley 4.5./10000

Reference: Wolverhampton Child Health Profile – March 2014

Map of infant mortality by electoral ward in Wolverhampton (2003-2012)



Child Health Data – Child Death Overview Panel Annual Report 1.4.13 – 31.3.14 (Summary)

Indicator	Local value	England average	Regional average
Breastfeeding initiation % 2012\13	64.5	73.9	67.9
Smoking in pregnancy % 2012\13	18.6	12.7	14.2
Low birth weight (<2500g) % 2012	7.5	7.3	8.2
Antenatal assessment by 12 weeks %	87.8	87.5	90.5
Completed MMR (measles, mumps, and rubella) (by age 2 years) %	89.5	91.2	92.0
Completed Diphtheria, Tetanus, Polio, Pertussis, hib immunisations %	95.5	96.1	96.8
Data Source: ChiMat 2008-2011			

The highest number of reported deaths occurred in the age group 0-28 days (Neonatal).

There is a regional variation in registering live births according to gestational age category. For instance, an infant born at 20 weeks gestation may be regarded as a miscarriage in the North East but as a live birth and then subsequently a neonatal death in the West Midlands.

A live birth occurs when an infant shows some sign of life at birth, for example, breaches or shows evidence of life such as voluntary movement, heartbeat, pulsation of the umbilical cord or definite movements of voluntary muscles.

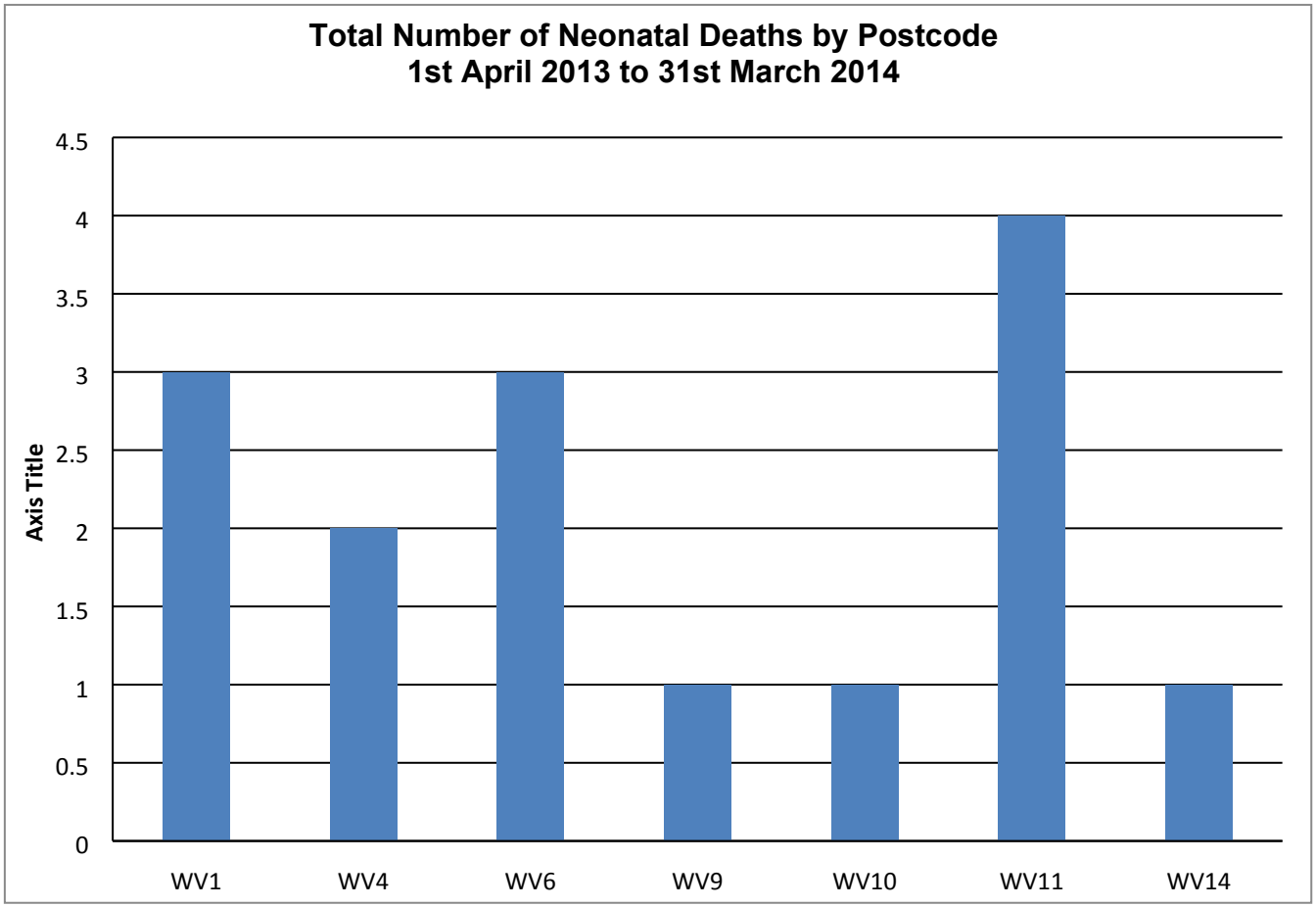
15 neonatal deaths have occurred in Wolverhampton this year (47 per cent male and 53 per cent female). With the exception of 2012\13 trend patterns indicate the number of neonatal deaths marginally decreasing year on year.

2012\13	2011\12	2010\11	2009\10	2008\09
16	14	18	21	25
Data Source: CDOP Statistics – actual number of deaths				

The main causes of death during 2013\14 are due to immaturity related conditions and congenital abnormalities including cardiac within the first 3 weeks of life with an average gestational age category of 23 weeks and the average age of mothers being 29 years.

Of the total number of neonatal deaths 15 recorded 34 per cent had ethnicity White-British; 13 per cent had any Other White Background (East European); Black African, Indian and White Black Caribbean ethnicity respectively. Seven per cent of deaths had Other Asian Background and Black Caribbean ethnicity.

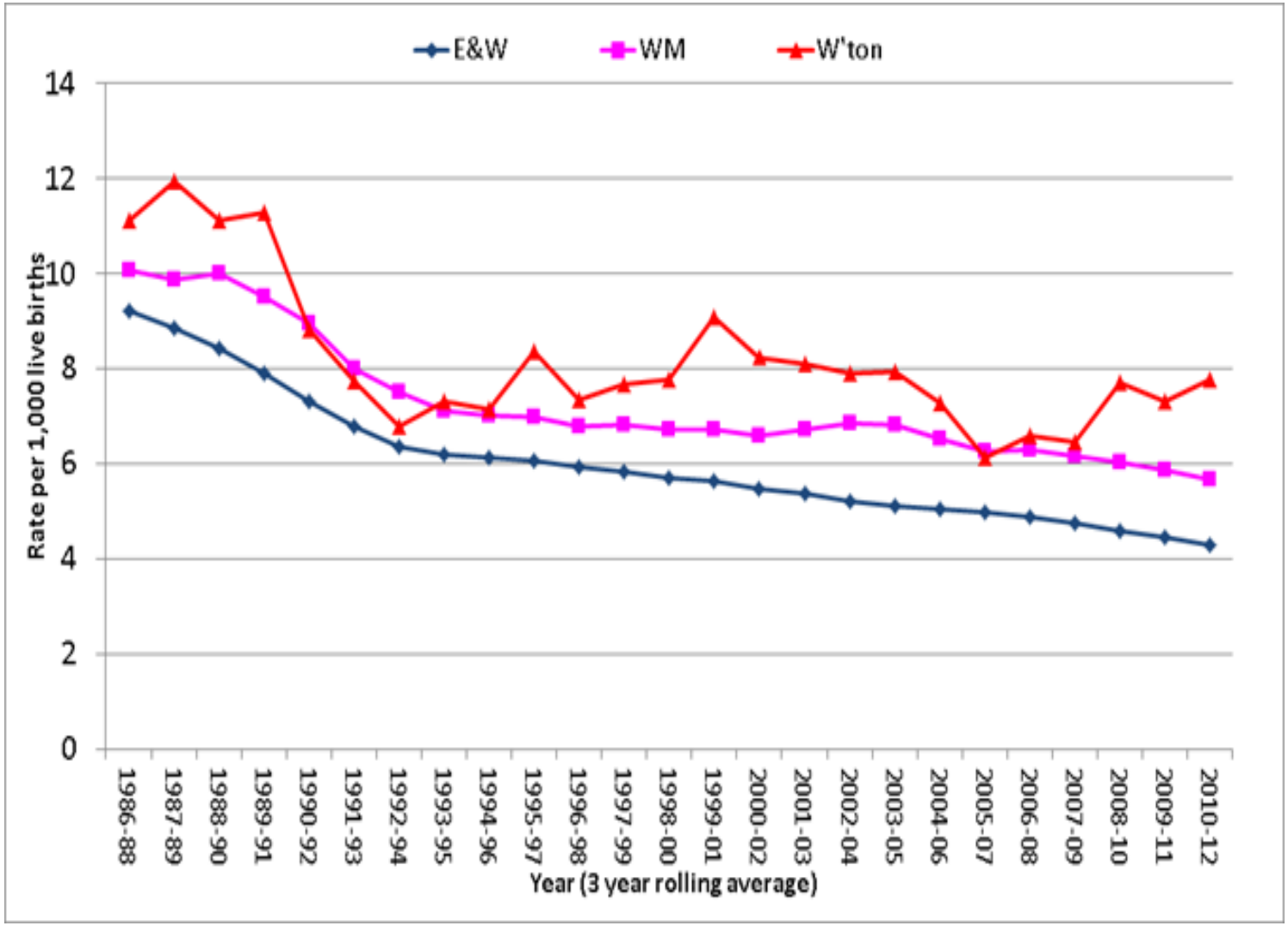
The geographic distribution of neonatal deaths is varied with the highest proportion of these deaths occurring in the City Centre (WV1), Ashmore Park\Wednesfield\Fallings Park (WV11) and Whitmore Reans (WV6) – recognised areas of socio-economic deprivation within the city.



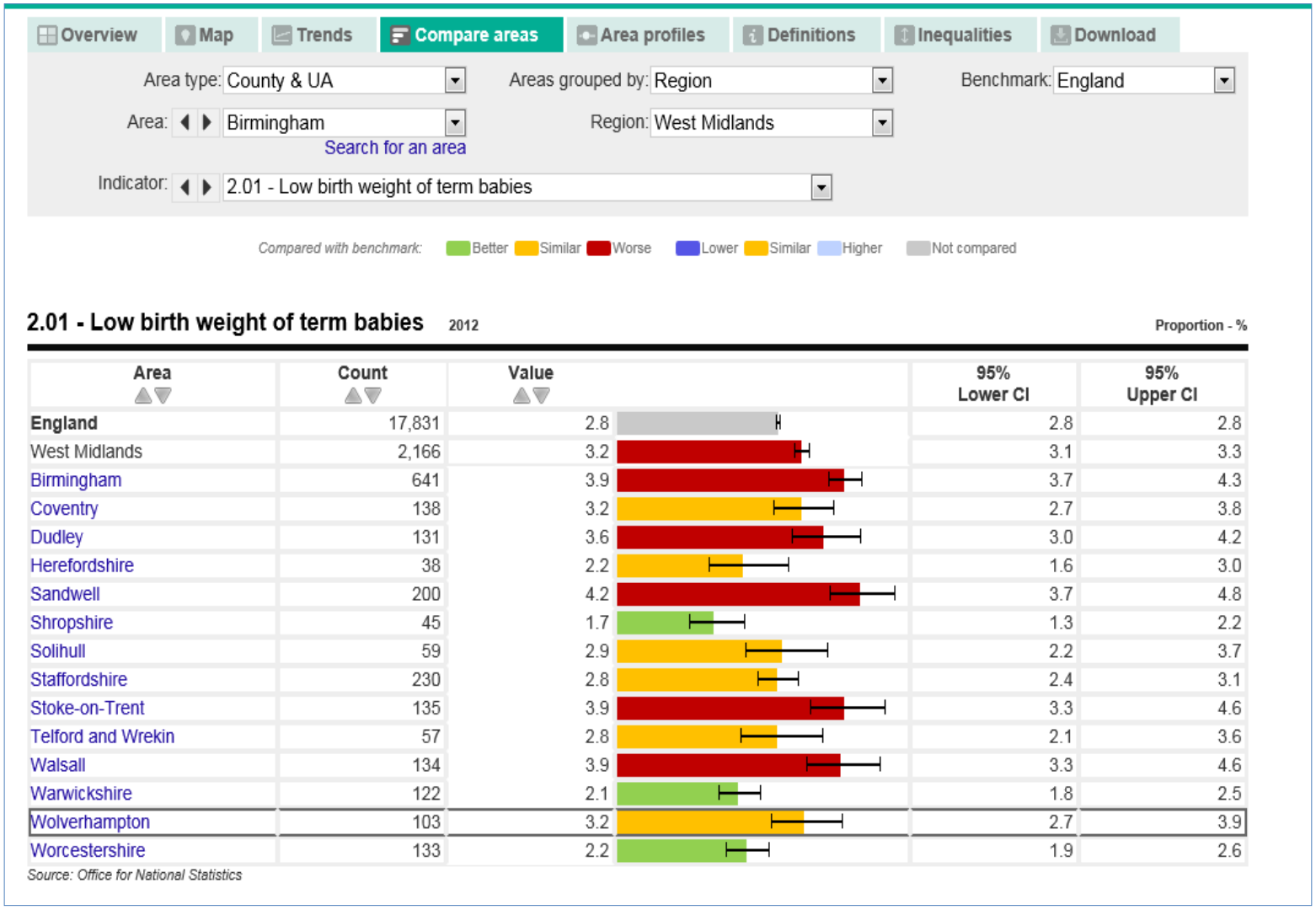
Overall CDOP trend analysis for infant deaths 29 days to under 1 year indicate a decrease in the number of reportable deaths year on year from 2011 to 2013; but with no noticeable change in the number of reportable deaths for infants 0-28 days of age.

Age	2013\14	2012\13	2011\12	2010\11	2009\10	2008\09
0-28 days	15	15	14	18	21	25
29 days to <1 year	2	7	13	9	6	5
Total	**17**	**22**	**27**	**27**	**27**	**30**
Data Source: CDOP statistics – actual number of reportable deaths						

Wolverhampton infant mortality rate time trend compared to regional and national averages



Comparison of low birth weight



2.01 - Low birth weight of term babies 2012

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	17,831	2.8	2.8	2.8
West Midlands	2,166	3.2	3.1	3.3
Birmingham	641	3.9	3.7	4.3
Coventry	138	3.2	2.7	3.8
Dudley	131	3.6	3.0	4.2
Herefordshire	38	2.2	1.6	3.0
Sandwell	200	4.2	3.7	4.8
Shropshire	45	1.7	1.3	2.2
Solihull	59	2.9	2.2	3.7
Staffordshire	230	2.8	2.4	3.1
Stoke-on-Trent	135	3.9	3.3	4.6
Telford and Wrekin	57	2.8	2.1	3.6
Walsall	134	3.9	3.3	4.6
Warwickshire	122	2.1	1.8	2.5
Wolverhampton	103	3.2	2.7	3.9
Worcestershire	133	2.2	1.9	2.6

Source: Office for National Statistics

Wolverhampton Trend data for low birth Weight

Overview | Map | Trends | Compare areas | Area profiles | Definitions | Inequalities | Download

Area type: County & UA Areas grouped by: Region Benchmark: England

Area: Wolverhampton Region: West Midlands

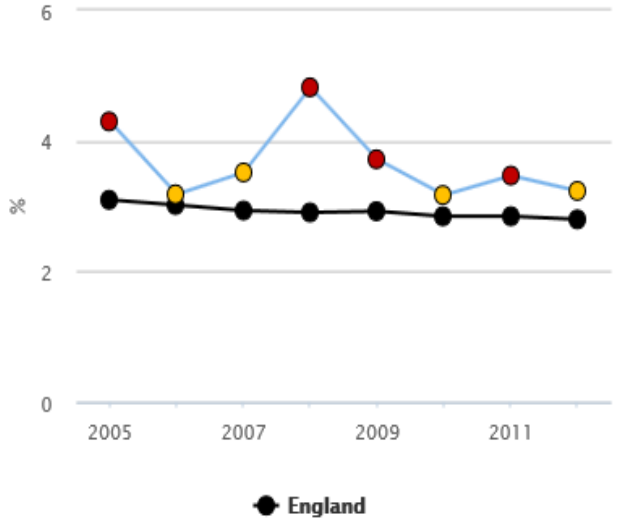
Search for an area

Indicator: 2.01 - Low birth weight of term babies Show all indicators

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Trends for: Wolverhampton

2.01 - Low birth weight of term babies Wolverhampton Proportion - %



Period	Sig	Count	Value	Lower CI	Upper CI	West Midlands	England
2005	●	120	4.3	3.6	5.1	3.5	3.1
2006	●	93	3.2	2.6	3.9	3.3	3.0
2007	●	106	3.5	2.9	4.2	3.4	2.9
2008	●	146	4.8	4.1	5.6	3.5	2.9
2009	●	112	3.7	3.1	4.5	3.4	2.9
2010	●	100	3.2	2.6	3.8	3.3	2.8
2011	●	115	3.5	2.9	4.1	3.3	2.8
2012	●	103	3.2	2.7	3.9	3.2	2.8

Source: Office for National Statistics

Appendix 3: Staffordshire Shropshire and Black Country Newborn (SSBC) Maternity and Newborn network

At the regional level the Staffordshire Shropshire and Black Country Newborn (SSBC) Maternity and Newborn network has been established.

The key functions of the network are:

- Ensure effective clinical flows through the provider system through clinical collaboration for networked provision of services.
- Take a whole system collaborative provision approach to ensuring the delivery of safe and effective services across the patient pathway, adding value for all its stakeholders.
- Improve cross-organisational multi-professional clinical engagement and patient/carer engagement to improve pathways of care.
- Enable the development of consistent provider guidance and improved service standards, ensuring a consistent patient and family experience.
- Focus on quality and effectiveness through facilitation of comparative benchmarking and auditing of services, with implementation of required improvements.
- Fulfil a key role in assuring providers and commissioners of all aspects of quality as well as coordinating provider resources to secure the best outcomes for patients across wide geographic areas.
- Support capacity planning and activity monitoring with collaborative forecasting of demand, and matching of demand and supply.

Draft Update 3 September 2013

The Royal Wolverhampton NHS Trust has a Level 3 Neo Natal Unit and is part of the SSBC Newborn Network which is working to ensure that the sickest and smallest babies in Wolverhampton are treated at the right hospital (NICU), at the right time, at the right place. Where it is suspected that a baby will be born very prematurely then the safest option is to transfer you to a neo natal unit before the birth as the baby will still be protected so that it will access to appropriate equipment and expertise.

Research evidence demonstrates that the place of birth can influence survival in the very small preterm baby. Babies delivered and managed at level 3 unit have the best survival changes.

This is known as in utero transfer. The following hospitals are part of the SSBC Newborn Network:

- University Hospital of North Staffordshire
- Staffordshire General Hospital
- Manor Hospital Walsall
- Russells Hall Hospital Dudley
- Royal Shrewsbury Hospital

Appendix 4: Healthy Child Programme responsibilities

The programme provides the basis for agreeing with each family how they will access the Healthy Child Programme over the next stage of their child's life. Any system of early identification has to be able to:

- identify the risk factors that make some children more likely to experience poorer
- outcomes in later childhood, including family and environmental factors;
- include protective factors as well as risks;
- be acceptable to both parents;
- promote engagement in services and be non-stigmatising;
- be linked to effective interventions;
- capture the changes that take place in the lives of children and families;
- include parental and child risks and protective factors; and
- identify safeguarding risks for the child.

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Executive response: **Scrutiny Review of Infant Mortality**

The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton

Recommendation 1

1. The Service Director- Public Health and Wellbeing to be responsible for collating a coordinated response from the officers responsible for to the following recommendations listed below. The Service Director to and advising Scrutiny present a report to Scrutiny Board with details of progress in implementing all the accepted recommendations and necessary follow up action, as appropriate, where accepted recommendations have not been implemented. The Scrutiny Board report to be presented to the Infant Mortality Working Group for information and comment:

a) Royal Wolverhampton NHS Trust to coordinate a response from the maternity, healthy lifestyles living and health visiting services which details specific actions aimed at reducing the percentage of pregnant women setting a smoking quit date, where the results are either not known or lost to follow up. The report to include details of the take-up rate of nicotine replacement therapy and the number who have set a quit date.

b) Royal Wolverhampton NHS Trust to coordinate a report from maternity, healthy living lifestyles and health visiting services on progress in the use and results of carbon monoxide testing of pregnant women at every contact. The report to include feedback from pregnant women recorded as smoking and subsequently referred, about their experiences of the stop smoking service.

c) Royal Wolverhampton NHS Trust to present a report on a review of effective interventions aimed at reducing the numbers of women smoking during and after pregnancy.

d) The lead officer for infant mortality at Wolverhampton Clinical Commissioning Group (CCG) to report on current commissioning arrangements and the extent to which services for pregnancy and infancy are delivering the right mix of enhanced and targeted interventions for pregnant women, particularly vulnerable women considered to be at risk.

e) A report on the benefits of providing a Pepi-Pod crib or similar alternative cot in Wolverhampton. A report of the potential value of using a mobile phone app for parents and parents-to-be with personalised information and content approved by doctors and midwives that spans from pregnancy right through to the first six months after birth. The schemes, if introduced, should be initially targeted a vulnerable women and the findings published with recommendations about a possible future roll out across the City.

f) The Service Director – Public Health and Wellbeing to work with lead officers from key partners to for infant mortality at Wolverhampton CCG to detail proposals to discuss proposals to make best use of available local intelligence in order to help with the early identification better of identify vulnerable pregnant women mothers and provide appropriate targeted interventions that can support them. that will contribute to the overall aim of reducing the numbers of infant deaths. The findings to be shared with the Wolverhampton Health and Wellbeing Board, and Wolverhampton CCG Governing Body and the Infant Mortality Working Group.

g) To invite Directors of Public Health across the West Midlands region to share examples of best practice in respect of delivering an effective smoking cessation programme to pregnant women and to discuss further opportunities to promote the adoption of best practice across the region.

h) The Service Director – Public Health and Wellbeing and the Chair of the Child Death Overview Panel (CDOP) to jointly report on progress in recruiting staff to collate current and future statistics. Analysis of comparative data at a regional level to be included in future annual reports.

i) The Chair of the Child Death Overview Panel (CDOP) to publish the annual report for Wolverhampton to be published prominently on the Council's website and also the findings shared with key local agencies to promote good practice and improve the quality of local intelligence.

j) The Service Director- Public Health and Wellbeing to report on outcome of review of the national funding formula for 2016/17. (The formula is used to calculate the number of health visitors that an area needs to deliver safe and effective services.)

	Comment	Timescale/progress so far	Officer Responsible
	1a-c **Accepted** The draft scrutiny report was presented to the Infant Mortality Working Group (IMWG) on Friday 8th May 2015. Representatives across the whole working group were present, including representatives in	1b. CO monitors have been purchased for midwifery and health visiting services and training will be delivered to support delivery.	Ros Jervis, Service Director, Public Health and Wellbeing (SDPHW)

	relation to recommendations 1a – 1c. Everyone is aware of the need to respond collectively to these recommendations regarding quit rates, use of carbon monoxide monitors (CO), nicotine replacement therapy and the use of stop smoking services in general by pregnant women.	A more detailed response by responsible organisations/services will be required at the Infant Mortality Working Group (IMWG) at the November 2015 meeting.	
	1d **Accepted** The executive nurse (EN) for the CCG alongside the Designated Doctor for Child Deaths (DDCD) will respond in detail to this recommendation. ***Manjeet Garcha*** has provided a detailed response to the recommendation – attached as Appendix 1	A more detailed response by responsible organisations/individuals will be required at the IMWG at the November 2015 meeting.	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG
	1e **Accepted** Public Health to undertake an evidence review in relation to available information relevant to use of: i. pepi-pod or alternatives ii. phone applications for personalised information	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting.	Ros Jervis (SDPHW)

	Cost effectiveness will be evaluated where possible		
	1f **Accepted** Public health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to age five pathway which will also address vulnerability) ***Manjeet Garcha*** has provided a detailed response to the recommendation – attached as Appendix 1	A more detailed response by responsible organisations/services will be required at the IMWG at the November 2015 meeting. **(Please read in conjunction with recommendation 2)**	Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG
	1g **Accepted** Public Health to work with Public Health England on a regional basis in terms of gathering and sharing good practice that supports women to stop smoking during pregnancy and to continue not to smoke after delivery.	A more detailed response will be reported by Public Health to the IMWG at the November 2015 meeting.	Ros Jervis (SDPHW)

	1h & 1i **Accepted** Public health working alongside the Chair of the Child Death Overview Panel (Joint) to report on the review currently being undertaken which will be completed by end June 2015.	A more detailed response by the Chair of the Child Death Overview Panel will be required at the IMWG at the November 2015 meeting. CDOP agree to publish the annual report through the WSCB.	Chair of the Child Death Overview Panel
	1j **Accepted** SDPHW has submitted a response to the consultation on the national funding formula for 2016/17. A national response is awaited.	It is possible that a national response will be published in December 2015.	Ros Jervis (SDPHW)

The importance of co-ordinating local efforts to tackle the underlying causes of infant mortality in Wolverhampton

Recommendation 2 Wolverhampton Clinical Commissioning Group (CCG) and the Service Director - Public Health and Wellbeing to agree a programme of work that supports enhanced targeted interventions for high risk families or vulnerable mothers with new babies identified by maternity services; including advice on contraception to avoid unplanned early repeat pregnancy, and support pregnancy spacing. This should include post natal support in the first few weeks of life aimed at parent education and support to reduce the risk of infant death after discharge from the neonatal unit/post natal ward.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Public Health working alongside EN for CCG, maternity and children services will review the vulnerable women's pathway. There is also a proposed task and finish group to discuss and develop a conception to age five pathway which will also address vulnerability.	A more detailed response by responsible organisations/services will be required at the IMWG in November 2015. (**This must be read in conjunction with recommendation 1f**)	Ros Jervis (SDPHW)

Recommendation 3

The Black Country clinical representative of West Midlands Maternity and Children's Strategic Clinical Network in discussion with representatives of SSBC Newborn and Maternity Networks to jointly present a report to the Infant Mortality Working Group regarding care pathways for anticipated extreme preterm births.

The report to include an update on work towards improving survival rates for this cohort and also progress on the outcome of discussions with West Midlands Ambulance Services about improving care pathways for intrauterine transfers of pregnant women in preterm labour. The overall aim of the policy is for pregnant women in preterm labour to be taken to the most appropriate hospital for the safe delivery and on-going care of their baby.

Comment	Timescale/progress so far	Officer Responsible
Accepted This recommendation will be addressed via the Black Country SCN lead update on infant mortality which will incorporate current discussions on intrauterine transfers across the network.	A final report will be presented to the IMWG in November 2015 with a view to a future joint presentation to the Health Scrutiny Panel.	Ros Jervis (SDPHW) alongside either a representative of the SCN or Tilly Pillay, Neonatal Lead, The Royal Wolverhampton NHS Trust (RWT)

Recommendation 4 The review group endorse the recommendations of the Infant Mortality Working Group Action Plan 2015 – 2018. A joint report to be presented by the lead officer for infant mortality at Wolverhampton CCG and Public Health to the Wolverhampton Health and Wellbeing Board on a six monthly basis on progress and achievements against recommendations accepted in the Infant Mortality Action Plan. The Service Director - Public Health and Wellbeing to ensure the action plan is reviewed and updated to include emerging risks and further services changes. The findings to be shared with all key partner agencies.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Update on the IMWG action plan will be presented to the Wolverhampton Health and Wellbeing Board (WHWB).	Update to be completed within two weeks of the May 2015 IMWG and forwarded as an agenda item to be considered for a forthcoming HWBB meeting. Careful consideration needs to be given regarding reporting progress against infant mortality actions (mechanisms and timescales) to various interested parties.	Ros Jervis (SDPHW)

A strategic and co-ordinated response to tackle the modifiable causes of infant mortality in Wolverhampton and also respond to the challenges of dealing with the effects of poverty and deprivation.

Recommendation 5 The findings and progress of the Infant Mortality Working Group to be shared with organisations with a special interest in reducing the number of child deaths, for example, the CDOP, SANDS, BLISS and the Lullaby Trust for comment. Representatives to be invited to comment on progress and invited to share learning locally and nationally on further improvements in the co-ordination of care from a neonatal setting, to home and whether there are any specific recommendations to build on good practice.		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A workshop event to be developed at the end of the calendar year and presented in 2016 to allow monitoring of progress and assessment of improvements.	Workshop discussed at IMWG November 2015 meeting with the proposal for the event to be delivered before March 2016.	Ros Jervis (SDPHW)

Recommendation 6 **The Service Director – Public Health and Wellbeing to draft terms of reference and agree membership for a task and finish group to review vulnerable pregnant women's care pathway. Representatives of Wolverhampton Integrated Substance Misuse Service (Recovery Near You) need to participate in a review of the effectiveness of the current working arrangements for supporting women referred to the service; particularly those involving drugs, alcohol, domestic abuse or long term mental health issues. A report of the findings to be reported to the Health and Wellbeing Board and Scrutiny Board.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A task and finish group will be established to address this complex recommendation, with representatives from CCG, Public health, LA Children services and Recovery Near You and possibly others) This work is a fundamental component of the vulnerable women's pathway and therefore will also link to recommendation 1f and 2. Helen Kilgallon ,Recovery Near You, representative of Wolverhampton Integrated Substance Misuse Service, provided a detailed response to the recommendation – attached as Appendix 2	Detailed report to presented at the May 2016 IMWG to include action against the linked recommendations 1f, 2 and 6. This can then be reported to either the Health Scrutiny Board or HWBB (or both).	Ros Jervis (SDPHW) and Manjeet Garcha Executive Lead for Nursing and Quality Wolverhampton CCG

Changing practices and policies and apply learning based on reliable evidence as to their impact and effectiveness in reducing the rate of infant mortality.

Recommendation 7 **Royal Wolverhampton NHS Trust to provide a detailed response to the NICE published guidance that all NHS hospitals and clinics should become completely smoke-free zones and to set out detailed proposals for implementation and a timetable for achieving this to be presented to a meeting of the Health and Wellbeing Board.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Discussions are being held between the Medical Director and the Healthy Lifestyles service manager regarding progressing this recommendation. Public Health will be presenting the Infant Mortality Action Plan (as approved by HWBB) to the Royal Wolverhampton NHS Trust Board on 1 June 2015.	Proposed update at the IMWG meeting in November 2015	Anne Mcleod, Manager Healthy Lifestyles Service, RWT

Recommendation 8 **The lead officer for infant mortality at Wolverhampton CCG to consider the availability of genetic screening and counselling support across Wolverhampton and to raise awareness generally of the service. The findings to be presented to the Health Scrutiny Board.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Genetic screening and counselling support is commissioned from Birmingham Womens Hospital NHS Trust on a regional basis. We are not aware of any issues with regards to access or availability of these services however we acknowledge the need to ensure good awareness across the public and professionals; including the conditions that would benefit from these services, how to access services and referral mechanisms.	August – October 2015	Manjeet Garcha, Executive Lead for Nursing and Quality Wolverhampton CCG

Recommendation 9 **Service Director - Public Health and Wellbeing, to work with partner agencies to create a public resource document similar to Bradford's 'Every Baby Matters' which explains the risk factors and provides practical advice and support that can help reduce the numbers of avoidable deaths of babies.** **The resource should be built into any planned public awareness campaigns and include details of the impact of lifestyle behaviours, such as smoking and alcohol that increases the risks of child dying. The document should promote positive health messages and signpost families to sources of available support and useful information.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted A task and finish group to be established to review developing a resource and the feasibility of delivering Making Every Contact Count training to key agencies	Task and finish group to be convened in July 2015	Ros Jervis (SDPHW)

Recommendation 10 **All newly elected Councillors to be given a briefing on the issue of infant mortality in Wolverhampton and the practical advice and information they can give when they meet people as part of their work. This should be presented as briefing of the key health messages and the main risks including sofa/bed-sharing, as well as smoking and alcohol in the lifestyle behaviours.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted		Earl Piggott-Smith, Scrutiny Officer

Recommendation 11 **Service Director - Public Health and Wellbeing, to report on progress in resolving the issue of getting access to personal confidential health data needed to assess the effectiveness of changes introduced to reduce the infant mortality rate.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted Information sharing agreement in progress and proposed infant mortality dashboard content agreed by IMWG	Data should be available by end of July 2015 and populated Infant Mortality dashboard presented at IMWG meeting in November 2015	Ros Jervis (SDPHW)

Recommendation 12 **The scrutiny review of infant mortality report to be sent to Wolverhampton CCG, Royal Wolverhampton NHS Trust and CDOP for information and comment and they are invited to give comments on the findings and recommendations.** **A progress report on those recommendations accepted by the Cabinet is reported to the Wolverhampton Health and Wellbeing Board in 6 months. The report recommendations to be tracked and monitored by Scrutiny Board at the same time.**		
Comment	**Timescale/progress so far**	**Officer Responsible**
Accepted	A final report will be sent to representatives when approved	Earl Piggott-Smith

Appendix 1

Recommendation 1d

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

Current arrangements

The Royal Wolverhampton NHS Trust is commissioner by Wolverhampton CCG to provide a full and comprehensive maternity service. The service is provided in accordance with all national and local policies in particular NICE guidelines and RCOG standards for maternity care. NHS England's Maternity Pathway payment system is in place which is split into three modules; antenatal, delivery and postnatal. For antenatal and post natal pathways there are three case-mix levels; standard, intermediate and intensive. Intermediate and intensive levels are where women require additional care and or intervention. The delivery element is split by whether or not there are complications and co-morbidities at a level that requires additional care.

Assurance

These pathways are underpinned by NICE guidance and should deliver the appropriate mix of enhanced and targeted interventions. In order to further understand the extent of interventions provided to women across the case-mix levels a multi-disciplinary case note audit is proposed. The aim of the audit will be to provide assurance of appropriate mix of enhanced and targeted interventions as well as provide learning, identify opportunities for training and education, for example.

Initial outline plan

Audit planning – May – June 2015
Undertake audit – July – August 2015
Review outcomes: September 2015
Develop plan: October 2015

Recommendation 1f

Manjeet Garcha Executive Lead for Nursing and Quality- Wolverhampton CCG

It is acknowledged that local intelligence can come from many sources; this intelligence should be disseminated across services to ensure appropriate consideration is given to the impact on relevance of the information on care needs along with any additional education required by providers. In addition, GPs are the primary point of access for pregnant women to maternity services. There is guidance in place for GPs however; the extent to which this is adhered to is unknown. Further understanding is required of the mechanisms in place across primary care for information sharing between GP and midwife. A survey to gather intelligence followed by education/promotion is opposed.

Survey: June – July 2015
Assess Response: August 2015
Review guidance: September 2015

Appendix 2

Recommendation 6

Helen Kilgallon
Programme Manager
Wolverhampton Substance Misuse Service

In April 2013 a newly commissioned integrated substance misuse service began. This is a partnership with NACRO as prime contractor, Aquarius and BSMHFT as sub-contractors. A recovery model was adapted within the service and a number of posts that were in existence at the previous service were no longer in the new service model. One of the reasons for this was RNY wanted to ensure all staff were skilled to a high level in safeguarding, pregnancy, domestic abuse and mental health and not rely on one particular specialist post.

The DALT (drug alcohol liaison team) has been successfully operating within RWT for over 5 yrs. When RNY were awarded the contract leads from DALT and the RNY consultant lead met with maternity as a priority to adapt existing pathways and ensure this particular group of women were given a priority within the service. This pathway has been revisited a number of times to ensure all processes and procedures work smoothly and effectively. I have every confidence that the maternity pathway within RNY and RWT is effective as I know RNY staff sit at maternity meetings, and daily discussions are had with specialist nursing staff within RWT. They can often be seen at meetings at RNY and are a visible presence.

As programme manager I have weekly reports sent to me on all pregnant service users and can view their treatment, attendance and offers of support. I also chair safeguarding meetings where they are discussed. I do not feel that RNY needs to review the process we have currently as they have been working successfully for over 18 months.

I would be more than happy to be part of any processes to look at referral routes into and out of the service i.e. mental health services, and more especially primary care. I feel that this is a particular area where much more work could be done at a very early level as they have access to patients where alcohol screening could be done, offers of smoking cessation, weight management and offers of support for mental health and domestic abuse.

A summary of the community maternity pathway is outlined below

SPOC- single point of contact
KW- key worker

Community Maternity Pathway – 'Recovery Near You' Wolverhampton

Aim

To ensure engagement with both substance misuse services and maternity services and maintain a multi-agency approach

To maximise the recovery potential for the client – consider the potential for positive change

To ensure clear and accurate information is given to clients who are pregnant

To maintain the safety of the unborn child

Our advice regarding alcohol should be to reduce quickly and safely - abstinence or 1-2 units 1-2 times week. Our advice regarding drugs should be to stabilise on OST and abstain from all illicit use

RNY Maternity Lead
Carolyn Musgrave
maintains list of current pregnant clients
0781 2260 821

RWT Midwife vulnerable adults
Tracy Kean
maintains list of current pregnant women misusing drug/alcohol
07970146030

Dr George Georgiou
Clinical Lead
0798 588 2230

- Carolyn and Tracy meet monthly
- Act as info source/ support to staff
- Attend maternity and addictions meetings to keep updated
- Maintain local and national guidelines on substance misuse and pregnancy
- Refer to clinical lead Dr. George Georgiou when appropriate

SPOC

Referral & screening
Ask if client pregnant – pregnant clients have potential for high risk and should have priority for immediate assessment

SPOC

Assessment
Ask again if pregnant.
Consider risk, physical health, drug and alcohol use, medications and safeguarding
Give clear information to client re substance misuse and pregnancy – consider leaflet information

ALLOCATIONS

High priority for fast track allocation, consider medical needs, risk and safeguarding alert manager on allocation that client is pregnant

KEY-WORKER

Ensure engagement
Support client with substance misuse goals that safeguard the unborn baby
Inform Maternity lead that you have a pregnant client
Make sure client is 'pregnant' on Illy

ILLY

Mark client as pregnant on Illy
Inform GP and midwife

ACTION

TOPS/OUTCOMES

Liaise with midwife; consider confidentiality, risk and safeguarding/Pregnancy test as appropriate

KEY-WORKER

- Maintain an empathic and non-judgemental approach
- If client discloses pregnancy during contract update as above and contact relevant professionals
- Give clear and accurate information to client re substance misuse and pregnancy
- Discuss client's plans re the pregnancy
- Actively support and encourage change
- Consider reduction/assisted withdrawal with support from medical team
- Engage with the family and consider family interventions
- Maintain a multi-agency approach and liaise regularly with relevant professionals especially named midwife
- Refer for medical appointments as necessary – medics to prioritise these clients
- Consider increase in stress and the impact on substance misuse after the baby is born, don't discharge too quickly

ACTION

- Pregnancy test to confirm pregnancy
- Prioritise appts, medical reviews and changes to medication that protect the unborn baby
- Liaise regularly with named midwife
- All actions recorded on Illy
- Inform midwife of any missed appointments, changes to recovery action plan/changes to medication
- Inform clinical lead of pregnancy status during medical review
- Urine screen as required
- Risks and needs assessed early
- Inform/update social services as required - consider CAF
- Attend all MDT meetings

Agenda Item No. 9

Health and Wellbeing Board

7 October 2015

Report title	Review of the Wolverhampton Joint Strategic Needs Assessment Process
Cabinet member with lead responsibility	Councillor Sandra Samuels Public Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders People
Originating service	Public Health
Accountable employee(s)	Ros Jervis Director Public Health Glenda Augustine Consultant in Public Health Tel 01902 551372 Email ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team 3 September 2015 People Leadership Team 7 September 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to support:

1.1 The formal establishment of a representative Joint Strategic Needs Assessment Working Group

1.2 The pulling together of a single compendium of demographic and population needs assessment information including health and social care need for Wolverhampton accessible for all.

1.3 The development of an updated interactive, electronic Joint Strategic Needs Assessment to provide access to the compendium mentioned above to support commissioning as well as the provision of information and the promotion of engagement for all.

1.0 Purpose

1.1 The purpose of this report is to present information as a result of a review of the local and national Joint Strategic Needs Assessment (JSNA) processes and propose an option for the development of an updated JSNA for Wolverhampton from 2016 onwards.

2.0 Background

2.1 The Local Government and Public Involvement in Health Act (2007) required upper tier Local Authorities and Primary Care Trusts to produce a JSNA of the health and wellbeing of their local community.

2.2 The Health and Social Care Act 2012 gave this duty to Health and Wellbeing Boards, with an additional statutory duty to prepare a joint health and wellbeing strategy to identify the needs identified in the JSNA.

2.3 The JSNA is a tool to understand the needs of Wolverhampton residents and agree collective action. It is a process that should identify the current and projected health and wellbeing needs of the local population across the life course, and bring together evidence in the form of numerical data, insights from communities and other high quality published evidence.

2.4 The JSNA should inform the priorities of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy (JHWBS) and provide a shared evidence base for consensus on local priorities.

2.5 The current JSNA, developed and approved during 2012, focusses on outcomes and is derived from indicators contained within the three national outcomes frameworks (Public Health, NHS and Adult Social Care). However, this approach should now be strengthened to incorporate insights from the community and include other high quality evidence of local need.

2.6 It is proposed that a representative JSNA Working group is established to support the development of an integrated partnership approach to the development of an updated JSNA.

2.7 Publication of JSNA updates needs to shift from a high level indicator focus which are derived from the national outcome frameworks to a JSNA that is better able to demonstrate the impact of services and interventions on identified need and accurately assess the effectiveness of commissioned services or gaps in service provision.

2.8 It was agreed at the Health and Wellbeing Board meeting held in March 2015 that the local JSNA process should be reviewed, alongside the resources required to deliver any change.

3.0 Summary of the process used for JSNA across England

3.1 A detailed review of all available national JSNAs produced by local authorities was undertaken to ascertain the process used for developing and producing the JSNA, alongside methods used to publish the findings.

3.2 Whilst information on the JSNA development process was not available for all local authorities, a significant number of authorities did publish their JSNA process which consisted of the following:

- A JSNA working or steering group with agreed terms of reference
- Stakeholder consultation events
- A template for subject matter to be included in the JSNA
- Guidance notes for subject matter authors
- An agreed methodology for the undertaking of new subject quality reviews

3.3 The majority of the JSNA working groups existing around the country consist of representatives from the local authority (including Public Health Intelligence, Children's Services, Adult Social Care and Business Intelligence), Clinical Commissioning Group leads, HealthWatch, Third Sector and the Police.

3.4 The content of the JSNAs reviewed varied covering local priorities and a large breadth of health and social care needs across the life course, mainly using the six life course principles derived from *The Marmot Review*.[1]

3.5 JSNAs have been produced since 2008 and over time there has been a shift in the publication of the JSNA findings and products. Whilst there were a number of printed documents, with up to 400 pages of comprehensive health and social care information, 85% (129/151) of JSNA reports are available electronically. Only 33% (52/151) of complete JSNAs were available as a hardcopy document only.

3.6 The electronic JSNA and products varied from the provision of a few electronic documents to an A-Z of health and social care need across the life course. An interactive facility for the JSNA was also developed on bespoke stand-alone JSNA or intelligence/insight websites or data observatories by 33% (31/99) of the authorities who did not produce a complete hard copy document.

3.7 The rationale for the move to electronic publication acknowledged the dynamic nature of the JSNA, citing the ability to make timely changes which are not possible with hardcopy publications.

3.8 None of the JSNAs reviewed were based solely on the national outcomes framework. Only one JSNA included framework indicators within the JSNA dataset, providing a local indicator summary document to define local need.

[1] Start well; develop well; live well; stay well; work well; age well

3.9 It was noted that websites hosting the JSNA frequently had a comments and query section to support on-going consultation regarding subject matter for inclusion in the JSNA.

4.0 Proposal for Wolverhampton JSNA

4.1 The current Wolverhampton JSNA, whilst outcomes focussed, needs to better reflect population need and include community insight and local evidence of need where possible.

4.2 A review of the JSNA process across England has demonstrated a consistent approach to content development and publication of the JSNA, supported by a defined governance structure.

4.3 To support the delivery of a dynamic, strategic assessment of population need and publishing of the findings it is recommended that the Health and Wellbeing Board support:

- The formal establishment of a representative JSNA Working Group
- The publication of a single compendium of population need including health and social care
- The development of an updated 'interactive' electronic JSNA to provide access to the compendium to support commissioning, the provision of information and the promotion of engagement for all.

4.5 A JSNA should not be just a document or a website. Implementation of these recommendations will ensure that the development and delivery of our local JSNA will be a clear process whereby consensus is reached on strategic needs and priorities supported by available evidence. This will support the identification of local priorities and the subsequent refresh of the JHWBS.

5.0 Financial implications

5.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The initial funding allocation for Public Health for 2015/16 is £19.3 million, this is subject to a half year funding reduction for which consultation is currently in progress to determine the actual impact of the proposed announcement on the Council.

6.0 Legal implications

6.1 There are no anticipated legal implications to this report.

7.0 Equalities implications

7.1 The are no equalities implications related to this report.

8.0 Environmental implications

9.1 There are no environmental implications related to this report.

9.0 Human resources implications

9.1 There are no anticipated human resource implications related to this report.

10.0 Corporate landlord implications

10.1 This report does not have any implications for the Council's property portfolio.

11.0 Schedule of background papers

11.1 There are no background papers for this report

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Agenda Item No. 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

07 October 2015

Report title	Better Care Fund Update	
Cabinet member with lead responsibility	Councillor Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Adult Health and Social Care	
Accountable employee(s)	Steven Marshall Tel Email	Transformation Director 01902 441 775 steven.marshall3@nhs.net
	Viv Griffin Tel Email	Director Mental Health and Disabilities 01902 55xxxx Viv.griffin@wolverhampton.gov.uk
Report to be/has been considered by	BCF Programme Board Integrated Commissioning Board	17 September 2015 17 September 2015

Recommendation(s) for action or decision:

1. None – information only update

Recommendations for comment:

The Health and Wellbeing Board is asked to:

1. Note the progress update provided in this report in relation to the Better Care Fund.
2. Note the draft out-turn position following the period 4 (end of July) monitoring and the forecast cost pressures in line with the risk sharing agreement for each organisation.
3. Note the position relating to current performance against the key Payment for Performance Indicator and relevant supporting indicators
4. Feedback comments to the report author.

1.0 Purpose

1.1 The purpose of the report is:

- To brief the Board on the development and progress of the Better Care Fund.
- To brief the board in relation to the financial risks relating to the Better Care Fund.
- To appraise the Board of next steps
- To secure continuing support from the whole Health and Social Care Economy to facilitate the successful delivery of the Better Care Programme

2.0 Background

2.1 The Better Care Fund Programme is now in the implementation phase with the aim of delivering six Outcomes:-

- Reduced delayed transfers of Care
- Reduction in avoidable emergency admissions
- Reduce admissions to residential and nursing homes
- Ensure effectiveness of reablement
- Improve patient/Service user experience
- Improve dementia Diagnosis rates

3.0 Progress, options, discussion, etc.

3.1 Better Care Fund Performance

The planned number of emergency admissions has been re-baselined due to revised 2014 actual data. Performance appeared to be improving in May but is above target in June and July. However, performance against the BCF HRG codes continues to be good.

- Work has now been done to ensure that planned performance against specific BCF HRG codes is unique to work streams and analysis is being undertaken to understand the specifics and complexities around performance in this area.

- Delayed Transfer of Care performance continues to decline with the planned number of delayed days for the whole of quarter 2 being met in July alone.

- The performance framework continues to be developed and more detailed commentary and RAG ratings provided by work stream leads will be included in future reports.

3.1.2 Current Performance

Please note the following in relation to performance monitoring:

Emergency admissions to hospital are currently being measured in two ways. The Payment for Performance (P4P) indicator is being measured using MAR (Monthly Activity Report) data that is submitted by hospitals. This measures episodes relating to admissions and an individual person admitted to hospital may have multiple episodes recorded as part of that admission.

Local plans and reporting are broken down by HRG code which gives an indication of the reasons for admission, allowing more detailed analysis. This uses SUS (Secondary Uses Service) data which is based on spells. There should only be one overarching spell per admission. This means that there will be differences in the way that the data sets are reported.

The Wolverhampton BCF plans and targets are based on mapping that involves 5 separate CCGs:

- *NHS Wolverhampton CCG – 93.7%*
- *NHS Dudley CCG – 1.5%*
- *NHS Sandwell and West Birmingham CCG – 0.1%*
- *NHS South East Staffs and Seisdon Peninsular CCG – 1.7%*
- *NHS Walsall CCG – 3.9%*

However, for ease of monthly reporting 100% of the Wolverhampton CCG figure is being used. This means that the final data used by NHSE when calculating the quarterly performance may differ slightly from what is reported locally, however any difference should not be significant.

3.1.2 Emergency Admissions

MAR and Payment for Performance

The planned number of emergency admissions has been slightly altered following revisions to the 2014 actual performance. This revision was submitted as part of the quarter 1 submission to NHSE.

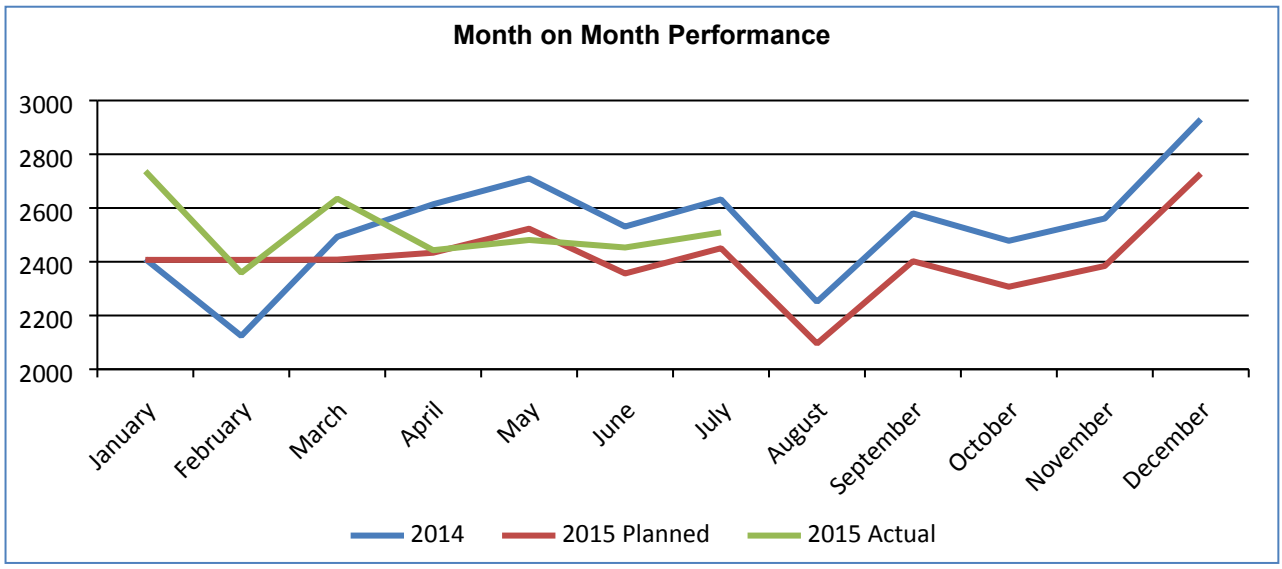
The planned and actual number of emergency admissions so far is:

Quarterly Performance	Q4	Q1	Q2	Q3
2014	7027	7855	7463	7969
2015 Planned	7222	7249	7365	7313
2015 Actual	**7731**	**7377**	**2509**	
Difference between planned and actual	509	128	-4856	
% Difference between planned and actual	7.0%	1.8%	-65.9%	

On a cumulative basis, performance is:

Quarterly Cumulative Performance	Q4	Q1	Q2	Q3
2014	7,103	14,983	22,459	30,436
2015 Planned	7222	14577	21877	29370
2015 Actual	**7731**	**15108**	**17617**	
Difference between planned and actual	509	531	-4260	-29370
% Difference between planned and actual	7.0%	3.6%	-19.5%	-100.0%

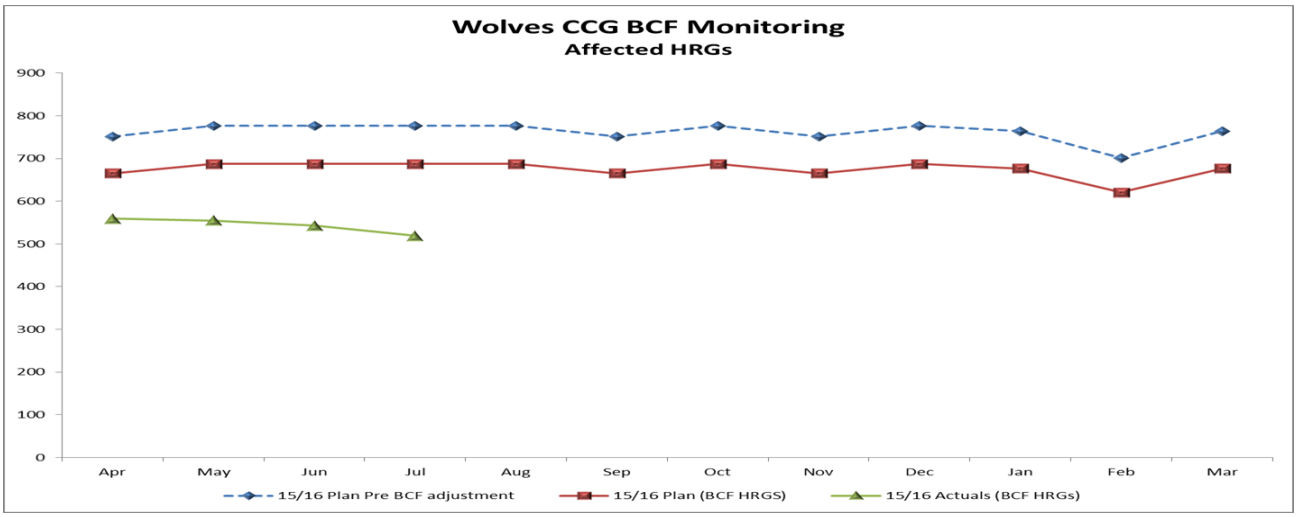
The difference is largely due to a higher number than planned admissions in January and March 2015 (as indicated by the green line in the graph below). This was not unexpected as many of the improvements and changes being instigated as part of the individual work streams did not come on line until April 2015, however, June and July have also seen admissions higher than planned numbers.



SUS and HRG Codes

A number of HRG codes have been identified as those most likely to be influenced by the Better Care Fund and planned reductions against these codes have been built into CCG plans and contracts with the Hospital Trust.

Performance against these specific codes in the first two months of the year is considerably better than planned as the graph below shows:

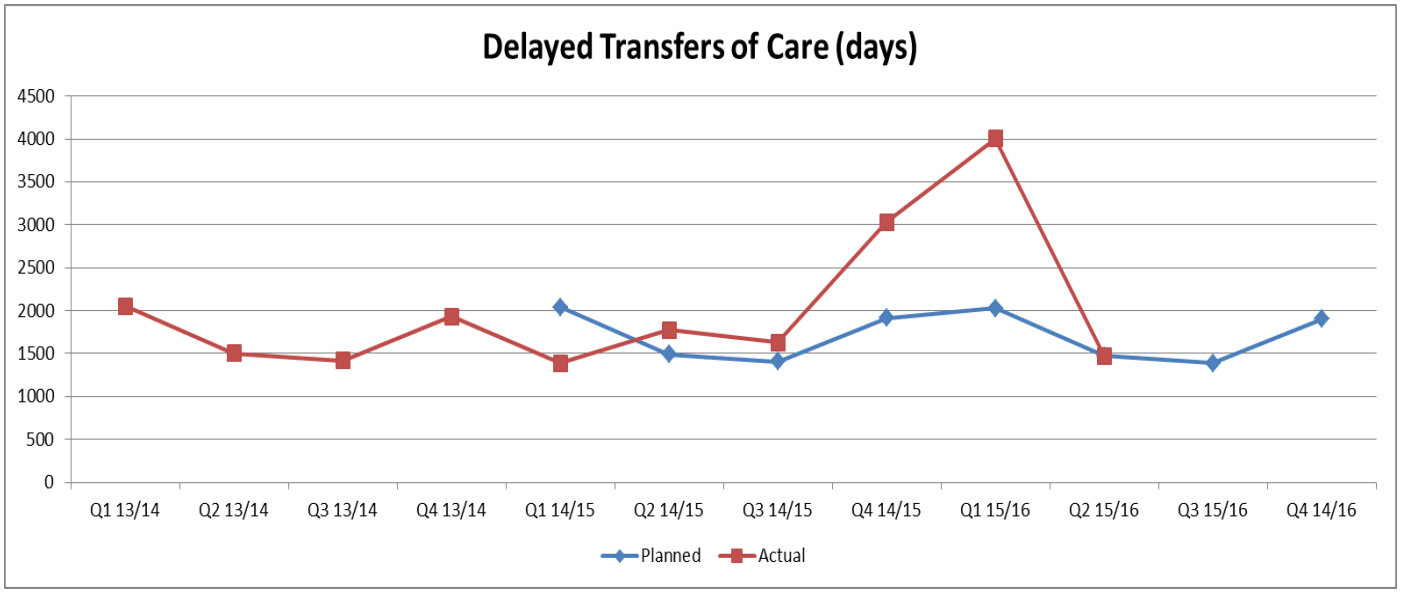


Although performance is positive against these specific HRG codes, it is a mixed picture amongst specific chapters with some performing better than others. The difference between reported SUS performance and the MAR data also re-enforces the previous assertion that there are increases in admissions against HRG codes that are not included within the BCF plans. Work has begun to analyse this area in more depth but is not yet complete.

3.1.2 Delayed Transfers of Care (DTOCS)

The table and graph below shows the number of delayed transfers of care (days) which has now been updated with June and July data.

Metric	13/14 plans (revised)	Q1 (Apr 13 - Jun 13)		Q2 (Jul 13 - Sep 13)		Q3 (Oct 13 - Dec 13)		Q4 (Jan 14 - Mar 14)	
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**1055**		**770**		**728**		**986**	
	Numerator	2054		1500		1418		1929	
	Denominator	194708		194708		194708		195605	
	14/15 plans (revised)	**Q1 (Apr 14 - Jun 14)**		**Q2 (Jul 14 - Sep 14)**		**Q3 (Oct 14 - Dec 14)**		**Q4 (Jan 15 - Mar 15)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1044**	**709**	**761**	**906**	**718**	**833**	**976**	**1543**
	Numerator	2042	1386	1488	1773	1405	1630	1916	3029
	Denominator	195605		195605		195605		196274	
	15-16 plans (revised)	**Q1 (Apr 15 - Jun 15)**		**Q2 (Jul 15 - Sep 15)**		**Q3 (Oct 15 - Dec 15)**		**Q4 (Jan 16 - Mar 16)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1033**	**2041**	**750**	**750**	**708**		**966**	
	Numerator	2027	4006	1473	1472	1390		1901	
	Denominator	196274		196274		196274		196857	



As the data shows, despite positive performance against the plan in the first quarter of 2014/15, in all quarters afterwards, actual performance has been seen a significantly higher number of delayed days than was planned and is increasing.

One month into quarter 2 2015/16, performance is already in line with the plan for the entire month. Price Waterhouse Cooper have recently been commissioned to undertake a review of DTOC issues within the City. The table below shows performance against plans for the other supporting indicators:

Metric		Baseline - final (2013/14)	Planned 14/15 (revised)	Actual 14/15	Planned 15/16 (revised)	Q1 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate per 100,000*	**726.9**	**682.6**	**645.4**	**638.0**	**642.7**
	Actual number of admissions	305	289	273	273	275
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**85.8**	**88.6**	**80.6**	**94.3**	**N/A - Annual Indicator**
	Actual number of people	300	310	329	330	

On an incredibly positive note, the actual 2014/15 result for the number of permanent admissions of older people to residential and nursing care homes, not only exceeded the planned 14/15 target but met the 2015/15 target (the rate is different due to different population denominators).

Although there has been a slight increase in admissions over the rolling 12 month period at the end of quarter 1, it is expected that performance will continue to improve throughout the year with the 15/16 being exceeded by year end.

On a less positive note, the proportion of older people who were still at home 91 days after discharge from hospital into reablement fell by 5.2 percentage points meaning that the ambitious 88.6% target was not met.

It is unlikely that the overly ambitious target of 94.3% will be met in 2015/16 as the reablement offer is due to be extended to a higher number of people as part of the BCF work and a reduction is effectiveness is a known result of a wider reablement offer.

3.2 Key Progress

3.2.1 Intermediate Care and Reablement

The Home In Reach Team ("HIT") has been operational for some time; however the BCF programme redesign has enabled the scheme to expand from a five day service to a seven day service and to increase the number of homes it supports. This will increase the efficiencies already demonstrated by this service.

A joint community reablement service pilot is now operational. The Community Intermediate Care Team ("CICT") and Home Assisted Reablement Team ("HARP") are jointly triaging referrals and working together to develop joint pathways of care that will enable seamless processes for patients/service users. An evaluation of the pilot will be undertaken in October and a future action plan and workforce plan for an integrated team will be developed.

The pilot is focussing on Integrated pathways and models of delivery in the first instance with a long term view to becoming fully integrated. This will enable more timely impact upon the delivery of care and subsequent efficiencies from more co-ordinated discharge and reablement pathways.

An overarching service specification is being developed between health and social care colleagues to develop a Rapid Response service that will be reactive to patients/service users need and enable them to remain in their usual place of residence avoiding emergency admissions and readmissions.

3.2.1 Primary and Community Care

Community Neighbourhood teams - This is the development of three Integrated Health and Social care teams. Core team members will be District nurses, Community matrons, Social workers and support workers all working closely with Primary care and the voluntary sector to meet the needs of individual patients and service users and carers and families.

The core team will have access to specialist teams; the aim of the teams is to prevent emergency admissions by risk stratification, prevention, promoting self- management of conditions, developing personalised management plans and, rapid response to patients with an urgent need. Whilst currently working virtually, the teams will be co-located in order to enable integrated working, multi-disciplinary team meetings and joint care planning.

End of Life - The Rapid Discharge project at Royal Wolverhampton Trust (RWT) has now gone live. This enables patients identified as end of life to be discharged promptly and appropriately back to their usual place of residence. This facilitates early discharge and enables the patients to die in their own home where this is their preference. The

development of a hospice as a hub is underway. The project has secured funding from Macmillan to provide project management support during implementation of this project.

Urinary Tract Infection ("UTI") Pathway – the UTI pathway went live on the 6 July. Patients with a UTI that previously may have been admitted to hospital are now referred to the Community Matron and social care teams in order to manage the patients in their own home.

Patients who are discharged from hospital or attend Accident and Emergency (A&E) with a UTI can also be referred to the team with the aim of preventing a re-admission. The pathway is being supported by a similar project being run by West Midlands Ambulance Service enabling the hours of the scheme to be extended until 8 p.m. in the evening, with each service able to refer to the other as appropriate.

GP Care Homes - A service specification and business case has been approved in principle by Clinical Commissioning Group ("CCG") Commissioning Committee and is in the process of being finalised. The project will see GPs allocated to all residential homes in the City.

Regular ward rounds and medication reviews will be undertaken and personalised management plans put in place for residents in order to reduce the number of emergency admissions from these homes, by working with the care home staff and ensuring the care plans give clear direction of management if the patient enters crisis.

3.2.2 Dementia

GP volunteers for each locality are now in place. The review of the use of hospital beds for people who have a dementia diagnosis is nearing completion. A detailed review of all current Dementia Support contracts has taken place which will be used to produce the commissioning direction for the next 3 years. An update on the Dementia Strategy has been submitted for October Cabinet.

3.2.3 Mental Health

The Street Triage service and Psychiatric Liaison services have been operating since the beginning of the programme, and is being embedded into the Mental Health service model as a substantive service. It is having a highly positive effect in the reduction of people with mental health challenges presenting at A&E.

Permission to undertake statutory consultation about new recovery house service is being sought. Consultation will be carried out between October 2015 and January 2016. This will be followed by staff consultation and implementation of the new model.

The resettlement programme continues to promote the move from residential and nursing care into supported housing. Twelve people have been resettled to date. Phase two resettlement activity has started.

4.0 Financial implications

4.1.1 The council and the CCG entered into a Section 75 agreement for the BCF pool fund for 2015/16. The value of the pool fund is £69.6 million revenue, of which £22.9 million are budget from the Council and £46.7 million from the CCG. It should be noted that the fund includes £6.3 million representing the NHS transfer to social care (Section 256 funding). In additional to the revenue budget, the pooled fund includes capital grant amounting to £2.1 million (Dedicated Facilities Grant and Social Care Capital Grant).

4.1.2 The Section 75 agreement made provision that the pooled fund including the risk sharing arrangements for any risks identified as a result of 2014/15 year-end closure would be negotiated between the Partners and the appropriate schedules of the Section 75 agreement would be amended accordingly.

4.1.3 Both organisations undertook a review of their year end position and as a result would revise the pool fund to £70.9 million, of which £24.2 million would be from council and £46.6 million from CCG. This is broken down into the workstreams as follows:

	CCG Contribution (£000)	Council Contribution (£000)	Total Contribution (£000)
Community and Primary Care	15,301	5,718	21,019
Dementia	4,307	299	4,606
Mental Health	6,622	2,821	9,443
Intermediate Care	20,414	15,381	35,795
Total Revenue	**46,644**	**24,219**	**70,863**
Capital Ring Fenced Grant	-	2,085	2,085

4.1.4 This would also change the risk sharing arrangements as follows:

	CCG Contribution %	Council Contribution %
Community and Primary Care	73	27
Dementia	93	7
Mental Health	70	30
Intermediate Care	57	43
Capital Ring Fenced Grant	0	100
Demographic Growth	66	34
Care Act	66	24
Performance Payment	100	0

4.1.5 The fund requires efficiencies to be realised to fund the council's demographic growth of £2 million and care act implementation funding of £964,000. The risk sharing arrangement is set out above if these effiencies are not identified by the workstreams. Detailed work is planned with the workstreams to identify how these efficiencies can be identified.

4.1.6 In addition receipt of a proportion of the BCF funding in 2015/16 is dependent on meeting the agreed performance targets, namely the reduction in the number of non-elective emergency admissions. The CCG is underwriting any non-achievement of the payment for performance in 2015/16. It should be noted that whilst in early months the target was not fully met, there is an opportunity to recoup the position over the rest of the year to mitigate the scale of the impact.

5.0 Legal implications

5.1 A Section 75 agreement is in place for the delivery of the BCF plan, which was approved in December 2014, and subsequently revised in August 2015.

5.2 Section 75 of the NHS Act 2006 (the "Act") allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority. The Act precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

6.0 Equalities implications

6.1 Each individual project within the work streams has identified any Equality implications, and a full Equality Impact Analysis has been carried at work stream level.

7.0 Environmental implications

7.1 Each individual project within the work streams will identify any Environmental implications, such as the need to review Estate for colocation of teams and services.

8.0 Human resources implications

8.1 Each individual project within the work streams will identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussion regarding potential HR issues such as integrated working and change of base for staff.

9.0 Corporate landlord implications

9.1 Each individual project within the work streams will identify implications

10.0 Schedule of background papers

10.1 None

The Royal Wolverhampton NHS Trust

New Cross Hospital

Quality Report

Wednesfield Road,
Wolverhampton,
West Midlands
WV10 0QP
Tel: 01902 307999
Website:
www.royalwolverhamptonhospitals.nhs.uk/

Date of inspection visit: 02 – 05 June 2015
Date of publication: 03/09/2015

This report describes our judgement of the quality of care at this hospital. 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 hospital	**Requires improvement**
Urgent and emergency services	Good
Medical care	Requires improvement
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection 02 to 05 June 2015. It was an announced comprehensive inspection. This trust had been inspected in the first wave of the comprehensive programme November 2013.

Our rationale for undertaking this inspection was to rate the trust because the initial inspections did not receive a rating due to being in the early wave one pilot programme. In addition to this the trust had taken over some services from the dissolved Mid Staffordshire NHS Trust, which included Cannock Chase Hospital.

The trust had previously stated its intention to become a Foundation trust, but had had to postpone the application a number of times; allowing them to address current matters such as the integration of new services appropriately.

We recognise that we saw this hospital, and the trust is a state of change. Integrating services between New Cross Hospital and Cannock Chase Hospital. We also noted some significant building work on the hospital site, including a new Urgent and Emergency Care unit.

We inspected all core services on the New Cross site; this included Urgent and Emergency Care; Medical Care, Surgical Care, Critical care, Maternity Services, Children's Services, End of Life care, Outpatients and Diagnostic Imaging.

Overall we rated the New Cross Hospital as Requires Improvement.

We rated Urgent and Emergency Care and Surgical Services as Good, we rates all other services are Requires Improvement.

We rated the hospital as Good for Effective, caring and Responsive; we rated the hospital as Requires Improvement for Safe and well Led.

Our key findings were as follows:

- Good services were provided by Urgent and Emergency Care. Safe systems were in place and the hospital was responding to the increase in demand by expanding the unit. In the interim; processes and procedures were effective.
- Good Services were provided by Surgical Services; care was delivered within national guidance and the trust was largely meeting the 18 week referral to treatment target.
- We saw good compliance with hand hygiene and with the trusts 'bare below the elbows' policy. We saw staff in outpatients remind visitors to use hand gel. On the occasions we saw non-compliance, we raised this with the clinical manager and it was immediately dealt with.
- We saw largely good and compassionate care within the hospital. Staff were focused on patient care.
- We did see a number of examples in medical care services that did not demonstrate the high standards of patient care set in other parts of the trust. These isolated examples demonstrated poor patient care.
- We saw nurse staffing levels sufficient for the needs of the service including Urgent and Emergency Care and Critical Care and Children's Care and Outpatients. However in Medical Care we saw staffing a challenge to meet the requirements of each shift. Staffing in Surgical Care was on the trusts risk register, although we saw the trust had taken action to recruit more staff.
- There were mainly sufficient medical staff to care for patients. Children's services and radiology had vacancies and the trust were aware of these.
- We saw sufficient equipment across the trust to meet the needs of patients, although in medical care services there was a concern about sufficient monitoring equipment.
- We saw that the trust was meeting cancer access targets and the 18 week referral to treatment times in outpatients and in many of its surgical specialities.

We saw several areas of outstanding practice including

Summary of findings

- The hospitals SimWard was being utilised to support staff competencies. Staff told us they were in the process of expanding the service externally to provide education and learning to other authorities.
- Doctors, nurses and therapists were provided with a stamp by the trust with their name and personal identification number. This enabled other staff to easily track who had completed the patient record when required.
- In surgical services, we saw that the trust recently instituted "In Charge" initiative was welcomed by patients and relatives. This was a badge worn by the person responsible for that shift on the ward.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.
- The "panel meeting" concept where senior trust staff provided high challenge and high support to wards managers after investigation of incidents. This meeting enabled staff to take the learnings from such events on board and ensure systems were put in pace to prevent reoccurrence.
- We saw that the mortuary staff were very passionate about delivering a high standard of care after death.

However, there were also areas of poor practice where the trust needs to make improvements.

Action the hospital MUST take to improve

Medicine

- The trust must improve the attitude and approach of some of its staff to patients in their care.
- The trust must improve the level of detail in patient care records, reflecting individual preferences.
- The trust must review the amount of monitoring and supporting equipment on its wards.

Surgery

- The trust must make sure that the recruitment of additional staff that was being undertaken to resolve the transportation of blood is completed in a timely manner.

Critical Care

- The trust must ensure that regular checks are recorded regarding the cleaning of equipment.
- The trust must ensure that locally owned risks are identified and recorded on the risk register and have appropriate actions to mitigate them, with timely reviews and updates.
- The trust must ensure the medicine room is locked to reduce the risk of unauthorised people accessing medicines.
- The trust must ensure that intravenous medicines are stored correctly to reduce the risk of the administration of incorrect medicines.
- The trust must ensure that the microbiologist input is recorded within the patient records to support their care and welfare.

End of Life Care

- Controlled medication must be labelled, prescribed to a patient and packaging must not be tampered with.

OPD and Diagnostics

- The trust must ensure that when controlled drugs are removed from the medicines cupboard in radiology, this is clearly documented at the time of administration.
- The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
- The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations

Summary of findings

Action the hospital SHOULD take to improve

Emergency Services

- The trust should improve staff understanding of the dementia care pathway for patients in the ED
- Medicine fridge temperature records in the ED should be recorded daily to ensure medicines were stored safely.
- Evidence of resuscitation status should be included in patient's records.
- ED staff take up of mandatory training should be improved.
- The trust should be clear about the use of the paediatric facilities in the ED
- The trust should improve public information about making a complaint in the ED

Medicine

- The trust should improve the attitude and approach of some of its staff to patients in their care.
- The trust should improve the level of detail in patient care records, reflecting individual preferences.
- The trust should review the amount of monitoring and supporting equipment on its wards.
- The trust should review arrangements for transferring patients to Cannock Chase Hospital late at night.

Surgery

- The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
- The trust should make sure that there are process in place to ensure formal "sign in" takes place in the anaesthetic room.
- The trust should make sure that a number of required policies and procedures identified from the national emergency laparotomy audit 2014 are put in place.
- The trust should make sure that patients with bowel cancer can access appropriate clinical nurse specialist.
- The trust should ensure there are resting seats available for vulnerable patients to avoid them to walk long intervals without resting.

Critical Care

- The trust should ensure there are procedures in place to record the checking of the resuscitation trolley.
- The trust should ensure that the trust's vision and strategy is cascaded to all staff.
- The trust should ensure that all policies and procedures are up to date and have been reviewed appropriately.

Maternity and Gynaecology

- The trust should improve the quality of record keeping in maternity.
- The trust should improve the checking of drugs and fridge temperatures where medicines are stored..
- The trust should ensure emergency equipment is readily available to use.

End of Life Care

- The trust might like to review staffing levels in particular on the oncology ward and surgical wards.
- The trust should develop clear guidance for staff on repositioning spinal cord compression and spinal cancer patients.
- Spinal cord compression and spinal cancer patients must be repositioned according to their assessment and trust policy. Staff should record incidents where appropriate.
- The hospital might like to improve on communication with families and better recording of their discussions with staff, ensuring discharge is consistently discussed and they are kept informed of patient's conditions.

OPD and Diagnostics

Summary of findings

- The trust should ensure that the renal unit complies with staffing requirements stipulated by the National Institute of Clinical Excellence.
- The trust should ensure that staff in radiology receives feedback in relation to shared learning and changes in practice resulting from incidents.
- The trust should ensure that call bells within radiology cubicles are fit for purpose and that there is clear signage outside x-ray rooms alerting patients not to enter and advising women to inform staff if they are pregnant.
- The trust should ensure that the procedure to check whether women are pregnant prior to receiving radiography tests is improved
- The trust should ensure that the nuclear medicine (imaging) service issues 'written instructions' to females who are breastfeeding and who have undergone a radio nuclide procedure.
- The trust should ensure that Local Diagnostic Reference Levels are available for the CT scanners (and other diagnostic procedures) and that CT radiographers have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended and how this should be reported.
- The trust should ensure that the clinical imaging protocols (operating procedures) are fit for purpose and that basic scan parameters are present that would allow an operator to follow and find operational information to be able to perform a scan safely and to check that recalled electronic settings within the scanning equipment is in concordance with the written protocol.
- The trust must ensure that the radiation risk assessments are fit for purpose and have enough specific detail for the radiation work undertaken in each area.
- The trust must ensure that there are Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
- The trust should ensure that paediatric reports within radiography are produced promptly.
- The trust should ensure that appointment letters and patient information leaflets are available in languages other than English.
- The trust should ensure that there is a method of monitoring whether patients have been present in outpatients or radiology for long periods to ensure they have adequate food and drink.
- The trust should ensure that patient feedback is received and acted upon in radiology to improve service provision.
- The trust should ensure that radioactive medicinal products and waste are securely stored and accounted for at all times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We found services provided by the ED overall were good. Safety systems were in place that supported incident reporting and learning from incidents, safeguarding children and adults and providing sufficient numbers of staff with the right skills to assess, treat and care for patients. Patient's care was planned and delivered in line with up to date guidelines and protocols. The ED checked its own performance regularly and took steps to improve on it if it was below standard or as a result of learning from incidents. There were good professional relationships between nurses and doctors and other specialist health and social care workers to support patients' needs and safe discharge. Staff were caring and responded compassionately to patients when they were in pain and were kind and warm towards patients and their relatives when they were upset and worried. Staff supported patient's dignity and privacy. The trust was responding to the increased need for emergency and urgent care services and working with local commissioners. The ED had not met national targets around seeing, treating and discharging patients within four hours but a new system had been put in place to help managers to improve the flow of patients through the ED and the wider hospital and avoid it becoming blocked at busy times. There were arrangements to make sure patients with particular needs were looked after such as children and people with mental poor health. Complaints were taken seriously, investigated and reported up to trust leaders. Staff learned from them. However, the complaints procedure was not readily available to patients in the ED. The ED was well supported by the rest of the trust, had strong local leadership and staff at all levels and roles worked as part of a team and enjoyed their jobs. There was an openness and willingness

Summary of findings

to learn from mistakes. Safety and quality was regularly reviewed and risk was managed. Staff and managers were also involved in planning the new emergency and urgent care centre.

Medical care

Requires improvement

Nurse recruitment within medical services was a known challenge for the trust. There were initiatives in place to recruit additional nurses but nursing staff shortages especially at night compromised patient safety. The trust policy, not to use agency nurses meant that shifts were frequently unfilled or the skill mix was inappropriate to meet patient's needs. Cardiology staff had particular concerns about how staffing was adversely affected when the day ward was open overnight which put cardiology patients at risk due to insufficient staff.

Incident reporting was established and was acted upon when needed; although staff felt staffing concerns were always adequately addressed.

Medical records were appropriately completed although nursing care records lacked detail and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. The availability of appropriate equipment used to monitor patient's observations was insufficient and caused staff concern and put patients at potential risk.

Care was provided in accordance with evidence-based and best practice guidelines. Care was monitored to show compliance with standards and there were good outcomes for patients. Seven days working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. Staff had access to training and had received annual appraisals.

Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed mostly kind and compassionate care although found not all staff appeared caring or compassionate.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the patients. We saw patient focussed approaches to care and treatment.

Summary of findings

Staff were positive about the standard of care they provided and the support they received from their managers. There was a culture of audit and improvement within the medical services.
There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been fully addressed and this had not been appropriately addressed by senior managers.

Surgery

Good

Patient safety was monitored on a daily basis and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.
The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place. The National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist.
Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.
The majority of patients were admitted, transferred or discharged in timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

Summary of findings

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and how to resolve these.

Critical care

Requires improvement

Critical care services required improvement to support safe care. There were significant risks posed by the infrastructure and environment of the integrated critical care unit (ICCU). Medical staffing was appropriate and there was good emergency cover. The storage of medicines in the integrated critical care unit (ICCU) required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines. We found intravenous medicines were mixed within the storage room visited which could lead to the misadministration of medicines to patients.
Staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control.
The critical care service demonstrated good effective care. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. The service participated and provided data for the Intensive Care National Audit & Research Centre (ICNARC). This ensured that the practice was benchmarked against similar services. Policies and procedures were accessible to staff. However, we saw that some hard copies of policies were dated 2007 to 2014 with no evidence of review. Staff told us they were able to access up to date policies on the trust's intranet system.
Patient's pain was appropriately managed as was the nutrition and hydration of patients. Staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service. Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Summary of findings

We observed good care within the ICCU. Staff cared for patients in a compassionate manner, with dignity and respect. They involved patients and, where appropriate, their relatives in the care. Emotional and spiritual support was also provided.
The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients had follow-up support from the outreach team.
Patients with a learning disability were provided with the necessary support. Staff also had access to translation services. Complaints were handled appropriately.
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We found that critical care services required improvement to be well-led. Most staff were not aware of the vision or strategy for the critical care service.
The ICCU held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register.
There was a culture of support and respect for each other, with staff willing to help each other. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.
Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.
Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Maternity and gynaecology	**Good**		Overall we found the service was good although the domain of safe required improvement. There were many good examples of the maternity unit being safe including incident reporting

systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans. However emergency arrangements needed to improve.
Obstetric consultant cover was not adequate being below the required hours for the number of births undertaken annually.
Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.
The birth to midwife ratio was 1:30. The named midwife model was in place and women told us they had a named midwife. Midwives provided one to one care in labour.
Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw limited patient information leaflets available.
In March 2013 the maternity service at the Royal Wolverhampton NHS Trust achieved compliance with level two requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2012/13, scoring 46 out of 50.
There was an active maternity services liaison committee (MSLC), which met quarterly.

Services for children and young people

Requires improvement

Overall we found the service required improvement.
We found that there was a reactive culture in the service which responded well after events had happened. They shared learning to prevent an event re-occurring and responded to issues which had been brought to their attention.
The service was less able to identify failings and prevent issues occurring in the first place.
We saw instances of unsafe practice in relation to services provided to children and young people both in the paediatric day-case unit and the fracture clinic. These were escalated and dealt with immediately, but the service failed to identify the risks themselves.
Similarly the Trust Development Agency (TDA) had completed a review of the paediatric ward earlier in

the year, they identified 77 minor issues. We saw evidence during our inspection that all the issues had been dealt with and interventions put in place to prevent them re-occurring, but again the issues were such that proper governance and supervision should have identified.
We found that services were caring and staff were dedicated and knowledgeable.
Services were based on recognised clinical pathways which meant patients received treatment based on the latest information and best practice guidance.
Patient care was individualised and designed to meet the physical and mental needs of each patient. The service responded to people's needs.

End of life care

Good

Out of the 94 incidents reported to the palliative team, we saw eight were in relation to low staffing levels. We noted some resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. However, they told us that the palliative team were aware of their pressures and were very supportive.
The palliative team were not solely responsible for end of life patients but they supported the medical and nursing teams in providing specialist advice.
We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Although improvement was needed to ensure that controlled medicines were safely and appropriately administered.
We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.
The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative members of the team were.

The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the advanced care plan, the 'practical information leaflet' and the feedback survey was redesigned to have the Swan logo.

The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.

We noted there was easy access to the palliative care team and they were responsive in supporting ward staff.

On both hospital sites the staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times and were able to discharge a patient with a complex package of care within 24 hours.

For both hospital sites the palliative team had a clear vision for their service. The leadership,

governance and culture promoted the delivery of high quality person centred care. The team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care. The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.
We saw the culture was a positive energetic one.

Outpatients and diagnostic imaging

Requires improvement

Overall the services within outpatients and diagnostic imaging services required improvement. Most of our concerns related to imaging within safety, effective, responsive and well led.
Outpatients was broadly satisfactory.
Within radiology there were concerns with the safety of signage, out of date clinical items and the management of controlled drugs. Clinical imaging protocols and risk assessments were not fit for purpose.
Staffing levels within the renal unit did not comply with NHS England and British Renal Society guidelines. Appointment letters and patient leaflets were only available in English. There was no method of monitoring the length of stay of patients within outpatients to ensure they were provided with food and drink.
There was not a clear vision and strategy within the outpatients and radiology departments. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.
Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to individual patient needs.

New Cross Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to New Cross Hospital

The Royal Wolverhampton Hospital NHS Trust is one of the largest acute and community trusts in the West Midlands. New Cross Hospital has more than 800 beds including 42 intensive care beds. This included 14 general beds, 14 cardiac beds and 14 neonatal intensive care beds. New Cross Hospital provides secondary and tertiary services, maternity, accident and emergency, critical care and outpatient services.

The trust employed over 8,000 with 6,700 staff providing a comprehensive range of services across New Cross Hospital.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were part of the team, they had experience of using services and caring for a person who used services.

Detailed findings

How we carried out this inspection

We analysed the information we held about the service, which included national data submissions and information which people had shared with us. In addition to this we reviewed the information the lead inspector had of the service.

We visited the service as part of an announced inspection. The trust had 12 weeks' notice of our inspection start date.

We spoke with patients and visitors and previous users of the service via listening events and specialist groups. We also spoke with staff both clinical and non-clinical staff. We also spoke the executive team about their roles and responsibilities strength and weaknesses of the trust. We spoke to staff individually and in focus groups arranged in advance and one arranged for the same day, as the demand to speak with the inspection team was high.

To reach out ratings we also reviewed documents in use at the time of the inspection and documents sent to us both pre and post the inspection, plus our observations of staff practice.

To get to the heart of people who use services' experience of care, 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?

We carried out an unannounced inspections between the dates of 08 to 19 June 2015.

Facts and data about New Cross Hospital

The Royal Wolverhampton Hospital NHS Trust is one of the largest acute and community trusts in the West Midlands. New Cross Hospital has more than 800 beds including 42 intensive care beds. New Cross Hospital provides secondary and tertiary services, maternity, accident and emergency, critical care and outpatient services.

The trust employed over 8,000 with 6,700 staff providing a comprehensive range of services across New Cross Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Inadequate	Good	Requires improvement	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Royal Wolverhampton NHS Trust is one of the Acute Trusts in the region. They provide a comprehensive range of district acute and specialist services for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire.

Wolverhampton is a multi-ethnic, multinational city and one of the most deprived local authorities. The deprivation is worse than the England average.

Emergency Department (ED) attendances across the trust from March 2014 to February 2015 were 153,315.

According to Trust Board performance report of April 2015, the ED continued to see increasing numbers of patients with attendances at year end 6.75% higher than last year. This equated to an additional 7,915 attendances at New Cross Hospital only and the total increase in attendances for 2014/15 (including Walk in Centres) was 10,735 (6.92%).

The emergency department includes a paediatric area. The ED was responsible for seeing and treating on average 75 children during a day.

The trust was in the process of completing construction of a new emergency and urgent care facility on the New Cross Hospital site at the time of our inspection and had taken over running the minor injuries unit at Cannock Chase Hospital in March 2015.

During our inspection, we spoke to approximately 50 people using the service and twenty staff in a variety of roles in the ED.

Summary of findings

We found services provided by the ED overall were good.

Safety systems were in place that supported incident reporting and learning from incidents, safeguarding children and adults and providing sufficient numbers of staff with the right skills to assess, treat and care for patients.

Patient's care was planned and delivered in line with up to date guidelines and protocols. The ED checked its own performance regularly and took steps to improve on it if it was below standard or as a result of learning from incidents. There were good professional relationships between nurses and doctors and other specialist health and social care workers to support patients' needs and safe discharge.

Staff were caring and responded compassionately to patients when they were in pain and were kind and warm towards patients and their relatives when they were upset and worried. Staff supported patient's dignity and privacy.

The trust was responding to the increased need for emergency and urgent care services and working with local commissioners. The ED had not met national targets around seeing, treating and discharging patients within four hours but a new system had been put in place to help managers to improve the flow of patients through the ED and the wider hospital and avoid it

Urgent and emergency services

becoming blocked at busy times. There were arrangements to make sure patients with particular needs were looked after such as children and people with mental poor health.

Complaints were taken seriously, investigated and reported up to trust leaders. Staff learned from them. However, the complaints procedure was not readily available to patients in the ED.

The ED was well supported by the rest of the trust, had strong local leadership and staff at all levels and roles worked as part of a team and enjoyed their jobs. There was an openness and willingness to learn from mistakes. Safety and quality was regularly reviewed and risk was managed. Staff and managers were also involved in planning the new emergency and urgent care centre.

Are urgent and emergency services safe?

Requires improvement

We found safety in the ED to require improvement.

There was an appropriate system in place to tell people when something had gone wrong with their care and openness and transparency about safety was encouraged. Incidents and errors were reported and investigated and lessons were learned and shared in order to improve safety.

There were processes in place to prevent infection and staff were generally compliant with them. Further improvements needed to be made around some aspects of infection control.

The trust had already recognised that improvement was needed in the completion of patient's documentation and we found some inconsistencies in the quality of records.

We found there were robust systems in place within ED, supported trust wide, for safeguarding children and babies. However systems for safeguarding vulnerable adults were not so visible although staff did understand their responsibility to respond to concerns.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe and there was a system in place to respond to staff shortages quickly without resorting to agency staff use. The ED was dependent on locum doctors and some nursing staff believed this had a negative impact on implementing a senior rapid assessment of patients.

The trust had already acknowledged that uptake of mandatory training by ED staff was poor.

There were systems in place to triage and prioritise patients quickly according to their condition and to monitor and manage the flow of patients around the ED for maximum safety in busy periods.

Nursing staff had the skills and experience to carry out their roles including treating children. There was a strong consultant presence in the ED including over weekends.

The trust had good systems in place to respond to emergencies and major situations and the role for the ED was well prepared and visible.

Urgent and emergency services

Incidents

- The ED department reported seven serious incidents requiring investigation to the NHS's Strategic Executive Information System (STEIS) between 1 April 2014 and 31 March 2015. These were two delayed diagnosis; two failures to act on test results; one attempted suicide; one critical care transfer and one grade 3 pressure ulcer.
- We asked to see the root cause analysis (RCA) for one of these incidents and noted that it had been carried out effectively and included an action plan for improvement.
- We noted a staff room notice board set out to keep ED staff informed of current RCA results and lessons learned. These included at the time of our visit a medication error and Methicillin-resistant Staphylococcus aureus (MRSA) as well as trust wide incidents shared learning.
- The trust had a policy and procedure for carrying out its legal duty to be open and candid with people where avoidable harm had occurred while they were receiving care and treatment and the system was well embedded within the Governance of the department.
- We tracked a sample of three recent such incidents through the electronic system that managed them, with an ED complaints officer. We noted that the process facilitated the trust's compliance with legal requirements in a timely way. We saw that RCA's included identified shortfalls in care, for example a grade 3 pressure ulcer analysis showed gaps in a care round on the ED and the Waterlow assessment score not recorded daily while the patient was in the Acute Medical Unit (AMU).
- These incidents were reported to ED Governance meetings and posted within the department for learning. We saw and heard evidence of this and noted, for example, that a new pathway to ensure that up to date poisons advice and guidance had been followed. This had been developed in ED as a result of an unexpected death from overdose.

Cleanliness, infection control and hygiene

- The trust had 51 toxin positive cases against a target of 38 for the whole year from March 2014 to March 2015.
- We noted infection control audit for the ED carried out by the trust in February 2015 found only 67% compliance for commode cleansing and a 50% compliance for the urinary catheter audit.
- The trust had policies for infection control and prevention and large bill board signs featuring the character 'Hans Klean' were displayed around the hospital to educate patients and visitors.
- We saw appropriate cubicles that were allocated for use for isolation when necessary including Ebola readiness.
- We noted that staff including consultants complied with the policy for being bare below the elbows and we saw most staff using gloves and aprons when they were treating patients.
- Hand washing facilities were provided at the point of care and most doctors and consultants that we observed used these before and after treating a patient.
- We did not observe much general hand cleansing as staff moved between different areas of the department or in and out of the main doors. However the hand hygiene audit for the ED carried out by the trust in February 2015 found 95% compliance among staff.
- The Trust Development Authority (TDA) carried out an infection control audit of the trust in February 2015 and found shortfalls against standards. The ED clinical lead told us that the ED had showed improvement since February to an average of 70% compliance.
- There was no clear invitation on display at the entrance to ED for people to cleanse their hands. The Hans Klean cartoon was obscured to incomers when the automatic entrance doors were opened by leavers which, was very frequently.
- We noted that there were bottles of hand cleanser on the reception desk at each of the three windows but we observed that patients did not use them. We heard one receptionist ask one patient to do so.
- We noted that the sharps audit for the ED carried out by the trust in February 2015 found 99% compliance.

Environment and equipment

- The trust had recognised that the current accommodation was too small to meet the demands placed upon it. They were building a new urgent and emergency care centre on site and anticipated it would open in November 2015.
- We noted that a temporary extension had been added to the existing ED footprint to provide eight further majors cubicles. This was spacious, bright and airy.

- The ED risk register identified a frequent lack of resources (capacity and staff) in the resuscitation area. During our visits this area was not busy so we could not make a judgement by observation about this.
- There was a clinical decisions unit (CDU) adjacent to the ED and this had seven cubicles with 24 hour access. The intention wasto have flexibility to provide a mix of trollies, chairs and beds according to patient's need. . We noted there were chairs in use for most patients but two were in beds.
- There was a separate paediatrics area with a waiting area separate to the main ED waiting area accessed by security pass. There were four dedicated paediatric examination cubicles and one resuscitation space. Staff told us that the short passage way connecting the adult minor's area to the paediatric area was a relatively recent modification to reduce the isolation of the paediatric services.
- We noted that this facility was not always used to treat children and we heard conflicting accounts about its use from staff and the trust including one senior nurse who told us it was too isolated from the rest of the department.
- We saw children; including a baby being treated in the adult's major's part of the ED during our visit.
- We saw appropriate resuscitation equipment around the ED and noted from records that it was checked regularly.
- The lighting was poor in the main reception area giving a gloomy atmosphere and further disabling people with visual impairment. By the end of our visit at 10pm on 4 June 2015 only nine of the twenty light bulbs in the ceiling fittings were working. We raised this with the trust before we left. We had assurances that this was going to be addressed promptly.
- We noted that the TV monitor used to inform patients of current waiting times was not working throughout our visit. We saw engineers in the department attempting to fix it on the morning of 4 June 2015 but reception staff later told us they had been unsuccessful.
- Nursing and clinical staff we spoke with raised no issues about shortages of equipment.
- We noted there were no pressure relieving mattresses on the trollies in the ED. A senior nurse told us that patients assessed as being at risk from pressure damage were turned 'regularly' by staff and if they were on a trolley for more than eight hours they were placed on a hospital bed.
- The trust subsequently told us there was one specific pressure reliving trolley mattress available in the ED. The remaining mattresses had variable pressure reliving properties ranging from medium to high risk.

Medicines

- The trust reported in March 2015 one medication error causing harm and this was in the ED.
- The Chief Pharmacist agreed that shared learning from medicine incidents needed to be strengthened which was a priority for the new trust level Medication Safety Group.
- An automated medicine control system was available to the ED which meant that nurses could control, dispense and manage medicines. A nurse explained that it was very easy to use and improved the time taken to obtain medicines to administer to patients.
- We found arrangements were not being followed to check the medicine refrigerator temperatures regularly. The pharmacy department had identified that medicine refrigerator monitoring across the trust was inconsistent.
- Fridge temperature records in the ED were not always recorded daily. However, the available records documented that the temperatures were within the safe storage range for medicines. We advised the ward manager who agreed that the records should be recorded daily to ensure medicines were stored safely.

Records

- The trust had a Health Records Policy and it carried out an audit of compliance for each quarter during 2014/15.
- The trust had recognised that the ED had achieved between only 26% to 56% compliance with this policy across a number of relevant questions asked by internal auditors.
- Action plans were put in place to improve this and report back to Governance by May 2015.
- We found a variable standard of documentation completion during our visit to the ED.
- We saw that sepsis documentation and also DNACPR in the resuscitation area had been completed fully for patients.
- However there was no evidence of resuscitation status having been discussed in at least five of the ten sets of records we looked at in the rest of majors. We noted that some entries including assessment scores had not been timed.

- Nursing assessments throughout ED were generally fully completed with, for example early warning scores, Waterlow and mobility assessments and hourly comfort rounds recorded.

Safeguarding

- The trust had policies and procedures that linked with the local authorities for the protection and safeguarding of children and vulnerable adults.
- Training in safeguarding children at level 1 and level 2 had a high compliance rate among all staff roles including consultants (over 86% and mostly 100% for trusts target at April 2015) from data provided to us by the trust.
- We were unable to assess from the data provided what compliance rates were for level 3 safeguarding children training as recommend by the Royal College of Nursing standards for an ED. The clinical lead told us that safeguarding children at level 3 stood at 73% across the department although doctors covered this as part of junior doctors training and consultants were up to date (with compliance)
- Safeguarding adults training at level 1 was 85% for medical staff and 100% for untrained nurses and clerical and administration staff at April 2015.
- We noted bruising on the arms of a frail elderly patient who arrived by ambulance waiting in the corridor for a cubicle to become available in the majors area of the ED. The nurse on duty to care for 'corridor patients' showed us that this had been noted in the assessment document that they had just completed of the patient. They told us they would mention it to the examining doctor who would make a judgement about whether the bruising was reasonable or untoward.
- However we didn't see any indication of a systematic prompt for considering a safeguarding referral and making a record of the decision on patients notes.
- Nurse managers in ED we spoke with were very clear about their safeguarding responsibilities and they were very positive about the support they received from the trust safeguarding team. 'We have a safeguarding specialist in domestic violence that does liaison with different agencies. There is also a learning disabilities team and we try to get them involved quickly. Safeguarding have merged teams now, all staff have been give explanatory leaflets. We do daily checks for child protection – we identify children who are at risk on the child protection register'.
- The ED saw between 70 and 80 children each day and had the highest rate of referral to children's social care services in the trust.
- We spoke with a paediatric nurse on duty in ED who showed us how staff access comprehensive information on safeguarding through the trusts intranet. They told us that doctors and nurses were trained to ask if a child had a social worker or was a cared for child but confirmed there were no specific prompts for this in the clerking proforma.

Mandatory training

- The ED clinical lead acknowledged that mandatory training in the ED was poor.
- For example for a trust target rate of 100%' infection prevention was at 90%; consultant compliance for moving and handling training was 0%; safeguarding children at level 3 stood at 73% across the department although doctors covered this as part of junior doctors training; consultants were up to date.
- We noted figures for April 2015 posted on the staff room notice board. These confirmed that compliance with safeguarding children training at level 3 for qualified nurses and junior doctors was 'red' risk rated. Safeguarding children training at level 2 was 'amber' risk rated for junior doctors as was basic life support at level 3 for qualified nurses. Compliance with moving and handling people was red risk rated for qualified nurses.

Assessing and responding to patient risk

- Between January 2013 to October 2014, there were a low number of ambulance handovers delayed over 30 minutes (in comparison to other trusts) in the winter period. However the ambulance time to initial assessment was worse than the England average at between five and ten minutes.
- Generally time to treatment was close to and just above the England average at 50 to 60 minutes.
- Between October 2013 and October 2014 the time to treatment for ED patients was generally just below the England average at 50 to 60 minutes, but peaked to match that average in January 2014, April 2014 and October 2014.
- Time to initial assessment and management of patients who arrived by ambulance for the same period varied. It was the same as the England average in the first quarter

of 2014 at about five minutes, then rose to a peak of eight minutes in the second quarter of 2014 and fell again to track the England average during the third quarter of 2014.

- All patients whose care and treatment journey we tracked were seen promptly by junior doctors but we saw no evidence in records of rapid assessment and treatment (RAT) by consultants. We noted within the draft RAT standard operating procedure that clinical staff had been identified to triage and treat patients. These were a support nurse, a triage nurse, a junior doctor and a senior doctor,
- Although there was a room with two cubicles set aside for this assessment we did not see them being used. Senior staff referred to 'roving rapid assessment; meaning that patients were assessed when they entered a cubicle for treatment, when we asked about this.
- Senior nurses told us that 'everyone was doing their own thing [with regard to RAT] because they were used to working at different places and there was no one consistent approach to RAT.
- However, as we did not see the ED during an extremely busy period, therefore we were unable to make a judgement about what this meant in practice.
- Streaming/triage arrangements were in place from the main waiting area of the ED. We observed patients being triaged and streamed into treatment according to priority in the minor or major's area.
- We also noted some patients being taken to the minor's area directly from the ambulance handover triage.
- Local leaders told us the ED responded to an incident of a deteriorating patient last year by establishing a system of rotation of patients within the major's area when it was busy. They said that there was some resistance to this practice from nurses and it was not yet consistent.
- A triage duty nurse was responsible for making sure that patients in cubicles were sicker than those in the corridor.
- We observed this system in practice as the department became busy on the Thursday evening that we visited and it appeared to be effective. We noted that patients who needed less close monitoring than others were sent to the majors number two area which was a short distance away from the hub of the ED.
- We noted there was an early warning tool in place to identify when a patient's condition was deteriorating.
- The department had escalation procedures in place and medical staff we spoke with understood the early warning score system and how to escalate.
- However we found no standardised or documented response to changes in the early warning score. 'Track and Trigger' protocol was not implemented in the ED.
- We noted figures for April 2015 posted on the staff room notice board that compliance with paediatric basic life support training for junior doctors was 'red' risk rated, as was basic life support at level 3 for qualified nurses.

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Nursing staffing

- We observed an effective bed handover in the ED from a senior sister to the nurse in charge of the shift.
- Local leaders told us that the ED employed 110 nursing staff and they used an electronic rostering system.
- We viewed the daily workbook and noted that nurses were allocated to areas within the department.
- On the afternoon of one day of our visits we noted that 13 qualified nurses were on duty for the late shift, three were on duty for the middle shift of 10am to 10pm and one was on from 12pm to 12am.
- Nurses were supported by five health care assistants on the late shift and one working 10am to 10pm.
- One qualified nurse was rostered to care for up to six patients should they be waiting in the corridor because the majors stream was busy. The clinical lead told us this number could be increased if necessary within the shift allocation up to nine patients and thereafter staff would be 'pulled in to work'.
- Within the majors one stream one registered nurse was allocated to three cubicles and a staff nurse was working on 'trolley triage'
- We noted when we visited the paediatrics area at 8pm that a senior nurse from the adults minors area was 'looking after it' while the rostered nurse was on a break.
- The senior nurse told us she was 'mainly on minors' but was a paediatrics' nurse with advanced paediatric life support training. We were told the senior sister on duty that night also had advanced paediatric life support training.
- The trust told us that although the paediatric area is open 7 days a week, 24 hours a day, the qualified nursing cover is from 0945hrs – 2200hrs with the nurse allocated to the minor injuries area covering paediatrics from 2200hrs until 0945hrs.

- The trust said that although it strived to have a paediatric nurse on shift each day, staffing levels at the time of our inspection and number of paediatric nurses available to the roster meant this was not always possible.
- The ED could not always allocate the paediatric nurse who was on shift, to the paediatric area, they may be allocated to the resus area. Therefore, they did not have a paediatric nurse on duty within the ED 24/7 at that time but local leaders expressed this as the ideal. However nursing staff attended from the paediatric ward and the Paediatric Assessment Unit (PAU) when needed. In addition to this the PAU and children's ward staff undertake a three month rotation in ED to maintain and upgrade skills. We noted the minor's stream was led by emergency nurse practitioners supported by junior doctors and an associate specialist.
- The clinical director told us the ED used only nurse bank staff and not agency nurses. There was a system of processes, checks and balances in place for monitoring the number of hours worked by nursing staff who requested bank shifts for safety. Local senior leaders expressed confidence in it.
- Senior nurses told us that despite the bank sometimes they found it difficult to fill shifts. On one day of our visit they reported that they were short of one nurse. Our observations were that there appeared to be sufficient staff on duty to meet the needs of the patients at that time.

Medical staffing

- There was a named consultant paediatrician for the ED three days per week.
- The ED clinical lead told us one of the strengths of the department was having consultants working on the floor and not in offices, this prevented unnecessary admissions. The current difficulty was recruitment.
- The establishment was up to 12 consultants. There were six whole time equivalent adult consultants; two paediatric emergency medicine consultants and four locums each with over six months service at the trust.
- Some local nursing leaders told us there were a lot of locum consultant shifts and locums did not always feel committed to the department, 'this is one of the reasons why the Rapid Assessment and Treatment (RAT) isn't working'.
- Junior doctors confirmed that consultants were on site until 2 am and back at 8 am on week days, and from 9am to 6pm, 10 am to 10pm or 6pm to 2 am on Saturday and Sunday, depending on their shift. During weekends, consultants are on call between 2 am and 9 am. "they are on call in between and paediatrics consultants will always come down".
- Capacity managers told us they had good discharge rates at weekends as there was a high consultant presence at weekends.
- ED consultants told us that New Cross Hospital ED was much better staffed with consultants than other hospitals they had worked in within the region.

Major incident awareness and training

- We noted that there were highly visible arrangements for major incidents and public emergencies (MAJAX) in place throughout the department. The 'silver command' control room was based in the ED.
- Staff regularly checked equipment, and pathways, action cards and specific information were available to them on the ED intranet pages. Staff we spoke with understood these arrangements
- Receptionist staff told us security arrangements were in place to lock down the ED if necessary from a panic button at the desk. They told us security staff responded to support them when they needed it.
- All staff and patients carried a security tag for safety. This allowed a software system to track them in most parts of the hospital and create an alert in a security situation.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We found services in the ED were effective.

People's care was planned and delivered in line with current evidence based guidelines and protocols were improved as necessary when a poor outcome had occurred or from national and local audit results.

Standardised systems were in place to triage and assess people's needs and their care and treatment was regularly reviewed and updated. Assessment was supported by a mental health crisis team based in the ED.

Staff were qualified and had the skills they needed to carry out their roles including minor surgery and the emergency treatment of children and people with complex acute medical conditions. There were systems in place to support and develop staff.

There were positive professional relationships between nurses and doctors and good multidisciplinary working. Patient flow managers worked within the integrated health and social care team alongside social workers.

Staff had easy access to the information they needed to care for and treat patients effectively and patient consent was embedded in staff practice.

Evidence-based care and treatment

- The ED had clinical guidelines and protocols easily available to staff on its intranet webpage. They included paediatric and CDU pathways. Staff showed us how to access these.
- The ED had a consultant lead for audit and had participated in a number of national, local and NICE audits during 2014.
- Audits in progress within the ED at the time of our inspection were College of Emergency Medicine (CEM) Asthma (children) Audit; CEM Mental Health; CEM Fitting Child; Audit of CG112 on Sedation in Children in the ED.
- Local audits were also undertaken for example Safe Sedation in ED: Compliance with trust and joint Royal College of Anaesthetists (RCOA)/CEM) guidelines was also in progress.
- The sepsis audit for 2014/15 in which the trust had participated showed poor results at that time. The consultant lead told us that action had been taken to improve safety. A new paper flow chart and pathway had been introduced to guide staff. A newly employed member to the team was able to show us where it was and talk us through it.
- Staff told us sepsis was now addressed early to avoid intensive care unit admission, 'we were slow in recognising sepsis, now we can prioritise patients.'
- A re audit subsequently carried out by the trust showed improvement in most areas of care and treatment, for example the administration of antibiotics had improved. Against a standard of 50% in 1 hour, only 16% had been achieved in 2013/14 and for 2014/15 this had improved to 38%. Against the standard of 100% before leaving, 80% was achieved 2013/14 increased now to 92% in 2014/15.
- We observed in the management of sepsis for a patient that the sepsis documentation was completed with early administration of antibiotics provided.
- We noted the stroke pathway was particularly effective, with stroke consultants responding rapidly to the ED and enabling treatment to begin quickly.
- The renal colic pathway had been improved and consultants told us this had resulted in sending the patients more likely to actually have stones for diagnostic scans.
- We observed patient hand over to the triage nurse from ambulance crew. The ED used a standardised triage system which included the patient's medical history, analgesia and discussion to establish pain score and observations were recorded. This data was put into the ED software system and was available to any staff treating the patient.

Pain relief

- We noted that pain was assessed in children by using the smiley face system. Staff told us this was the same system used by the paediatric department in the hospital to ensure consistency. Teenagers were asked to rate pain on a scale of 1 to 10.
- We noted the results of the recent nursing documentation audit reported a compliance rate of 95% for pain scores.

Nutrition and hydration

- A senior nurse told us that the department had recently trialled a trolley service for patients refreshments and has now ordered a beverage trolley. Nurses conduct hourly comfort rounds and will obtain food if required.
- A senior nurse told us that each day between 8am and 4pm, a ward assistant went around the ED
- However, during our evening visit of 4 June 2015 we did not observe any patient being offered food or drink. We did see some patients given food and drink in the major's area when they asked for it.

Patient outcomes

- In-hospital mortality figures for May 2013 to April 2014 showed conditions associated with mental health to be a risk factor for this trust. Staff told us crisis team was based in the hospital from 8am until 10pm and the aim was to see mental health patients in ED within 1 hour during these times.
- The ED responded to learning from an incident involving an overdose by developing a pathway to reduce error in relation to toxic substances. We observed this in use during our visit.
- We noted local audits were undertaken in the ED. For example we saw that recent nursing documentation audit had been carried out by a Band 6 nurse. They told us this showed improvement in recording of standard assessments and observations from the previous audit.
- The ED had participated in a number of national audits during 2014/15 and we noted it had an audit plan.
- The number of unplanned readmittance to the ED within seven days of being discharged was consistently just higher than the England average of about 7.5% during 2014/15. However it peaked to 9% in July 2014 and in January 2015.
- We asked consultants how the ED re attendance rate was being addressed by the trust. They told us that analyses had been undertaken but no particular factors had been so far identified.
- There was a system in place to ensure all potential admissions to wards from the ED were seen by a consultant in order to try to reduce admissions.
- The number of patients who left the ED without being seen was lower than the England average of 3% between October 2014 and February 2015.

Competent staff

- The ED had four Band 7 nurses and 25 Band 6 nurses.
- There were six whole time equivalent Band 6 RSCN (children's nurses) on its establishment and the paediatrics nurses in the hospital did a rotation through the ED.
- We noted a paediatric trained nurse on duty when we visited including in the evening and overnight, however local leaders told us that it was not always possible to roster paediatric trained nurses on duty in the ED.
- The ED had two associate specialists in emergency medicine.
- Consultants worked alongside nurses and this included an acute medicine specialist and a paediatric specialist.
- The ED carried out its own minor surgical procedures and this helped to reduce demand for

orthopaedic work and speeded up the patient journey. For example hand and finger injuries.

- The clinical lead acknowledged that annual appraisal rates in the ED were poor against the target of 100%. Nursing staff had achieved only 70% compliance. There had been a 'big push' with medical staff and that stood at about 90% compliance.
- Band 7 nurses had their own teams of nurses for supervision and appraisal. Junior doctors said they received good supervision and support from seniors and consultants.
- There was a Band 7 and 8 nursing, midwifery and health visitor forum in place within the trust to provide opportunities for supporting and mentoring these managers. We noted that the April 2015 meeting had no representation from the ED.

Multidisciplinary working

- We noted effective integration with the rest of the hospital. For example we observed one patient presented to ED with headache and weakness, they were received by an ED consultant and had a scan within ten minutes. They were then received by a stroke consultant and Thrombolysis (treatment to prevent blood clotting) was started in the ED within 20 minutes.
- Senior nurses told us the ED had a good grasp of the availability of beds and resources to best plan for patient treatment.
- Senior nurses told us they had a good and effective relationship with the mental health team.
- There was an acute medicine consultant working within the ED whose role was to expedite and avoid admissions.
- Patient flow managers worked within the integrated health and social care team alongside social workers. They told us this provided them with 'opportunities for creative thinking around the discharge of patients'.

Seven-day services

- ED staff told us that speciality consultants, registrars and specialist nurses provided a consistent, responsive service 24 hours a day and seven days a week.
- Senior nurses told us there was good senior medical cover out of hours and at weekends.

- The paediatrics area of the ED was available seven days a week.

Access to information

- Staff had access to patient's information and treatment activity through an electronic system.
- We noted there were also paper records completed. We found notes made by one consultant in the minor's stream were not legible and a junior doctor attending confirmed this. The information had been handed over and discussed verbally between them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff demonstrated to us the trust web site safeguarding adult pages provided clear and easy to access information about MCA and DoLS.
- We noted that a formal consent process was embedded within procedures throughout the ED for example, for minor operation such as abscess incision.

Are urgent and emergency services caring?

Good

We found services in the ED were caring.

Every patient or relative we spoke with was very positive about the way staff in all roles had responded to them. Staff responded compassionately to people when they were in pain and were kind and warm towards people when they were upset and worried.

People's privacy and dignity was respected including when they had to wait on trollies in the corridor or when they challenged the service by their behaviour.

Staff helped people and those close to them to cope emotionally with their care and treatment and gave them time and attention.

Compassionate care

- We observed throughout the ED that patients were given appropriate privacy with curtains, screens and blankets. For example we saw staff preserve the privacy and dignity of one very drunk patient in resuscitation during clean up and examination.
- We saw and heard many positive examples of staff at all levels and roles treating patients and their relatives with kindness across the two days of our visit throughout the ED. We also sat in the main waiting area for 40 minutes during one afternoon observing staff interactions with patients.
- We noted reception staff were friendly and took time with and were focussed on patients when they arrived. We saw a senior local leader physically comfort a patient who arrived in a state of fear and anxiety.
- We tracked a patient with a hand injury through their treatment pathway and they told us that staff were very careful not to cause them further pain when they examined and dressed the wound.
- We noted that staff were patient and supportive of a person who presented with mental ill health while ensuring their challenging behaviour did not have an impact on others.
- We saw children being treated with warmth and interest and spoken to at a level that matched their understanding.
- We also noted however that initial contact with their patients varied in quality among some triage nurses. Some staff greeted some patients warmly when they called them into the consulting rooms and invited them to sit down. But other patients were not warmly greeted, given eye contact or invited to sit. Staff resumed their own seat in front of the computer monitor after opening the door and expected the patient to know what to do, including to close the door behind them.
- We heard a consultant sensitively discussing end of life care with a family.

- The Care Quality Commission patient survey found patients experience of using the ED in 2014 was 'about the same' as most other trusts that took part in the survey.
- Low response rates were common for Friends and Family test (FFT) in ED's. However the response rate for the ED at New Cross Hospital in the friends and family test in March 2015 was higher than the England average (22.9%) at 26.3%.
- Data shared with us by the trust showed there had been an almost consistent decline in the number of respondents recommending the ED service from 94% in

December 2013 to 84% in November 2014 with a sharp drop to less than 81% in September 2014. There was no analysis to investigate this apparent decline in satisfaction.

- During our visit we noted a large notice publicising the FFT which was slightly obscured at the entrance to the ED from the main corridor. There was a pile of FFT response cards beside each receptionist's window.
- We saw one receptionist prompt a patient to complete a card by handing it to them when they booked in. Otherwise we saw no patients pick up a card. We looked in the comment card box on two successive days of our visit and noted there was only one card in it.
- Data that we saw posted on the staff room notice board showed the April 2015 FFT results as 83% recommending the service and 9% not recommending it out of a total response of 1,471 (attendance figures for April 2015 indicated that approximately 2300 people used the ED each week).

Understanding and involvement of patients and those close to them

- Relatives of patients we spoke with told us they were satisfied with the care provided by the ED.
- We saw relatives being involved in discharge plans of patients and compassionate discussion between a consultant and relatives about end of life care for a patient with dementia.

Emotional support

- Local leaders told us ED patients received emotional support from the nursing and medical team whilst they were in the ED. If there were other requirements the ED had access to the trust bereavement service, chaplaincy service, PALS, psychiatric services, social workers, safeguarding services and alcohol / drug liaison service.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

We found services in the ED were responsive.

The trust was responding to the increased need for emergency and urgent care services and working with local commissioners to include primary health care access.

Social care was integrated with health care to improve patient flow from the ED through the hospital and collaborate in appropriate discharge arrangements for patients with complex ongoing needs.

Paediatric emergency services were provided on site but there was a lack of clarity about the use made of the separate accommodation and facilities that were available for treating children. There were facilities for specialist eye treatment, end of life care and for people experiencing significant mental ill health. Systems to identify and support patients with dementia through the ED were not well embedded.

The trust had not met the national target of treating, admitting discharging 95% of patients within four hours of attendance at the ED for the six months October 2014 to March 2015. A new system had been put in place to better support capacity managers to improve the flow of patients through the ED and the wider hospital.

The ED had good systems in place to handle concerns and complaints and to learn from them. Access to the complaint procedure was not very visible to patients in the department however.

Service planning and delivery to meet the needs of local people

- The trust was in the process of building a new urgent and emergency care centre on the New Cross Hospital site. This was to include primary health care and an urgent care centre.
- . The health and social care manager was part of the emergency services group which included the ED.
- Patient flow managers told us that a capacity team member and a social worker reviewed each delayed transfer of care to make a daily plan towards discharging the patient.
- There was a step down to a nursing home arrangement in place and this could be funded for a patient for up to six weeks.
- The trust provided a walk in centre in a different part of Wolverhampton and this referred patients to the ED at New Cross Hospital if they needed treatment it could not provide.

- Patients referred by their GP were admitted directly to the Acute Medical Unit and by passed the ED.
- There was a specialist eye treatment service with its own consulting room within the ED.

Meeting people's individual needs

- The ED risk register identified as a 'yellow' risk a need for more paediatric resources in the unit 'to enable meeting CQC and OFSTED guidelines'.
- We found that ED had a paediatric area including waiting area, treatment rooms and resuscitation. It did not have its own reception.
- We observed that it was used some times and not others during our visits and on one afternoon we saw a child and a baby being treated in the adult's major's area.
- We found staff had conflicting perceptions about the paediatrics ED area. ED leaders told us it was used and staffed constantly. Some senior nurses told us it was not often used because it felt isolated from the hub of ED and children were often treated in the minor's area instead.
- When we asked senior nurses later about a child and a baby being treated in the adult's majors area they assumed at first we were mistaken and then said it 'probably' happened because they needed close monitoring.
- The trust told us that paediatric trained staff were not always on duty 24/7 in the ED although that was the intention. Also if rostered to the ED they were not always available to the paediatrics area.
- The paediatrics waiting area was also used by parents with children while they waited for their own care within the minors ED. It was secure from the main ED waiting room and provided toys.
- The mental health liaison team was based on site and available from 8am to 10pm, seven days a week and provided a service to the ED and wards. Out of hours the mental health team were contactable through Penn Hospital. The crisis team was based in the health and social care team office .
- We noted there was a 'quiet' room designated for patients who presented in a state of high anxiety or distress while they waited for mental health assessment. The room was designed to be a safe environment physically and included a panic strip.
- Senior nurses told us there was good domestic violence support to the ED and staff awareness was high.
- There was a private viewing room for families of patients who had died and this was set up in keeping with the trust's approach to end of life care.
- Staff confirmed they had access to a language line service.
- The ED was very well served with a good quality information displayed on the walls explaining the function of each part of the service. All of this information was written in English only. We noted on a number of visits to the ED waiting area over three days that people from a broad range of ethnic origin and nationality reflecting the current population of Wolverhampton, were accessing the service.
- The trust had a learning disabilities specialist team on site and ED staff reported they received good support from this team when they needed it.
- For one patient with dementia whose care pathway we tracked to the Acute Medical Unit (AMU), we noted that the dementia bundle had not been completed in ED. We asked the nurse on duty in the AMU at the time about this but they had not noticed its absence.
- Local leaders told us that dementia awareness nurses in the trust ran study days. Nurses assess through triage whether a patient may have dementia but there was no system for identifying these patients immediately to staff throughout their treatment and care pathway.

Access and flow

- The Care Quality Commission A&E survey of October 2014 found in response to the question 'overall, how long did your visit to the A&E Department last? Patients of New Cross Hospital ED reported better experience than other trusts.
- When we visited the ED on the evening of 4 June 2014 at 8pm there were five ambulance crews waiting to transfer patients into the major's area and there were no available cubicles at that time. There was a duty triage nurse managing the patient flow through cubicles in major's area one and two and the minor's area if applicable.
- The trust had an electronic system in place to monitor and analyse the flow of patients through the ED department and the wider hospital. This data could be accessed by staff throughout the department and in the capacity management team situated in a different part of the hospital.
- Between April 2014 and March 2015 there had been delays in the handover of patients to the ED from

ambulance staff of between 30 and 60 minutes each month. For ten months there had been greater than forty delays with a peak in January 2015 of 103 and a drop in February to 11 delays. The number returned to over 40 in March 2015.

- For the same period there had been delays in the handover of patients to the ED from ambulance staff of over 60 minutes during six months peaking at 13 in November 2014, 21 in December 2014 and 29 in January 2015. Other months were below four, which was broadly in line with the national average.

We reviewed documents from the trust which demonstrated a 3-4% increase in the number of ambulance attendance comparing January to June 2014 and 2015

- The trust had not met the national target of treating, admitting discharging 95% of patients within four hours of attendance for the six months October 2014 to March 2015. April to June 2015 we saw the trust met the target for April and missed the target by one and two percent for the following two months.
- There were no trolleys waits (patients waiting over 12 hours from decision to admit to admission) from April 2014 to March 2015. Senior staff told us that only on one recent occasion (January 2015) the CDU had been used for the overflow of E D medical patients.
- We noted by 8.15pm on our visit of the evening of 4 June 2015 there had been eight breaches of the national four hour target.
- The on-screen trust analysis in the ED showed the reasons for the breaches were: unwell, overdose ANC (clinical need) first assessment, admission avoidance, three clinical needs, one for change of condition and psychiatric liaison.
- Staff told us there were 56 patients in the ED at that time. We observed the ED was starting to use the corridor at that point, two patients were there. Throughout the evening until 10pm we saw no more than three patients waiting in the corridor at any one time.
- There was a duty triage nurse reviewing and controlling the flow of patients from the corridor where they were assessed by a staff nurse and into cubicles to be seen by doctors as soon as a cubicle became free. This kept the waiting time in the corridor to a minimum.
- The number of patients leaving the ED without being seen was almost consistently below the England average from October 2014 and January 2015 at between 2% and 3% with a decrease to about1% in February 2015.
- The number of ED attendances resulting in an admission had risen by just over 2% from 2013/14 but remained well below (5%) the England average (that remained broadly the same for 2013/14 and 2014/15).
- We followed the journey of five patients on the evening of 4 June 2015. They had presented to the ED earlier that day.
- We found their records showed that they waited on average 30 minutes for a junior medical assessment. Three patients were admitted to the AMU, two of which were discharged from there later in the day.
- Three patients admitted that day waited on average over three hours to see a consultant.
- There was a patient flow manager on duty in the hospital 24hours a day and seven days each week. Patient flow was managed from a control room in a different part of the hospital. As part of an integrated health and social care team, the office space was shared with social workers.
- We spent some time with a patient flow manager, who was a clinician, on duty on the evening of 4 June 2015. They worked closely with the ED shift flow manager to prevent blockage in ED.
- We observed a new interactive tele tracking bed management system in action. Staff told us that this had been in place for five weeks and the paper system would be phased out. At the time of our visit the two systems were running together to provide real time information on bed state and capacity within the whole hospital.
- A software bracelet system was in place. Worn by every patient, it meant their care and treatment journey could be tracked from admission through to discharge. When the bracelet was removed into a box on discharge this triggered and tracked a series of actions, including cleaning, that led to the bed being free for a waiting patient in ED.
- The trust planned to make this real time information available on screen to all wards and this meant that the whole hospital was engaged with keeping the ED flowing.
- A number of capacity meetings were held each day attended by the chief operating officer, to assess the

flow situation and we observed one. Staff told us that at weekends a meeting was held at 12 noon and included consultants, the sister in charge of ED, the on call duty manager, a member of the executive team and a capacity manager.

Learning from complaints and concerns

- The ED had a dedicated complaints officer working within the governance team. We tracked three recent complaints and noted there was a time targeted procedure for responding to them and this was tracked by an electronic system with prompts.
- We looked at an agenda for the May 2015 Governance meeting and noted that five complaints were tabled for discussion.
- Lessons learned from one complaint that was also reported as an incident led to the development of a new overdose pathway in the ED. We saw this used in practice in the ED major's area.
- We observed in the control room during our evening visit, the senior matron pro-actively dealing by phone with a concern raised by a relative about an inpatient. The patient flow manager told us that they would take any complaint or concern that came in overnight and escalate it to the on call matron if they could not resolve it.
- We noted on the shared learning notice board in the ED staff room four complaints that had been received during April 2015, the department's response and the lessons learned.
- We did not see any conspicuous invitation around the ED for patients to share their concerns about the service or raise a complaint through the procedure.

Are urgent and emergency services well-led?

Good

We found the ED was well led.

There was clear vision and values driven by quality and safety that staff understood. Staff and managers were also focussed on and involved in planning the new emergency and urgent care centre.

Safety and quality was regularly reviewed and risk was managed by good governance arrangements.

The ED was well supported by the rest of the trust, had strong local leadership and there were good professional relationships. Staff at all levels and roles worked as part of a team and enjoyed their jobs. There was a culture of openness and willingness to learn from mistakes.

An interactive patient tracking system was being embedded at the time of our inspection and this innovation engaged the whole hospital system in addressing the challenges faced by the increasing public demands being made on the ED.

Vision and strategy for this service

- The trust was constructing a new emergency and urgent care centre on site at New Cross Hospital. All staff we spoke with were aware of the plans and said they had been consulted about its design and purpose.
- We found staff were very focused on and enthusiastic about the prospect of improved service delivery through the new facility.
- The acute medicine consultant told us the trust had good plans for integration with acute medicine and the ED to maximise ambulatory care in the new emergency and urgent care centre.
- The trust took responsibility for providing services at the minor injuries unit in Cannock Chase Hospital from 1 March 2015. It was unclear to staff we spoke with at New Cross how these two services would work together.

Governance, risk management and quality measurement

- The ED held a monthly Governance meeting where incidents, complaints, Duty of Candour issues, staffing levels and clinical audit outcomes were reviewed and discussed.
- We found that although clinical audit action plans had resulted in improvements in practice for example over sepsis, staff 'on the shop floor' did not always seem aware of this.
- Junior nursing staff were involved in undertaking local audits such as nursing documentation quality.
- We found that three of the ten ED consultants took responsibility for all head injury care including inpatients and some post neurosurgical rehabilitation and review clinic follow-up. They told us that no arrangements were in place to avoid consultants being taken out of the ED to carry out these duties.

- There was a system of checks and balances on the number of bank (overtime) shifts that staff could undertake.
- The ED department appeared to cope well with the 75% increase in ambulance attendance for the first six months of 2015. The trust had not met the four hour wait target five times but had done so for April. The percentage of people who had been seen and treated within the four hour target ranged from 90-94% for the five months it did not meet the target.

Leadership of service

- The ED directorate was led by a clinical director, group manager and a matron. The emergency department was part of the emergency services group which also included an integrated health and social care team. This team included five 24 hours patient flow managers working together with social workers
- The ED was led by a charge nurse, a unit manager and four senior sisters. The unit manager's post was vacant at the time of our inspection and it was being recruited to.
- Departmental leaders said the ED had good support from the executive and senior leaders.
- Leadership at a local level seemed effective and staff said they felt supported. Nursing and medical staff told us they enjoyed their work. We observed good professional relationships between staff in all roles.
- Junior nursing staff told us they felt 'part of the team', for example they were included in newsletters and email about departmental issues and involved in team building exercises such as a Go Karting event. They said all staff were approachable and listened to them.

Culture within the service

- The ED had an open culture which enabled learning from error. We observed that nursing and medical staff worked well together in effective team work and respected each other. Junior and trainee staff said they received support from seniors. Staff attended focus groups during our visit and told us about the open and supportive culture.

Public engagement

- We noted the Friends and Family Test cards in the ED main waiting area were not being taken up by patients and staff were not promoting their use.

Staff engagement

- Although the response rate was low for the trust overall, the ED services staff score for the 'Chatback' was just above trust target (70%+ agreement), representing an improvement from 2014.
- The ED team was nominated for a trust award for outstanding teamwork. Staff confirmed that they had opportunities to become involved with the new emergency and urgent care centre development project through project groups. One Band 7 nurse had been seconded to the project.

Innovation, improvement and sustainability

- A new interactive tele tracking bed management system had been put in place five weeks before our visit. It provided real time information on bed state and capacity within the whole hospital. The information would be available on screen to all wards and this meant that the whole hospital was engaged with keeping the ED flowing.

Medical care (including older people's care)

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

Information about the service

The Royal Wolverhampton NHS Trust had between July 2013 and June 2014, the Royal Wolverhampton NHS Trust received 48,737 medical admissions.

Medicine specialities included elderly care, diabetes, respiratory medicine, renal medicine, gastroenterology, haematology and oncology. The Trust had an acute medical unit (AMU) which incorporated a 48 bedded ward and an acute ambulatory unit. In this report we will also report on cardiology which was managed by the trust within a separate division. The Royal Wolverhampton NHS Trust provided medical care on three hospital sites: New Cross Hospital, Cannock Chase Hospital and West Park Hospitals. Cannock Chase Hospital and West Park Hospitals are reported on in separate reports.

Both stroke thrombolysis and primary percutaneous coronary intervention were delivered 24 hours a day, seven days a week at New Cross Hospital.

During our inspection, we visited fifteen medical wards including: A7 and A8 (elderly care), B7 (general medical ward), B12 (stroke ward), B14 (cardiology day and overnight ward and catheter laboratory), C21 (acute medical unit), C22 (dementia ward), C18 and C19 (respiratory), C15 and C16 (diabetes), C24 and C25 (renal), C41 (gastroenterology). The oncology/haematology wards Deanesly Ward and Clinical Haematology Unit (B11) were inspected by the end of life team and will be reported within the end of life section of the report.

The CQC inspection of medical services was undertaken announced between 2 and 5 of June 2015, we also [illegible] unannounced on 15 June 2015. We spoke with over 110 members of staff, including nurses, doctors, therapists, healthcare assistants and housekeepers. We spoke with 54 patients and 13 relatives. We reviewed 55 care records and observed interactions between staff and patients. We attended nursing and medical handovers and multidisciplinary team meetings. We held focus groups which were also attended by staff working within medicine.

Medical care (including older people's care)

Summary of findings

Nurse recruitment within medical services was a known challenge for the trust. There were initiatives in place to recruit additional nurses but nursing staff shortages especially at night compromised patient safety. The trust policy, not to use agency nurses meant that shifts were frequently unfilled or the skill mix was inappropriate to meet patient's needs. Cardiology staff had particular concerns about how staffing was adversely affected when the day ward was open overnight which put cardiology patients at risk due to insufficient staff.

Incident reporting was established and was acted upon when needed; although staff felt staffing concerns were always adequately addressed.

Medical records were appropriately completed although nursing care records lacked detail and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. The availability of appropriate equipment used to monitor patient's observations was insufficient and caused staff concern and put patients at potential risk.

Care was provided in accordance with evidence-based and best practice guidelines. Care was monitored to show compliance with standards and there were good outcomes for patients. Seven days working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. Staff had access to training and had received annual appraisals.

Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed mostly kind and compassionate care although found not all staff appeared caring or compassionate.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the patients. We saw patient focussed approaches to care and treatment.

Staff were positive about the standard of care they provided and the support they received from their managers. There was a culture of audit and improvement within the medical services.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been fully addressed and this had not been appropriately addressed by senior managers.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We judged that this domain was inadequate people were not adequately protected from avoidable harm. Nurse recruitment within medical services was identified as a challenge for the trust. There were initiatives in place to recruit additional nurses including overseas nurse recruitment. However we found continuing nursing staff shortages especially at night which compromised patient safety. The trust policy was to use agency for specialist provision such as patients requiring mental health support. Where that provision was not required bank staff were used, but this was not always the case and impacted negatively when shifts were unfilled and the skill mix was inappropriate to meet patient's need. Cardiology staff had particular concerns about nurse staffing and particularly how patient safety was adversely affected when the day ward was open overnight with no additional staff available. Incident reporting was established and acted upon when needed. However there was a need to ensure that all incidents including staffing concerns were appropriately reported as some staff felt this was discouraged.

The performance of medical services had a good track record of patient safety. However with on-going shortages of nurses there was a risk this would not continue resulting in increasing risks to patients. When things went wrong there were appropriate systems in place to review or investigate and when needed lessons learnt and acted upon.

The ward and patients areas were mostly tidy although three fire exits were obstructed on one ward. Adjustments were made by the trust to address this. Infection control policies and procedures were followed. Staff had required mandatory training and this was monitored to ensure it was sustained.

Nursing care records lacked detail and did not reflect patient's preferences, all their needs and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. Equipment in working order was not sufficient on some wards to monitor patients' observations to ensure there was timely action should a patient's condition deteriorate.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero never events registered for medical care services from 1 April 2014 to 31 March 2015.
- The trust had an established electronic system for reporting incidents and near misses. Between 1 April 2014 to 31 March 2015 there were 107 serious incidents which required investigation, 48 grade 3 pressure ulcers, 30 slips, eight confidential information leaks, six episodes of clostridium difficile and hospital-acquired infections and three episodes of MRSA bacteraemias. Each incident submitted was reviewed and graded by a senior nurse and the investigation was proportionate to the grading and any harm to the patient involved.
- Staff we spoke with were aware of, and had access to, the incident reporting system. This allowed them to report incidents, including 'near misses', in which patient safety may have been compromised. Staff confirmed they received feedback from incidents they had reported.
- Two nurses working on the cardiology ward told us that they had been discouraged from reporting staffing concerns. We also spoke with another nurse who told us that they had reported their staffing concerns but remained concerned that the risks were on-going. The risks were present on the directorate risk register, which meant it was still under regular review.
- The trust investigated every serious incident through a root cause analysis (RCA) process. We looked at a selection of RCAs, which involved pressure ulcers, falls and incidence of infections, and saw that required actions were being addressed. For example junior doctors, told us that following confidential information leaks their induction training had included information on maintaining confidential information and they had been instructed not to put patient names on handover sheets.
- Incidents were reviewed by medical and senior nursing staff depending upon the nature of the incident. Incidents were discussed at the monthly directorate clinical governance meetings. Staff told us that the ward manager would ensure that any learning from incidents was shared with them.
- Mortality and morbidity meetings were mostly held monthly for each directorate i.e. renal, diabetes, elderly

care, cardiology, respiratory, stroke and acute medicine. During the meetings attendees reviewed the notes for patients who had died in the hospital within the previous month and when needed actions were taken and shared to improve practice. We saw noticeboards and bulletins that identified learning needed on the Ward C21. Staff on other wards also told us that the ward manager would ensure that any learning was shared.

Safety thermometer

- The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-associated urinary tract infections (CAUTIs), venous thromboembolism (VTE) and falls. Safety information including some of the information from the safety thermometer was displayed at the entrance to each ward so that staff and visitors to the ward were aware of the performance in the ward or department. This included information about infections, new pressure ulcers and falls.
- For medical services between December 2013 and December 2014 the rates of all grades of pressure ulcers were fairly consistent throughout the year changing from one to three instances each month.
- The number of falls within medical services was generally low. Staff identified patients at high risk of falling and when needed actions were taken to reduce this risk such as one to one care or a staff member to remain within that bay/ area at all times.
- The trust used a management tool which contained information about each ward or unit's performance against agreed targets. It included: staffing information in relation to breaches in staffing levels, incidence of infections, and incidence of pressure ulcers, slips, trips and falls, patient feedback and risks such as late patient observations (reported as less than 5% of late observation) and medication errors.

Cleanliness, infection control and hygiene

- We saw that care environments were clean and well maintained. All wards we visited were clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and marked as ready for use with 'I am clean' labels.
- We found when we visited C21 (Acute Medical Unit) during our unannounced inspection that a used blood syringe was left by the blood gas machine. The nurse in charge addressed this whilst we were there and confirmed that medical staff would be reminded this was poor practice.
- Staff followed the trust's infection control policy. We observed that staff were 'bare below the elbow'. Staff had access to personal protective equipment that included aprons and gloves.
- Staff compliance with hand hygiene was checked by a senior nurse as part of their 'five moments' audit when hand washing by five staff members was checked monthly. Nursing staff told us that all had an annual practical assessment of the effectiveness of their hand washing. We saw records that confirmed that compliance with this assessment was reviewed as part of staff mandatory training.
- The trust used 'Safe Hands' this system had a location device on staff name badges and on devices worn by patients to show their location on a ward. Senior nurses told us that the 'Safe Hands' system enabled them to track and check that staff used hand gels appropriately before and after patient contact.
- The trust had a target that 95% of staff should receive infection control training and receive an assessment of their hand washing annually. Within the medical services division 92% of clinical staff had infection prevention training and a hand washing assessment.
- Instructions and advice on infection control were displayed at the ward entrances for patients and visitors..
- There were three cases of MRSA bacteraemias recorded across medical wards/ units between April 2014 to March 2015. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics.
- We reviewed the records for three reported MRSA bacteraemias in the trust. We found that detailed root cause analysis (RCAs) investigations were completed and when needed lessons were learnt.
- We saw and staff confirmed that side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk (for example patients with MRSA). We saw there was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms could also be used to protect patients with low immunity.

Medical care (including older people's care)

Environment and equipment

- Generally we found the majority of wards were tidy and well maintained. We found on ward A7 that furniture and equipment were blocking three fire doors.
- We observed a desk and chair with files and a stack of visitor chairs in front of two fire exits and two hoists, a stack of chairs, intravenous stands, blood pressure machines and other equipment obstructing another fire exit. We escalated our concerns to the senior manager in charge of the hospital who told us that this would be addressed. However, the trust sought the advice of an independent fire services officer. It was agreed as appropriate to have a one person desk and chair that was clearly labelled 'to be moved in the event of a fire alarm'. This was confirmed with the trust following the inspection.
- The trust used the 'safe hands system'. Staff name badges had a location device and patients also wore a device that identified their location on a ward and movement between wards. The safe hands system could identify when staff attended to patients and highlighted if they had not been checked upon for some time. The safe hands system was able to identify and record when staff used hand gels or washed their hands before and after patient contact. We found the safe hands system to be an excellent initiative to promote patient safety.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place. The trust had a central equipment bank for pressure-relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- The trust required that all resuscitation equipment was checked and ready for use. Resuscitation equipment on the wards we visited had been recorded as checked regularly; equipment was in date, appropriately packaged and ready for use.
- We observed that all but two of the call bells we checked were accessible to patients so they could summon staff when they needed to.
- All medical wards had a good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers and syringe drivers, which were well maintained.
- Staff of the majority of wards did not raise any concerns about the sufficiency and availability of equipment. However on C21 (AMU), B14 (cardiology) and B12 (the stroke unit) staff told us that despite ongoing replacement of equipment there was sometimes a shortage of equipment such as monitor leads and infusion stands as equipment went with the patient when they moved to another ward. One nurse told us that there could be a delay obtaining equipment which was required for seriously ill patients. One staff member on B14 told us that they had 10 and not the required 12 electronic units (Vital Pac) to monitor patient's observations and frequently some of the units required repair. When we visited the ward unannounced we found that just three units were available with another three having broken screens and could not be used. This meant that equipment provided to identify an early warning about patients whose condition was deteriorating was not available. However, the trust was aware of this issue and was taking steps to resolve it.
- Nurses on B12 said that they did not have enough blood pressure machines. They told us that three beds had blood pressure machines which could not be moved away from the beds. They had just one portable blood pressure machine for the remaining 22 patients.
- Nurses also told us that they also had to share an electrocardiogram machine (ECG machine) used to monitor patients' electrical activity of the heart with the trans ischaemic clinic. This meant that essential equipment was not on the ward.
- Nursing staff told us that they had a central store for equipment such as intravenous infusion pumps. Nursing staff told us that there was a shortage of these pumps which were used to control the flow of intravenous infusions which frequently contained medicines such as antibiotics

Medicines

- We found the medical wards we visited had appropriate storage facilities for medicines.
- Before our inspection a need to ensure that all medicines refrigerator were locked was identified. We found during our inspection that all medicines refrigerator were locked with the exception of the medicines refrigerator on C24. We also found that medicines refrigerator temperatures were regularly recorded and checked, recorded and adjusted as appropriate.
- Patients across most medical wards were prescribed and administered medication as per their prescription charts. We observed that when medicines were not

administered the reason for this was usually recorded. On wards C15 and C16 we found nursing staff had recorded 'no stock' or were 'out of stock'. This meant that patients did not have the medicines they were prescribed. We found three omissions on medication charts on ward C16 where patients had not received a diabetic medication and pain relief. One patient that we spoke to told us they had been waiting two days for newly prescribed medication.

- On C16 and C17 we checked the 'Hypo Kit' and glucagon kit which were used in an emergency situation for patients with a low blood sugar. We found that all medicines were available and in date.
- We observed that staff wore red plastic tabards when they were administering medicines which identified they should not be disturbed. We saw that this was good practice and protected patients from potential harm.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular checks of controlled drug balances were recorded.
- To take out (TTO) medicines were ordered when patients were deemed medically fit for discharge. Staff said they told us that sometimes there may be a delay obtaining patient's TTOs and whenever possible they asked the doctors to prescribe TTO medicines the day before the patient's anticipated discharge, although this was not always possible.

Records

- Medical wards used a combination of paper and electronic records. Medical records for that hospital admission were in paper files which were then included in the patients electronic records. We found that medical records were legible, dated and with the name of the doctor who had completed the record.
- Nursing records were also in paper and computer format. Nurses wrote a summary of the patient's condition and day in the medical notes. Patient's daily care charts such as records of change of position and food and drinks provided were in paper format. Patient observations were recorded within the electronic records.
- Care plans lacked detail and did not reflect patient's preferences or all their needs as they were all a standard template and all read the same. Care records did not detail washing and dressing needs, including oral care needs or their dietary needs. For example we looked at care records of three patients who preferred non British food. There was no record of what they preferred to eat. We noted that two patients had been eating and drinking only minimal amounts but their care records did not provide staff with information about their preferences to assist in tempting them to eat and drink. One of these patients told us that they were given chicken and rice but they did not like chicken. We shared our findings with the ward manager who told us that they would discuss our findings with the staff.
- We looked at eight patients who required/ or were receiving oral care. We found that care records for two patients did not identify a need for oral care although their mouths were dirty and coated. We found that the other six records patients were receiving oral care. However there were no instructions in care records we looked at that identified the frequency that oral care should be provided or an evaluation of the effectiveness of the care provided. We shared our findings with senior staff who agreed that the records did not fully identify patients care needs or the effectiveness of the care provided. Following our inspection the trust confirmed that additional input was sought and delivered which involved members of the multidisciplinary team to support these patients.
- We found the fluids patients had received was mostly recorded. However we found that they were not completed in the three of the five records we looked at on ward C15 and two of the four records we looked at on A7.
- Risk assessments such as pressure ulcer risk and nutritional risk were included in both paper and electronic records. We found that this system provided duplicated information and in some case essential information was not recorded for example we found that nutrition risk assessments were either not undertaken or reviewed at the required frequency on ward C16 for three of the five patient records we looked at.
- The trust used an admission assessment booklet which detailed observations and assessments patients had received. We found that there was no confirmation that the venous thromboembolism (VTE) assessment had been completed in eight of the nine assessment booklets we looked at. Also there was no record of a nutritional risk assessment in two booklets. We

discussed this with the sister in the acute admissions unit. We were able to later confirm that VTE assessment had been undertaken but not documented. However the nutritional risk assessments had not been undertaken. There was a need to review the use and completion of this booklet.

- The trust provided all medical, nursing and therapy staff working within medical services with a stamp with their name and confirmation of their personal identification number. This enabled other staff to easily track who had completed the record when required. We saw this as a good practice initiative.

Safeguarding

- Staff were able to describe situations in which they would raise a safeguarding concern, and how they would escalate any concerns. We saw and staff told us about examples that appropriate actions were taken to protect patients from abuse.
- Staff received safeguarding training at induction and at regular intervals and this was well-attended. Figures provided by the trust showed that 100% of staff on the majority of wards had attended safeguarding adults training. Achieving a compliance rate of 99.5% against a trust target of 75%.

Mandatory training

- Mandatory training included for example: fire safety, infection control, basic life support, moving and handling, conflict resolution training and information governance. In addition clinical staff also had an annual hand hygiene assessment and a blood transfusion assessment, trained nurses had intravenous administration training. Qualified and unqualified nurses had level one nutrition training and doctors and nurses had oxygen administration training and route cause analysis training.
- Training records we looked at on the wards confirmed that most wards were achieving almost 100% compliance. If compliance was lower ward sisters were able to explain the reason for this such as, long term sick leave or maternity leave or that training had been arranged. For instance Bullying and Harassment training trust target was 95% actual achievement was 99.4%. Hand hygiene assessment trust target was 75% actual achievement 92.8%.
- Nurses and healthcare assistants across medical services told us that ward managers ensured they completed all their mandatory training.

Assessing and responding to patient risk

- Medical services used an electronic patient observation recording system. The technology enabled quick and reliable recording of observations and automated early warning score calculation at the bedside. If a patient's deterioration was detected, an urgent alert was generated to enable appropriate escalations to be made to duty clinicians and hospital-wide teams. We saw the technology allowed for a quick response
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, attendance to the ward was swift and assessments were thorough.
- All patients diagnosed to be 'FAST' positive strokes were assessed by a stroke registrar and stroke nurse immediately on arrival at the hospital. FAST is a process of recognising the most common signs and symptoms of a stroke. F= face, A= arms, S= speech and T= time to call 999.
- Patients' individual risk assessments were completed weekly or more frequently dependant on identified risks. However we found that one patient's risk assessments on C16 did not reflect the increased risk of poor diet and fluid intake or other system to mitigate this risk. We escalated our concern to the ward manager who reviewed the patient and agreed that staff should have taken additional actions. The ward manager completed an incident report to identify the increased risk and failure to provide appropriate care, the patient was also referred the patient to a dietician.
- We observed nursing handovers on a number of wards, both during the day and at night time. We saw nursing handover sheets that contained information about care needs, past medical history and plans for discharge. There was a thorough discussion of each patient, which included information about their progress and potential concerns.
- Patient handovers took place at the beginning of every shift change. We observed handovers on five wards. We saw that handovers were given to all staff coming on duty by the nurse in charge of the previous shift. On AMU the handover took place between individual nurses handing over to the nurse that would care for those patients on the next shift.

- We found that nurses routinely attended ward rounds, making communication of nursing and medical information efficient and enabling nursing and medical staff to respond to patients' needs in a timely manner.

Nursing staffing

- The safer nursing care staffing tool was completed daily by the senior nursing staff for medical wards. The rotas were managed by the trust's electronic rostering system.Senior nurse managers told us that nursing vacancies was an on-going challenge. The head of nursing for division two told us that throughout the division (which also included emergency care), there were 27 (WTE) nurse vacancies. A recruitment drive was on-going which had included recruitment from overseas but in line with national data nurse vacancies were difficult to fill. Following the inspection the trust confirmed that 6.1 (WTE) had been recruited and were awaiting start dates.
- Wards managers told us that they had difficulties ensuring that their wards were fully staffed. Ward managers told us that they frequently had to replace a trained nurse with an untrained as they had insufficient trained nurses.
- The ward manager for B7 told us that they had vacancies for up to four full time nurses (3.7 whole time equivalents), B12's ward manger told us that they had two qualified nurse vacancies, one of which was a new post for a practice development nurse and an additional qualified nurse was on maternity leave. The wards managers on wards C15 and C16 also confirmed that nurse staffing was an ongoing challenge. Between C15 and C16 there had 7.85 WTE nurse vacancies. In addition there were several junior and overseas nurses who needed support and supervision to ensure patients received safe and appropriate care.
- A staff nurse on ward C16 told us, they are "frantic some days" and went off duty late due to poor staffing levels. They told us that they had a lot of newly qualified nurses who work autonomously and did not have proper supervision from senior staff which was unsafe. They said, "There have been no accidents so far but it is just a matter of time". Staff told us and we noted from incidents that on some days they did not have breaks on 12 hour shifts which staff told us was unsafe.
- Nursing staff working on B21 the cardiology ward told us about their concerns around staffing. The cardiology ward had 12 cardiac beds where the patients' needs were of a higher dependence and 25 other cardiology beds. Nursing staff told us that the higher dependency beds were staffed on a 1:3 ratio and the remainder of the beds on a 1:7 ratio. The cardiology ward had 12 beds for patients with higher dependency needs and 25 other cardiology beds. There was one shift coordinator over all 37 beds. The shift coordinator on night duty also was in charge of the separate cardiology day ward which may mean they were in charge of up to 51 patients. This did not appear to be sufficient.
- Nursing staff on B14 also told us that frequently the cardiology day ward was used overnight in response to bed pressures. Nursing staff told us that when the cardiac day ward was used overnight they were expected to provide staff to cover this ward within their usual night staff. When we visited the cardiology ward during our unannounced inspection we found that there was one shift coordinator who was supernumerary, five band five nurses and one band two. The band five nurse and band two health care assistants went to work on the cardiac day ward. This meant that three band five nurses were allocated to the nine higher acuity patients and left two band five nurses to support the remaining 25 patients. This ward admitted patients twenty-four hours a day who are acutely ill and required emergency treatment for a heart attack and initially required one to one care of a qualified nurse. Nursing staff told us that staffing arrangements were unsafe.
- When we visited unannounced we observed that the cardiology day ward was in open overnight. We found that staff had been moved from B14 which meant that B14 was short staffed. Whilst we were on the ward a patient rang their bell because they were worried about the wellbeing of another confused patient. We had to go and find staff in another bay to ask them to come to assist the patient as there were no staff either in the bay or nearby. Following the inspection the trust sent us documents to demonstrate that they had undertaken a review of staffing this area in November 2014. The staffing ratio was in line with the trust review and risk assessment. However the experience of the nursing staff and some patients was still not satisfactory.
- Nurses working on Deansley ward told us they felt staffing levels at night were insufficient. They told us that there were insufficient staff on duty to provide care for spinal patients who required specialist lifting by up to five nurses. A failure to provide sufficient nurses meant that patients were at increased risk of unsafe

movement or could not be safely moved and put them at increased risk of pressure ulcer development. Staff told us they had not recorded this as an incident. Following the inspection the trust informed us that there was a procedure for moving staff to the ward when they needed assistance.

- We found during our announced inspection that the wards mainly had the required number and grade of nursing staff on duty. Ward managers told us that night staffing was problematic and frequently they had to replace qualified nurses with untrained nurses particularly on night duty although there were still nurses in charge of ward/ units.
- When we visited unannounced we found that six of the ten wards we visited were short staffed with at least nine qualified nurses short between the wards we visited (late evening and on the night shift).
- The trust ward performance dashboard (March 2015) identified a 'red flag' for breaches of agreed staffing levels for the following wards, with number of breaches identified in brackets: AMU (3), A7(2), A8(3), W3(2), C15(2),C16(3), C41(4), C24(5), C25(2), C17(5), C18(4). Wards C17 and C35 staffing concerns were highlighted by a 'red flag' for actual staffing against planned: C17 (21 shifts), C35 (22 shifts). The ward dashboards highlighted the impact of staffing which identified 'a red flag' more than 5% late patient observations for: AMU, C15, C16, C17, C24, and C17. Increased patient harm was identified for AMU (avoidable pressure damage), A8 (avoidable pressure damage, falls with harm), C15 (avoidable pressure damage, falls with harm), and C25 (avoidable pressure damage). We saw that staffing shortfalls had resulted in patient harm.
- We observed during our announced inspection that planned and actual staffing levels were displayed on all wards with the exception of B14 (cardiology). However when we visited unannounced we found that planned and actual staffing were not displayed on three of the ten wards (B12, B14, C25) we visited.
- When shifts could not be fully staffed from their own staff working their contracted hours, staff could work additional hours on the hospital bank. There was a policy that agency nurses were not used within the trust. This meant that if cover could not be provided by bank staff following escalation to hospital management, staff would be reallocated from other areas if available.
- Ward managers were supernumerary and not counted in the daily staffing rota, although they sometimes had to form part of the core staffing to cover short notice vacancies due to staff sickness.

Medical staffing

- The proportions of consultants across medical services were slightly higher than the national average. Of the overall Medical staff establishment in the trust there were 36% consultants compared to 33% in England; 5% middle career doctors within the trust compared to 6% in England; 38% registrars within the trust compared to 39% in England; 21% junior doctors within the trust compared to 22% in England.
- There had been a reorganisation of the medical bed base and consultants providing cover for medical patients. The reorganisation had separated medical wards into directorates around medical specialisms such as: rehabilitation, acute medicine, renal, diabetes, elderly care, and gastroenterology and respiratory. Consultants and junior doctors we spoke with were positive about these changes.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.
- Junior doctors covered weekends and had access to consultants and medical registrars as required. Junior doctors confirmed that consultants would come into the hospital when on-call. One doctor confirmed said, "Consultants expect to be called". Another doctor said, "We are well staffed at night and we are supported. On-calls (shifts) really aren't as bad as other hospitals".
- There was minimal requirement for medical locum use.

Major incident awareness and training

- The trust had an 'Emergency Preparedness and Resilience Strategy' (EPRS). This strategy provided an agreed framework to prepare for all emergencies and ensure business continuity plans were in place. The policy which emergencies and disruptions to services such as: period severe bed pressure, extreme weather conditions, an outbreak of an infectious disease, industrial action or a major transport accident.
- Staff we spoke with had mixed understanding and awareness of the procedures for managing major incidents and winter pressures on bed capacity. The ward sister on C21 showed us the major incident folder which had action cards, call and contact details and

debrief documents as well as basic information about major incidents. Some staff told us that they were aware that an annual practice for actions in a major incident took place. One staff member (a healthcare assistant) told us that they had been asked if there was a major incident if they would be willing to come in. However other staff did not know what the system was. One staff nurse in AMU thought the sister would tell people what needed to be done, they couldn't remember seeing anything about major incidents nor having had any training in actions that were required.

- Emergency plans and evacuation procedures were in place and on display on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- Staff told us that there was a bed management system that aimed to ensure that patients' needs were met when there was an increased demand for beds. The lead consultant told us that previously medical services had used winter pressures wards.

Are medical care services effective?

Good

The trust showed that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patients' care.

Policies and procedures were accessible to staff and they were able to guide us to the relevant information. Care was monitored to show compliance with standards and there were good outcomes for patients.

There were mainly suitable arrangements for ensuring that patients received timely pain relief. Patients were assessed for their nutritional and hydration needs and mostly referred to a dietician when required. However there was a need to ensure that patient's diet and fluid intake was appropriate and this was recorded.

Multidisciplinary working was evident to coordinate patient care. Staff had access to training and had received annual appraisals.

Evidence-based care and treatment

- All medical services delivered evidence-based practice and followed recognised and approved national guidance across the medical directorate. When speaking with nursing staff we found they had a good knowledge of guidelines, best practice and where to find guidance.
- There were care pathways based on NICE guidance for stroke patients, heart failure, diabetes and respiratory conditions. The hospital contributed to national audits. We saw that action plans were in place if required to improve performance.
- Medical services were encouraged to take part in both national and local audit to review and improve practice. We saw several examples of this which included: dietetic involvement with patients who were at high risk of low nutrition; improvements in stroke care and an audit of weekend prescriptions for insulin and renal treatment. The audits identified when further actions needed. We also found that an audit had identified that a larger audit with a larger number of patients should be undertaken to provide assurances of effective treatment.

Pain relief

- All but two patients told us they received the pain relief they needed. We looked at these patients records and found both had their pain relief regularly reviewed by medical staff. However we did observe that there had been a delay obtaining topical (gel that is applied to the skin) pain relief.
- Patients were administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels. We saw staff were quick to identify patients in pain, for example on AMU and cardiology. We saw on B12 that patients were assessed for pain at every medicine administration round.
- We saw nurses ask patients if they were in pain and when needed ensure that pain relief was administered.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patients' nutrition and hydration when applicable. We observed that fluid balance charts were completed on the majority of wards. However we found on A7 and C16 they were not fully completed to reflect the amount of fluid given and daily fluid totals used to monitor patients' hydration status.
- Patients had access to a cold drink by their bedside.

- A patient on C16 told us at when we visited the ward at 8pm that, "I can speak up for myself but the majority of patients can't and they have not had a hot drink since 2pm"; We asked a nurse if patients had received a drink. The nurse told us that the shift had been very busy and agreed that patients had not had a hot drink. Patients who do not receive adequate drinks were at increased risk of dehydration.
- Patients said they were given choices of food and snacks. However, they had mixed views regarding the quality and suitability of the food available. The majority of patients told us that the food was of excellent quality and that they had a choice.
- Two patients we spoke with on C15 said that they did not like the English food and preferred meals that met their cultural preferences. There was a need to ensure that patients were consistently offered a choice of meal available.
- Patients on diabetic wards C15 and C16 told us that snacks were available outside meal times.
- Nursing staff said they monitored patients' nutritional state and would make a referral to the dietician when needed. We saw evidence of a referral to the dietician in some of the records we read. However we noted that one patient on C15 did not have a recent nutritional assessment completed, had no accurate weight recorded despite being in hospital for almost four weeks and had not been referred to a dietician. We highlighted this to the ward manager, when we visited the following day we saw that appropriate actions had been undertaken.
- The wards had introduced protected meal times when visiting was not allowed. This was to allow patients time to have their meals undisturbed.
- There were 'red trays' to identify patients who needed support with eating and 'yellow jugs' for patients who needed assistance with drinking. We observed one patient with a red tray being helped by staff. When we asked two members of staff on the ward what the red tray system meant, they were able to tell us.

Patient outcomes

- The Standard Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre (HSCIC) for July 2013 to June 2014 was banded "as expected". Royal Wolverhampton Hospitals Trust had the 20th lowest SHMI value in England for this period (out of a total of 137 acute trusts).
- The trust had demonstrated on-going improvements in stroke resulting in a score level B (level A is the highest achievement and level E is the lowest) in the Sentinel Stroke National Audit Programme (SSNAP) in September 2014.
- Physiotherapists told us about improvements identified in response to the SSNAP for the care received by stroke patients, such as identified patient care goals. Audit results we looked at also confirmed this.
- **The Myocardial Ischaemia National Audit Project** (MINAP) audit for 2013/14 showed that the trust performed better than the national average in two out of three areas that data was submitted for. For example; the audit 2013/2014 demonstrated that the trust performed better than the national average for people with ST segment elevation myocardial infarction (nSTEMI – a form of heart attack) being seen by a cardiologist, with a record of 100% against the national average of 94% and 87% of patients were referred for or had angiography (heart procedure involving widening of the arteries) against the national average of 79%. Patients who were admitted to cardiac unit or ward within the trust scored worse at 22.5% against a national target of 55%.
- The trust performance in the National Diabetes Inpatient Audit (NaDIA) was mixed compared with the England average. Ten of the 22 indicators were better with 11 indicators worse than the England average and no data was available for one indicator. Examples where improvement was needed included medicine errors, including insulin errors, patients seen by the MDT within 24 hours of admission to hospital and foot risk assessments within 24 hours, after 24 hours and during a patient's stay. However indicators such as visits by the specialist diabetes team, staff awareness of diabetes and patients' overall satisfaction were better than the England average. An action in response to the audit identified a need to change the prescription sheet to reduce medicine including insulin errors. We observed during our inspection that identified changes had been made to the prescription sheets.
- The trust had a dementia care strategy and advocated 'person centred dementia care'. The strategy included a person centred assessment which included completion of the 'About Me' booklet.

- The reach out care bundle developed on the specialist dementia ward for patients and their carers living with dementia, had shown positive results for patients and demonstrated within the first 12 months of implementation:

1. Reduction in complaints (1 compared to 3.4) and increase in compliments
2. Reduced number of falls and no multiple falls
3. 75% reduction in acquired infections
4. 50% of patients had either gained weight or weight had remained the same
5. Increasing percentage discharged back to previous residency
6. Consistency low use of anti-psychotic medicines
7. Improved staff job satisfaction with 50% lower mean stress assessment scores than and lowered staff sickness absence (2.8% compared with overall trust level of 4.8%).

- We saw a diabetes audit which assessed the care given to 25 diabetic patients. It identified that: 22 out of the 25 patients had been reviewed by a diabetes consultant at least three times weekly, 24 out of 25 patients had been reviewed by a doctor daily, 23 out of 25 patients had a VTE assessment within 24 hours of their admission and 25 out of 25 had their observations recorded. This audit identified why required standards were not met and where further improvements were needed.

- Junior doctors working on the C22 and A8 told us about actions taken to highlight patients who were at increased risk of falls and included stickers in patients notes which identified an increased risk and prompting doctors to review patients medicines The trust's emergency standardised readmissions rates were generally worse within medical services than the England average, with the exception of general medicine which performed better than the England average.
- Respiratory medicine had developed a 'Respiratory Network Group' for monitoring and improving respiratory medicines both within the hospital and local community. The Respiratory Network group had shown improvements in reduction in length of stay, high patient satisfaction and an embedded structure for monitoring and improving performance of integrated respiratory services.
- The trust participated in the Joint Group on GI Endoscopy (JAG) and received five year certification which confirmed that satisfactory standards were in place on 29 June 2010.

Competent staff

- We observed clinical practice, attended staff handovers and MDT meetings and saw that staff working across medical services were competent and knowledgeable within their chosen wards.
- Competency assessments were in place to show that staff had been assessed and were proficient within their respective specialist wards. For instance the stroke ward had a competency assessment for nurses to assess patients who might be having a stroke. However the nurse in charge told us that staff shortages on the stroke ward had meant that it was difficult for nurses to gain experience alongside an experienced staff nurse to gain this competence. However, staff did have the opportunity to gain this competence in the emergency department.
- Respiratory, cardiac, stroke and renal specialist nurses worked within their designated specialist wards and provided support and advice to staff and patients.
- New nursing staff received induction training and were supernumerary for at least one week. We spoke with a nurse who had transferred from another ward in the hospital. They confirmed that they had been supernumerary both when they had first come to work at the hospital and were now supernumerary for a further week since moving to their new ward (C21 AMU).
- As part of the trust's dementia strategy there was a plan that all staff should receive dementia awareness training. Information provided by the trust showed that this training had commenced at the time of our inspection although uptake within medical wards had been minimal.
- Staff told us that they could access their own education and training via the trust's intranet. The education programme identified both mandatory and development training that was available. Staff were able to book on to the training courses to develop their knowledge and skills.
- Junior medical staff told that us on A7 and A8, weekly teaching sessions were held for staff to help them look after patients living with dementia.
- On B14 (cardiology) 28 out of 52 (56%) registered nurses had post registration qualification in cardiology.

- Junior doctors we spoke with said they felt supported by consultants and nursing staff. Junior doctors working within elderly care told us that the consultant provided them with good teaching in medicine and dementia care. They confirmed that they had plenty of opportunities to perform audits and research. They also said that they had dedicated time each week to attend teaching sessions.
- On AMU we spoke with two nurses from overseas who had recently moved to the UK to work at the hospital. The nurses told us that they felt well supported in settling in and that they were getting all the training that was needed. We also spoke with a student nurse who told us that they had good learning outcomes from their time on the ward and was well supported by senior nurses to make sure that these outcomes were achieved.
- Information provided by the trust identified that the trust target for staff appraisal was 75% with actual achievement of 85.5%. Information we looked at on the wards identified that the majority of staff had received an appraisal.
- All staff we spoke with confirmed they had an annual appraisal. Staff told us that as part of their appraisal they discussed their development and any training needed. Ward managers received monthly information about staff who required a forthcoming appraisal in the next two months

Multidisciplinary working

- Therapy services, such as respiratory and musculoskeletal physiotherapists, occupational therapists and the mobility team were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.
- Speech and language therapists were part of the multi-disciplinary team. One speech language therapist told us that they felt there were insufficient speech and language therapists available for stroke patients. They told us that there had been long term sickness within the team of (two) speech and language therapists. Nursing staff told us that they would undertake an initial swallowing assessment and when needed would make a referral to a speech and language therapist. The SSNAP survey which reviewed stroke services had identified an improvement was needed for speech and language therapy for patients who had a stroke.
- On the stroke unit (B12) staff told us that twice weekly multi-disciplinary team meetings (MDT) took place. We attended a MDT meeting and observed that stroke consultants and junior doctors, nurses, a speech and language therapist, an occupational therapist and discharge coordinator attended the meeting. The meeting discussed the patient's progress referral to other services such as psychologist and plans for further treatment and discharge.
- Speech and language therapists and dieticians attended the medical wards as required.
- Patients were also referred to clinical psychologists if necessary. We saw evidence of this in the records we saw on the B12.
- On the elderly care and dementia wards (A7, A8 and C22) staff told us and we observed that MDT meetings took place.
- On respiratory ward there were fortnightly MDT meetings to discuss chronic respiratory patients. They also undertook daily ward huddles.The MDT consisted of community matrons, respiratory nurses, physiotherapists and both respiratory and palliative care consultants.
- A respiratory consultant reviewed respiratory patients on the AMU, seven days a week from 09:00 until 11:45, helping to provide specialist opinion for acute respiratory problems and facilitating discharge and evidence-based management for others with appropriate follow-up.
- Staff told us that there were twice weekly MDT meetings within cardiology.
- Staff on other wards told us and we also observed that daily MDT 'huddles' took place with involvement of other professionals, such as physiotherapist and social workers. Doctors told us that following a reorganisation of social services social workers did not attend as frequently as previously. We observed these huddles taking place on several wards we visited.
- On B12 we observed that appropriate arrangements were made to transfer stroke patients to West Park Hospital to continue their stroke rehabilitation. We also observed arrangements to transfer patients from the care of the elderly wards to West Park Hospital.
- We observed on the stroke unit that when required arrangements were made for patients to be reviewed by a psychiatrist.

Seven-day services

- The medical lead for medicine told us that there was seven day consultant cover within medical services and were working towards having two ward rounds a day, seven days a week.
- Consultant cover over the weekends was provided on a rota within each directorate such as diabetes, renal, respiratory, elderly care and stroke. This ensured that consultant/ senior doctor ward rounds took place seven days a week. This provided continuous patient review and staff told us they felt supported to manage patient care effectively.
- Therapy services, such as respiratory and musculoskeletal and stroke physiotherapists, occupational therapists and the mobility team were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.
- Speech and language therapists and dieticians were available five days a week.
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Urgent medicines could also be accessed by senior on-call staff.

Access to information

- On most of the wards we visited, nursing notes were kept close to patients and were accessible at all times. "Skinny" medical notes which related to the current admission only were kept on the wards securely within notes trolleys.
- All medical wards used a large electronic screen detailing number of beds patient details, admission and estimated discharge date and listed healthcare professionals involved in the patients care. This information was accessible to all medical wards and provided staff with instant information as to the location and condition of each patient.
- Nursing staff told us that, when patients were transferred between wards, staff teams received a handover about their medical condition. We saw that ongoing care information was shared appropriately in a timely way.
- Discharge summaries were given to GPs to inform them of a patient's medical condition and the treatment they had received before discharge.
- The trust used an electronic system to record patient's observations and provide early warning of possible deterioration. We saw this being used by the nursing staff. It was seen as vital to ensuring patient safety on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant the trust had ensured that decisions about the care and treatment arrangements for a person without capacity did not amount to a deprivation of their liberty.
- Patients were asked for their consent to procedures appropriately and correctly. We saw examples where staff had acted in accordance with the MCA when patients did not have capacity to consent.
- When patients did not have capacity to consent, staff said they would apply for best interest decisions in deciding the treatment and care they required.
- Ward staff were clear about their roles and responsibilities regarding the MCA.
- The records, when applicable, showed clear evidence of informed consent that identified the possible risks and benefits of care.

Are medical care services caring?

Requires improvement

Overall patients we spoke with were positive about the care they received from staff. A number of patients commented that staff were caring and friendly and that they felt they were being looked after. Patients felt that their dignity and privacy were respected and we observed this on the wards. We observed mostly kind and compassionate care on all the wards we visited.

However on three different wards we observed staff interactions with patients that were neither caring nor compassionate. We saw these did not meet the standards set by other members of staff.

The Friends and Family Test (FFT) was used and the results displayed on most wards. The trust response rate to the FFT was worse than the England average.

Compassionate care

- All of the wards we visited monitored responses from the NHS Friends and Family Test (FFT) and the number of compliments received.

- The trust used the FFT. This was a single question survey which asked patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The response rate varied between 11% and 50%. The average FFT response rate for the Trust was 23%, which was worse than the England average of 30%.
- Patients across all medical wards were satisfied with the quality of service they received and all 53 patients and relatives we talked with told us they had no complaints.
- We observed many examples of caring and compassionate care on the medical wards we visited. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- However on C16 we observed two health care assistants were abrupt and uncaring they did not explain what they were doing when they moved a patient and 'tutted' when the patient asked them to make them more comfortable. We shared our observations with the deputy ward manager who told us that the staff concerned were very caring but they would discuss our observations with them.
- On C15 a patient told us that some patients had not had a drink. We asked a qualified nurse about this, they told us they had not been working in that bay and said they had been very busy. We also highlighted that a patient was walking around the bay without footwear. The same nurse said they were not working in that bay. We highlighted to the nurse as a trust employee all patients were under their care and this was neither caring nor promoted the patient's dignity. A second nurse who was working in that bay confirmed the patient without footwear had been regularly encouraged to wear them.
- Also on a separate occasion we observed a different member of staff state loudly that a (named) patient had asked to go the toilet. They went on to say this was before they had provided care to another patient. The patient then quietly explained the reason why they no longer needed to go to the toilet. The staff member then from across from the other side of the bay said: "What, you have wet your pad?". It was evident that the elderly patient was embarrassed by this exchange. However we then observed a student nurse come over to the patient and quietly reassure them that everything was ok and they would take them to the bathroom to make them more comfortable. All the patients in that bay had earlier told us that staff were lovely and caring. We shared our observations with the ward manager who told us that the staff concerned were very caring but they would discuss our observations with them.
- During our unannounced inspection we visited C19. We observed a staff nurse administering medicine to patients. They were very loud, abrupt in their manner and did not appear either friendly or empathetic. However, the family of other patient said they were one of the best members of staff and was really friendly and helpful.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors, nurses and healthcare assistants were caring, compassionate, and responded quickly to their needs. One family told us that not all nurses had being caring when another family member had been a recent patient. They told us that they had raised their concerns with senior staff and it was being investigated. However they made positive comments about caring staff on ward A7.
- We observed doctors conducting ward rounds and saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- On B12 and C15 we observed physiotherapist assisting patients with mobility, walking at the patients' pace and waiting whilst the patient rested along the ward corridor when mobilising as part of their programme of therapy. They acted in a caring manner and maintained the patients' dignity throughout. It was obvious from the interaction and the way the patients responded that this level of care was normal.
- Patients told us they felt that the nurses and doctors "Really do care". Another commented "Nothing is too much trouble".

Understanding and involvement of patients and those close to them

- All the patients we spoke with told us they felt generally involved in aspects of their care and treatment.
- We observed interactions between doctors and patients, we saw how issues were explained and patients had opportunity to discuss what they were being told. Consent was always obtained prior to any interventions taking place. They asked patients if they had any questions and gave them time to reply.
- There was evidence of when a patient's family had been involved in their relative's care and discharge plans. For

example, discussions with family members were documented in patients' notes on the stroke ward. These discussions detailed information about the care and support patients would require when discharged from hospital.

Emotional support

- Patients had access to further support from clinical nurse specialists. For example, diabetes nurse specialist were available to support patients with diabetes, clinical nurse specialists provided advice for and support for stroke patients and dementia outreach nurses provided support and advice for patients and their relatives living with dementia.
- We observed that on the stroke unit patients were offered counselling services to give them additional emotional support.
- The hospital chaplains visited the wards on a regular basis. A multifaith room was available in the hospital for patients or relatives to access.

Are medical care services responsive?

Good

The trust has several initiatives to prevent admissions to hospital and facilitate patients timely discharge from hospital as soon as they are well enough or able to leave. This meant that patients could rest and recover at home or in a place they were comfortable sooner and had less time in hospital.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the population, patients and winter pressures. Different departments worked together to provide better environments for patients with complex needs.

There were initiatives and facilities on wards to meet the need of individual patients. Patients were encouraged to identify goals and targets and their needs assessed so that the right level of care could be provided. We saw patient focussed approaches to care and treatment.

Service planning and delivery to meet the needs of local people

- The trust provided primary percutaneous coronary intervention primary (PCI), an emergency treatment for patients who were having an acute ST-segment-elevation myocardial infarction (STEMI), 24 hours a day, seven days a week.
- The trust provided emergency treatment, 24 hours a day, seven days a week for stroke patients.
- The trust had implemented the 'SWAN' pathway which included advanced care planning for patients at the end of their life.
- Respiratory medicine had a 'Respiratory Network group' which had developed the Respiratory Action Network for the benefit of Wolverhampton (RAINBOW) group. The RAINBOW group oversaw the integration of community, acute trust and palliative care services for people with Chronic Obstructive Pulmonary Disease (COPD).

Access and flow

- National standards state that 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between November 2013 and November 2014 the trust met this standard for medical services. Gastroenterology, geriatric medicine and rheumatology achieved 100% figures for patients who were admitted. This was above the England average.
- The trust did not meet the target for the two week cancer wait, 62 day wait for first treatment and 62 day wait for screening between January and March 2015.
- The trust's emergency standardised readmissions rates were generally worse within medical services than the England average, with the exception of general medicine which performed better than the England average.
- There were occasions when there were insufficient beds for medical patients which required medical patients to be accommodated on a non-medical ward; this is sometimes called a medical outlier. Consultants and junior doctors told us that each directorate (or specialism), had a duty rota which included named doctors on call for the division. The division had 'paired wards' the 'paired wards' had named consultants who they were able to contact if they had medical patients who needed to be seen. We saw during the inspection that this system worked well and patients on outlier wards mainly received timely assessment, care and treatment. However we did find one patient on C41 who

had previously been on a surgical ward and had not been seen for several days. The patient's records identified that an incident report had been made to ensure any shortfalls were identified and addressed.

- A specialist respiratory nurse completed the discharge bundles for patients with COPD and asthma and coordinated the early supportive discharge for respiratory patients.
- On C21 (AMU) staff told us that there was no cut off time for transfer of patients to wards. They told us that they continued throughout the night to move patients out from AMU if beds became available. The only exceptions were –
  - Dementia patients in general weren't moved after 8.30pm so as to reduce their anxiety.
  - If AMU was particularly quiet, and plenty of beds were available then patients were not moved until morning.
- Information provided by the trust identified that the average number of bed moves for each medical patient stay between April 2014 to March 2015 was 1.5.
- The average length of stay for the majority of elective and non-elective medicine patients was higher than the England average. This meant that patients were staying in hospital longer than in other hospitals around the country.
- Patients discharge dates were discussed at daily ward rounds and MDT meetings. This was to ensure those patients who were medically fit could be prioritised to leave the hospital.
- Prior to discharge patients' needs were assessed so that the correct level of care could be put in place at home or a care setting. On the stroke ward an occupational therapist discussed the outcome of a home visit during the MDT meeting. This was to assess the patient's ability to undertake tasks within their home. Staff then made appropriate discharge arrangements with care agencies or families.
- During the handover on C15 we observed that staff identified those patients who were fit for discharge and their discharge plan and arrangements were discussed.
- Medical and nursing staff told us that most delays in discharges were because patients were waiting for care packages to be in place if returning to their own home, or for a rehabilitation or care home place to be available.
- Staff told us they felt that there was good communication and work between hospital staff and social care providers. We saw evidence in medical notes of working with local authorities, care homes, and GPs in discharge planning.
- We noted that significant numbers of patients were transferred to Cannock Chase hospital late at night to assist with flow.

Meeting people's individual needs

- There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us that although they had used this service the hospital had a multi-cultural staff and they were able to get a member of staff to translate. We spoke with one patient and their family who told us they had been offered access to an interpreter on several occasions.
- We saw a wide range of information available to patients and their families on large notice boards and leaflet racks on the wards and visitor waiting areas. The notice boards were clearly visible and accessible for patient and families. All the information we saw was written in English and so was not easily accessible for some patients who did not have English as their first language.
- Patients over the age of 75 were routinely screened for signs of dementia. This enabled staff to put in place the right level of care and escalate any issues. If there were signs of dementia it would be escalated to medical staff to undertake further assessment. We saw examples of completed screening questionnaires and escalation in patients' records.
- Staff told us that patients living with dementia, learning disabilities and mental health problems were provided with one to one support where needed on wards. Some wards also operated supervised bays where patients who needed it could have continual support and supervision which we observed during our inspection. Staff told us that when people living with dementia were confused or agitated they could request 'one to one' care for this person. Staff said mostly this would be arranged.
- The trust had a dementia outreach service which provided specialist multi- disciplinary care and follow up for patients living with dementia and their relatives. The leaflet highlighted the dementia outreach service and gave contact details for outreach staff.

- We saw that patients who were living with a cognitive impairment had a 'About Me' document in their nursing notes. This enabled staff to better understand their communication requirements and social background to improve their experience of the hospital environment.
- People told us before our inspection that only one pillow was available for patients on AMU. When we visited AMU the availability of pillows was assessed. Staff confirmed that patients had one pillow and said this was because the head of the bed could be raised. Staff told us that if requested additional pillows would be made available. We spoke with four patients on AMU all said they usually slept with more than one pillow and felt that more than one pillow should be available but were not aware they could ask for additional pillows.
- Relatives contacted us during the inspection and told us that patients on A7 (elderly care) were allocated just one pillow as the bed head could be raised. They told us when they asked staff for additional pillows they were told that just one pillow was allocated. The relative told us in response to this they had brought in two pillows from home for their relative and put the patients name on it. Staff told them that the pillows may go missing. They told us when they visited their relative the following day they had just two pillows and the hospital pillow had been removed. The relative felt that this local cause of action for just one pillow was not appropriate for frail and elderly patients.
- For people with diabetes there was an 'Emergency Nurse Service'. This service was a nurse-led telephone service that provided help and guidance to patients and negated the need to attend hospital.
- The services offered by a lead respiratory consultant and their team included a chronic respiratory multi-disciplinary team (MDT) meeting, respiratory HOT clinics (clinics for fast access to respiratory consultants to prevent admission), respiratory consultant review within AMU and community clinics to ensure that people received timely review and both evidence based and effective early treatment.
- Between 1 November 2014 ad 30 April 2015 235 primary PCIs were performed within the trust. Most effective results are achieved if patients receive treatment within 90 minutes, this is called 'door to balloon time'. Data provided by the trust show this standard was met in four of the six months between November 2014 and April 2015. The average 'door to balloon' over this time period was 79 minutes.

Learning from complaints and concerns

- Information available to patients and visitors about how to raise concerns or complaints was displayed on notice boards and leaflets available throughout the medical wards.
- Nursing staff told us they knew how to deal with concerns and complaints. Most staff we spoke with wanted to try and deal with concerns quickly and immediately. If this could not be resolved patients would be signposted to patient advice and liaison service (PALS).
- One relative we spoke with before our inspection said they had previously raised concerns with ward staff on a medical ward but had found that improvements were not made. They told us when they raised their concerns with PALS they would only accept their concerns in writing. They told us that in response to their concerns that the consultant and matron were both responsive and they had met with them to discuss further.
- Nursing staff told us that feedback from patients was shared in a variety of ways including staff noticeboards, emails, and team/ward meetings and in person.
- Nursing staff told us that they had meetings with patients and their families to resolve complaints or deal with concerns. Nursing staff gave us examples of changes to practice on wards as a result of complaints. For example, a member of staff told us about a change in filling out property lists after a patient complained that their property had gone missing.

Are medical care services well-led?

Requires improvement

We rated well led as requires improvement. The leadership were sighted on the staffing issues, but the actions undertaken had not been effective. This in turn had had a negative impact on safety and caring due to overworked staff.

Staff felt well supported by their immediate managers. Staff were positive about the standard of care they provided and of that their achievements were recognised. There was a culture of audit and improvement within the medical services.

Medical care (including older people's care)

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been appropriately addressed by senior managers.

The trust's vision was well embedded within medical services. Staff demonstrated commitment to its vision and values. However evidence of staff shortages compromised this vision.

Vision and strategy for this service

- Staff were aware and understood the vision and values of the trust and how their role and behaviours that would achieve these values.
- Senior Sisiters told us that they discussed the trusts values during ward meetings, handovers, and recruitment interviews and staff appraisals.
- Ward managers told us about strategies to aid nurse recruitment which included ongoing advertisements for nurses, nurse recruitment days, sharing the benefits of working for medical services within the trust. Ward managers told us that wards which had most difficult recruiting nurses and had a high vacancy rate agreement would be made by the head of nursing for an enhanced bank nurse rate for that ward.
- The trust had a dementia strategy which was in place for all services including medical services. This strategy identified: high quality person centred care that meets the needs and expectation of patients and their carers. Staff caring for people living with dementia were passionate about providing high quality care for people living with dementia and their carers.
- Staff working within the stroke unit told us that the vision for their service was to extend the service and provide specialist stroke services 24 hours a day, seven days a week for other local hospitals. At the time of our inspection there was a regional stroke review being undertaken and one of the options was to provide emergency stroke treatment for patients from Walsall Manor Hospital, however, no agreement had been reached.Senior managers for the division told us the vision for acute medical services was for twice daily senior doctor ward rounds, seven days a week.
- Doctors working within respiratory medicine told us that their vision for their future included: Closer working with community services and improving the hospital-community interface and seven day working.

Governance, risk management and quality measurement

- Monthly ward reviews were completed and monitored by senior managers. These included ward hygiene, staff hand washing and compliance with staff training and appraisals.
- There were weekly core team meetings within the directorate which discussed the day to day management and performance of the directorate.
- There were monthly governance meetings for each directorate within medical services. We looked at minutes and found that, incidents and complaints were discussed and actions identified to reduce further the risks during the meetings. We also saw that lessons were shared between the directorates.
- Risks that affected the delivery of safe care were clearly identified on the division's risk register. Ward managers told us that they could add risks to the risk register at any time. The risks were then assessed by the directorate management team and when needed escalated onto the division and trust risks registers. This ensured that senior trust managers were aware of significant and ongoing risks. The risk logs included actions that were required to reduce risk and were reviewed at each risk meeting. However on the risk register they identified low staffing levels on several medical wards however a blanket decision not to use agency staff remained in place. We did not find there had been a suitable response to this ongoing risk. We found that some ward managers were concerned that they were not able to always meet required staffing levels, despite efforts by the trust to recruit additional nursing staff. Two ward mangers told us that were particularly concerned about night time nurse vacancies. The ward managers told us that if they were unable fill qualified nurse shifts they would put an additional untrained staff member on duty to cover. Ward managers also highlighted their concerns about the blanket decision not to use agency staff.
- We found when we visited at night that a capacity manager was on duty with a senior manager on call from home. There was a band six nurse on duty on cardiology but for the remainder of the wards we visited the most senior staff on duty were band five staff nurses. When we finished our unannounced visit we struggled

to identify a senior staff member on site. We did feedback our concerns over the telephone but were unable to show a senior manager our concerns about potential risks.
- The senior manager we spoke with however did assure us that actions would be taken to remove furniture and equipment that was blocking the fire exits.
- A root cause analysis investigation was undertaken following each serious incident, the investigations undertaken were detailed identified actions to reduce the risk of further similar incidents in the future.

Leadership of service

- General medicine, acute medicine, elderly care, stroke, diabetes, renal, respiratory and gastroenterology were part of division two. The division had a divisional medical director, deputy chief operating officer and head of nursing. Cardiology were part of division one which had the same senior management structure. The divisional management team reported to the trust board.
- A management structure was in place and understood by all staff if that was the case
- Modern matrons provided leadership to the specialties.
- The leadership drove continuous improvement and staff were accountable for delivering change.
- Ward managers were all supernumerary (additional to nurses on shift) and mainly worked Monday to Friday.
- We observed during both our announced and unannounced inspection that staff who were in-charge of the shift wore a badge that identified: "In charge" to assist patients and relatives and staff from other wards to identify the most senior person on the ward should they need to speak to them.
- Nurses told us that matrons were visible and supportive and felt able to raise concerns and were listened to.
- Two ward managers told us that they were relatively new in post. They told us that their matron had been supportive. One ward manager told us that they had been concerned about the ward skill mix with junior and inexperienced nurses. They told us that the matron had agreed and had facilitated the transfer from other more established wards to ensure that more experienced staff were available.

Culture within the service

- Staff told us that the hospital was a friendly place and they liked coming to work.
- Staff in several areas we visited commented that they were "A good team". They told us that they would recommend the hospital to their friends and family for care and treatment.
- Staff commented that patients come first.
- Staff were encouraged to complete incident forms or raise concerns. Staff felt that these concerns were usually adequately addressed and were appropriately responded to by senior managers. However some staff on cardiology told us they had been discouraged from reporting their staffing concerns.
- All the managers told us that they were proud of their team and their commitment to high quality patient care.
- Medical staff told us that there was "A culture of audit and improvement" within the trust.

Public engagement

- There were walkabouts undertaken by the executive team during which patients were spoken to about their experiences of care within medical services. Some but not all of the nurses we spoke with were aware that visits had been undertaken.
- There were patient group involvement for the stroke or cardio patients. For example there was a Stroke User Group which met regularly at West Park Rehabilitation Hospital.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with staff.
- Managers were visible on the medical wards. Staff spoke positively about ward managers and matrons and the support they provided.

Innovation, improvement and sustainability

- There were appropriate systems in place to review service delivery and when needed ensure that lessons were learnt and appropriate actions taken. As a consequence of medication incidents, nursing staff involved have to complete additional training and assessment.
- Medicine services had a trust cost improvement programme. We had mixed comments from staff about the cost improvement plan. Some staff were concerned that when shifts were unfilled the decision not to use agency was an inappropriate cost saving. Staff also said

they thought that a lack of basic equipment was the result of an effort to save money. However the trust refuted these, pointing out that staffing and equipment had never been part of a cost improvement programme.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital offers emergency and elective surgical procedures on an inpatient basis as well as day case surgery. Surgical specialities include general surgery, cancer surgery, trauma and orthopaedics and urology.

There are seven surgical wards (one of which is gynaecology which is being reported in the maternity and gynaecology section), a surgical assessment unit and one Admission / Day Case Unit. There are 19 theatres. Wards that were visited as part of this inspection included trauma and orthopaedics, urology, surgical assessment unit, general surgery, cardiac surgery and ear, nose and throat.

We spoke with 20 patients, 10 relatives, and 30 members of staff. These included nursing staff, healthcare support workers, ward clerks, junior and senior doctors, pharmacists, physiotherapists, operational support staff, and managers. We observed care and treatment and looked at 10 care records including medication charts and pain management records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

Patient safety was monitored on a daily basis and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place. The National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.

The majority of patients were admitted, transferred or discharged in timely manner. The surgical services

achieved the 18 week referral to treatment standards for most specialties. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and how to resolve these.

Are surgery services safe?

Good

There were good systems and processes in place to prevent avoidable harm. Patient safety was monitored on a daily basis. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff told us they were fully supported when they did so. However, we found there was no systematic approach to sharing the learning of incidents across all wards.

Medicines were stored safely and given to patients in a timely manner. The staffing levels and skill mix was sufficient to keep people safe at all times.

There were plans in place to respond to emergencies and major situations.

Incidents

- Surgical services reported no never events since 2011.
- Staff across all areas we visited told us they were encouraged and supported to report incidents. Matrons and ward managers described the processes they used to investigate incidents and how they used investigation findings of incidents to inform their quality assurance processes. For example, when a pressure grade 3 or 4 ulcer is recorded on a ward, staff are called in to a "panel meeting" at which they are asked to present their findings and the panel comprising of the director of nursing and matrons from other areas provide challenge. Staff told us that these meetings whilst highly challenging and highly supportive, enabled them to take the learnings from such events on board and ensure they put in systems in place to prevent such events.
- Nurses, healthcare support workers, and doctors were able to describe changes which were made as a result of incidents. For example, a recent incident of C difficile resulted in increase in a dedicated domestic staff on a ward and changes to the cleaning regimen.
- Staff on individual wards and in theatres told us they received feedback from incidents they reported and that learning points from incidents were shared at staff team meetings.
- Although there was evidence of learning from incidents, learning from incidents which took place on individual

wards was not consistently shared across the hospital. Most of the staff we spoke with were not aware of learning points resulting from incidents which had been made in other areas of the trust.

- Morbidity and mortality meetings were used across surgical specialities to review incidents and unexpected death in order to identify learning and improve services. Senior and junior doctors told us that monthly mortality and morbidity meetings were used to discuss complications and learning points where patient care could have been better.
- Within the surgical division there were a total of 45 incidents reported to the Strategic Executive Information System (STEIS) for the year April 2014 to March 2014. These incidents were, for example, pressure ulcers, slips/trips/falls and delayed diagnosis. We saw that these were discussed in the division's governance meetings and learning was shared with staff in ward or unit meetings.

Duty of Candour

- The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and, where mistakes are substantiated, to offer an apology if the patient experienced a defined level of harm or was at risk of harm. The principles aim to improve openness and transparency in the National Health Service (NHS).
- Staff we spoke with understood their responsibilities with regard to the new Duty of Candour legislation. Staff in almost all areas we visited told us incidents involving potential mistakes in patients' care or treatment were investigated and findings were shared with patients, and where appropriate, their relatives. They also described the need for patients involved in incidents to be given an apology.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. Patients, visitors and staff could access safety thermometer information at the entrance to each of the wards we visited. This included information about falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers.
- Safety thermometer data showed that, for the surgical specialities, the rate of falls and urinary tract infections was better (lower) than the English average.
- The prevalence of pressure ulcers was better (lower) than the English average.
- Nursing and healthcare support staff we spoke with were able to tell us how they used skin care bundles and why, and how they could access support from the tissue viability nurse.

Cleanliness, infection control and hygiene

- The ward areas and theatres we visited looked clean. Overall standards of cleanliness in theatres and in the wards we visited were good.
- We saw that staff across all three areas wore clean uniforms, with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff. Hand washing and sharps disposal was undertaken as per established protocols.
- Cleaning schedules were displayed on the surgical wards we visited and cleaning tasks were clearly identified. Clinical equipment, such as IV pumps, was cleaned by nursing staff.
- Hand hygiene gel was available at the entrance to every ward, along corridors and at the bottom of each patient's bed. We observed good hand hygiene practices on all wards.
- Hand hygiene audits were completed at ward level and monitored at divisional level. Overall, they showed good compliance with hand hygiene standards.
- Each surgical ward had an infection control lead who took responsibility for infection control issues on the ward and who could provide advice and support in relation to infection control.
- Patients and relatives we spoke with had no concerns about the cleanliness of the wards and told us cleaners were regularly seen on the wards.

Environment and equipment

- Equipment was regularly checked.
- Resuscitation equipment checks in all areas we looked at were completed daily. Appropriate resuscitation equipment was available in all the areas we visited.
- Staff said they were able to access equipment that was needed to deliver care safely to patients.
- The trust had ensured all surgical patients had access to patient mattresses that if required could be converted to a pressure relieving mattress.

- We found there was attention paid to patient safety including the availability of pressure prevention aids
- We visited theatre suites and found they were fit for purpose. Maintenance records showed the trust reviewed the safety and suitability of its theatres. Recovery areas were well planned and there were separate recovery areas for adults and children.
- During our inspection, we were provided information by a whistle-blower regarding lack of staff and availability of equipment in Nucleus theatre. This was investigated by the inspectors who found that the Nucleus theatre did not have its own blood fridge and if a particular type of blood was required, staff would need to go to the intensive care unit for that type of blood. This was about 11 minutes away from Nucleus Theatre. Without the necessary complement of staff to do that run, it could adversely affect patient outcome. We highlighted this to the trust who investigated these concerns and undertook formal risk assessment of the current situation. The outcome of this risk assessment was that it was the staffing required for the transportation of blood from the blood fridge to Nucleus Theatres that was the issue and not the location of the blood fridge. As a result, the recruitment of additional staff that was being undertaken would help resolve the matter. The trust had taken action to resolve this.

Medicines

- Medicines were stored safely. The temperature of medication fridges was monitored.
- Patients we spoke with told us they were given good explanations of their medicines and usually understood why they had been prescribed.

Records

- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre.
- Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- The paper patient records we looked at were generally legible and well maintained.
- Surgical safety checklists (based on the World Health Organisations WHO checklist) should be used at each stage of the surgical pathway – from when a patient is transferred to theatre until return to the ward. In the patient records we saw, WHO patient safety checklists were always completed.
- However, during one observation undertaken in theatres, we observed there was no formal "sign in" in the anaesthetic room. There was no introduction by the anaesthetist and no "pause" to discuss issues covered by the surgical safety checklists. There were delays whilst additional anaesthetic help was arranged by the anaesthetist. However, there was no explanation given to the surgeon or the theatre team. During the same observation, a full formal "time out" was taken and this was well embedded.
- We looked at 15 patient records in the recovery area for theatres. We found that documentation intended to alert staff to patients who were deteriorating was available.
- In all other areas we visited, patients had clearly documented treatment plans written by doctors and nursing care plans were in place. There were records of care from physiotherapists, dieticians, and pharmacists. Patient records on surgical wards were usually complete.
- We saw evidence of risk assessments completed for each patient when they were admitted onto a ward. For example falls risk assessments were undertaken to alert staff to potential falls risks. There was a system to identify patients who were at risk of developing a pressure ulcer which provided prompts on the actions to be taken to manage the risks.

Safeguarding

- Training records shared with us by the wards we visited for its surgical divisions, showed a high take up (over 90%) of safeguarding training by nursing staff. Nursing staff told us they had safeguarding training and were aware of safeguarding procedures and protocols. They were able to describe situations where they would raise a safeguarding concern.
- Nurses who had raised safeguarding concerns explained how they had done so and how such concerns were investigated and addressed.
- Staff on all the wards we visited could identify a safeguarding lead to whom they could go for advice and support.

- There had been no reported safeguarding incidents relating to surgery at the hospital during the past 12 months.

Mandatory training

- There was an induction programme for all new staff. We spoke with six new staff on various surgical wards and they were complimentary about the trust's induction programme. They told us they felt well supported when they started working in the trust. They were able to describe induction arrangements and what was included in their induction.
- We saw the training figures for nursing staff for mandatory and statutory training for the surgical division. This included fire, infection control, moving and handling and code of confidentiality. All these were over the 90% trust target. Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and could describe what was included in the training. Theatre and ward managers told us they monitored attendance at mandatory training and their staff were up to date.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was daily involvement by the ward and theatre managers and the matron to address these risks. For example, all wards had a daily written safety briefing that took place during nursing handover to identify patients at risk of harm. These safety briefings included review of staffing, bed capacity issues, risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- If a patient's health deteriorated, staff in theatres were supported with anaesthetist input and on wards were able to contact the surgeon or in urgent situations the critical care outreach team.
- Staff used a surgical safety checklist based on the internationally recognised WHO checklist to ensure required pre- and post-operative safety checks were undertaken. The trust conducted an audit of compliance with its WHO surgical safety checklist in April 2015 and found overall compliance with required standards was at 100%.

Nursing staffing

- Staffing levels on the trauma and orthopaedic wards had been recorded on the trust risk register. At the time of our inspection, there were 16 vacancies across two wards (A5 and A6). The trust had taken appropriate actions to mitigate this risk by recruiting more nurses and healthcare assistants. The trust had recently recruited five nurses who were going to start in July 2015. There was a commitment by the trust to fill all 14 vacancies with the right candidates. Until then, there were plans in place to ensure the ward was safely staffed. We spoke with staff on the wards who told us that the orthopaedic wards were improving and the appointment of a new ward manager and matron had a positive impact on the wards.
- At the time of the inspection, the ENT department had been running with vacancy levels of 30%. Though the department was safely staffed with bank staff, the service had recently recruited three additional staff and would be in post by July 2015
- On the surgical admissions unit they had a handover each morning to discuss the day ahead and their planned admissions. They had the required staffing levels in place. We spoke with seven nursing staff who told us there were enough staff on the ward. We cross checked this information with 4 randomly selected sets of weekly rotas that also confirmed staff numbers on the ward.
- The day unit staff told us they had the correct number of staff as per their allocation.
- The nursing staff on surgical wards told us they were working at their allocated numbers.
- The staffing levels for theatres to include anaesthetics and recovery were meeting the Association of Perioperative Practice (AFPP) guidelines. They had recruited from overseas to fill vacancies and the staff from overseas we spoke with told us they were well supported through training and induction.

Surgical staffing

- This trust had slightly more consultants at 44% compared to the England average of 40%. They had 7% middle grade doctors compared to England average of 11%. For the registrar group they were slightly less at 34% compared to England average of 37%. They also had slightly more junior doctors at 14% compared to the England average of 13%.
- There was a daily safety and staffing briefing in theatres.

- We were shown copies of the duty rotas for out of hours cover. This showed junior doctors, middle grade and consultants were on call.
- There was 24-hour consultant on call cover for the surgical wards, seven days a week. Nursing staff told us there was no difficulty in getting support from a consultant. They said consultants were easily contactable and responsive.
- Junior doctors were part of the 'hospital at night team' that stayed on site for emergencies. We were told they could contact senior staff for support if required.

Major incident awareness and training

- There was a trust major incident plan and staff were able to tell us their role in it. They said they had major incident exercises to practice and ensure their familiarity with the plan.
- Emergency plans and evacuation procedures were in place.
- Staff told us about the hospital's business continuity plans and said these had been used to manage demand for services over the winter.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.

Improvements in general health and condition-specific indicators after procedures were slightly better than the England average. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place.

The trust had overall good results in the National Lung Cancer Audit 2014 and most of the results of the National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist where the trust performed worse than the England average.

The majority of patients had a positive outcome following their care and treatment. Patients received pain relief suitable to them in a timely manner.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Most staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Surgical services adhered to National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of patients.
- Staff told us NICE guidelines were discussed at clinical governance meetings and we saw this in the minutes and records of these meetings.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommendations.
- The use of national guidelines and the enhanced recovery programme was used, where relevant.
- Regular clinical governance meetings were held to discuss changes to guidance and the impact of changes on services.
- The trust participated in relevant national clinical audits for surgical procedures. There was also evidence of a trust-wide audit and ward based audit programmes which were used to monitor the quality of care.
- Results of audits were disseminated and this was noted in the clinical governance meetings minutes we saw. Ward staff told us they received feedback from audits done on their wards.

Pain relief

- In the national inpatient survey published in April 2015, which included 361 respondents, the trust scored 8.0/10 for pain management. The trust scored 'about the same' in this area as similar trusts nationally.
- In theatres, there was a system in place whereby an intravenous morphine prescription was sometimes used by anaesthetists so that the patient relief was provided immediately.
- There was a dedicated pain team that could be accessed for support in controlling patients' pain. Staff told us the pain team was easily accessible and could be contacted for support when required.
- A system of assessing pain called the 'Abbey Scale' was used to assess pain in patients who could not

communicate well. Staff told us they usually used this scale with patients who have learning disabilities and who are unable to verbalise how much pain relief they require.

- We inspected 10 patient records which showed patients were given pain relief and, once patients were given pain relief, they were usually asked later whether the pain relief was sufficient to control their pain.
- All patients we spoke with reported that their pain was well-controlled and staff provided them with pain relief promptly when requested.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the wards.
- A malnutrition screening tool (MUST) was used to identify patients who were at risk of malnutrition. Patients identified as being at risk were referred to a dietician and we saw care plans were in place to address special requirements. Fluid balance charts were used to monitor patients' hydration status.
- We observed that patients usually had access to drinks which were within their reach although there were few exceptions.
- The patients told us they were given meal choices and most rated the quality of food as adequate. In the national inpatient survey published in April 2015, the trust scored 5.5/10 for describing the hospital food as good. The trust scored 8.8/10 for having been offered a choice of food and 7.3/10 for being given enough help from staff to eat their meals, if they needed this. The trust scored 'about the same' in all these area as similar trusts nationally.
- We observed meal times and found patients who needed assistance were identified to staff and were being provided with necessary assistance.

Patient outcomes

- The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- The Hip Fracture Audit 2014 highlighted that 79% of patients with a hip fracture received surgery within 48 hours; this was better than (above) the England average, as was the trust's score for patients receiving a preoperative assessment by a geriatrician. According to the survey, the percentage of hip fracture patients developing pressure ulcers post-surgery was worse than the national average. Data showed the length of stay of patients with hip fracture was lower (better) than the England average.
- The surgical division took part in national audits, for example, the elective surgery Patient Reported Outcome measures (PROM) programme, national hip fracture database and national joint registry.
- PROM scores for improvements in general health and condition-specific indicators after procedures were slightly better than the England average.
- Results from the national emergency laparotomy audit 2014 were varied and identified a number of required policies and procedures were not yet in place.
- The trust had overall good results in the National Lung Cancer Audit 2014. The results of the National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist where the trust performed worse than the England average. There were action plans to address these gaps.
- Standardised relative risk readmissions for non-elective surgery at New Cross Hospital compared favourably with national comparators. However, data showed urology elective readmissions were significantly higher than the national average.

Competent staff

- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.
- Medical staff told us there was good access to clinical supervisors within the trust.
- Junior doctors told us there was good support and teaching from senior house officers.
- Nursing staff told us they received annual appraisals and regular supervision.
- All nursing staff on band 6 on the orthopaedic wards had been on a specific orthopaedic training programme designed to uplift the skills of the nursing staff and give them the necessary confidence to care for this group of patients.
- The trust had a procedure it was following to achieve revalidation for medical staff.

- Approximately in 2013, the trust ensured that all surgeons received a full five days training programme offered by the Association of Perioperative Practice. This ensured all surgeons were compliant with sign out briefs and debriefs in theatres.
- The trust had ensured staff were trained on the use of high risk medical devices. It was now undertaking a similar programme for medium risk medical devices. The results of these were submitted to the board on a regular basis.
- The directorate had two healthcare assistants dedicated to check equipment and label them appropriately.

Multidisciplinary working

- There was evidence of multidisciplinary team working on all the wards we visited. Staff on wards confirmed that the multi-disciplinary approach was part of the culture of the trust.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these.
- We inspected ten patient records that showed care and treatment was provided by a variety of healthcare professionals including nurses, doctors, pharmacists, physiotherapists, dieticians, social workers and others.
- Staff on orthopaedic wards told us that the physiotherapy teams worked very well with ward staff in an integrated manner and this had a positive impact on patient care. Staff described physiotherapy staff as “effective and passionate” about the care they provided.
- Patient records showed patients were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.

Seven-day services

- Staff told us there were consultant led seven-day services. Patient records we looked at showed surgical patients on surgical wards were reviewed during the week and at weekends.
- Staff told us access to medical advice at night came from the hospital at-night team, although junior doctors could contact consultants if they needed to. Staff told us the hospital at night team provided advice and assistance when needed.
- Physiotherapy was available seven days a week for orthopaedic patients. Reduced physiotherapy was available on weekends for patients who needed it.
- Radiology on call services were available at all times, including weekends. Staff could access CT scans, MRIs, ultrasounds and emergency plain films. Services were consultant led.

Access to information

- Patient records were stored in hard copy. When patients were transferred between wards, all their nursing and medical records were transferred with them. Staff told us they always provided a verbal handover as well as the written records.
- Staff told us about the handovers between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.
- Nursing staff told us when patients were transferred between wards they received a handover.
- We found patient discharge summaries were not always sent immediately when the patient was discharged from hospital. This posed a risk that patients might not have received the care they needed when they returned home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required.
- Where patients were confused or there was a question about their capacity to consent, mental capacity assessments were undertaken by medical staff to determine whether they could make decisions relating to their care and treatment.
- However, we found a few ward staff were not clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They were unable to summarise the key points of the MCA and the implications of the MCA on their work.

Surgery

Are surgery services caring?

Good

Staff were caring and compassionate and treated patients with dignity and respect. The results of the NHS Friends and Family test were better than the England average. Privacy and dignity were maintained. We spoke with 20 patients and most spoke positively about their care and the way they were treated by staff. Patients spoke positively about the staff who looked after them. There was emotional support for vulnerable patients.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us they had no concerns about how staff maintained their privacy and dignity. For example, we observed staff closing curtains when providing personal care and interacting patiently and respectfully with very confused patients.
- We found privacy and dignity maintained at all times.
- Many of the patients we spoke with felt staff treated them with compassion and empathy. They generally felt well cared for and told us staff were responsive to their needs.
- We did not observe any breaches of single sex accommodation. Staff told us a breach of single sex accommodation was rare and would be reported as an incident.
- Each ward had details about their friends and family test results. For example, on ward A12 for April 2015 they had a response rate of 41% and of these they had a positive score of 95.2%. On ward A14 they had a response of 48% and of these 96.4% were positive.
- Patients on the day surgical unit told us the staff were “great” and “very helpful”.
- We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.

Understanding and involvement of patients and those close to them

- Patients told us they were kept updated with their condition by doctors and nurses. One patient said “they keep changing what is happening to me”.
- We spoke with patients who had undergone surgery. They told us they had been given details about the operation and what to expect post operation.
- Patients told us they were pleased with their pre-operative assessment. They said they were given sufficient verbal and written information about their procedures and their questions were satisfactorily answered.
- Most of the patients and relatives we spoke with said they felt involved in their care. They said they were given opportunities to speak with the consultant looking after them and to ask questions.
- Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families, in planning and providing care and treatment.

Emotional support

- Clinical nurse specialists were employed throughout the trust to provide support and advice to patients undergoing various types of procedures. We saw and spoke with a number of clinical nurse specialists on the surgical wards we visited.
- Almost all the patients we spoke with praised staff for their responsiveness, friendliness and emotional support.

Are surgery services responsive?

Good

Services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Concerns were addressed at a local level before the issues resulted in a complaint. The majority of patients were admitted, transferred or discharged in a timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties.

Service planning and delivery to meet the needs of local people

- The Hip Fracture Audit 2014 highlighted that 79% of patients with a hip fracture received surgery within 48 hours; this was better than (above) the England average, as was the trust’s score for patients receiving a preoperative assessment by a geriatrician

- Recognising the needs of the aging population, the trust had recently agreed a business case to recruit an orthogeriatrician across both sites. This post was going to be advertised shortly.
- There was a surgical waiting list initiative in place on Saturdays. The trust undertook two lists every Saturday.
- To meet the needs of local people, there were plans in place to increase beds for the centralised head and neck emergencies, and these will be accommodated on the Surgical Assessment Unit (SAU). Staff told us that these plans would only be implemented subject to the trust recruiting appropriate nursing cover.
- The trust told us they were planning to reconfigure some more of their services. This is where a specific service is moved to one location rather than being at both hospitals. Senior staff told us that prior to any discussions being made they would consult with staff and the public.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patients admitted via accident and emergency or GP referral were directed to the surgical assessment unit. The unit also had three assessment rooms and a seated area for up to eight patients that were waiting to be assessed by staff.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- The trust had recently appointed a “flow co-ordinator” who was responsible to ensure patients were effectively discharged to nursing homes. Staff told us that this had improved discharge arrangements.
- There was a discharge lounge that operated between 0800-2200. We observed arrangements were in place for patients to be given food and drink if there were delays in their transport or medicine to take home.
- Surgical doctors told us they were issued with a daily list of surgical patients across the hospital’s wards and they made sure surgical outlier patients were seen daily.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation. There was a designated area in recovery for critically ill patients that required stabilising prior to transfer to the intensive care unit (ICU).
- Bed occupancy of the trust was significantly higher than the national average. 85% occupancy level is the accepted level at which bed occupancy can start to affect the quality of care afforded to patients and the systematic running of a hospital. The trust’s bed occupancy rate of 90.2% between April-June 2014 was higher than the England average of 88%.
- The trust was not meeting the 18-week referral-to-treatment time (RTT) target of 90%. The specific specialities meeting the targets were urology, oral surgery, plastic surgery and cardiothoracic surgery. Overall, since April 2013 to April 2015, the trust met the standard set by NHS England only once. It performed better than the England average six months out of the 25. It performed the same as the England average five months out of the 25. Fourteen months out of 25, it performed worse than the England average. The specific specialities not achieving the target included general surgery, trauma and orthopaedics, ophthalmology and ENT. The plan to ensure these specialities met the 18-week RTT target of 90%, was to add additional patients to the operating lists to avoid cancellation. This had not yet started.
- NHS England data showed that between April 2011 and March 2015 the trust performed better than the England average for the number of patients whose operations were cancelled and were not treated within the 28 days. For the period April 2011 and March 2015, for those patients whose operation had been cancelled, staff arranged a new date with the patient on the day of cancellation. The trust honoured the new date given and the operation was never cancelled again.

Meeting people’s individual needs

- There were arrangements in place to respond to the needs of patients with special needs and staff in all the areas we visited were aware of these. Staff told us there was a specialist learning disabilities nurse whom they could access for advice and support.
- Patient information leaflets about different conditions and surgical procedures were available in the hospital and on the wards we visited. Leaflets were only available in English.
- The theatre recovery areas had designated paediatric recovery bays. These were separate to adult recovery area and were quiet.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The ward manager on the ENT wards told us patients were provided with a choice of meals. The result was patient satisfaction with the service increased. Patients provided positive comments to the nursing staff about the care and their well-being.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.
- We observed there were no resting seats between wards C1 to C19 and from C24 to C37. These were long intervals for people with mobility issues to walk without resting.

Learning from complaints and concerns

- The service had a proactive approach to handling complaints. They addressed concerns at a local level before they became a complaint. Staff told us that this proactive approach helped reduce the number of complaints and gave them opportunities to learn from these complaints.
- We were told how one ward invited someone who had received poor care on the ward to come and share their experience at a staff meeting. The ward sister told us this helped staff receive feedback and encouraged reflective practice. Nursing staff we spoke with also welcomed this initiative.
- Information related to complaints was reviewed at ward level and staff told us they received feedback about complaints at team meetings. Staff were able to give us examples of complaints and changes which were made in response.
- Information boards on many of the wards we visited showed information about key concerns raised by patients and relatives and the ward's response. This took the form of "you said, we did" posters.

Are surgery services well-led?

Good

The trust had a vision and strategy in place. Senior staff in the surgical service had outlined a service business plan on how they would contribute to this overall vision. Staff in all areas knew and understood the vision and objectives. The focus on patient safety was highlighted as a central

The organisation had audit processes to monitor performance against objectives.

The service proactively engaged and involved staff and ensured that voices of all staff were heard.

Vision and strategy for this service

- The trust had a vision and strategy in place. Senior staff in the surgical service were aware of this vision and had outlined a service business plan that incorporated how they would contribute to this overall trust vision.
- The service business plan incorporated the trust's overall strategy and had specific performance targets and action plans relating to safety, quality and patient outcomes. These included plans for improving compliance with national clinical audits and developing care pathways and improvements in patient admission processes.
- The trust vision and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.

Governance, risk management and quality measurement

- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- During the inspection, we looked at the surgical divisional risk register and saw that key risks had been identified and assessed. This risk also appeared in the trust wide risk register. The risk register was reviewed at routine clinical governance meetings.
- In each area we inspected, there were regular staff meetings to discuss day-to-day issues and to share information on incidents and audit results.
- There were audit and monitoring of key processes across the wards and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to wards and theatre managers. For example, cancellation of operations were analysed and reported at monthly clinical governance meeting.

Leadership of service

· Staff told us they felt supported by and listened to by their immediate line managers, divisional management and the executive board.

· Staff we spoke with knew who the chief executive and nursing director were. Nursing staff said they felt well supported by the nursing director and all said they could approach the leadership with any concerns.

· Senior nursing staff told us they felt they were being listened to by the executive team and there was a real focus on patient safety.

· Staff also told us about the executive walk around and how they had taken part in these and fed back any issues they might have had.

· All staff spoke highly of their immediate line managers and felt well supported by them

Culture within the service

· A number of staff we spoke with said they had worked for this trust for considerable number of years and all said it was a good place to work.

· Staff told us they would feel comfortable in reporting any concerns to their line manager or a senior member of staff. Staff were also aware of the trust's whistle blowing policy and raising concerns policy and where to find them. Concerns were investigated and lessons from these were acted upon.

· Staff told us there was an open culture that was not about blame. They were encouraged to report incidents as it was seen as by the trust as important learning.

Public and staff engagement

- Theatres and ward-based staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.
- The trust's proactive approach to complaints had resulted in a positive outcome with a reduction in complaints.

Innovation, improvement and sustainability

· The trust had recently instituted the "In Charge" initiative. This was a badge worn by the person responsible for that shift on the ward. Patients and relatives we spoke with welcomed this initiative.

· The cardiothoracic department recently introduced an innovative system to drain chests after cardiac operations. Staff told us this innovation sets a new standard in thoracic drainage therapy and had reduced patient length of stay in hospital.

· Recently (November 2014) the orthopaedics wards had a high number of incidents relating to patient safety and poor patient experience. The matron who was in charge of the service took plans to reduce the ward by six beds to senior managers and thus improve the service. This plan was agreed and put in action in December 2014. The matron restructured the wards to meet the needs of patients. For example, there was an improvement in the mandatory training programme for nursing staff from 60% in December 2014 to 90% in April 2015. During the inspection in June, we observed the improvements had begun and there were indicators the matron was using to continually monitor and improve.

Critical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The critical care service at the Royal Wolverhampton Hospital NHS Trust is provided at New Cross hospital. The service has a total of 28 beds allocated to adults. The hospital undertook approximately 800 elective operations a year and a further 100- 200 urgent surgical operations a year. Critical care included areas where patients received more intensive monitoring and treatment for life threatening conditions. The hospital provided special expertise and facilities to support vital functions using the skills of medical, nursing staff and other members of the multi-disciplinary team. Patients receiving coronary care were also treated within the critical care service. The unit included an outreach service.

As part of our inspection we visited the integrated critical care unit. We spoke with six patients, four relatives and 22 staff. These included nursing staff, junior and senior doctors, a pharmacists, domestic staff, therapists and managers. We observed the care and the treatment patients were receiving and viewed 11 records. We reviewed performance information about the service.

Summary of findings

Critical care services required improvement to support safe care. There were significant risks posed by the infrastructure and environment of the integrated critical care unit (ICCU). Medical staffing was appropriate and there was good emergency cover. The storage of medicines in the integrated critical care unit (ICCU) required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines. We found intravenous medicines were mixed within the storage room visited which could lead to the misadministration of medicines to patients.

Staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control.

The critical care service demonstrated good effective care. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. The service participated and provided data for the Intensive Care National Audit & Research Centre (ICNARC). This ensured that the practice was benchmarked against similar services. Policies and procedures were

accessible to staff. However, we saw that some hard copies of policies were dated 2007 to 2014 with no evidence of review. Staff told us they were able to access up to date policies on the trust's intranet system.

Patient's pain was appropriately managed as was the nutrition and hydration of patients. Staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service. Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We observed good care within the ICCU. Staff cared for patients in a compassionate manner, with dignity and respect. They involved patients and, where appropriate, their relatives in the care. Emotional and spiritual support was also provided.

The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients had follow-up support from the outreach team.

Patients with a learning disability were provided with the necessary support. Staff also had access to translation services. Complaints were handled appropriately.

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We found that critical care services required improvement to be well-led. Most staff were not aware of the vision or strategy for the critical care service.

The ICCU held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register.

There was a culture of support and respect for each other, with staff willing to help each other. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.

Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Critical care

Are critical care services safe?

Requires improvement

Critical care services required better procedures to support safe care.

The service did not have clear procedures for the disposal of used blood bags or the cleaning of equipment which we found to be dusty and dirty. We found intravenous medicines had been mixed up in the storage area which meant there was a risk of patients receiving incorrect care. The storage of medicines was not secure and action was required to reduce the possibility of misappropriation of medicines.

Critical care staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control. Medical staffing was appropriate and there was good emergency cover.

The hospital's critical care safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical handovers were well structured within the unit whereby they discussed the patient's well-being.

Incidents

- There have been no "never events" reported in critical care between April 2014 and March 2015. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- During April 2014 and March 2015 three serious incidents were reported in critical care which required investigation. Two were related to unexpected deaths and the other to a grade three pressure ulcer. A further 35 incidents were reported through the National Reporting and Learning System (NRLS) for critical care of which 27 were classed as "no harm", six as low harm and two as moderate harm. We were shown a copy of the action plans that had been recently developed and saw how the learning was shared across the department through team meetings.
- We saw that there had been 21 recorded incidents within the unit in April 2015. We saw the majority of these related to medicine errors with no effect to the patient. The records identified the action taken for example; additional medicine administration training.
- The integrated crucial care unit (ICCU) used an electronic system to record incidents and staff said they knew how to report incidents. Staff were able to describe the types of incidents they would report for example, challenging behaviour.

Duty of Candour

- The responsibilities of Duty of Candour was already embedded into the running of the ICCU.
- Staff understood their responsibilities with regard to the new Duty of Candour legislation. The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake resulted in a severe or moderate level of harm. Staff described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not.
- Staff were able to describe the process to follow which involved a conversation with a patient explaining what had happened and how they would provide assurance this would not occur again.

Safety thermometer

- The NHS Safety Thermometer information was displayed on the ICCU. The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included for example; new pressure ulcers, catheter-related urinary tract infections (UTI's), venous thromboembolism (VTE), and falls.

Cleanliness, infection control and hygiene

- We observed, during our visit, used blood bags stored in the sluice room. We saw these on 04 June 2015 and on our return visit on 05 June 2015. This meant the blood bags had been left unattended for at least 36 hours. We asked senior staff to address the matter and we observed the appropriate disposal of the blood bags.
- We found that during our visit on 04 June 2015 the utility room which held cleaning materials was unlocked. This was brought to the attention of senior staff. We were informed that this room would be locked when not in

use and remain open when in use by the domestic staff working in the area. During our revisit on 05 June 2015 we saw this matter had been addressed and a secure entry system had been installed.

- Cleaning of the unit was carried out by permanent members of staff specifically allocated to the ICCU. However, on our visit to the unit we did not see a cleaning schedule in place which meant that staff could not ensure that the standard of cleanliness was being maintained. However, the trust informed us that a cleaning schedule was displayed in the main noticeboard within the clinical area. They told us there were also additional cleaning books and duties by the nurse's bed station.
- Staff had received training on infection prevention and control at induction and during mandatory training. The records showed that 89% of non-clinical staff and 97% of clinical staff had received their infection control training.
- Staff were aware of the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to. There were hand-washing facilities and protective personal equipment, such as gloves and aprons, available. We observed that not all staff used gloves and aprons and did not always change these between attending to patients. This was brought to the attention of the senior sister during our inspection.
- We saw good procedures in place for a patient diagnosed with campylobacter (a group of germs (bacteria) that are a common cause of food poisoning). We observed staff adhering to infection control processes. The records identified daily microbiological review. However, we saw the door of another patient diagnosed with an infection being propped open. This meant there may be an elevated risk of infection to people who used the service. This was brought to the attention of senior staff. Staff however could articulate the rationale for the propping open of doors whereby the infection was not airborn and effective risk assessments had been undertaken to reach this decision.
- There were effective arrangements for the safe disposal of sharps, including the dating of when the sharps box began to be used. All sharps boxes we inspected had their lids closed and were not overfilled.
- There were information leaflets and posters on display in the relatives' room and on notice boards about how visitors could help prevent and control infection when visiting the ICCU.
- The unit contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) which was evaluated against similar departments nationally. The ICNARC data for 2013/14 showed that the trust had two infected patients; one with methicillin-resistant staphylococcus aureus (MRSA) and the other with vancomycin-resistant enterococci (VRE). VRE is a bacteria which is resistant to many antibiotics.
- We checked the store room and found a renal filtration machine and a nasogastric (NG) feed pump which were dirty**.** NG intubation is a medical process involving the insertion of a plastic tube through the nose, past the throat and down into the stomach. We also found a dirty and taped up TV/Video remote control.
- We saw two "continuous positive airway pressure" masks which were out of date. The masks are used as a sleep aid for people with sleep apnoea. These were disposed of by senior staff.
- We were unable to identify which equipment had been cleaned as they did not display the "I am clean" stickers. We saw clean/decontaminations stickers were available but not used.

Environment and equipment

- The units environment was bright and spacious and in good decorative order. There was adequate space between each bed area.
- There was a specific room that was used by relatives to stay in, and there was also a sofa bed within it for relatives to use.
- There were regular safety checks of medical equipment used in the ICCU, signed by the individual undertaking the checks.
- The resuscitation team checked their equipment each day which included; the defibrillators and the "bleep" to ensure they were working properly. We saw the records which showed these equipment's checks were undertaken daily.
- We saw the cardiac arrest trolley audit for 2015 and found the records identified inconsistencies in the daily

checking within ICCU. This was confirmed in the records viewed. The trust had introduced a new resuscitation booklet but we found there was no structure within the unit regarding the completion of the booklet.
- The unit had three resuscitation air bags. During our inspection we found that one of the bags was out of date. Senior staff removed the bag to ensure that it would not be used.
- One of the safety checks included fire safety arrangements, we saw that the fire doors into theatres from the unit were broken and remained open. This had been a problem since October 2013. It had been reported and repaired numerous times but a final solution had not been found. The fire risk is acknowledged on the directorate risk register which incorporated actions with regard to the fire door. During our inspection we raised the issue and engineers were present on 05 June 2015.
- We saw that all safety alerts were reviewed by the matron. Any alerts identified for the unit were placed in the staff folder and noticeboard and included in handovers. This was confirmed by staff spoken with.
- All equipment used by the unit were managed by the technicians. We saw they were able to track equipment on the trust's intranet site using a tag system. Some staff said that occasionally new equipment was introduced without an implementation plan or training. This meant there was a risk of patients being attended by staff who may not have knowledge of the equipment being used.

Medicines

- Within the storage cupboards we saw that intravenous (IV) fluids for saline and potassium were mixed up. We saw out of date medicines identified for "training" were stored with medicines which were in daily use. There was a risk of staff accessing and administrating incorrect medicines to patients. These were brought to the attention of senior staff who arranged for the storage of medicines to be reviewed and re-stored.
- Controlled drugs were safely and securely stored. We looked at the controlled drugs book for each area and found that the records accurately reflected the supply. The process for reviewing and recording controlled drugs was in line with the Royal Pharmaceutical Society guidelines.
- The medicine records of 11 people we looked at during our inspection were found to accurately reflect the prescribed and administered medicines for those patients.
- The medicines and stock records were accurate.
- The area used to store medicines in the ICCU was not locked and there was a risk of unauthorised people accessing medicines. This was brought to the attention of senior staff.
- Fridge temperatures were monitored daily; this ensured medicines were maintained at the recommended temperature and the checks were signed by the individual undertaking these checks.
- Senior staff told us the fridge which stored blood was not working and had been out of action for six weeks. Staff said they utilised blood which was stored and situated 10 minutes from the ICCU. In an emergency, staff said they had access to blood within the adjacent theatre fridge. We saw evidence requesting the fridge to be serviced and the purchase order for new software in relation to the fridge.
- There were arrangements for the effective access to medicines out of hours. The ICCU had its own allocated pharmacist who visited the unit daily and reviewed all medical prescriptions to ensure sufficient stocks were available. Doctors told us that their input as part of the multidisciplinary team worked very well.
- We saw the medicines were audited by the pharmacists who did not identify any issues or concerns.

Records

- We reviewed 11 records of patients using the service. Medical and nursing records were in paper form and followed the same format which meant information could be found easily. The unit also used the electronic VitalPAC observation system. The system replaced paper based observation systems and manual Early Warning Score (EWS) calculations with easy-to-use touch screen technology.
- Records were completed and stored in accordance with trust policies.
- Records were designed in a way that allowed essential information, for example, allergies and medical history to be documented and easily viewed. The records contained treatment details and care plans.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for falls, pressure ulcers and nutrition screening.

- The wards had care plans to identify what care should be given to patients. This meant that staff had access to information on how to care for a patient.
- Vital signs were well documented along with cardiac and respiratory indicators. Observations were clearly recorded.

Safeguarding

- Most staff were able to explain safeguarding arrangements and said they would raise any queries with the senior sister on duty. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients.
- The training records within the service identified that 100% of medical and nursing staff had attended their safeguarding training.

Mandatory training

- The consultants said they ran an in-house cardiac advance life support course which was well supported by staff.
- Resuscitation officers provided training in basic life support, intermediate life support, advance trauma life support and care of the critically ill patient. They told us this was mandatory training for staff working in the unit.
- We saw that 83% of staff had completed their basic life support training as of April 2015. Staff told us they had a couple of link nurses who monitored the training and identified staff who needed to attend. The training was made up of two parts which included face to face training and a practical assessment. Anaesthetists completed two sessions on life support training which covered both adults and paediatrics.
- The unit had a training plan for all nursing staff to ensure they met their mandatory training targets. Data provided for April 2015 showed that the unit had an overall rate of 97%. For example; pressure ulcer and manual handling was at 96% and infection prevention at 98%.

Assessing and responding to patient risk

- The national early warning score escalation process for the management of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients were monitored using recognised observational tools. The frequency of observations was dependant on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patients' condition. This meant deteriorating patients would be identified and action taken and escalated to the appropriate team without delay.
- The resuscitation team were a part of the cardiac arrest team and covered the "bleep." Each morning there was a team handover run by the registrar to review all cardiac arrests attended to.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission and prophylactic therapy initiated for VTE prevention.
- Staff from the Critical care outreach team told us they operated from 08:00-21:00hrs. However, the trust informed us they were able to provide an outreach nursing team throughout the organisation 24 hours a day seven days a week. At night an anaesthetist was usually available, but not in every instance.

Nursing staffing

- The consultants said they had good staff and the retention of cardiac nurses was excellent.
- We saw the staffing rosters and found that staff worked on a rotational basis of days and nights. All level 3 patients were nursed one-to-one, and level 2 patients were one nurse to two patients.
- The business manager of critical care told us they had adequate staff to meet the patient's needs. Where there were shortfalls in staffing levels, they were covered by bank (overtime) staff. The unit did not use agency nurses.
- The matron had the responsibility to ensure there was always adequate staff with the right skills. The rosters seen demonstrated adequate staffing levels. On the day of our inspection there were enough staff on duty.
- We saw the staff sickness levels within ICCU from January 2015 to May 2015 which averaged 7%. We saw this had increased from 6% for the whole of 2014. Staff said there had been some restructuring within the unit during December 2014 and January 2015 which had impacted on staff morale. We saw the sickness level figures showed a steady decrease each month from February 2015.

Medical staffing

- Care in the ICCU was consultant-led. The medical staffing included an anaesthetist, consultants and fellow surgeons. They provided cover seven days a week 8am to 8 pm and were available on-call at other times.
- The consultants said that the majority of their middle grade doctors came from overseas. This often caused difficulties with retention as the doctors were predominantly on short term contracts. For example, they informed us that in September 2015 four of their middle grade doctors would be leaving the trust. They also said that communication and training could, on occasions, be challenging.
- We saw the consultants' work patterns ensured continuity of care.
- There were vacancies within ICCU for a consultant intensivist and an anaesthetist. The consultants said they were actively recruiting for these posts.

Major incident awareness and training

- Staff were aware of the procedure for managing major incidents, winter pressure and fire safety incidents.
- We saw a plan located within the staff office regarding evacuation procedures.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds.
- There were emergency battery back-up supplies and this ensured that vital medicines and life support systems would continue in the event of an electrical power cut or a disruption to the supply of medical gases.
- There were clear procedures instructing staffs what to do, for example, in the event of a fire. This meant that staff working in the unit were clear of their responsibility in the event of a major incident.

Are critical care services effective?

Good

The service demonstrated that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patient's care. Policies and procedures were accessible for staff on the trust's intranet system. However, we saw that some policies relating to critical care were dated 2007 to 2014 with no evidence of review. Care was monitored to demonstrate compliance with standards.

Patient's pain was appropriately managed as was the nutrition and hydration of patients. Multidisciplinary working was evident to coordinate patient care. Overall, staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE) and Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided. This included the guidance for rehabilitation after critical illness. Patients had a rehabilitation assessment completed within 24 hours of admission to critical care.
- Policies were accessible for staff and were developed in line with national guidelines such as the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) guidelines for managing patients with a subarachnoid haemorrhage and managing patients with a tracheostomy.
- The unit complied with the NICE Interventional Procedure guidance for the Trans Catheter Aortic Valve Implantation (TAVI). The consultants said they had a TAVI standby list but very rarely received these patients.
- The ICCU used the Ramsey sedation score based on the Intensive Care Society guidelines. This meant that they effectively managed pain, anxiety and sleep as part of the sedation therapy regime.
- Nationally recognised care bundles were followed. These included care bundles to reduce the risk of ventilator acquired infections and central line infections and complications.
- We saw staff utilised the delirium assessment tool in accordance with NICE guidance. This ensured that staff were able to evaluate patients and assess the risks.

- The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The ICNARC data supports critically ill patients by providing information/feedback about the quality of care provided.
- We saw the resuscitation team's trolley annual audit for March 2015. Staff said the audit was incorporated in their key performance indicator. The audit showed they were 100% compliant with the seal, 96% complaint regarding the equipment check and 98% for the expiry date. We saw evidence to asure the appropriate reporting of broken equipment. We saw procedures in place to performance manage bank nurses not aware of how to use the equipment. We saw that additional training had been completed to address this.
- The unit covered all non-invasive ventilation (NIV) treatment. NIV is the management of patients with chronic obstructive pulmonary disease admitted to hospital with acute respiratory failure.

Pain relief

- In ICCU staff followed the unit's protocol on pain control for ventilated patients. Patients were assessed pre-operatively for their preferred pain relief.
- Patients' pain scores were regularly assessed and documented using the pain scale found within the medical early warning score (MEWS) system. Records showed that pain relief was administered promptly and patients' pain reassessed after they had received the pain control medicines.
- Most staff said they had received appropriate training in the use of medical devices to assist with pain control, such as syringe drivers. This ensured that they were used safely and effectively.
- Patients told us that they had received pain control medicines when needed.

Nutrition and hydration

- The unit used the malnutrition universal screening tool (MUST) to assess the nutritional needs of patients. We inspected 11 records and found the assessment tool had been appropriately recorded and utilised.
- In the ICCU, staff followed the protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated. Staff told us there was support and guidance available to support patients' needs.
- The audit data showed that 304 patients (38%) were given nutritional support during 2013/14.

Patient outcomes

- The unit displayed their outcome data on a notice board at the entrance to their unit.
- The cardiothoracic surgical governance meeting reviewed the mortality and morbidity cases within the trust. We looked at six cases; five of which were closed and one which required action to be taken. This was identified in the meeting minutes.
- The cardiothoracic surgical governance meeting also reviewed readmissions. We saw that two cases had been discussed which reviewed the reasoning for readmission and the outcome.
- The resuscitation team collated the number of arrest calls to patients. For example, between January 2014 and March 2015 they had attended 148 arrest calls of which 67 were actual arrests.
- The critical care outreach team had collected a considerable amount of data on the quality of the service. For example, the data identified that the number of ward cardiac arrests had declined over the past year. We saw this trend was continuing and the data from August 2014 to February 2015 showed a decrease from 25 to 13 ward cardiac arrests.
- The annual audit for the ICCU showed a continuous downward trend in the overall Standardised Mortality Ratio (SMR) as measured by the Acute Physiology and Chronic Health Evaluation Classification System (APACHE II). For example; in 2013/14 the overall mortality rates were 18% compared to 21% for 2012/13.
- ICNARC data was displayed in the unit so that patients, their relatives/carers and staff could see the quality of care on the unit.

Competent staff

- Staff confirmed they had received annual appraisals. These processes covered training and development needs and practices. We saw that 100% of staff had received their appraisals.
- The unit had professional development nurses (PDN) attached to the service. They said they monitored all training which we saw was up to date.
- There was an induction programme for all new staff. Data provided for April 2015 showed that 100% of staff had attended their induction. New members of staff said

they had been supported when joining the hospital. They had completed a trust wide induction programme. When on the ward they were given the opportunity to understand processes and procedures.

- All new staff undertook competency tests to ensure they had the necessary skills to carry out their role. The PDN said the trust had bought the rights to the Manchester competencies framework which they utilised. We saw they had created workbooks, which were target based, for staff to complete. Examples of areas covered included anaesthetics and care of deteriorating patients. We reviewed the record of a new staff member which had been completed and signed by senior staff.
- Consultants said the nurses they had on the unit were very good and competent in their role. They said they would like to develop the nurse practitioner role so that they became specialised nurses who could prescribe and insert arterial lines for example.
- The trust had launched a new bereavement service called "The Swan Campaign". The trust provided training exercises for staff to enable them to deal with the emotional circumstances when a patient passed way and support both the patient and relatives appropriately. Staff said they had attended training which they found to be beneficial.
- The physiotherapists provided in-house training to staff. They told us this was not ICCU specific with the exception of the critical care on-call role. We saw competencies in place for the on-call role.
- The outreach team told us they had recently begun to complete the National Outreach Forum (NOrF) competencies for the critical care outreach services framework document. They told us this was a work in progress and would in due course evaluate the data collected.
- The professional development nurse said they facilitated courses for staff progression. Staff told us they had attended the Acute Life threatening Events—Recognition and Treatment (ALERT) course. The course is designed to teach healthcare staff to anticipate, recognise, and improve the quality of care for critically ill patients.
- In the ICCU, 58% of the nursing staff had achieved a post-registration award in critical care nursing.

Multidisciplinary working

- There was a multidisciplinary team who supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit.
- The unit was well-supported by physiotherapists who were available five days a week with an on-call service at the weekend. The physiotherapists had their own morning round. We observed a morning round and saw physiotherapists discussing with the patients their needs before sharing the outcomes with the nursing staff.
- Doctors undertook daily ward rounds which had input from nursing, microbiology, pharmacy and physiotherapy. Input from dieticians and speech and language therapists were sought if needed. We were given an example of a recent patient in ICCU who required expert dietician input and how this was accessed.
- The unit had an outreach team that was fully integrated and provided valuable support in the care of the critically ill patients. The outreach team reviewed any patient who staff felt would benefit from their intervention or whose condition was causing concern. The team also followed up all patients discharged from the ICCU.
- There was a specialist nurse for organ donations based at the ICCU. The unit had good links with the organ donation team. There was support available for potential donors and their families.
- The microbiologist visited the unit daily. However, most of the records read did not identify any guidance from the microbiologist regarding the prevention, diagnosis or controlling of infections. This meant that staff may not have the necessary information to attend to the care and welfare of patients.

Seven-day services

- There was consultant cover for patients in the unit during the day from 8am to 8pm and an on-call service out of hours.
- Consultants carried out daily ward rounds and were available for advice and support at other times.
- There was an outreach team that provided support seven days a week from 8am to 9pm for the management of critically ill patients in the hospital.

- At the weekends, support was available on site from the multidisciplinary team, including microbiology and pharmacy. The unit also had access to a radiologist via the on-call system at weekends.
- The physiotherapists assessed patient's needs Monday to Friday. They provided an on-call service at the weekend.

Access to information

- Staff told us they had good access to patient related information and records whenever required. The bank staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us when patients were transferred between wards staff received a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Whenever possible, patients were appropriately asked for their consent to treatment and procedures. Staff were able to provide examples of patients who did not have the capacity to consent to treatment. The Mental Capacity Act 2005 was adhered to appropriately.
- The senior sister told us that, during our inspection, there was no one who was receiving care under the Deprivation of Liberty safeguards (DoLs). Staff we spoke with were aware of Mental Capacity Act 2005 and DoLs and could show how this related to the patients they cared for.
- The records, where applicable, showed clear evidence of informed consent which identified the possible risks and benefits of surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- Staff confirmed they had received training from the Deprivation of Liberty Safeguards (DoLS) nurse. This was confirmed in the training records seen.
- We saw the DoLS forms were available at the nurse's station and a DoLS flow chart was on display in the nurse's room.

Are critical care services caring?

Good

We observed good care within the critical care service. Patients we spoke with gave us examples of the care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect. Staff provided good care, by understanding what was significant to patients and making arrangements to ensure patients retained what was special in their lives.

Patients said they were kept informed and felt involved in the treatment received.

Compassionate care

- We observed staff caring for patients in a kind, compassionate and professional manner. We saw that patients were treated with the utmost respect and dignity throughout their treatment. Nurses were attentive and were always in close proximity to patients. When they provided care to patients, they always introduced themselves and spoke in a gentle and kind way. However, we saw some staff entering patients side rooms without knocking and introducing themselves.
- We observed staff dealing with a patient with agitated behaviour with compassion and empathy.
- We attended a ward round. However, we observed that doctors did not introduce themselves to patients when carrying out ward rounds although curtains were drawn to maintain patient dignity and confidentiality.
- We observed good interaction between patients and their consultant during our visit. We saw the consultant explained everything to the patient and provided guidance when required to.
- We observed the receptionist speaking to families in a polite way when they visited their relative. One relative said they were "very happy and well informed."
- Patients spoke positively about the care provided by staff. One patient said staff were "helpful and friendly." Another said the care was "fantastic."
- We saw the results of the critical care survey. Examples of the feedback were: "really impressed" and "everyone is "kind, informative and supportive."

Understanding and involvement of patients and those close to them

- We observed staff explaining procedures to patients to help them to understand and be involved in decisions concerning their treatment. Patients told us they were given appropriate information in a way they could understand, and this helped them to be able to make decisions.
- Families said they had been involved in decisions about their relative's care and treatment. We spoke with a family member who told us they had been kept well-informed about the condition of their relative.
- The hospital had an interpreter policy which provided guidelines to staff in the use of interpreters.
- Many patients who attended the ICCU often had little memory of their stay. Patients' treatments were recorded in patient diaries which were completed by nursing staff and families to improve patient memories of their stay. Patients had access to these diaries after they left the unit. If a patient passed away, the dairies were made available to relatives as part of the bereavement process.
- The trust had launched a new bereavement service called The Swan Campaign. We saw a swan box which contained various prayer books, sincere condolence cards and the ability to take photographs of relative's hands. Staff said that friends and families had told them they found this service really helpful during their bereavement.

Emotional support

- The trust had a dedicated bereavement service. Bereavement support was offered through the ICCU 24 hours a day, seven days a week. Staff provided support and guidance to the family.
- Access to specialist nurses was available to support the emotional needs of patients and families. We spoke to a relative and they told us how members of staff spent considerable time with them to help them with their loss.
- Patients from ICCU could access the multi-faith chaplaincy services for support, including clergy and equivalents from other faith groups. Information on how to access chaplaincy services was available through staff. Staff told us they regularly interacted with the trust's palliative (end of life care) team, who provided support and advice during bereavement.
- Staff were passionate and driven to provide good care to patients. For example, we saw staff spending time talking to a patient who was confused and distressed. We also saw staff being supportive to a relative of a patient within the unit.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients that were discharged had follow-up support from the outreach team.

Patients with a learning disability were provided with the necessary support, including the services of a learning disability nurse who shared their expertise with members of staff in the unit. Staff also had access to translation services. Complaints were handled appropriately.

Service planning and delivery to meet the needs of local people

- The critical care unit provided a service for patients undergoing elective and emergency cardiac and general surgery.
- The consultant surgeons said they undertook approximately 800 elective operations a year and a further 100/200 urgent surgical operations a year. They said that all patients identified as level 3 patients did not go to recovery but were transferred straight to the ICCU ward. Hospitals classify patients according to their needs from level 0 to level 3. This helps them to provide the best possible care and tailor their services to meet patient's requirements. Most patients who require critical care services are categorised as either level 2 or 3.
- Planning the delivery of the service was co-ordinated at bed meetings held during the day.
- The unit had 28 critical care beds. Between 2013 and 2014, figures showed that the bed occupancy for adult critical care beds across the trust was similar to the national average.
- The ICCU had a specialist nurse organ donation service attached to the unit. We saw the audit data regarding

organ donation for 2013/14 which showed that 34 patients had been referred to the transplant co-ordinator of which 10 granted permission and 24 declined.
- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records and information given to them or to those receiving them into their care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the ICCU to offer continued support. We saw the outreach figures which showed they achieved 100% in their critical care follow up.

Meeting people's individual needs

- The unit had processes to support people with a learning disability and staff knew how to access these. For example, there was a learning disability nurse who provided support to staff in the unit.
- The unit had flexible visiting hours that allowed relatives to come in when they wanted to. However, relatives were informed that, during certain hours, patients would be provided with intensive support and relatives would be requested to leave the unit. We spoke to two relatives who told us they were well-informed of when they would be asked to leave so that doctors and nurses could continue to provide the necessary care to the patient. They told us they did not mind this because once the care was completed, the nurse would invite them back to visit the patient.
- The unit had access to translation services. Staff could contact the NHS interpretation service by telephone, or request interpreters to visit the unit. However, because relatives were present most of the time, staff were able to use relatives to help patients understand the care being provided.
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- Written information was available in multiple languages. Literature we saw explained the different formats and languages in which information could be accessed.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for moving and handling and pain assessments.
- A chaplaincy team was based at the hospital to provide support for patients' spiritual and religious needs.

Access and flow

- The consultants said that access to the wards could be a problem but the hospital had an effective pre-planning bed arrangement process which addressed these issues.
- The consultants said that some "bed blocking" occasionally occurred if a patient had an intra-aortic balloon pump as they had to be admitted to the cardiac section of the ICCU coronary care section.
- The consultants said they accepted level 3 patients from other hospitals who required a stent. A stent is a small mesh tube that's used to treat narrow or weak arteries. The consultants told us the trust's policy was that these patients were returned to their original hospital as soon as possible and this process worked very well.
- Consultants said the return to theatre rate was 10% which was higher than the national average. They said they were more proactive and took patients back earlier which they felt was good and aided patient recovery.
- Patients were admitted to the unit within the standard four hours from the decision to admit.
- The ICNARC data showed the length of stay on the ICCU was similar to the national average. The unit saw 803 patients for 2013/14 of which for example; 173 patients (22%) stayed for 24 hours, 94 patients (12%) stayed for 48 hours.
- Most discharges from the unit occurred during the day between 8am and 10pm, which followed national guidelines. Staff said they did not discharge patients out of hours which was confirmed by the consultants spoken with.
- Patients who were discharged to other wards had follow-up visits by the critical care outreach team within four hours of discharge or when required.
- We saw the audit data which reviewed patient readmissions within the unit. For example in 2013/14 six patients were re-admitted within 24 hours, post ICCU discharge and all six were discharged from hospital. Two patients were re-admitted within 48 hours, post ICCU discharge and both died in the ICCU. We saw the readmission rate was lower than 2012/13 which was 28 patients.
- There were zero non-clinical transfers out of the unit between April 1st 2014 to March 31st 2015.

Learning from complaints and concerns

- Complaints were handled in line with the trust's complaints policy. If a patient or relative wanted to

make an informal complaint, they would be directed to a senior staff member. Staff would direct patients or relatives to the Patient Advice and Liaison Service (PALS) team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. We were told that there had been no complaints received in the past six months.

Are critical care services well-led?

Requires improvement

We found that critical care services required improvement to be well-led.

Most staff were not aware of the vision or strategy for the critical care service Staff however, were able to access the trust's mission statement and philosophy of care on the critical care intranet site.

The service held monthly clinical governance meetings and senior nurses' meetings where quality issues such as complaints, incidents, a audits and actions were discussed. Governance processes had a focus on risk and quality and we saw reviews of the provision of the service. Although there was evidence of department risks which were highlighted on the directorate risk register; some concerns highlighted by staff were in the process of being assessed. There were clear actions around the risks accepted. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register. We found that interim plans to manage and mitigate risks were not addressed at local level.

There was good local leadership on the critical care unit. Within the service there was a culture of support and respect for each other, with staff willing to help each other when they were short staffed. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff told us they felt there was effective and supportive team working across professional groups in the critical care service.

Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.

Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Vision and strategy for this service

- The business manager and the clinical consultants demonstrated a clear vision for the future of the service. There was a sense of purpose and passion to deliver the vision. Staff we spoke with were clearly passionate about the critical care unit and how it supported the wider hospital and trust.
- Some staff said the trust's visions and values were the six "C's" which are the enduring values and behaviours that underpin compassion in practice. However, most staff said they did not know what the vision and values of the trust were.
- Staff said they did not know what the aims of the unit were and were unable to describe the trust's strategy for ICCU.

Governance, risk management and quality measurement

- The unit had regular joint steering group meetings which included nurses, and consultants. We saw these involved small working groups to resolve problems, for example; a review of the delirium policy.
- The unit had a risk register and we saw the risks identified in critical care. However, we saw written evidence of a broken fire door between the unit and the cardiac theatres dating back to 17 October 2013 which was not identified on the risk register. Staff said that this was a longstanding intermittent problem. From 24 May 2015 to 03 June 2015 the fire doors had been broken for 16 days. During our visit on 04 June 2015 we observed the fire doors to be broken and open. This was brought to the attention of the senior staff and escalated to senior management. On our return visit on 05 June 2015 we observed that the fire doors had been mended.

- When asked about the risks detailed on the risk register for ICCU, the senior sister in charge appeared unaware of what was on the risk register or how to mitigate the risk identified.
- We saw the health and safety audit for June 2014. This looked at actions and progress for the unit which included risk assessments and associated hazards regarding work equipment.
- We saw the senior sister meeting minutes and the cardiothoracic surgical governance meeting minutes for April 2015. Areas identified included incidents and the actions taken, staffing levels and training. The outreach team also attended the meetings and fed back to the team.
- The unit had a quality dashboard for the service and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The resuscitation team said there was good governance and interaction with the education team.
- Staff said the monthly morbidity and mortality meetings provided them with the opportunity to discuss unexpected deaths.
- We found that the policies relating to critical care were out of date and found no evidence of review. For example; the critical care procedure policy was dated 2012 and the pulmonary artery catheter policy was dated 2008. This meant that the information provided to staff may not be up to date and could affect the care and welfare of patients who used the service.
- Local leadership were either not aware of the risks or were not acting on them appropriately.

Leadership of service

- The unit was led by senior sisters and consultant clinical leads.
- Staff told us the team operated collaboratively. They told us the leadership was visible within the unit.
- Staff were aware of the head of nursing within the hospital whom they said was visible and approachable.
- The general and cardiac section within the unit each had a senior sister who provided day-to-day leadership to members of staff on the unit. Staff told us the senior sisters were visible and approachable.
- Some staff said the leadership and communication from the trust was good. They said they were aware of the chief executive officer and felt the trust listened to them.

Culture within the service

- Staff told us that the senior sisters and medical staff were visible and approachable on the unit.
- Staff we spoke with worked well together as a team and said they were proud to work for the trust.
- Staff spoke positively about the lessons learnt from reporting incidents and raising concerns.
- All staff spoke with pride about their work, including those who were working in difficult circumstances

Public and staff engagement

- During our inspection we saw a number of cards and letters from patients and their relatives thanking staff for the care they had received in ICCU.
- The unit undertook a relative's satisfaction survey, used patient diaries and obtained feedback from patient and their families. We looked at 17 returned surveys and found that all were positive. Comments included "thank you for saving a very special person" and "staff are dedicated, knowledgeable and informative."
- Staff recommended the trust as a place to work or receive treatment. Staff told us there was good communication between senior management and staff.

Innovation, improvement and sustainability

- Staff told us the unit had created an environment where all members of staff were recognised and rewarded regarding the improvements to quality and innovation. Staff said they had received thank you letters and e-mails for the good work they had done. Staff said they were also thanked by the team leaders for the day.
- The trust had created a "Sim Ward." The aim of the SimWard was to improve patient safety through curriculum based simulation. The ICCU said they found the SimWard invaluable as an educational aid for staff and allowed all learners to develop their skills through real time participation. Staff said they used the SimWard as part of their competencies and were fully debriefed on their performance.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Between July 2013 and June 2014, 4,034 babies were born at the Royal Wolverhampton NHS Trust.

Consultant led obstetrics services were transferred from Stafford hospital January 2015.

Services offered included a Midwifery Led Unit (MLU) and a consultant-led delivery suite including an induction of labour unit and triage area, antenatal clinics, a foetal medicine unit, a maternity assessment unit, and an antenatal and postnatal inpatient ward. Women could also choose to have a home birth supported by community midwives.

There were ten delivery rooms, a high dependency room, a two room bereavement suites, six triage beds with two assessment couches, and a ten bed induction of labour unit located on delivery suite. The MLU has five rooms, the ante-natal and postnatal ward has 36 beds, which are interchangeable according to activity. The majority of the time there are 8-10 antenatal beds and 26-28 postnatal beds.

Specialist services were available for example, diabetic care, substance misuse and mental health support.

Community midwifery was part of the Royal Wolverhampton NHS Trust's maternity services. Working in partnership with GPs, health visitors, family nurses, children's centres and lifestyle services they promoted well-being during pregnancy and in the early days following a baby's birth. Six teams of community midwives provided antenatal care, parent education classes, home births and postnatal care in Children's Centres, GP surgeries and in women's homes.

The gynaecology service offered inpatient services, day care and emergency assessment facilities. Outpatient services included colposcopy, hysteroscopy, fertility management, treatment for miscarriage and pre-operative assessment. The gynaecology ward had 26 beds and can increase to 30 beds to respond to increased capacity.

A team of gynaecologists specialised in specific problems and were supported by a specialist gynaecology oncology nurse, general nurses and health care assistants

We visited all the wards and departments relevant to the service. We spoke with 34 maternity patients, 14 midwives and support workers individually and 28 midwives in two focus groups. We spoke with 18 gynaecological patients, four nurses, one student nurse and two support staff who care for gynaecological patients. We met and spoke with seven medical staff that worked across both the maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

Overall we found the service required improvement but the domains of, effective, caring and responsive, were good.

There were many good examples of the maternity unit being safe including incident reporting systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans. However emergency arrangements needed to improve.

Obstetric consultant cover was not adequate being below the required hours for the number of births undertaken annually.

Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.

The birth to midwife ratio was 1:30. The named midwife model was in place and women told us they had a named midwife. Midwives provided one to one care in labour.

Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw limited patient information leaflets available.

In March 2013 the maternity service at the Royal Wolverhampton NHS Trust achieved compliance with level two requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2012/13, scoring 46 out of 50.

There was an active maternity services liaison committee (MSLC), which met quarterly.

Are maternity and gynaecology services safe?

Requires improvement

Arrangements for emergencies needed to improve as this put patients a risk of poor outcomes. We were not assured that the maternity team was supported by the **critical outreach team at night time**

Consultant obstetric cover on the delivery suite was on average 60 resident hours per week at the time of the inspection. A 98 hour labour ward consultant presence is required for 4,000 – 5,000 deliveries.

The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We noted equipment needed in an emergency was not readily available to be used. Controlled drugs and fridge temperature checks were not undertaken as per trust policy.

Records were not maintained in a neat order and we found email addresses of another patient in one set of records.

The midwife to birth ratio was 1:30 in December 2014, this is in line with the national average. The named midwife model was in place and women told us they had a named midwife. Women received one to one care in labour and women expressed their satisfaction with this. However we did see some issues with staffing numbers and difficulty in achieving skill mix. The planned staffing levels were displayed at the entrance to each maternity ward, however it was not displayed on the gynaecology ward.

There were no never events reported in 2014. We saw that a robust process of investigation would take place if a never event occurred including a root cause analysis (RCA), establishment of lessons learned, an action plan and dissemination of learning points.

All areas of the hospitals were visibly clean and well maintained. However, we saw that equipment was not consistently labelled with tags to indicate that it had been cleaned.

We noted that the battery was low on the VitalPAC and were told' it happens all the time'. We saw that labels on intravenous cannulas which were not dated which could put patients at risk of infection.

- 26 serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between April 2014 and March 2015. There were eight unexpected admissions to the neonatal unit (NNU), seven intrauterine deaths, two intrapartum deaths, one unplanned maternal admission to the intensive care unit (ITU) and six unspecified incidents.
- We reviewed action taken regarding a recent maternal death in the maternity unit during our visit. We saw that an RCA had been undertaken and that a multidisciplinary risk meeting had taken place to review the RCA. We saw that a table top review was planned and that lessons learned had been identified in the early stages of this investigation. Duty of candour had been observed; relatives had been offered explanations, apologies and been invited to the review meetings.
- There were 23 stillbirths reported in the trust between January and September 2014, with a further six babies stillborn between October 2014 and April 2015. We saw a robust approach to the investigation of these deaths and the subsequent review undertaken to identify suboptimal practice and trends. We saw evidence that an action plan had been drawn up and reviewed. Actions included the introduction of NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth which recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour.
- Ten cases were identified where there had been suboptimal care that might have made a difference. Four of the women involved were smokers or had just given up smoking. They had not been referred for smoke cessation support in line with trust policy. Community midwives were issued with carbon monoxide monitors and they were recording CO levels on all women and referring them for smoking cessation support if indicated.
- We saw that the trust recognised their data around reporting episodes of reduced fetal movements was flawed. Between November 2013 and October 2014, there were 1000 episodes of reduced fetal movements recorded. However, the trust was unable to identify whether this was single episodes or repeated episodes. The impact of this was that it was difficult to accurately estimate the numbers of women who would require an ultrasound scan following an episode of reduced fetal movements, which was the recommended course of action.
- Posters were distributed to GP surgeries and children's centres to inform women about fetal movements and when to seek advice.

Women who required induction of labour for post maturity were no longer cared for on the Midwife Led Unit (MLU). Such women had previously been able to have their baby on the MLU and, following an incident of a misinterpretation of the cardiotocograph (CTG) monitoring of the baby's heart rate on the Maternity Ward prior to transfer to MLU, this pathway is no longer available.. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour.

- Staff told us that they were able to raise concerns and were confident that their concerns would be listened to.
- Escalation of risk was identified through a computer based incident reporting system (Datix). Royal College of Obstetrics and Gynaecology (RCOG) trigger list was used to guide the inputting of Datix forms. This meant that incidents were identified, investigated and that necessary learning could take place.
- We saw from the Maternity Trend Analysis Report for Quarter 4 (Jan – Mar 2015) that there were 172 incidents reported.
- 153 incidents were reported regarding patient care. This included Intrapartum incidents, staffing, issues with the patient journey, treatment and procedure and medication errors.
- Intrapartum incidents included complications at birth and babies born before admission (BBA) to hospital. We saw that there was some under reporting of some types of incidents. For example there were six cases of shoulder dystocia recorded on the maternity information management system but only three Datix forms were submitted. Nine babies were born before admission to hospital and only two Datix forms were submitted. The risk manager emailed ward managers to ask them to remind staff to complete Datix forms for shoulder dystocia and BBAs.
- Patient care related incidents included treatment and procedure. The most significant change was an increase

from 3 incidents in the previous quarter to 10 in the Quarter 4 in delay to treat. This included delay in suturing after birth, delay in screening and a delayed elective caesarean section due to on-going building works.

- Patient care related incidents included 14 medication errors, the main incident was medication not given or delayed (seven). We saw that in response to medication being given late or delayed, a 2pm drug round was reintroduced and a laminated sign left for women who were not by their bedside informing them to let the staff know they wanted medicine once they returned to their bed.
- We saw that incidents are reviewed at the weekly risk meeting which are minuted and attended by the senior management team. Following every reported serious incident, a full investigation would be undertaken. This would include a RCA review and a report would be developed. We saw examples of RCA reports from both obstetrics and gynaecology completed and presented.
- We saw that learning from incidents took place and was disseminated to staff. A safety brief was introduced at handover in all clinical areas to ensure direct and timely feedback. Each area had as risk management folder and an information board. We saw a risk management board specifically for junior doctors to ensure they had access to learning from incidents. Information was also distributed to all staff via email.
- Feedback was given on an individual basis and we saw evidence of a management plan that was developed in response to concerns over a doctor's management of a patient on the labour ward.

Gynaecology

- Staff on the gynaecology ward told us of a change in practice that arose following and incident of a retained vaginal pack. Yellow wrist bands were used to indicate when a woman had a vaginal pack in situ. This was removed once the pack was removed.
- There had been two never events in the gynaecology unit since 2012, one retained drain and one retained pack post operatively. The risk of never events was on the Directorate risk register and the risk was being managed. A modified WHO checklist was in place and audited for procedures that took place outside of theatre, for example hysteroscopy.
- We looked at the minutes of the Obstetrics & Gynaecology Governance Risk meetings from October, November and December 2014 and January 2015 and saw that there were 93 gynaecology related incidents reported. We saw that these were reviewed at each meeting and actions had been taken.
- We looked at one set of minutes from January 2015 that showed that two Datix reports were made against gynaecology by external directorates. The facilities department reported poor disposal of a needle injuring a domestic. Nursing and Quality reported an incidence of hospital acquired venous thromboembolism (VTE).
- We saw that an RCA had been undertaken in response the hospital acquired VTE and that lessons learned had been identified and staff reminded of the importance of risk assessment.

Safety Thermometer

- We asked to see the maternity safety thermometer as it was not displayed. The trust was not yet using the maternity safety thermometer. The NHS Patient Safety Thermometer was used and information was inputed into the on-line Kite site. The maternity safety thermometer allows maternity teams to take a temperature check on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from **perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby** and **psychological safety**. It also records babies with an **Apgar of less than seven at five minutes** and/or those who are **admitted to a neonatal unit.** We saw that on the whole harm free care was provided on the gynaecology ward. There had been one pressure ulcer in April, which was the first one in three years.

Cleanliness, infection control and hygiene

- All areas of the maternity and gynaecology units were visibly clean and well maintained. We saw environmental audits for all areas. Areas in the

maternity unit achieved 100% in the audit. Ward D7 (Gynaecology) scored 66%. We did not see an action plan to address the shortfalls identified at the time of the Inspection however this has subsequently been provided to the CQC.'.

- Sluice areas were clean and had appropriate disposal facilities, including disposal of placentae.
- We observed some elements of compliance with the trust infection control policy. Staff were seen using hand gel and protective clothing and the bare below the elbow policy for all staff was adhered to. We saw that cleaned equipment was labelled with tags to indicate that it had been cleaned. However this was not consistently applied. For example, we saw that two out of five pieces of equipment had been labelled on the induction suite.
- We looked at the birthing pools on all wards and found them to be well maintained. Staff we spoke with knew the pool cleaning procedure.

Environment and equipment

- The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We observed that the emergency trolley on the maternity ward lacked two defibrillator pads; staff told us they would access emergency equipment in a neighbouring ward.
- It is It is the responsibility of the coordinator of each clinical area to ensure that resuscitation equipment is readily available and regularly maintained. The rescusitaire (emergency equipment that is used to resuscitate babies) was stored in a cupboard on the MLU to preserve the home from home environment. This was not readily accessible because it was not plugged in and ready for use. In the case of a baby not breathing at birth, staff used basic equipment in the birthing rooms and the rescusitaire had to be obtained, plugged in and set up for use. This could put babies at risk in the first few minutes of life. A rescusitaire has a stop clock that is used in the management of resuscitation of the newborn along with an overhead heater. Accurate measurement of time is important in the assessment of a baby's progress during resuscitation. Maintaining heat is a vital component of the management of a baby requiring resuscitation.
- Midwives had access to the equipment they needed to confirm the health and well-being of mothers and babies. We saw that equipment such as fetal monitoring machines, vital sign observation monitors and rescusitaire had been maintained and stickers applied to confirm that checks were up to date.
- Telemetry CTG machines were available for women whose babies needed monitoring in labour but did not want to be restricted to the bed. Monitoring with a CTG machineinvolves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. Telemetry CTG machines operate by Wi-Fi and enable the woman to be mobile.
- Staff were able to tell us about the procedure to evacuate a mother from the birth pool in the case of an emergency.
- We saw that VitalPAC was used to ensure intravenous therapy safety. VitalPAC is **a clinical monitoring system that** monitors and analyses patients' vital signs and enables staff to automatically summon timely and appropriate help when a patient deteriorates. This removes the need for paper based monitoring charts.
- We noted that the battery was low on the VitalPAC and were told' it happens all the time'. We saw that labels on intravenous cannulas which were not dated but labelled with messages such as 'review Friday'. We were told that nurses enter reminders into the notes which prompted the them to check the cannulas.
- It was noted that the directional signage was generally poor across the site and that the maternity and gynaecology unit was difficult to find. This could be a challenge for people who use the services particularly when trying to finding the maternity unit when a mother was in labour.

Medicines

- We saw that medication was stored in locked cupboards within clinical rooms. Controlled drugs were checked twice a day in most areas. We found that the controlled drugs had not been checked as per trust policy four times in six months on the gynaecology ward and that they had not been checked 39 times on the MLU since 1st March 2015.

- We saw that the drug fridge on the gynaecology ward had not been checked 57 times in six months. We asked the manager about this and were told that it was not checked at weekends, although the ward was open on weekends, and this accounted for the deficit.
- We saw that VTE scores were recorded in patient's records and monitored. Prophylactic treatment was prescribed and administered in accordance with the trust guidelines.
- We saw that the nurse undertaking the drug round was identified by wearing a red tabard. This indicated that she was not to be disturbed during the medicine round to allow her to concentrate on the administration of medicines.
- We observed respectful, clear explanation of medicines being given to a patient with assurance that the medicine could be changed from a tablet as the patient had difficulty swallowing.
- We were made aware of delays with medicines due to charts being in pharmacy. This also affected patients waiting for take home medicines. One patient told us her medication was delayed by two days because "The pharmacy computer was broken". We were told that there were plans for an automated medicine control system to be installed on the ward which would mean that nurses could control, dispense and manage medicines.
- Midwives may supply and administer substances specified in medicines legislation under midwives exemptions for use in their professional practice. We found an inconsistency in the arrangements for midwives to dispense medicines. We were told that community midwives at Cannock had medicine packs dispensed by the pharmacy for them to supply and administer. This was good practice and ensured the available medicines had been checked for safe administration. However, Wolverhampton based community midwives obtained medicines for home birth from the labour ward stock. This meant it would be difficult to track and check what medicines had been taken; this increased the potential for a medicine error.

Records

- We saw that records were mostly kept secure and away from public view. We did observe that the records trolley was left open at the time of our inspection and unattended on the maternity ward.
- Records were not maintained in a neat order and were difficult to navigate. We saw that loose leaves were contained in many of the records we looked at. Sections were not clear and we found email addresses of another patient in one set of records.
- On the maternity unit we saw the individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born.
- We reviewed eight sets of maternity records and two sets of gynae records and noted that risk assessments was recorded in all records. VTE status was missing in two sets of records.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse and reflected safeguarding legislation and local policy.
- Data for training was held by each ward manager. Training rates for Safeguarding was recorded between 88% and 98%
- All ward staff followed the trust's safeguarding policy and reporting procedure. Staff reported that they get good support from the safeguarding midwife who visits each Monday to review safeguarding issues and was available by telephone throughout the rest of the week. The safeguarding midwives also met women who had working agreements or other plans in place to ensure that they understood their circumstances.
- A flag showed on maternity service information system for any woman who had a safeguarding concern. Records were also kept in in the patient records and a note was made in the special features of the handheld maternity records.
- If a woman presented herself for treatment who was not known to the service, staff informed the local safeguarding board who then made enquiries with the social services department in the patient's home area.
- We were told that the trust was developing a policy on Child Sexual Exploitation.

- Community midwives told us that on occasions they did not have adequate time for safeguarding activities, which meant that they wrote reports and made referrals in their own time.
- We were told about and saw evidence of support being put into the community to minimise the risk of safeguarding issues being missed. A risk was identified that safeguarding could be missed due to shortage of staff in the community. This could impact on safeguarding due to lack of continuity. A named midwife was allocated to higher risk clinics to monitor and act on safeguarding issues. We saw that all women are asked about domestic abuse in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded. Staff knew how to make referrals to other agencies in cases of disclosure.
- A safeguarding case supervision policy was in date. Community midwives had group supervision offered three times a quarter and it was mandatory to attend one session a quarter. The named midwife for safeguarding held quarterly group supervision sessions for midwives working in the hospital and it was mandatory to attend two sessions a year. Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010).
- There was an abduction policy. We observed that CCTV was in operation. We saw that babies were tagged once they were admitted to the postnatal ward. We were told that babies were not tagged from birth on the delivery suite due to on-going work with the fire protection system that was interfering with the baby tagging system. Baby tagging would commence on delivery suite once this work was completed.
- We saw that due to on-going building work, some access doors to delivery suite were not locked or swipe activated. We also observed that codes to security key pads were written on the door frames to some rooms.
- Community midwives based at Cannock shared an office with administrative staff. They told us that this caused concern when they needed to make telephone calls about child protection or to refer women to the hospital as they did not have the facility to speak in private when discussing confidential information. We were told that alternative accommodation was due to be provided from July 2015.

Mandatory training

- Mandatory training covered subject matters including maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- The lead midwife for education and development was responsible for mandatory training and other learning within the directorate.
- Mandatory training was provided over two days and covered subject matters including; maternal and neonatal resuscitation, electronic fetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia and cord prolapse. The unit had the use of the SIM Lab five times a year. The Simulation Lab offers staff the opportunity to practice emergency situations in a safe and supported environment. Staff told us that they did not have adequate access to the SIM Lab and this could mean that some staff could not access the training.
- Data for training was held by each ward manager. Overall completion of mandatory training was high. Infection control was recorded for each ward and varied between 93% and 96% and basic life support was 100%, except the MLU that was 86%.
- CTG machines were used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. CTG training compliance for delivery suite in February 2015 was recorded as 70%. This had been 80% in January and the drop in compliance was put down to the transfer of midwives from County Hospital who had yet to undertake the training.
- Mandatory training for nurses on the gynaecology ward was recorded and RAG rated on a ward performance monitoring form. We saw that the form was predominantly green for April 2014 – March 2015 with the exception of blood transfusion competency and training (88%).

Assessing and responding to patient risk

- **Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.**

We asked about the response time for emergency teams in view of the location of the maternity unit in relation to the rest of the hospital. We were told that there was always an anaesthetist on the labour ward. We reviewed an RCA that demonstrated that on call anaesthetists could be divided between administering anaesthetics in theatre, inserting epidurals as well as caring for HDU patients. It also demonstrated that the anaesthetist on call for ICCU was not always available as in this case the doctor was stabilising a patient in the accident and emergency department. Whilst the on call anaethetist was called in and reviewed the patient this instance, there is a risk that patients could be put at risk due to the anaesthetic workload.

- **We were told that the critical outreach team supported midwives with the care and management of critically ill women. I**t was noted that there was no outreach team available within the Trust on this occasion due to sickness, however there is normally a Critical Care Outreach Team available at night time. Midwives had needed to transfer a collapsed woman to intensive care and following this no Datix had been submitted or escalation initiated. The decision was made to call the emergency services and the transfer continued with three paramedics and a midwife.
- Women that had problems in pregnancy were reviewed on the fetal assessment unit (FAU). From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' guidelines. The checklists we looked at showed that all the stages were completed correctly.
- The senior midwives on duty provided cardiotocograph (CTG) review known as 'fresh eyes'. This was recommended by NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters.
- We reviewed 10 patient records and saw that there were detailed risk assessments and plans of care in place.

Midwifery staffing

- A recent Birthrate Plus® assessment had been carried out at the trust for April 2015. The use of Birthrate Plus® (a midwifery workforce planning tool) had been recommended in recent Department of Health maternity policy; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority.
- Birthrate Plus® assessment demonstrated that 135.8 WTE midwives were required for activity. Calculations based on an increase of 750 birth per year showed that 171.5 WTE midwives would be needed.
- The midwife-to-birth ratio is currently 1:30 (one midwife to 30 births). Midwives told us that they were able to provide one to one care in labour.
- Managers and staff told us that staffing was much better than it had been. However the trust expected increased capacity as data demonstrated that women who would have booked at the County Hospital were choosing to book at RWT. There was active recruitment taking place and the trust anticipated recruiting six newly qualified midwives in September 2015.
- Nursing and midwifery staff were very flexible and worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.

The planned staffing levels were displayed at the entrance to each maternity ward.

- Delivery suite, triage and the induction suite required 11 midwives on the early shift, and 10 on the late and night shifts. On the day of our visit, we saw that there were eight midwives on duty for the morning shift and seven midwives on the late and night shifts respectively. Staff told us that this was a normal occurrence. They felt that it would be safer if triage and the induction suite were staffed separately; particularly as they told us that the emergency buzzers could not be heard on delivery suite and there was often only one midwife in each area. The

trust confirmed that emergency buzzers on both the Induction Unit and the Maternity Triage Unit are set to be heard on Delivery Suite. The panel on delivery suite also indicates the area that requires attention.

- Community Midwives told us that their workload had increased since the dissolution of the former Stafford Hospital. This included increased safeguarding concerns. Workloads had also increased since community midwives began undertaking examination of the newborn and recording of CO2 levels for all women.
- Team leaders were not having management time which was impacting on their capacity to undertake management activities such as coordination, appraisals and sickness management.
- Staffing requirements for the postnatal wards was five midwives on the early shift, four on the late shift and three on the night shift. This was adhered to at the time of our visit.
- The vacancy rate was 4.0 WTE at the time of our inspection and recruitment was in process. We saw that the sickness rate was 5.2% and maternity leave rate was 2.5%.
- The maternity and gynaecology wards did not use agency staff and had its own bank of staff. This was made up of existing staff who undertook extra work to cover shortfalls. Staff told us that they 'liked to help colleagues out', worked on 'goodwill' and that they were tired.
- Staff expressed concern that the skill mix was sometimes difficult due to the combination of grades on duty.
- The rotation of midwives to all areas on the maternity unit has made the escalation policy more robust because midwives were confident to work in all areas.
- We saw that the Band 7 delivery suite coordinator was supernumerary and we were told that in times of increased activity, they may have to look after labouring women. This could impact on the safety of labouring women as the co-ordinator needs to have an overview of activity at all times in order to manage the ward safely
- The trust expected staff shortages in the forthcoming summer months. We saw an action plan to support the community throughout this time until on-going recruitment was completed. This included community midwives not working shifts on the MLU and other staff helping with postnatal clinics at the weekends to release community midwives.
- We saw that maternity support workers (MCAs) were on duty in all areas to provide additional support according to their training and designated responsibilities.

Nursing staffing (Gynaecology)

- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse for eight patients. We did not see a safe staffing board that displayed planned and actual staff on duty on the gynaecology ward.
- We were told that although the gynaecology ward had 26 beds an additional four beds could be used. The ward was only staffed for 26 beds and this put the staff under pressure. We saw documentary evidence from risk meetings that this had been an issue for the service over the winter months and had been escalated to Divisional managers.
- We looked at six months off duty and saw that the rota was organised around workload which meant more staff were on duty on days when there were theatre lists. The monthly template for night staffing was amber. We were told that if three registered nurses were on duty, one was always moved. We saw that bank usage was high for unqualified staff on night duty and staff told us that this was because the pressure of work was higher in the day and that health care assistants (HCAs) were therefore allocated to day duty. The ward manager told us that she would like more HCAs.
- There was a clinical nurse specialist for gynae-oncology and an advance nurse practitioner who undertook colposcopy and hysteroscopy examinations.

Medical staffing

- The trust employed 29 whole time equivalent medical staff in the maternity services. There was a higher level of consultant cover than the national average 48%:34%; fewer registrars than the England average 37%:51: medical staffing mix was similar to the England average.
- Consultant obstetric cover on the delivery suite was on average 60 resident hours per week at the time of the

inspection. The consultant staff stayed on the delivery suite every day from 08.30 until 17.00 Mon – Fri and 08.30 until 13.00 on Saturdays. There was a consultant on call at all other times.

- A 98 hour labour ward consultant presence is required for 4,000 – 5,000 deliveries. We saw that consultant cover on labour ward had been on the directorate risk register since 2013. Documentary evidence on the risk register demonstrated that in March 2015 there was an approval in principal for a business case for additional resource to recruit two consultants.
- There was a separate on-call rota for gynaecology consultants. This meant that two consultants covered the service and that women were seen in a more timely way. At any time two registrars covered the gynaecology ward and delivery suite; we were told that delays were experienced for gynaecology patients due to their workload.
- We noted that it could be difficult to arrange for an obstetric review to take place. We reviewed an RCA that described how the on call obstetric team was busy on delivery suite all night and the obstetric registrar called in the afternoon to review the woman had been in clinic and also on-call for gynaecology emergencies. The impact of this put patients at risk because they are not assessed and treated in a timely manner.
- There was 24 hour senior anaesthetic cover for labour ward.
- Handovers were carried out four times during each day. We observed the formal 8.30am handover which included discussion on inpatients and overnight deliveries.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- We were told that the gynaecology ward was 'twinned' with a medical consultant who managed the medical outliers. This meant that patients were seen by the right doctors and that doctors treating gynaecology patients were not taken away from their duties.

Are maternity and gynaecology services effective?

Good

People have good outcomes because they received effective care and treatment that met their needs. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.

Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and outcomes were used to improve care.

Patients we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24 hour period.

Staff were mostly competent in their roles and received performance reviews and supervision.

We saw good examples of multi-disciplinary team (MDT) working the maternity service. Staff worked collaboratively as part of the multidisciplinary team to serve the interests of women in the hospital and community settings.

Some issues were identified with relationships between medical and nursing staff on the gynaecology ward that could be prohibitive to safe and effective patient care.

Women were provided with information which helped them to understand their treatment and care before consenting to this. Patients told us that they felt 'safe and secure' with their care and treatment.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home birth service.

Evidence-based care and treatment

Maternity

- Policies were based on NICE/Royal College guidelines; the best clinical outcomes were promoted.
- The care of women using the maternity services was 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, safe staffing levels, staff roles and education, training and professional development. In addition to the facilities and equipment to support the service.

- Staff had access to guidance, policies and procedures via the trust intranet.
- We saw that there was a good process for screening for fetal abnormality. High risk women were invited into the clinic for counselling and on-going treatment
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included for example; having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw that a 'fresh eyes' approach was used to peer review electronic recordings of the baby's heart rate. This involves a second person assessing the baby's heart rate against certain criteria to confirm that the baby is coping with labour.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff were supporting women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Audits

- We saw an audit of the Modified Early Obstetric Warning System (MEOWS).. The audit recommended that the chart was reviewed and updated. The updated chart and guideline should be re-launched as part of 'Campaign of the Month' to help improve compliance. We saw the action plan had been put in place to achieve these recommendations.
- The trust provided us with further audits on the uptake of rubella screening, CTGs, caesarean section, induction of labour, babies born before arrival (BBA) and group and save and we saw the same robust approach to audit and the implementation of findings.
- The trust actively participated in national audits such as the National Screening Committee antenatal and newborn screening audit.
- The Morecombe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that the trust had monitored its performance against the recommendations of the report and that action plan was in place to address any shortfalls identified.
- We saw that the trust used a mandatory audit system called Symbiotixs and included a catheter bundle, C.Diff bundle, documentation, falls, medication, nutrition and hydration, pressure ulcers, patient experience and transfer and discharge. All were reviewed monthly and discussed at the Gynaecology Care Meeting.

Gynaecology

- Minor gynaecological surgery was undertaken on the day unit. The expectation was that the patient went home on the day of the procedure. Patients told us they had received good care and they had been informed about their discharge home.

- There was evidence from information reviewed and from discussion with staff that the service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4. We found that the documentation completion of both forms followed a robust process.

Pain relief

- Patients we spoke with in maternity and gynaecology felt that their pain and analgesia administration had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines and Entonox. Epidurals were available 24 hour a day.
- Birth pools were available on the MLU and delivery suite so women could use water emersion for pain relief in labour.

Facilities

- We observed an effective outpatients/specialist clinic service with good facilities and pleasant patient waiting areas. Privacy and dignity was maintained with quiet areas available for consultations.

Nutrition and hydration

- An infant feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the important health benefits known to exist for both the mother and her baby. Their policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they will feed their baby.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative (BFI) stage three accreditation, which is the highest level of the BFI accreditation process.
- We saw that the initiation of breast feeding rate was 65.6% in April 2015 which was below the national average of 75%. Women told us that they received support to feed their babies.
- In relation for food and drink, women were able to choose from a varied menu, which also met their cultural needs. The support staff told us that it can be difficult to communicate with patients about food and that an interpreter would be helpful. The same staff told us that if people do not finish their food, they record this, offer an alternative and inform the nurses.
- We saw that patients were helped with drinks on the gynaecology. They had three different options of drinks.
- Patients told us that food was available outside of set meal times if they did not feel like eating at set meal times.

Patient outcomes

- The maternity dashboard was the tool for recording activity and outcomes. We looked at the dashboard for March 2015 and saw that six items were rag rated red. These were the number of bookings, the numbers of mothers delivered, the caesarean section rate, the number of unexpected term admissions to the NNU, the number of formal complaints and the number of red incidents.
- Eleven indicators were rag rated amber. These included induction of labour rate, transfer of women from the MLU to delivery suite, weekly consultant hours on delivery suite, midwifery staff sickens, the supervisor of midwives to midwife ratio, booking achieved by 12+6 weeks, third and fourth degree tears, smoking rates at delivery, initiation of breastfeeding rates, and early neonatal deaths.
- Information on the maternity dashboard demonstrated the following outcomes in March 2015:
- There had been one maternal death in Quarter 4 (January- March 2015). This was recorded on the dashboard under the categories of STEIS and Red.
- We saw that the induction of labour rate was 29%, which is higher than the national average of 25%.
- The instrumental delivery rate was 8.9% in April 2015, which is below the national average of 12.9%. Of these, 4% were Ventouse and 3.4% were forceps deliveries.
- The rate of third and fourth degree tears was 3.7% which is above the trusts target of below 3%. A third-degree laceration is a tear in the vaginal tissue, perineal skin, and perineal muscles that extends into the anal sphincter (the muscle that surrounds your anus). A fourth-degree tear goes through the anal sphincter and the tissue underneath it.

- There were four babies admitted to NNU in February 2015 three of whom required intubation at birth and one required level 3 care but was not intubated at birth.
- The Caesarean section rate had increased (worse) from the previous year being 27% for 2014. For the first six months of 2015 the rate was 28%. The national average was 26%.
- The number of normal deliveries had increased (better) from the previous year being 61% for 2014. For the first six months of 2015 the rate was 62%

Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology assessment unit. A team of staff supported patients in investigative procedures, giving advice as necessary.

Competent staff

- Community midwives had been trained in Newborn and Infant Physical Examination (NIPE) and carried out this examination within 72 hours of birth. However, very few midwives on the ward were trained and this impacted on women waiting for a paediatrician to examine the baby before discharge home.
- All newly qualified midwives undertook an 18 month preceptorship period prior to obtaining Band 6.
- Appraisal rates for staff were provided for us and these demonstrated that between 86% and 100% of midwives, 100% of the nurses on the gynaecology units and 100% of medical staff had been appraised.
- We saw that there were 55 live sign off mentors who are able to confirm a student midwife's competence. Additionally there were 39 midwives who were mentors but not sign off mentors. This meant that students had adequate support to achieve the competencies required to qualify as registered midwives.
- The function of statutory supervision of midwives to ensure that safe and high quality midwifery care was provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- There were varying reports of the ratio of supervisors of midwives (SoMs). The NMC Midwives Rules and Standards (2012) requires a ratio of one SoM for 15 midwives. We saw that the midwifery report dated 1st June 2014 stated that the SoM to midwives ratio was 1:11 with 15 established SoMs and two new qualified SoMs awaiting appointment by the LSA and that this 'has the trust in a strong position'. The maternity dashboard recorded the SoM ratio as 1:17 and we were told that, at the time of our visit, the ratio was 1:19 due to retirement which was higher than the ratio of 1:15 required by the NMC. We were unable from our observations to confirm that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- We saw good examples of multi-disciplinary team (MDT) working in the hospital in both the specialised antenatal clinics and on the delivery suite. Community staff told us they had support from health visitors, GP's and social services.
- We observed staff and medical handovers where patient care was discussed and discharges planned.
- Communication with community maternity team was efficient. In the community we were told of effective multidisciplinary team work between Health Visitors, GP's and social care. The gynaecology wards and departments ensured patients discharge arrangements were appropriate.
- Medical staff reported that the relationship between them and the nurses on the gynaecology ward could be improved. They told us there was 'no verbal communication between nurses and juniors' and that 'it feels like a nurse led ward and not a consultant led ward'. Instructions, via post it notes on patient records, were left in a tray for junior doctors to action. This was unsafe as the post it could become detached from the records. We were told of pressure from nurses to discharge patients, in one instance against the instructions of the consultant.

Seven-day services

- Access to medical support was available seven days a week.
- There was a consultant on the delivery suite Monday to Friday between 08.30 and 17.00. At the weekend, a consultant was present between 08.30 and 13.00. There were always two consultants on call out of hours to cover obstetrics and gynaecology.
- The lead anaesthetic consultant for obstetrics was available for 10 sessions during weekdays, with on call cover out of hours. There was other senior anaesthetic cover for labour ward 24 hours a day.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- There was a live board for bed management on the gynaecology ward that assisted with keeping up to date with patient information and patient flow.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 sets of notes and saw that the process for obtaining consent was thorough and robust. Women told us that they had provided written consent for surgical procedures.
- Women told us that the doctors made the decision to induce labour and that they gave verbal consent for induction of labour.
- Staff on the gynaecology ward had a good understanding of consent when capacity was diminished. We were told and saw that there were three types of consent and that next of kin or another appropriate person could assist with the consent process.
- We saw that the procedure of consent was readdressed before going to theatre which was good practice.

Are maternity and gynaecology services caring?

Good

Feedback from people who used the service and those who were close to them was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.

People were involved and encouraged to be partners in their care and were supported in making decisions. Patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Staff responded compassionately when people needed help and supported them to meet their personal needs and those of their babies. People's privacy and confidentiality was respected. We observed nurses being gentle and caring with patients.

Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs were understood.

Compassionate care

- Maternity Services were added to the Friends and Family Test (FFT) in October 2013. The data was collected on a prepaid postcard or by text message. The November 2014 FFT achieved the following results:
- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? The trust did not submit a score for this question: the national average was 95.5%.
- How likely are you to recommend our delivery suite/ birthing unit to friends and family if they needed similar care or treatment? A score of 100% was achieved which is above the national average of 97%.
- How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? A score of 91% was achieved compared to the national average of 93%.

- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? A score of 98% was achieved compared to the national average of 97%.
- We observed caring and compassionate interactions between staff and patients.
- We observed patients being cared for during 'comfort rounds'. Comfort rounds included changing beds, offering pressure area care and enquiring about fluids and food requirements.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from patients.
- Patients on the gynaecology wards told us that the staff were 'absolutely wonderful' and that 'nothing was too much trouble, if anyone called, they were there'.
- One patient told us of the kind, patient way in which staff cared for an elderly patient with dementia.
- The trust results were within the national averages for the CQC Midwifery survey 2013.

Understanding and involvement of patients and those close to them

- Patients told us that they felt well informed and able to ask staff if they were not sure about something.
- One woman who had her baby on the MLU told us that she had a good experience, the midwife was 'always there and was very supportive'. Her partner felt involved throughout the birth. Another woman told us that her husband 'was very involved' and that the midwife and he were 'having good chats'.

Emotional support

- Patients reported continuous one to one support during in labour.
- Women told us that they received support and reassurance from the midwives when their babies were transferred to the neonatal unit after birth.
- Midwives observed women for anxiety and depression levels. They made referrals as necessary to the mental health team.
- A specialist mental health midwife and obstetrician offered support to women. The team had links to the mental health team for on-going support and continuity. This meant that women with mental health conditions were seen in a 'one stop shop' style clinic where their needs were assessed and treatment plans developed.

Are maternity and gynaecology services responsive?

Good

People's individual needs and preferences were considered when planning and delivering services. The maternity service was flexible and provided choice and continuity of care.

A team of specialist midwives provided care to vulnerable patients and staff had access to the team for support. The individual care needs of women at each stage of their pregnancy was acknowledged and acted on as far as possible.

There were arrangements in place to support people with particular needs.

Translation services could be arranged as required.

The complaints were investigated and responded to when raised.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- We saw limited information leaflets and posters in use across the maternity service. However, the oncology gynaecology ward displayed a wealth of Macmillan (not trust) information leaflets for women with gynaecology related cancer.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and where necessary doctors. The Red Book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- There were arrangements in place that recognised women and babies with additional care needs and for referring them to specialist services. For example, there

was an on-site Neonatal Unit (NNU). We were told about and were shown the ward that would become the transitional care ward for babies that needed close observation but did not need admission to the NNU.

- Women had a choice regarding the management of miscarriage. Women could choose medical or surgical termination or expectant management and await the natural expulsion. For ectopic pregnancies the choice was either medical or surgical. Information leaflet were available to help women in making their choice in addition to discussion with staff.

Access and flow

Maternity

- The trust reported that the maternity unit had no closures between July 2013 and December 2014.
- We were told about and saw written documentation which confirmed women were supported to make a choice as to the place to give birth. This decision was made at 34 weeks and information was provided to assist in making their choice. We saw that there were specific risk factors, which needed to be considered and would lead midwives to advise a hospital birth, rather than home or the MLU.
- A Fetal Assessment Unit (FAU) provided care to women with concerns such as such as reduced fetal movements. The Maternity Triage Unit was run by midwives attached to labour ward and were allocated to the unit on a daily basis. Medical cover was provided by the on call medical team for obstetrics.
- The labour ward, triage and induction suite were managed and staffed as one unit. The triage area of six beds was situated on the same floor as the delivery suite and was staffed by midwives who were allocated to the unit on a daily basis Medical cover was provided by the on call medical team for obstetrics. We saw documentary evidence that births took place on this unit but were unable to confirm that this was due to flow through delivery suite.
- Women could be referred by community midwives, GPs or they could self-refer. Women told us that at times they had to wait for review because doctors were busy on labour ward.
- The 10 bed induction suite was also situated on the same floor as delivery suite and staffed by midwives who were allocated to the unit on a daily basis.
- Midwives were competent in examination of the newborn. However, the community midwives undertook this examination once the baby was transferred home. Women and babies with high risk needs had to be seen by a doctor which could result in them not being discharged in a timely manner.
- We were provided with documentary evidence of an increase in births following dissolution of the former Stafford Hospital. Between April 2014 and October 2014, the number of women choosing to have their babies at RWT ranged from 18 (August) to 32 (May). There was an increase to 95 women in January 2015. The trust had planned for approximately 700 more births however an estimated 850 women had chosen to give birth at RWT. The impact of this will be evident to the service in September.
- We saw evidence that 304 women had birthed at RWT in April 2014 compared to 355 in April 2015.
- Staff told us that the service was 'pressurised' and that woman were required 'to move around' the wards to free up beds. We spoke with one patient who had her baby at 06.30 that morning. It was not possible to transfer her to the ward due to capacity. She asked to have a bed so she could sleep and was taken to the pool room on labour ward where two delivery beds were stored. She remained in this room until 16.00 hours when she was transferred to the MLU. During this time, she had waited for a doctor to check her baby. She had also waited for medicines to be administered to her. Her parents had visited and had to sit on the emergency bed in the room on labour ward as there were not any chairs. We observed that the patient transported her own luggage to the MLU.
- The neonatal unit was a Level 3 unit that takes babies from outside of the trust and partnered with Walsall who transferred babies under 28 weeks gestation to the RWT. This could impact upon flow through the maternity unit and could result in women being transferred to other units if their babies required admission to a neonatal unit at birth.

Maternity and gynaecology

- Bed occupancy for maternity for Q2 2014/15 was 98.1% compared to the England average of 59.9%. This indicated that women were having longer stays in hospital in comparison to the other trusts.
- In May 2015, the trust introduced an enhanced recovery plan as part of the elective caesarean section pathway. This meant that, following preparation, women would be discharged home to the care of community midwives within 24 hours of caesarean birth.
- We were not clear about the function and use of the 'departure lounge'. We were told it was used for women awaiting discharge from the ward and the HoM told us that it was used for women waiting to go to theatre for caesarean section. However, we did not see it used in either of these ways on our visit and it remained empty despite problems with flow.

Gynaecology

- The Early Pregnancy Assessment Unit (EPAU) was open from 08.00 until 18.00 weekdays and 08.00 – 13.30 on Saturdays. It was staffed by a nursing assistant and two nurse sonographers who normally saw patients within 24 hours. Referrals were accepted from midwives, GPs, nurse practitioners and A&E.
- Women with suspected gynaecological cancers were cared for by a three specialist doctors (Gynaecology Oncologists) supported by a specialist nurse who followed women through their treatment journey.
- We were told that medical outliers on the gynaecology wards had been a challenge since July 2014 but this had resolved in the past few weeks. We saw that this matter was on the Directorate risk register and that 50 operations were cancelled since December 2015 as beds were not available.
- A discharge nurse was allocated to the gynaecology ward. We saw the use of a checklist to ensure safe discharge from hospital. The expected date of discharge was noted on live patient management system 48 hours prior to discharge. This enabled relatives to be informed, social care referrals to be made and take home medicines to be ordered. We saw that there were two delayed discharges on the day of our inspection.

Meeting people's individual needs

- Women with complex requests or needs were said to be discussed with the supervisor of midwife and a plan was then developed. We saw evidence of detailed recordings where a woman had made specific requests around the birth of their baby, which were outside of normal expectations that midwives would have.
- The trust ran a number of specialist clinics to support women with complex needs through their pregnancy. These included fetal medicine, diabetes and vulnerable women.
- A number of midwives had chosen to specialise in a specific area of practice. Many of the midwives worked with specialists to provide a link between community maternity services. Having undertaken additional training they gave additional advice and support to midwives and parents in areas such as female genital mutilation (FGM) diabetes, substance and alcohol misuse, antenatal and newborn screening, mental health, bereavement support, infant feeding and child protection.
- Partners could visit between 10 am and 10 pm. However, facilities for partners to stay overnight varied across the maternity unit. They were able to stay on the MLU. Partners were not encouraged to stay on the delivery suite or the maternity ward.
- We saw that there was a translation service both face to face or via telephone.
- The MLU promoted a 'home from home' experience, where partners could stay overnight, for low risk women who wished to have the comforts of a home birth with the added reassurance of being in a hospital. They offered a birthing pool facility, home furnishings and specialist equipment such as beans bags, mattresses and birthing balls to promote the comfort of women in labour.
- We found that women who had experienced still birth were cared for in a suite that was situated away from the main delivery suite so they and their partners could remain private and avoid areas where women had just given birth.
- The trust offered a bereavement service for parents. Two individual rooms were available with cold cots which meant the babies could stay longer with parents. This area was accessed by a lift that was situated opposite the rooms. This meant that parents did not have to

access the bereavement rooms through areas where women had babies with them. A self-contained bereavement suite was being refurbished at the time of our visit.

- A dedicated bereavement midwife had been nominated by the Stillbirth and Neonatal Death Society as bereavement midwife of the year. She was the Swan champion for maternity and ensured that the Swan symbol was used to identify women who had suffered a loss.
- We spoke with a patient waiting for a bed in the gynaecology waiting room that had restricted mobility and hearing loss. She told us that she was worried and anxious about being on the ward. She had been waiting to be seen for four hours since 7am. We asked if she would like the television on to help with the wait and she nodded. We asked a nurse to do this. We asked the staff what measures had been put in place to communicate with the patient and were told that a signer had been arranged and was usually punctual. We spoke with the patient later that morning who, although satisfied that after speaking with the doctor accompanied by the signer, did not have a communication plan in place for her post-operative stay and this was making her feel anxious.
- The same patient indicated to us by writing that she needed the toilet. She confirmed that she had not been shown the facilities. We asked the staff to assist her.
- We were told by a patient that she had requested a bath and was told by the staff on the gynaecology ward that there was not a bath on the ward due to hygiene reasons. We saw that there was a bath on the ward.
- Another patient told us that she had called her mother from her mobile phone in the night because she was unable to reach her call bell. This was close to hand at the time of our visit.

Learning from complaints and concerns

- We saw a Patient Advice and Liaison Service (PALS) information leaflet for patients informing them of how to raise concerns of make complaints.
- Initially complaints were managed locally and we were told that many complaints were resolved at this stage. If formal complaints were made, PALS forwarded the complaint to directorate managers who investigated the complaint, including asking staff to review the letter of complaint. A response letter was composed that was reviewed by the divisional manager for factual accuracy and signed off by the Chief Executive.
- We were told by a patient that she had made a complaint about her care in 2013 and that it was still not resolved. We were unable to corroborate this at the time of our visit.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint. Themes arising from complaints were attitude and communication. In response to this, the supervisors of midwives led a training day based on the '6Cs'; the Chief Nursing Officer's vision for care in the NHS.
- The maternity dashboard showed that there was one complaint made in April 2015.

Are maternity and gynaecology services well-led?

Good

Overall we saw that the service was well led. The governance arrangements facilitated discussion and review of quality and safety matters, with dissemination of learning. There was oversight of quality and safety at the trust board meetings.

However we saw that leadership capacity was insufficient. The Head of Midwifery was also covering the Head of Nursing role and a matron was acting head of midwifery (HoM). We were told that the acting HoM was doing two jobs and had 'no decision making power'. Staff felt that this created a lack of direct control and that the HoM did not have direct sight on all the issues. Staff were confused as to the accountability of the current model.

There was an active maternity services liaison committee (MSLC), which met quarterly.

Vision and strategy for this service

- We were told the maternity strategy was to develop expertise in maternal and fetal medicine by offering for women with complex health conditions such as congenital heart disease, renal disease, hypertension and haemoglobinopathies.
- Staff were aware of the trust vision and values when asked about this.

Governance and risk management

- We saw that robust clinical governance and risk management arrangements were in place.
- We saw evidence that separate obstetric risk management meetings and gynaecology risk management meetings were held weekly and that new incidents were reviewed. These meetings were attended by clinical risk managers, obstetric and gynaecology consultant leads for risk and clinical nurse and midwifery managers.
- Perinatal case reviews were held to review intrauterine deaths, stillbirths and neonatal deaths. These meetings were attended by paediatricians as well as obstetric and midwifery staff to provide a full and robust review and make recommendations.
- All incident reporting forms were reviewed by the Head of Midwifery, the Deputy Head of Midwifery, clinical matrons and ward managers. Staff told us they recieved feedback if they had completed an incident reportng form.
- We saw evidence of a robust approach to investigations. Root Cause Analysis was undertaken in line with the NPSA format. We were told that when necessary parents were involved in all reviews because of the duty of candour.
- Staff told us that they recieved feedback in various ways. Specific issues were taken up with the individual. A Quality and Risk newsletter was available electornically and in hardcopy.
- We asked what was on the trust risk register and we were told and saw evidence that midwifery staffing and the on-going building works were on the register.
- There were care group meetings for each area including gynaecology that were held monthly. We saw that risk and audits were included in the agenda of these meetings.
- We were told that a management and a supervisory investigation took place after an incident and 'run alongside each other'. This is not in line with the requirements of Rule 10 of the Midwives Rules and Standards, 2012 and the recommendations of the Local Supervising Authority which both advocate sharing of investigations. Undertaking two investigations is not recommended as the impact could be onerous on the person being investigated, it is confusing for parents and supervisory investigations have not always been shared with the Trust with is contrary to the duty of candour and prevents learning from incidents.
- The contact Supervisor of Midwives met bi-monthly with the chief nurse to discuss supervisory issues.
- The projected numbers of births exceeded what was expected following the disillusion of the former Stafford Hospital. The trust estimated 700 more women may choose to have their babies at RWT and data showed this was more likely to be nearer 850 extra women and that impact would be keenly felt in the late summer. The HoM told us that the trust had collaborated with neighbouring trusts who would also be affected by an increase in births. We were informed that another Birthrate Plus® assessment was planned for September and that there were plans around the model of care that would deliver the services.
- There were agreed plans to open a further two delivery rooms in June 2015.
- We noted that there was maternity services workforce strategy in place
- We were told that on-going recruitment needed to be successful or the midwife to birth ratio would increase to 1:32. This could impact on the ability to provide one to one care in labour. The trust had agreed that the service could over recruit to accommodate people who do not take up offers of employment. 17 band six midwives had expressed interest in working at the trust and six midwives due to qualify in September had accepted preceptorship posts.

Leadership of service

- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level. For example, the maternity ward staff were enthusiastic, motivated and spoke highly of the ward manager.

- The Head of Midwifery (HoM) was covering the Head of Nursing role. A matron was acting up into the HoM role but still retained her responsibility for inpatient maternity and the gynaecology service.
- Staff told us that the acting HoM was very visible and came to the wards frequently. However, the HoM was not as visible. Staff told us that they were not sure of the whereabouts of the HoM and had not seen her for some time.
- We were told the Head of Midwifery had access to the trust board but the acting Head of Midwifery did not. The acting HoM provided information and the HoM prepared the Midwifery Report to the board. We saw documentary evidence to confirm this in the trust board minutes of 1st June 2015.
- Staff said they had access to meet the senior managers whose offices were based on the unit. We saw an 'open door' policy in operation.
- It was the staff's impression that members of the trust board were not visible.
- Eighteen staff transferred from County Hospital were supernumerary for four weeks. The practice development midwife developed a programme, which included a meet and greet session and an induction to the trust.
- Community midwives based at Cannock shared an office with admin staff. They had one computer between nine midwives and found it difficult to access emails and other documents on the trust intranet.
- Medical staff told us that the board 'do not really understand the service, particularly in relation to reducing the number of stillbirths, which a trust can never completely reduce. The medical director was 'not very approachable' and they had 'contacted the CEO once, but it was a waste of time'.

Culture within the service

- The trust promoted a positive safety culture and encouraged incident reporting.
- Staff told us that they felt valued and enjoyed working at the trust.
- From our observations and discussion with staff there was a strong commitment to meeting the needs of and experiences of people using the service. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.
- Staff reported that a more 'punitive' approach had been noted in recent months. We were shown documentary evidence of management response to an RCA. It was identified that a neonatal registrar had not been called to attend a delivery. Staff were advised that the division wanted actions strengthened and wanted HR action to be taken against any staff who did not request the right staff to attend a birth. We noted that the Intrapartum Care Group had raised their concerns about this approach and were 'appalled and outraged that there would be a disciplinary issue for a midwife who failed to call a NNU Registrar where it was a judgement call'.
- Staff were supported to meet with parents who had suffered pregnancy loss in response to the requirements of duty of candour.

Public and staff engagement

We were told that the Maternity Services Liaison Committee (MSLC) had been re-energised over the last six to nine months. Attendance had improved and membership was more diverse than previously. We were told that the MSLC had input into the refurbishment of the bereavement rooms. However, we did not we did not see or hear of wide public engagement or efforts by the trust to involve users

- We saw minutes of the MSLC meetings held in January 2015. Three lay members attended the meeting. A standard agenda was followed and lay members had the opportunity to provide input and ask questions.

Innovation, improvement and sustainability

- Multidisciplinary training took place for maternity staff in the simulation room. This involved technical skills but also 'human factors' training. We were told that managers had 'seen changes in behaviour in response to this training'. Human factors encompass all those factors that can influence people and their behaviour. Staff corroborated that this training was enjoyable and useful.
- Robotic assisted surgery was being used in gynaecology. This method of surgery caused less pain and enabled a faster recovery for patients.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Royal Wolverhampton NHS Trust consists of two hospital sites, New Cross hospital in Wolverhampton and Cannock Chase Hospital in Cannock. The two hospitals amalgamated in November 2014.

The neonatal unit provided seven intensive car cots, seven high dependency cots and 14 special care cots for seriously ill and extremely premature babies. The service catered for 450 admissions a year

At the time of our inspection the only dedicated services for children and young people at Cannock consisted of outpatients clinics which took place twice per week. For this reason information about the Cannock service is included in this report rather than being reported separately.

Services for children and young people include neonatal services for new born babies through to children up to the age of 18yrs.

The neonatal unit is part of the Staffordshire, Shropshire and Black Country New-born Network. Networks were encouraged by the NHS to provide peer support and encourage the spread of good practice.

In addition to medical patients the paediatric unit undertook approximately 2000 surgical procedures each year.

Summary of findings

Overall we found the service required improvement.

We found that there was a reactive culture in the service which responded well after events had happened. They shared learning to prevent an event re-occurring and responded to issues which had been brought to their attention.

The service was less able to identify failings and prevent issues occurring in the first place.

We saw instances of unsafe practice in relation to services provided to children and young people both in the paediatric day-case unit and the fracture clinic. These were escalated and dealt with immediately, but the service failed to identify the risks themselves.

Similarly the Trust Development Agency (TDA) had completed a review of the hospital during Fenruary 2015, they identified a number of minor issues and highlighted 11 action points. We saw evidence during our inspection that all the issues had been dealt with and interventions put in place to prevent them re-occurring, but again the issues were such that proper governance and supervision should have identified.

We found that services were caring and staff were dedicated and knowledgeable.

Services were based on recognised clinical pathways which meant patients received treatment based on the latest information and best practice guidance.

Services for children and young people

Patient care was individualised and designed to meet the physical and mental needs of each patient. The service responded to people's needs.

Are services for children and young people safe?

Requires improvement

CQC inspectors identified and escalated two areas of concern, one in the paediatric day-case unit and the second in relation to services provided to children and young people in the main outpatients fracture clinic.

Local nursing audits were not always effective, information was collated but not always reviewed by senior nursing staff meaning opportunities to improve were missed.

There had been one never event which involved a dental surgical procedure on a paediatric patient, and four serious incidents

Consultant numbers did not meet all aspects of the Royal College of Paediatric and Child Health (RCPCH) 'Facing the Future' guidance.

Neonatal staffing did not meet British Association of Perinatal Medicine (BAPM) guidance.

We saw evidence of good practice in relation to keeping people safe in the neonatal and paediatric areas. However, potential risks were not always identified until external agencies such as the Trust Development Authority (TDA) or Care Quality Commission (CQC) highlighted them.

We found that staff had a good reporting culture when incidents had occurred staff understood the process for reporting and sharing learning.

Staff were supported to complete their training and had the necessary skills to provide safe care.

Incidents

- Incidents were reported electronically on the trust's electronic reporting system. Staff understood how to use the system and saw incidents as part of the learning cycle. A healthcare assistant described how they had reported a safeguarding issue which involved completing a Datix incident report. They told us how this had been escalated and how feedback was provided in their department by having the incident responses posted in the staff room. We visited the

staffroom and saw how information including guidance on incidents and avoiding risks was posted on the noticeboards. Staff also described how incidents were discussed during handovers between shifts.

- The children's services had reported four serious incidents and one 'never event'.
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Services for children and young people in the trust had recorded one never event between April 2014 and March 2015. The event related to a dental procedure which had been undertaken on a young person. The event was recorded under the paediatric services due to the age of the patients. We saw evidence to show that the incident had been fully investigated and the identified learning had been shared between the dental, surgical and children's services teams.
- The paediatric inpatient ward had highlighted potential risks of never events to staff. A member of the nursing staff had been tasked with highlighting the potential issues to the rest of the team. We saw how they had created a wall chart in the staff room. The chart highlighted the most likely areas within the ward which could lead to a never event occurring. The chart was colourful and drew the attention of staff to the risks and how to avoid them. We were told how the staff member who created it challenged staff about the content testing their knowledge of the risks. Staff we spoke with told us they had found this useful and managers told us that they were looking to expand the system to include other areas of learning.
- The serious incidents related to two incidents of grade 3 pressure sores and two incidents of confidential information being leaked. Pressure sores had occurred in the neonatal unit from nasal tubes rubbing against baby's skin. We were told how the management of nasal tubes had been raised within the team and best practice identified to reduce or prevent further incidents. Staff we spoke with confirmed this. Additional protection was used between the nasal tubes and babies' skin, and more frequent checks were introduced. Following these incidents a robust tool had been developed and shared with the neonatal networks. This was accepted by the network as good practice to mitigate the risk in the future.
- Mortality meetings were a regular feature of the governance of the service. All paediatric deaths were reviewed by a multi-disciplinary team to identify trends and share learning. Meetings took place every month.

Duty of Candour

- Staff we spoke with understood the need to be open and honest with patients and carers about all aspects of care including if care or treatment had gone wrong.

Cleanliness, infection control and hygiene

- We saw that the wards, corridors and public areas of the hospital were clean and tidy. We spoke with housekeeping staff in relation to their duties and how they were supervised. They explained how they had identified areas which they were responsible for. Where cleaning could not be carried out due to rooms or areas being in use, this was highlighted to nursing staff. When the area was free and available to be cleaned they contacted the housekeepers. Cleaning schedules were posted in the ward areas which allowed patients, carers and visitors to understand what work was undertaken and planned.
- Staff were trained in infection prevention and control as part of their induction and during regular mandatory training sessions.
- The paediatric ward was visited in February 2015 by the Trust Development Authority (TDA) as part of their routine monitoring. The visit identified a number of items which impacted on hygiene standards; these included such things as dust accumulating on bed frames and other surfaces. The TDA highlighted 11 action points. Following the findings an action plan was developed to address the issues. We saw how all the issues had been addressed which demonstrated the department's willingness to respond to issues, but further demonstrates their inability to identify the issues for themselves.
- Local audits of processes were not always effective. For example on the paediatric inpatient ward we saw that audits were being completed but when we asked about the analysis and learning from the audits we found that this was not always being undertaken. More senior nursing staff relied on the band six nurses who completed the audits to raise issues with them if they found any. This meant that trends were not always identified and shared with teams. An example of this was when we reviewed the hand hygiene audit for May.

We saw that it highlighted potential issues for doctors not following best practice after having patient contact. The issue had not been identified by senior nursing staff and so had not been challenged or addressed.

- The trust used a 'safe hands' monitoring system to track the movement of staff. The system enabled analysis to be completed to see when, where and how often staff had visited patients, used hand gels or washed their hands. The system worked on a distance to patient ratio which triggers a requirement for staff to clean hands. The gel and soad dispensers had monitors attached, if hand hygiene took place the system recorded this. Managers were confident that the system was effective in monitoring patient contact.
- During the course of our inspection we observed good practice in relation to hand hygiene from all nursing, medical and support staff.
- We saw that hand cleaning gel was readily available throughout the hospital and we heard reception staff reminding people to use the gel when they entered children's wards.
- Nursing staff wore aprons and protective gloves when providing care.
- There had been no Methicillin-Resistant Staphylococcus aureus (MRSA) or **Clostridium difficile** (C.Diff) outbreaks in the paediatric ward or neonatal wards for over twelve months.

Environment and equipment

- We found that equipment for paediatric patients was on the whole maintained well and ready for use. We identified two portable appliances in a store room which had expired electrical safety tests according to the test lables attached to them. However there were several similar devices available in the store should staff require them. Staff immediately labelled the out of date appliances so that they would not be used until they had been checked.
- We examined paediatric resuscitation trolleys on the paediatric and neonatal units and we saw that they were appropriately stocked with regular checks completed and recorded. Physical contents were checked on a weekly basis and trolleys sealed with tamper evident seals. Daily checks were completed which evidenced that the seals had not been broken. We were assured that if a trolley were used and the seal broken, the contents would be checked and restocked or cleaned as appropriate and a new seal applied. This meant that staff could be confident that the drugs and equipment required for emergencies were all in date and ready for use.
- Paediatric resuscitation equipment was available in other areas of the hospital such as the theatre areas. We checked paediatric resuscitation trolleys in maternity theatres, main theatres, day-case theatres. We found the trolleys were properly stocked and regularly checked. Other equipment in the department did meet the care and treatment plan needs of paediatric patients.
- There were many areas and clinics within the trust which were not specifically targeted at paediatric care or did routinely treat children and young people. One such area was the outpatients department at New Cross Hospital. In the fracture clinic we were concerned that a fire door had been wedged open which led to an open flight of stairs. There was no barrier to prevent small children reaching and falling down these stairs. When we escalated this we found the trust responded immediately to make the area safe.
- Neonatal intensive care unit was located within the maternity unit.
- We saw that systems were in place in paediatric areas to ensure patients were protected against the risk associated with improper storage, administration and management of medicines.
- Medicines were stored securely and temperature sensitive drugs were refrigerated and temperature checks were completed and recorded, which meant staff could be confident that drugs were fit for use.There had been 32 incidents of medication errors without harm identified within children's services and reported through Datix, These 32 incidents were reviewed at local unit meetings and Governance meetings by the Paediatric management team. All incidents were investigated by the appropriate manager under NP04 Policy and lessons learned and actions shared through the meetings and minutes. At the time of the inspection, Matron showed the Inspectors a designated drugs preParation room being developed with plans for automated medication dispensing and general drugs preParation. This designated area and use of automated dispensing will reduce the number of incidents encountered.

Records

- During our inspection we checked a number of different records both electronic and written. These related to the running and governance of the children's services. Records included minutes of meetings, audit logs, risk assessments and patient notes.
- All the notes we reviewed were concise and legible.
- We reviewed a total of twelve sets of patient notes. We did this to check the accuracy of information in the ward reports, to ensure that risk assessments and care plans had been completed in line with the information provided to staff. We saw that records were clear, patient centred and reflected the needs of individual patients and where appropriate the wishes of parents or carers. Some written notes were harder to decipher which may have made the reviewing notes more difficult for staff.
- We saw evidence of patient's risks being assessed on admission and after any significant events. General health assessments, risk of falls, potential for pressure ulcers, medication risks such as allergies had all be completed and reviewed. Patient specific risks relating to individual conditions such as cystic fibrosis and other conditions had also been completed.

Safeguarding

- All staff including administrative staff had received safeguarding training in line with their role. We saw records which showed that 96% of nurses and health care assistants on the paediatric ward and 100% of nurses on the neonatal unit had completed level three safeguarding children training.Level 3 safeguarding training is provided 4 times per year specifically in each of A21 and Neonatal Unit. In addition the training is available every month as part of the rolling programme available within the Trust. Ad hoc requests for training are also provided by the safeguarding team for any members of staff requiring it.
- The trust had appointed a head of safeguarding who had recently reorganised the department and brought together all the necessary staff under one safeguarding umbrella including the adult and children safeguarding nurses, midwifery and learning disability safeguarding leads, the domestic violence lead, and the Looked after Children (LAC) nurse. This not only provided peer support within the safeguarding team but also meant that staff on the wards had easy access to advice from multiple disciplines.
- We saw examples of how incidents or concerns had been reported to safeguarding authorities for further enquiries or investigations. We saw that updates were shared with staff who had reported concerns.
- The trust had a safeguarding children declaration which encompassed all departments. The declaration was published on the trust website.

Mandatory training

- Comprehensive information was collated in respect of staff training. Matrix showed staff groups such as admin, ancillary, trained nurses, student nurses and healthcare assistants. Individual subjects which made up the trusts mandatory training were listed.

Staff and managers we spoke with all saw training as an important part of their role. Training attendance was excellent with most staff groups attaining 100% attendance on all mandatory subjects. Exceptions to 100% attendance were still well attended, for example, trained nurses on the paediatric ward had 98% attendance on information governance courses, 96% had attended paediatric life support and 89% had attended manual handling training. Untrained nursing staff had similar excellent attendance. We saw that untrained nursing staff also attended training on subjects such as tissue viability 74%, health records 71% and blood transfusion 71%. All band 5's and above have completed a degree level foundation neonatal course within 12 months of commencing in post and are progressing to the neonatal intensive care course.

Assessing and responding to patient risk

- Recognised acuity tools were used to assess patient's needs. On the NICU and Neonatal HDU babies are under continuous monitoring and assessment is undertaken. Within SCBU and for transitional care babies the NeoNews system is used to monitor and assess the babies.
- The paediatric services used systems based on recognised national best practice to monitor the health of children and identify deteriorating patients. The neonatal unit NeoNEWS was adapted from the National Early Warning Score (NEWS). NEWS uses a number of measures to monitor patient's health including such things as heart rate and blood pressure. The NeoNEWS system was based on a traffic light system for escalation.

- Green – where all scores were within the green range; staff continued routine observations based on the patient's needs.
- Amber – If one score fell into the amber range; a midwife intervenes and additional more frequent monitoring is carried out.
- Red or multiple amber scores – Immediate medical team intervention.

This system was understood by staff we spoke with. Senior staff explained how the trust had been instrumental in rolling the system out within the Staffordshire, Shropshire and Black Country New-born Network, so that all neonatal units in the network used the same system.

- We were shown an aid memoir which had been produced for the guidance of nursing staff in children's services. The complex care aid memoir, provided prompts to ensure that consideration was given to all aspects of care and to the involvement of support services such as physiotherapy, dieticians and others. The guidance covered inpatient and home services and included details of charities to signpost people onto.
- We attended the 07.00 nursing handover on the paediatric ward. We saw how patient's needs were discussed as a team. Individual nursing staff were assigned duties for the day and guidance was provided on anticipated issues. The handover also served as a general team learning event with discussion about cases and exchange of ideas within the team. A handover form was used which highlighted issues for individual patients but also included useful information such as the named consultant for the day. The ward nurse in charge of each shift conducted a more in depth hand over in respect of patients on ward A21 and the paediatric assessment unit. This included details of social history, patients who had a do not attempt cardio pulmonary resuscitation (DNACPR) decision in place or other limitation of treatment. The handover also covered safety issues on the wards as well as general matters.

Nursing staffing

- Staffing levels on the paediatric ward were based on and in most instances exceeded guidance from the nursing and midwifery council.
- We were concerned about staffing levels in the bays being used for paediatric day surgery. At the time of our inspection there were seven children or young people on the unit which was staffed by one qualified nurse and one healthcare worker. This would have been adequate for the number and acuity of the patients; however we saw that the practice was for the nurse to leave the unit to escort patients to theatre or to collect them from resuscitation. Whilst this provided continuity for patients during what could be quite frightening experiences, it meant that the remaining patients had only a healthcare worker to see to their needs or respond to emergencies. Some patients using the unit may have undergone procedures which could lead to complications requiring urgent intervention which the healthcare worker would not be in a position to provide.
- We escalated this to the matron who explained that the correct procedure was not being followed. She told us that the day case nurse should not leave the unit until a colleague from the neighbouring assessment unit had come to relieve them, if nurses on the assessment unit were busy the day case nurse should contact the nurse in charge on the ward who would arrange cover. However there was no written procedure to explain this process to staff. Following the escalation a written procedure was created and shared with staff and an additional qualified member of staff was brought on duty to ensure there was adequate cover.
- Planned staff absences were highlighted on the electronic staffing system and offered to ward staff initially and then to bank staff. The trust did not use agency nursing staff other than for child and adolescent mental health services (CAMHS) patients who required one to one supervision by appropriately trained staff.
- Senior nursing staff told us that maintaining the right skill mix of staff was challenging particularly when staff reported sick with little or no notice. We saw evidence of how managers had maintained a safe environment for patients, an example being where no replacement was available to cover the absence of a qualified nurse, two healthcare workers were brought on duty which freed-up time for other qualified staff and ensured that all patients received appropriate care.
- The planned verses actual staffing levels were monitored by senior managers and any failure to meet the planned levels or cases where planned levels had been exceeded had to be explained together with details of how the vacancies had been filled. For example, we saw how planned levels of health care assistants on the neonatal unit on one occasion were recorded as 174%. The explanation was given that

additional staff had been used to provide one to one support and to supplement those registered staff whilst in their supernumerary period on commencement in post..

- Nurses and healthcare workers confirmed that senior nursing staff were more visible on wards when other staff were absent and would assist with general nursing duties. Senior nurses told us that they had protected time to complete administrative tasks but they prioritised patient care.
- Neonatal staffing levels did not meet British Association of Perinatal Medicine (BAPM) guidance. Staff shortages had occurred on 38 occasions during February 2015 according to the ward dashboard. During our inspection of the neonatal unit we saw that one band 5 nurse was caring for two babies in the high dependency unit side rooms. These should have been cared for on a one to one basis. On 3 June 2015 we saw that two extra cots had been placed in the High Dependency Unit increasing capacity. We did not see additional staff although the trust reported that a staff nurse had been redeployed from the childrens ward as backfill and the senior sister had undertaken clinical duties. We were advised that there had been no ITU cots available in the region and therefore nowhere else to accommodate the babies. The capacity situation was resolved with 36 hours. Staff on duty stated that this was a regular occurrence. Senior staff told us that they would not use agency staff and relied on the flexibility of ward staff and bank staff to cover vacancies. The department had a sickness rate of 3.8%. A senior member of staff said “The problem is we won’t turn babies away, how could we”.
- Following the inspection the trust confirmed they had outstanding 1.2 Band 6 neonatal nurse vacancies. The trust had a programme to attract nurses to it. Examples of which were varied training opportunities, a recruitment and retention group and rotation in the community.

Medical staffing

- Medical skill mix within children’s services consisted of 33% consultants, 2% middle career, 57% registrar and 8% junior doctors. Middle career doctors were those with at least three years at senior house office or higher grade within their chosen speciality. The national average for middle grade doctors was 7%. The trust had a higher proportion of registrar level doctors. Doctors we spoke with considered that this did not pose a problem as peer support and support from consultants ensured that patients received effective care.
- Medical staffing in the paediatric services did not fully meet the Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future’ recommendations. The RCPCH recommended a team of ten consultants. The unit had seven full time and two part time consultants. An additional full time consultant was undergoing induction. This meant that when the new consultant had completed their induction there would still be one less consultant cover than recommendations suggested were required. We were told that recruitment was continuing and the trust had planned and budgeted for ten. One consultant we spoke with suggested that the department required 12 consultants in order to provide a comprehensive service.Consultant cover in Paediatrics was available between 08.00 and 20.00 on weekdays with plans to increase this to 08.00 to 22.00. Weekend cover was 08.00-17.00. Outside these hours there was an on-call system, which provided junior staff with support.
- Consultant cover in Neonatal unit was available between 09.00-22.00 Monday to Friday with plans to increase to 22.00 on Saturday and Sunday. Weekend Consultant cover in Neonatal is from 09.00-13.00 and on call thereafter, and night shift ward round and handover from 21.00-2230.
- We attended a doctors teaching session followed by the medical handover. The teaching session related to resource management and human factors training following this a simulation session took place. We saw that junior doctors were encouraged to take part and were supported by those with more experience.
- The handover was consultant led and included nine senior house officers or registrars. The handover was structured and included a written handover sheet which could be referred back to if required.

Major incident awareness and training

- The trust had a major incident plan which was available to staff on the intranet. Incident cards to assist staff understand their role were available in ward sisters offices.
- Nurses and health care assistants were mostly aware of the plans. One nurse we spoke with said she could not recall having had any training or information on major incidents, however they did say that they would expect

senior nursing staff to take charge and direct the remaining staff in any actions. A healthcare worker told us they had been given basic details during their mandatory training. They told us they were aware that planning took place as they had been contacted at home by the trust and asked if they would be willing to be included in a list of staff who could be called out in the event of a major incident.

Are services for children and young people effective?

Good

Services for children and young people were effective.

Recognised care pathways were followed which ensured patients received treatment in line with the latest guidance.

Engagement with national audits was good with clear analysis and learning being put into practice.

Review of poor audit outcome had resulted in interventions being identified and implemented to prevent or reduce the number of new born deaths.

Evidence-based care and treatment

- We saw that pathways of care were based on national guidance using audit and benchmarking. For example neonatal services engaged with national and international audits.
  - The Neonatal Critical Care Minimum Data Set (NNCCMDS) using the Badger IT system. The data collects information on 29 individual items relating to neonatal care.
  - Neonatal data analysis unit (NDAU) The NDU aims to support UK neonatal units, networks, and NHS Trusts to improve the quality of care for newborns and their outcomes through health services support and research.
  - Vermont-Oxford, An international collaborative organisation of nearly 1,000 centers around the globe that voluntarily submit data about the care and outcomes of high-risk newborn infants. Data on over 2 million babies was used to inform and improve practice.
- We looked at how young people were cared for when they were accommodated and cared for in adult ward areas. Staff on adult wards described how they would deal with young people between the ages of 16 and 18 if they needed or wanted to be on an adult ward rather than in the paediatric ward. The practice described in each of the wards we visited was very similar. The trust had a policy in relation to admitting 16-18 year old's. However, staff we spoke with on adult wards were not aware of a policy We were told that the vast majority of young people were dealt with on the paediatric ward, and most adult areas confirmed that they had not accommodated young people for a number of years.

Pain relief

- The trust pain team provided guidance and assistance to the paediatric services in relation to supporting people with their pain relief.
- Patients and carers we spoke with during the inspection all described having had appropriate and adequate pain relief.
- Staff in the paediatric assessment unit said that on occasions they had been late administering pain relief due to the number and acuity of patients on the ward. We were given an example of a four year old child requiring pain relief following a minor operation, the nurses had been unable to access the medication and administer it due to having to provide care to other patients. This meant that the child had suffered pain and discomfort which could have been avoided.

Nutrition and hydration

- Prior to our inspection we had received some information about meal portion sizes. The information suggested that young people over 16years received portions suitable for a small child.
- We asked staff about this during our inspection and they stated that in their experience the opposite had been true and meals had often been left due to their large size. We noted that meals we saw were more than adequate for the needs of all ages in the paediatric area.
- We saw that there was a regular supply of drinks available for young people.
- Patients who required more intense monitoring had full assessments of their dietary needs and fluid and food charts were available for staff to complete if they were required.

Patient outcomes

- The trust engaged with the Royal College of Paediatric and Child Health (RCPCH) national paediatric diabetes audit. Staff explained how the outcomes had informed the trusts control of diabetes during the last three years. The national paediatric diabetes audit was based on NICE guidance which required that all paediatric diabetes patients over the age of 12 years should be screened against seven care processes. New Cross had scored well in relation to the principle measurement which was Glycated Haemoglobin screening, with a compliance rate of 99% of eligible patients screened. However, in common with many other trusts engagement with other screening methods was very low and screening across all seven NICE processes was only 20%.
- The clinical effectiveness lead in the neonatal unit outlined how the trust had introduced a project aimed at reducing the number of deaths in new born babies. The project involved admitting all women with premature ruptured membranes who were over 28 week's gestation. This was actioned regardless of bed availability.
- We saw evidence that emergency readmission rates for children under one and for children between the ages of one and 17 were both slightly higher than national averages in a number of specialities. Between October 2013 and September 2014 paediatrics saw 1.5% of elective patients and 4.7% of non-elective patients return within two days. This compared with national averages of 1% and 3% respectively. Non-elective colorectal surgery saw a readmission rate of 3% against an average of 3%. Ear, Nose & Throat (ENT) had 2% against an average of 1%. No one speciality had more than six cases of readmissions during the period.
- Local audits on the paediatric ward were not always as effective as they could be. The audits were delegated to the Band six nurses. Information was collated but was not always analysed by managers to identify trends and learning. Managers said they were confident that the nurses would highlight any issues if they found them and therefore did not review the information. When we looked at the hand hygiene audit for May 2015 we saw that one aspect of the audit had recorded that no doctors had washed their hands after having patient contact. As the information had not been escalated there had been no opportunity to feed-back to the doctors and reduce non-compliance through learning.
- We were provided with information regarding medical audits which had been completed. A total of 23 audits had been completed in acute children's services, although it was not clear from the information provided over what period these had taken place. Five of the audits were dated these were:
  - 2014-15 Local Acute Audit – Doctor communication with parents within 24hrs of admission of baby to neonatal unit.
    - Minor non-compliance was identified which resulted in the process being changed so that meetings were recorded on the electronic patient records. Consultants were tasked with overseeing doctors and ANPs to ensure the records were updated.
  - 2014-15 NICE Audit – Are newly diagnosed Type 1 Diabetes patients being referred appropriately.
    - Minor non-compliance was identified which resulted in consultation with local GP's to improve awareness and NICE compliance.
  - 2014-15 Local Acute Audit – Delegated Consent,
    - Minor non-compliance was identified in relation to parent information and consent to MRI scans. - New forms with clear information and consent details were being developed so that staff can clearly identify when parental consent had been given.
  - 2014-15 Local Acute Audit – Infections and choice of antibiotics –
    - Minor non-compliance was identified which resulted in awareness training for doctors in relation to fully documenting decisions on antibiotics on patient notes and on drug charts.
  - 2014-15 Nice Audit – Urine Tract Infections in children.
    - Minor non-compliance was identified which resulted in encouragement to all doctors to consider whether the UTI is upper/lower & whether atypical/recurrent and to document and during handover/on handover sheets, ward rounds, clinical notes and e-discharge.

Competent staff

- Staff we spoke with told us that they were supported by the trust and their managers to complete their

registration and revalidation. Medical and nursing staff were required to evidence their work to show that they have maintained a proficient level of competence to continue working.
- We saw evidence that all the nursing staff on the paediatric and neonatal wards had all received an appraisal within the last twelve months.
- Junior doctors described the support they received from consultants which encouraged them to seek advice and improved learning.

Multidisciplinary working

- We saw how different disciplines worked together to provide holistic health care to young people. Diabetic services worked closely with speech and language therapists (SALT) and physiotherapy and occupational therapists.
- Transitional services were in place which ensured that young people who were approaching their 18th birthday were seen by members of adult teams when they saw their usual paediatric team. This assisted with the transfer from the children's services to the adult services so that patients received a seamless service.
- We saw guidance sheets for nursing staff which included reference to other disciplines and services with contact details for specialist staff. A member of staff explained how they had used this when they were considering what additional support a child had required. They explained how the information had reminded them of services and had made contacting them easier as the sheet contained contact numbers.
- We saw how community services were considered and involved both prior to admission and at discharge. This included liaison with schools and school nurses over the educational needs of children.
- The department had a psychotherapistpsychotherapist who was a member of the trust community childrens nursing team, they supported patients and parents or carers. Patients who required psychiatric assessments were referred to the children and adolescent mental health service (CAMHS). CAMHS services were provided by the Black Country Partnership Foundation Trust and staff said that whilst relationships were good, it was difficult to arrange CAMHS assessments due to the availability of the team. Patients who required more intensive support to keep them safe were nursed on a one to one basis.

Seven-day services

- Neonatal services were provided 24/7 with consultant cover between 08.00 and 22.00. Inpatient paediatric services were also provided 24/7. In addition the children's assessment unit and day-case units operated 08.00 to 20.00 daily.
- Out of hours consultant services were on an on-call basis. Junior doctors were very complimentary of on call consultants, they told us that consultants were always happy to assist with advice regardless of the time of day or night, and where required would turn out to provide support.
- The paediatric ward had dedicated therapies staff. Imaging services were available although the imaging services did not have a dedicated paediatric radiologist.
- We met with the clinical lead for radiology who explained that a number of radiologists had an interest in paediatrics and were able to provide imaging, however the interpretation of images was more specialised and only two members of staff one of which was the clinical lead, felt confident to review and report on images. They explained that this meant there was always a delay of several weeks for non-urgent reviews and reports.
- Normal pathways for imaging in respect of serious conditions would be referral to specialist children's hospitals such as Birmingham Children's Hospital; however we were told that referrals to Birmingham could take up to five days. Wolverhampton imaging services were able to complete such imaging but due to availability of the qualified staff, there could be a delay of up to three days. This meant that paediatricians and specialist services in the hospital preferred to wait three days and used in house services rather than wait five days for external referrals.

Access to information

- The trust used electronic patient records, which meant that information was accessible from any location within the trust.
- The trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides to policies and procedures to assist in their own role.

- Audit information was shared during meetings and copies were available in the manager's offices if staff wished to review them.
- Learning from incidents and complaints was posted on the staff room walls in addition to being discussed at meetings. This acted as a constant reminder to staff about issues which had affected patient care or welfare.
- Guidance on avoidance of risk was highlighted in the staff room on the paediatric ward.

Consent

- Consent was a high priority for staff in children's services. Parental consent was required for care and treatment for babies and young children. Children over the age of 16 years were considered to be able to make reasoned decisions about their health care, however parental support and agreement was always sought.
- Children under the age of 16 are presumed to lack capacity, but can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. Otherwise, someone with "parental responsibility" can consent for them.We saw how staff informed children what about what they were going to do and sought consent with phrases like 'is that alright' or 'shall we do that then' this showed how children were involved in and encouraged to understand and be involved in their care and treatment even when parents had consented to procedures being done.
- We observed nursing staff dealing with children both when parents were present and in their absence. We saw that nurses and healthcare workers always explained what they were doing and sought consent with phrases such as 'Is that okay?' or 'shall we do that then?', and similar phrases which meant the child had to respond.

Are services for children and young people caring?

Good

Children's services were caring.

We saw examples of how staff supported children and their families with kindness and empathy. Patients were comfortable in the presence of staff

The neonatal unit and the children's ward do not participate in friends and family test as it is not paediatric focussed. However they do undertake patient feedback by use of the parent passport in neonates, and the comments tree in both areas as well as the caterpillar in children's outpatients. The comments were found to be constructive and positive in all of these areas.

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Children were involved in discussions about their care and treatment. Parents and carers were also engaged in the process and were able to prompt and support young people.

Support was available from a psychotherapistpsychotherapist for children, carers or staff following bad news having had to be given.

Compassionate care

- We saw how staff interacted with patients and their families. We observed staff in all the children's services locations in the hospital. We saw that staff without exception were polite kind and caring. We saw many examples of staff taking time to speak with children or their parents both to explain processes but also to exchange pleasantries. We saw how children and parents were happy to be in the presence of staff and how they greeted each other with smiles and friendly comments.
- The paediatric ward had a large wall picture of a tree, parents and children had been asked to write comments on leaves and stick these to the tree. Comments included such items as "Thank you for making X (name of child) smile and looking after him", "I would like to say a very big thank you to all the staff on the ward for all the care and support they gave. They were so helpful, caring, loving and understanding. Big hugs and kisses to you all", Children's comments included "I like playing in the playroom" and, "Staff are happy and friendly".
- The neonatal unit and the children's ward do not participate in friends and family test as it is not paediatric focussed. However they do undertake patient feedback by use of the parent passport in neonates, and

the comments tree in both areas as well as the caterpillar in children's outpatients. The comments were found to be constructive and positive in all of these areas.

The paediatric areas post 'You said, we did' updates to inform parents and children of changes made as a result of the information fed back to the services.

Understanding and involvement of patients and those close to them

- Parents and carers we spoke with were very complimentary about the nursing staff and doctors who cared for their babies and children. They felt fully informed about their child's condition and the options for treatment.
- We were told that they had been able to make comments and ask questions about care and these had been explained in a way which they understood.
- We were told how even small children were involved in discussions with doctors; doctors would ask a question of the child and wait for a response before then confirming with the parents that the response was accurate. Parents and carers told us this made the child feel that their comments were important and enabled them to say how they felt about their care and treatment and how it had affected them.
- Neonatal nursing staff constantly spoke to babies as they provided care.

Emotional support

- We saw how nursing staff smiled and joked with children and their parents, parents told us that they found the calm and friendly manner of staff helped them cope with their anxiety.
- Children's services had a psychotherapist who staff were able to contact for assistance when patients or relatives or carers had been given bad news. We saw that the psychotherapists contact details were readily available. We were able to speak to the psychotherapist who confirmed their involvement and support to the ward with counselling services and signposting to external agencies.
- The paediatric palliative care system ensured that parents and carers received emotional and where wanted spiritual support.
- We spoke with the lead chaplain who explained how the team of chaplains and volunteers provided compassionate and friendly support to staff, patients and their family members and to carers.
- Chaplaincy team members made regular routine visits to all areas including the children's services; in addition they could be called by staff to attend if there were a particular need. We were given examples of how chaplains had been called to neonatal and paediatric areas to provide support for families.
- The lead chaplain explained how all the chaplains from different faiths were able to provide emotional support and how they could refer on to specific chaplains if spiritual support were required, which was outside their faith.

Are services for children and young people responsive?

Good

Children's and young people's services were responsive.

People received individualised treatment based on their medical and welfare needs. Risk assessments were completed and reviewed in relation to everyday care and treatments.

Elective services were tailored to ensure that school examination timetables were not interrupted. General inpatient services continued school activities in line with curriculum based programmes.

Interpretation services were available. Staff diversity reflected the diversity of the patient catchment area. Information leaflets were in English, with reference to alternative languages in a font size which was exceedingly difficult to see.

Guidance was available to staff regarding accomodation for children between 16 and 18 on adult wards where this was either required to meet their physical needs or requested because they preferred not to be on a children's ward.

Service planning and delivery to meet the needs of local people

- The paediatric services had formed excellent links with children's community services this included liaison with schools so that children who were admitted to the ward could continue with the same study programme as their peers.
- Transitional services for young people as they approach adulthood took account of their changing needs. Older children would have joint consultations with nursing and medical staff from adult and children's services so that they and the staff became familiar with each other. This also ensured that the patient's needs were fully understood before transferring wholly on to adult services.
- Neonatal services were centred round the family. The service had two parent's flats on the unit and a further three within the maternity block, where parents who were not from the local area could be accommodated while their child was being cared for on the unit. The children's ward haad an en-suite flat and a parents room offering drinks on the wrad. The trust advised us that there is a refurbishment programme in place to improve these facilities.
- The Wolverhampton area had a very diverse population. When we looked at information available to patients and carers, we found very little reference to foreign languages. Many leaflets had extremely small print which advised people to speak with a healthcare worker if they required the information in another language; however; we asked three members of staff to provide a foreign language version of a leaflet and only one knew how this could be sourced.
- We saw that although there were significant numbers of young people using the fracture clinic service. The trust suggested in the region of 4,000 per year; there were no child friendly areas for young people to sit and no distractions for children to help them cope with what could be several hours waiting.
- Following escalation of safety issues in the paediatric surgical day-case unit, we saw how managers addressed issues and provided staff with a written standard operating procedure so that everyone understood the procedure for qualified nurses leaving the unit. We were told by senior managers that meetings had been arranged with the theatre teams to see how the two services could link to reduce the impact for the day case nurses or to reduce the time involved in the transfers.
- In the plaster room we saw that even small children were having plaster casts removed or adjusted by staff using adult cutting equipment. Adult cutters tended to be larger, noisier and potentially more frightening to small children. We escalated this and some other safety issues in the department to senior managers. We found that the next day the department had created a child friendly area. Seating had been moved to form a barrier between adult and children's areas, child friendly frieze's had been ordered and a variety of toys and games had been purchased. The response to safety concerns had also been addressed. A child friendly plaster saw had also been ordered. This showed that children's services were extremely responsive to people's needs when they had been identified. However, we would have expected the trust to have identified these issues as part of their ongoing governance.
- When we highlighted issues in the fracture clinic in relation to the poor environment for children and young people. The trust responded immediately. Seating was re-arranged to form a children's area; wall art stickers, toys and games were purchased to help distract children during their wait.

Access and flow

- The neonatal and paediatric wards and areas were protected from the capacity issues found elsewhere in the trust. No adult patients were accommodated in children's areas which meant that staff could concentrate on their primary role.
- The neonatal ward catered for premature or sick babies. The unit had around 450 admissions each year. The unit had seven intensive care cots, seven high dependency cots and 12 special care cots.
- Parents were encouraged to help care for their babies whilst on the ward and staff supported them to do so. We were told that this process assisted with discharge as it increased parent's confidence. Discharge procedures were also supported by community based services which visited families at their home.
- The lead paediatric anaesthetist advised us that approximately 2,000 operations were carried out on children and young people each year. Of these around 200 were emergency procedures and the rest were elective procedures. Most of these children were recovered within the paediatric ward. Occasionally during out of hour's periods children were recovered in

the main adult recovery area; however we were assured that during such times there was always sufficient space to enable children to be kept separate from adults. We were told that patient discharge could be delayed as a result of having to wait for discharge medication to be dispensed. Discharge medicines were known as 'to take outs' (TTO's). An example was given of a one child who was ready to be discharged at 10.00 and waited until 19.00 for the medication to arrive on the ward. Staff told us that it was not unusual for delays of four to five hours. The directorate have identified this as an amber risk following trends in incident reporting and further analysis by the governance team. As a result it is included in the issues being addressed by the medication management task and finish group. The business case for the drugs preparation room was approved and in development .Works were in progress on the ward at the time of the visit.

- Cannock hospital provided two morning outpatient clinics per week for children and young people. This enabled people in the area to engage with services without having to travel to New Cross. There were no paediactric outpatient clinics operating at the time of our visit. We did not see any provision for small children, however the trust pointed out that there was a small play area within the paediatric corridor, and distraction boxes were available in each of the consultation rooms.

Meeting people's individual needs

- Many of the patients who used the children's services had complex needs. Children were assessed for various types of surgery in the pre assessment unit, they were supported in the day-case unit and on the ward if they needed support prior to or following surgery, or for illness or injury.
- We saw that there were information leaflets available to parents and young people which explained medical conditions and in some cases provided contact details for support groups and charities outside the trust.
- Staff told us that they had access to a telephone translation service if it was required. They said that most patients and families who used the service were able to understand English even if it were not their first language.
- We saw that there was an information centre in the hospital and we took time to view a number of publications and information leaflets. We noted that all the leaflets were all in English. We were told that information was available within leaflets on how to obtain them in alternative languages. The advice suggested that for alternative languages people should ask a healthcare worker. We asked four nursing staff of varying rank if they could tell us how we could get information in alternative languages and only one was able to do so.
- The trust had a learning disability lead nurse, who was part of the safeguarding team. They were available to advice or assist staff when dealing with people of all ages who had a learning disability. Nursing staff on the paediatric ward were familiar with the additional needs which some patients required due to their disability, they were knowledgeable about how to support people and their families. We saw that there was appropriate play and learning materials for children and young people of all abilities.
- We visited the critical care unit to assess how young people were dealt with if they needed admission to the unit. We were told that the unit did not routinely take children under 16years, where this did occur the patients were stabilised and transfer was arranged to specialist hospitals such as Birmingham Children's hospital. Staff described how they used the 'Kids Intensive care Decision Support' (KIDS) service at Birmingham Children's hospital. The KIDS team provided expert advice, located suitable intensive care beds and operated a retrieval system to collect and transfer paediatric patients. This ensured that staff had the support they needed to manage children in the department until they could be transferred to a specialist unit. We were told that the department had probably one such case in the last five years.
- Young people under 18 were accommodated and systems were in place to enable those who wished to do so to visit the department to be shown where they would be cared for and the equipment which might be used, this meant the experience was far less stressful.
- We saw how educational and clinical needs were personalised to individual patients. The children's ward had its own schoolroom. Staff explained how they liaised with schools and school nurses to ensure that children could continue with curriculum based studies during their stay in hospital. We were also told that clinics such as diabetes clinics did not run during exam periods.
- Young people were sent texts or telephoned to remind them of their appointments.

- Many specialist clinics and services were provided by the trust which were not targeted directly at children and young people but which still had significant numbers of young patients. There did not appear to be a trust wide approach or guidance to ensure that processes and procedures for children and young people were uniform across all services. Some area's such as the ENT clinics did not have child friendly decoration, facilities or distractions for children. Others such as ophthalmology had toys and films to help amuse children; bright child friendly stickers were used in consulting rooms and on equipment to make items appear less intimidating.

Learning from complaints and concerns

- We had received some feedback from service users regarding poor care in the paediatric assessment unit. We saw how the trust had responded to patients comments on NHS Choices and signposted complainants to the PAL's system so that their issues could be investigated and learning identified.
- Staff told us how they tried to address any concerns of patients as they arose to prevent issues developing into complaints. We saw how complaints were recorded, investigated and feedback provided to complainants. One parent we spoke with explained how they had raised concerns about how their child had been cared for during a previous stay in the hospital. They told us that although the matter had been reported and they had been told of an investigation they had not been told what the outcome was. We spoke with senior staff about the incident. They were aware of the circumstances and the investigation which had taken place and that a senior nurse had spoken personally with the parent about the outcome. They advised that the parent must have believed that the enquiry was ongoing, and they went immediately to update them about the result.

Are services for children and young people well-led?

Requires improvement

We found that improvements were required in relation to how children's and young people's services were led.

There was a culture within the service of reacting to issues rather than identifying them before they became an issue.

In all other respects the service was well led. Staff understood their role and felt supported by managers.

Learning from incidents and complaints was evident.

Vision and strategy for this service

- Staff we spoke with understood their role within the organisation and how they contributed towards the overall vision of the trust.

Governance, risk management and quality measurement

- There were systems and processes in place which should have enabled the trust to satisfy itself that processes were safe, effective, caring and responsive. Local nursing audit systems did not always include analysis by senior nurses, which meant that opportunities were missed to improve services.
- Medical audits did appear to have the required level of scrutiny which enabled outcomes to be measured and tailored to reduce risk and maintain quality.There was a rolling recruitment program to recruit neo-natal nurses Therefore the management appeared reactive. This open recruitment opportunity is seen by the trust as proactive alongside other activities which the site below;
- The neonatal unit had very few vacancies when benchmarked with other services of a similar size1.2 whole time equivalent band 6 vacancies. As a proactive action to ensure retention of staff a recruitment and retention group including all bands of staff commenced approximately 1 year ago. This group has supported recruitment as required and developed a variety of ideas to promote retention. For example. newsletters, training, staff involvement and engagement events. Supplementary evidence requested and submitted 4/8/15
  - Rotation through the 3 levels and shortly to Transitional Care when the trust open an additional 14 cots from September 2015
  - Rotate to Paediatrics – good for staff who are RSCN trained and want to keep up their generic skills

- Recruit NNU nurses who are also midwifery trained to practice (1 has just completed her return to midwifery and as a community nurse will also undertake mum's post-natal check)
- Rotation into Community Neonatal Team for 6/12 period
- All new starters after induction are put on the relevant NNU course – either introduction or intensive care level courses(Keele University)
- attend relevant bespoke study days
- Actively encourage staff from other units in the Black Country to spend some time during their neonatal course with us to expand their knowledge
- Recruitment and retention group set up about a year ago, led by band 6s but incorporating a band 7, 5 and 3 to get a wide range of views.
- Improved induction package, commenced newsletter to improve communication
- Raising the profile of the Unit generally

Leadership of service

- Both the medical and nursing staff told us they felt supported by their managers and believed that any issues raised would be properly represented and escalated.
- Local managers were empowered to take responsibility for their own areas and had the autonomy to make changes within their own budget limits. An example of this being the planned re-development of areas within the paediatric ward. The matron described plans to change an older section of the ward which was divided into side rooms in bay areas as bays had proved to be a better environment for the children and parents. A number of rooms had already been converted into four new bay areas which had been very popular with children.
- Senior managers understood their staff and the importance of supporting them to complete their role.

Culture within the service

- There was a culture of support and learning within children's services. Staff and managers reported incidents and used learning from them to improve services.
- We did find that there was a heavy reliance on providence in relation to issues rather than a proactive approach to prevent issues arising in the first place.
- There was a culture of reaction rather than prevention.
- The department and trust were quick to respond when incidents had occurred or when potential risks were pointed out; as demonstrated by their response to issues we had highlighted in the fracture clinic and day case areas.
- In response to the TDA findings the trust in order to monitor actions identified by staff during weekly (and ad hoc) ward manager environmental audits drew up an action planning document proforma. The aim of this proforma was to empower all staff from housekeepers upwards, to follow through items of work. Ward managers were encouraged to keep the action plans in a visible staff area to enable items to be addressed in a timely manner including in the absence of the ward manager. In the case of wards A20 / PAU / A21, each Band 6 Sister was also allocated a specific area of the department to have responsibility for, and to follow-up any outstanding actions. The documents were displayed on notice boards. Comments, rag rating and then final completion dates were added to denote the degree of completeness of each item. The proforma template was discussed at trust level and shared with all Matrons and Heads of Nursing.

Public engagement

- Children's services were very open to parent and carer involvement. Neonatal services were based on a system of assisting parents to care for their child rather than taking responsibility away. The paediatric ward supported and signposted parents and carers to support groups in the community.
- Details about the neonatal unit and paediatric services were available on the trust website together with news articles promoting good work in the departments.

Staff engagement

- Staff were encouraged to engage with the annual staff survey and results were published.
- All medical and nursing staff had access to the trust intranet and email systems. Medical alerts, news items and general information were distributed to staff through the intranet.
- Team meetings and handover sessions were used to enable open discussion and learning from incidents, complaints and compliments.

Innovation, improvement and sustainability

Services for children and young people

- Consultant numbers were being increased to enable the trust to meet Royal College of Paediatric and Child Heath (RCPCH) and National Institute for Health and Care Excellence (NICE) guidance.
- Paediatric ward planned to convert old outdated side rooms into bay areas with modern facilities.

End of life care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

New Cross Hospital provided care for people who were at the end of their life and had a palliative care team who worked across the hospital and community supporting these people. From data submitted by the trust we saw there were 688 deaths at New Cross Hospital (Apr 2013 – Oct 2013). The palliative team received 937 referrals across the trust (Apr 2014–Mar 2015) 30% of the referrals were for non-cancer patients.

We inspected the service by interviewing staff, reviewing records and undertook observation over three days. We received comments from patients who contacted us to tell us about their experiences and we reviewed performance information about the trust.

During our inspection we visited several wards such as the dementia unit, acute medical unit, trauma and orthopaedic ward, gynaecological ward, haematology unit, oncology wards, care of the elderly ward, medical renal wards, respiratory ward, diabetes ward, the chapel, chapel of rest and the mortuary.

We spoke with 35 staff including nursing, medical, allied health professionals, the chaplaincy, mortuary staff and all of the palliative care team including managers. The palliative care team consisted of one whole time equivalent (WTE) specialist palliative consultant, one specialist palliative registrar, lead palliative care nurse, advanced specialist nurse, two clinical nurse specialists, 0.69 WTE rapid home to die facilitator, one band seven specialist palliative occupational therapist, two band six palliative occupational therapists and one occupational therapy assistant. The mortuary was staffed with one WTE band four. The whole palliative care team worked across New Cross Hospital and the Cannock Chase Hospital. The specialist palliative consultants also worked at Compton hospice and the outpatient's department allowing for continuity of care.

We spoke with five relatives and two patients currently using the service. We reviewed 30 patient care records and 29 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records across a selection of wards, units and recently deceased patients from the bereavement office.

End of life care

Summary of findings

Out of the 94 incidents related to the palliative team, we saw eight were in relation to low staffing levels. We noted some resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. However, they told us that the palliative team were aware of their pressures and were very supportive.

The palliative team were not solely responsible for end of life patients but they supported the medical and nursing teams in providing specialist advice.

We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Although improvement was needed to ensure that controlled medicines were safely and appropriately administered.

We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.

The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative members of the team were.

The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information' leaflet and the bereavement feedback survey were redesigned to have the Swan logo.

The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.

We noted there was easy access to the palliative care team and they were responsive in supporting ward staff.

On both hospital sites the staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times and were able to discharge a patient with a complex package of care within 24 hours.

For both hospital sites the palliative team had a clear vision for their service. The leadership, governance and culture promoted the delivery of high quality person centred care. The team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.

We saw the culture was a positive energetic one.

End of life care

Are end of life care services safe?

Requires improvement

Out of the 94 incidents related to the palliative team, we saw eight were in relation to low staffing levels. We noted two resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff noted in most of the incidents they were unable to have breaks during their shifts. Staff told us and we saw evidence that they were reporting other incidences and these were all reviewed by managers.

Nursing staff on the wards told us there were sometimes insufficient numbers of staff on duty to ensure the needs of patients were being met. Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. We found there was insufficient numbers of staff on duty to be able to safely reposition high risk patients correctly. Incidents in relation to this were not recorded. They told us that the palliative team were aware of their pressures and were very supportive.

The palliative team and medical team worked closely with nursing staff and regularly reviewed deteriorating patients.

We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Arrangements for medicines were mostly satisfactory although improvement was needed to ensure that controlled medicines were safely and appropriately administered.

We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.

Incidents

- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents.
- No 'Never Events' had occurred within the palliative care service between April 2014- March 2015.
- The hospital implemented a system in which any incident throughout the hospital for any palliative or end of life patient could be sent and reviewed by the palliative care lead nurse as well as the responsible ward manager. This meant the palliative team were able to review incidents and monitor trends.
- From June 2014-June 2015 there had been 94 incidents reported across the trust in relation to palliative patients. All had been reviewed by managers and action had been taken in order to reduce harm to the patient and details of 'lessons learnt' were documented most of the time.
- Staff told us they received feedback, learning was disseminated through e-mails. Several staff were able to tell us about one previous incident where a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form had been completed but it had not been discussed with the family. We saw staff across the trust had learnt from this incident. Although improvement was still needed. We saw in Emergency department that five of ten sets of patient records reviewed with DNACPR discussions with family had not taken place.
- We spoke with a nurse who shared concerns that end of life patients with spinal cord compression or spinal cancer should be repositioned with three members of staff. The nurse told us only two members of staff were used to reposition these patients at night due to low staffing levels. We saw the trust policy (2014) advises staff to 'log roll' patients but does not specify the number of staff required. Policies produced by the Spinal Cord Injury Centres of the United Kingdom showed that most repositioning required three members of staff, minimum. We asked ward staff if they logged this as an incident, they told us they did not. We saw that patients were at risk of being harmed and that learning did not take place. We were told that the ward manager was aware and that it happened across the hospital due to staff shortages on the wards.
- The palliative team were able to explain duty of candour and the importance of reporting incidents. The Duty of Candour regulations require a provider to be open and transparent and follow some specific requirements such as when things go wrong with care and treatment, including informing the person and or family.

Cleanliness, infection control and hygiene

- The wards and mortuary we visited were visibly clean, bright and well maintained. In all clinical areas the surfaces and floors were covered in easy to clean materials allowing hygiene to be maintained.

End of life care

- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or whilst caring for people after death.
- Mortuary staff were clear on infection control guidelines and knew how to access hospital policies.
- Personal protective equipment, such as gloves and aprons, were available for use in all clinical areas.

Environment and equipment

- Staff across the hospital told us side rooms were prioritised for end of life patients, staff told us it was rare to have a patient dying on an open ward. The families that we spoke with confirmed that they were offered a side room in a timely manner.
- All equipment in use had been maintained and staff were able to describe the process of reporting faulty equipment.
- The trust used McKinley T34 syringe drivers to deliver consistent infusions of medication to support end of life patients. Staff told us were readily available across the hospital, were regularly calibrated and tested by the medical devices team.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in all areas in the mortuary although cameras were not used in the fridge storage area to maintain the dignity of the deceased.
- We saw the mortuary had been recently refurbished and had a range of fridge sizes from bariatric patients to babies.

Medicines

- We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. We were told by staff on the wards we visited that medication for end of life care was available on the ward. For medication that was not commonly used on the wards this was available within two hours from pharmacy.
- Through reviewing records we saw evidence of effective symptom control for patients that were at the end of their life.
- We saw evidence that staff adhered to guidelines of anticipatory prescribing medication, required to keep patients that are end of their life comfortable and pain free.
- From data submitted by the trust we saw 85% surgical staff and 81% of medical staff had been trained in using syringe drivers, we noted the trust target was 95%. We were told by nurses that the palliative team were supportive if they required any assistance with syringe drivers.
- The palliative team developed an annual syringe driver audit (February 2015) in which they checked the correct and safe use and documentation of syringe drivers. We saw any learning points were fed back to ward managers and e-mailed to nursing staff.
- Staff told us they accessed the Adult Medical Guidelines & Palliative & End-of-Life care department guidelines which provided them with guidance on when to prescribe anticipatory medicines.
- We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation on all wards except for one oncology ward. On Deansley ward we found some controlled drugs had been packaged and supplied by pharmacy as individual strips placed inside clear bags. We noted that two controlled drugs did not have a batch number or expiry date displayed because they had been cut off the end of the strip. It was therefore not possible to determine if the controlled drug was safe to be administered. We also noted that one of the clear bags had no label because it had fallen off. Labelling of medicines helps to ensure that the correct medicine is selected to use it safely and therefore help to minimise medicine errors. We raised this to the attention of the trust during inspection.

Records

- We reviewed 30 medical and nursing paper care records which included doctor's notes, plans of care and reviews, comfort round charts, food and fluid balance sheets, risk assessments, syringe driver administration charts and a range of care plans.
- Some records were completed electronically and staff had systems in place to remind them to assess patients' pain and vital observations. Observational charts were consistently completed.
- Nursing care plans for all patients including end of life, lacked detail and did not reflect patient's preferences as they were all a standard template and all read the same. They were not personalised or person centred.
- Medical staffing records were consistently detailed and gave a good holistic overview of the patient during every review. We found that patients nearing the end of the palliative were frequently reviewed.

End of life care

- Records lacked evidence that families were always kept informed and updated about the patient's care. We spoke with two relatives who told us they had not been kept informed or updated in several days. The palliative team were aware of this issue and told us they would often prompt staff to contact the family and told us sometimes communication was 'reactive' not 'proactive'.
- The Liverpool Care Pathway documentation had been removed as recommended by relevant guidance. The hospital were in the process of piloting 'The Swan' project as a care planning tool and guidance for patients in the last few days of life. Some staff had been trained to use the documentation and implement the scheme, only a small amount of staff had trialled it so far. The wholescale roll out of the project was set for December 2015. However mostly all staff were able to tell us the aims of the project and how to identify someone for the Swan Project.
- We reviewed 29 DNACPR records and found these were consistently well completed. Staff ensured they documented whether the patient had capacity to be involved in the decision making and discussions with families were documented. DNACPR records had been signed and dated by appropriate senior medical staff. Discussions with families were documented in the medical notes as well as the patients preferred place of dying.

Safeguarding

- Safeguarding policies and procedures were in place. Staff understood their safeguarding responsibilities and knew what to do if they had concerns; 76.1% (trust wide) of staff had completed standard safeguarding training and 82.1% of staff from the medical division in which palliative team sits. We found evidence that staff were confident in having sensitive discussions around safeguarding issues with families and patients near the end of their life. We were given examples where staff had acted appropriately.

Mandatory training

- The hospital had a program of mandatory training for all staff, the palliative team were 100% compliance with their mandatory training.
- End of life staff training was not mandatory for all staff groups across the hospital however we saw considerable measures had been taken to train [illegible] on the new end of life project 'The Swan'. As from May 2015, an end of life care and bereavement study day was being held monthly which would be available to all hospital staff.

Management of deteriorating patients

- Ceilings of care were identified and shared with all the staff involved in their care and treatment. Therefore interventions which control symptoms would always be offered, but more invasive treatment would not be offered.
- Early Warning Score (EWS) observations were monitored for patients and we saw evidence of staff responding to deteriorating patients.
- Risk assessments were in place for patients, and where these directed additional support it was provided.
- The palliative team and medical team worked closely with nursing staff and regularly reviewed deteriorating patients. We were told nurses were very good in escalating any concerns or developments in the patient's condition with the team.
- Nursing staff told us the palliative team would be there immediately to support them if need be. Staff gave us examples of when they needed further support and told us the palliative team were 'Excellent and very supportive'.

Nursing staffing

- The palliative care team consisted of one whole time equivalent (WTE) lead palliative care nurse, one WTE advanced specialist nurse, two WTE clinical nurse specialists, 0.69 WTE rapid home to die facilitator, one WTE band seven specialist palliative occupational therapist, two WTE band six palliative occupational therapists and one WTE occupational therapy assistant. The mortuary was staffed with one WTE band four.
- The team told us they were currently well staffed however to ensure the sustainability of the continual development of the service and the addition of community hospital services they would require staff at the community sites and were putting forward a business case to increase staffing provision.
- Nursing staff on the wards told us there were sometimes insufficient numbers of staff on duty to ensure the needs of patients were met. Staff on medical wards told us they were able to prioritise patients at the end of their lives to ensure their needs were met. Staff on surgical wards disagreed with this and told us they were unable

to prioritise end of life patients and would struggle to ensure they received the care that they needed. They told us that the palliative team were aware of their pressures and were very supportive. They would sometimes move patients to a more well-staffed area to ensure end of life care was not compromised.

- Out of the 94 incidents we saw eight were due to inadequate staffing levels. We noted two resulted in palliative patients not being attended to or observed as often as they required and 'care was compromised'. Staff noted for most of the incidents they were unable to have breaks during their shifts.
- From risk registers submitted by the trust we saw 'inadequate staffing levels, seven vacancies on the oncology ward for June 2015 which has led to increased sickness levels and low morale.

Medical staffing

- The palliative care team consisted of one WTE specialist palliative consultant with links in the community and one WTE specialist palliative registrar. They did not use any locum staff but were looking at expanding their team. We saw the registrar had regular support and feedback from the consultant on a weekly basis. The registrar had told us it was the best out of three other end of life care placements due to the level of support and encouragement to develop skills, expertise and advance learning.
- The two specialist palliative care consultants also worked at Compton Hospice (inpatient and community) and the hospital outpatient's department allowing for improved continuity and management of patients who were using more than one of the services.

Major incident awareness and training

- Staff were aware of the major incident and the business continuity policy, and understood their roles and responsibilities within a major incident.
- There was clear advice and guidance for mortuary staff regarding a major incident within the policy.
- Staff told us about the mortuary's capacity escalation procedures and noted there was enough for 124 deceased patients and had space for a portable refrigeration unit as well as an additional capacity at other mortuaries.

Are end of life care services effective?

Good

We saw measurements had been taken to work on performance indicators and improve the effectiveness of the service. Within the National Care of the Dying Audit 2013 improvements were required and action plan was produced and as a result the Swan Project has been introduced.

We saw that anticipatory medications were prescribed for all patients who were palliative or at the end of their life.

The hospital did not audit the percentage of preferred place of death so they could not be certain of the exact amount of patients that die in their preferred place. Although we saw this was appropriately recorded in the medical notes from the 30 care records that we reviewed. Two out of the five families we spoke with told us these discussions had not taken place.

We saw staff trust wide were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

Palliative care multidisciplinary team meetings were held weekly. Staff told us they had good links in the community for example with coroners, hospice staff, funeral directors and religious community representatives.

DNACPR forms were appropriately completed but capacity assessments were not always completed where appropriate.

Evidence-based care and treatment

- The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found that evidenced based care was the same across both sites.
- Following an independent review the Liverpool Care Pathway was discontinued across England by July 2014. The pathway was associated with poor experiences of care because of a lack of tailored, personalised care. The hospital were aware of this and had removed all documentation in relation to the Liverpool Care pathway.
- On reviewing the National Care of the Dying Audit (Hospital) (NCDAH) (2013-2014) results, the hospital was not meeting six out of seven the organisational key

performing indicators (KPIs) and five of the ten NCDAH clinical KPIs such as :- access to information relating to death and dying, access to specialist support for care in the last hours or days of life, care of the dying: continuing education, training and audit, the hospital board did not have a representative, plans were not in place for a formal feedback processes regarding bereaved relatives/friends views of care and clinical protocols were not in place promoting patient privacy, dignity and respect up to and including after the death of the patient. They were meeting the clinical protocols for 'the prescription of medicine for the five key symptoms at the end of life' performance indicator. They did not measure continual progress of improvement since the results of the audit however did develop action plans.

- The Palliative & End-of-Life Care Strategy 2015 addressed areas for improvement and the direction for the service. We saw measures had been taken to correct performance indicators and the hospital had registered for this year's NCDAH audit to see how well they were meeting the targets. We saw leaflets had been developed as a part of the 'Swan Project' to improve the KPI 'access to information relating to death and dying'. We saw considerable steps had been taken to train all staff trust wide in the new Swan Project and specific training for ward staff to improve the KPI 'care of the dying: continuing education, training and audit' and promoting patient privacy, dignity and respect . We noted the board now had a representative and had supported the team in implementing the Swan Project trust wide. The team were currently implementing a more formal feedback processes regarding bereaved relatives/friends views of care and sending out more detailed surveys and comment cards.
- The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life.
- Staff adopted the award winning practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information' leaflet and the bereavement feedback survey were redesigned to have the Swan logo.
- The rationale for the Swan logo was to trigger a compassionate response, kind communication and respectful care from any staff member. The logo on canvas bags or outside the doors alerted staff to the presence of dying/deceased patients and identifies the relatives throughout the hospital if they are seen carrying the canvas bag and the logo on the door/ curtain was aimed at triggering a calm and respectful environment on the wards.
- All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.
- Despite not having a specific personalised care plan since the removal of the Liverpool Care Pathway 2014-April 2015 we saw staff still adhered to the recommended five priorities of care such as: - recognising that the patient may die within the next few days, decisions made and actions taken in accordance with the person's needs and wishes, sensitive communication had taken place and patients and families were involved in decisions about the care.
- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to recognise, communicate, involve, support, plan and do, the SPCT had developed a personalised care plan for each patient in the last days of life with guidance for staff of how to best meet the five priorities of care. The implementation of the Swan provided the means to address the recommendations of the National Care of the Dying Audit and fulfil the requirements set out by the National Leadership Alliance for the care of Dying people.

End of life care

- As recommended from the five priorities of care, we found that care notes included food and drink charts, symptom control was regularly reassessed by medical staff and psychological well-being was assessed often. However it was not always clear spiritual support had been assessed.
- Staff developed guidelines where no national guidance existed, for example with the use of the medicine naloxone when given to palliative care patients to combat the side effects of too much pain relief such as respiratory depression.
- The palliative care consultants engaged in research trials such as:- the hydration in the last few days of life feasibility study and a multicentre randomised controlled trial to assess the impact of regular early specialist palliative care treatment on quality of life in malignant mesothelioma.

Pain relief

- Patients we saw appeared to be comfortable and pain free. When we spoke with family members they confirmed their relatives were pain free.
- The hospital scored 10% worse than the national average for the prescribing of anticipatory medication (NCDAH) (2013-2014). However they were meeting the clinical protocols for the prescription of medications for the five key symptoms at the end of life performance indicator.
- From the 30 care records we reviewed we saw patient's suffering ongoing pain did not have pain care plans in place. Their symptoms were controlled and were regularly reviewed by staff using medication charts and risk assessments. For patients who were on the electronic care record assessments we saw pain was consistently assessed every 12 hours. However, patients who were at the end of the life and were not on the electronic monitoring system did not have an assessment in place to formally record their pain scores.
- We saw that anticipatory medications were prescribed for all patients who were palliative or at the end of their life.
- Out of the 94 incidents only one incident was related to a delay in pain relief for patient receiving end of life care. We saw the patient had been assessed as being in mild pain for a short period of time and the family was informed.

Facilities

- All wards had side rooms which could be used for patients who were dying. Staff in all areas told us they always ensured patients were moved to a side room if they were in the last days of their life and understood the importance of providing the patient and family with privacy.
- Mostly all wards had a 'quiet room' in which staff were able to use if they needed to have private discussions with families such as, breaking bad news. We saw some of these rooms had clutter, staff told us there was plans in place to improve on this and redecorate some of the rooms more appropriately. On the critical care unit we were told the 'quiet room' was through the relative's room. This meant distressed or upset relatives had to walk through a room of other relatives before going through to the 'quiet room'. Staff on the critical care unit were aware that this was not ideal. Rooms were available throughout the hospital for families to stay overnight.
- The mortuary (Swan suite) had recently been redecorated and had a quiet room which had tea and coffee making facilities, soft furnishings, a viewing area and brightly painted walls. The mortuary staff thought this was an excellent facility to be able to support families and allow them to take time with their relatives. They gave us examples of how families would gather and make good use of the area. This was an improvement following the last CQC inspection (2013).

Nutrition and hydration

- The NCDAH (2013-2014) demonstrated that the hospital was worse at achieving the KPIs for reviewing patient's nutritional requirements and reviewing patient's hydration requirements by 5% less than the England average.
- We found evidence that patient's hydration and nutrition needs were assessed.
- Where appropriate, patients were seen by dieticians, we were told new dieticians were supported by the palliative care team and they would discuss what was appropriate and what was not for a patient in the last days of their life. Intravenous fluids were prescribed by medical staff where appropriate in order to keep the patient comfortable. Staff told us they would discuss this with families beforehand.

- Staff were aware of how to keep patients comfortable and had recently implemented the idea of using the patient's favourite drink on oral swabs as oppose to using chlorhexidine mouth wash which can be an unpleasant taste for some patients.

Patient outcomes

- At both New Cross Hospital and Cannock chase we found the hospitals did not audit the percentage of preferred place of death so they could not be certain of the exact amount of patients that die in their preferred place. Staff told us they recorded it in the Somerset software but did not review it. We saw this was also well recorded in the medical notes from the 30 care records that we reviewed.
- It was evident from the care records that if the person wanted to die at home it was a priority for staff and was continually reviewed and discussed with families. Although two out of the five families we spoke with told us these discussions had not taken place. We saw the hospital needed to be consistent in ensuring these discussions took place.
- The NCDAH (2013-2014) demonstrated that the hospital achieved the KPIs for:-staff communicating with the patient and their relatives regarding their recognition that the patient was dying, a review of the number of assessments undertaken in the patient's last 24 hours of life and communication regarding the patient's plan of care for the dying phase.
- The palliative team conducted a service evaluation of the syringe driver prescriptions (January 2015). This identified that prescriptions were not meeting recommended standards and therefore a supplementary prescribing document (syringe driver prescription template) had been created in an attempt to improve prescribing practice.

• Staff conducted an audit for monitoring for steroid-induced diabetes in cancer patients (March 2015). The aim was to determine whether the Hospital Diabetes in Palliative Care guidelines were being met. We were told no patients met the management of steroid-induced diabetes guideline criteria and therefore changes were implemented as per the guideline after guidance from the oncology & haematology directorate audit meeting in March 2015.

- The bereavement office presented their quarterly audit results at the mortality meeting and feeding back how responsive doctors were at completing death certificates and if the doctor has documented discussions with the consultant.

Competent staff

- Members of the palliative care team were qualified to meet people's needs. Documents supplied by the trust indicated that every member of the team was qualified to degree level and some completed master's modules. One had completed the non-medical independent prescriber's course, one had a certificate in counselling, one had completed level two psychology training and all had completed advanced communication skills training in 2010.
- We saw evidence from the specialist palliative care work programme June 2015-June 2016 of ongoing continual professional development and identified training needs for the team.
- The palliative care team provided some training for medical staff in addition to the medical university training course. Medical staff had bi-annual palliative care teaching as a part of the foundation trainee course, core medical training programs and had regular contribution to the oncology and haematology junior doctor teaching programs. Other training for specific staff groups included management of opioids training to respiratory staff, oncology and haematology medical teams and DNACPR training for GPs.
- Staff had developed E-learning packs for use by GPs which was designed for sharing clinical learning from the acute into the community.
- The nursing development programme; new starter induction training included: - end of life care teaching in practice, breaking bad news e-learning and we were told a bespoke teaching programme could be arranged according to development needs identified by line managers. Overseas nurses received an introduction to end of life care.
- The palliative care team had implemented the use of 'Swan Champions' on every ward to ensure there was a palliative link in most areas whose responsibility would be able to disseminate information and learning to staff in their area.
- The mortuary staff had supported the palliative team in developing and delivering training, they had recently started to develop a package to educate student nurses.

- We were told a 'Rapid Home to Die' education and training program was currently being rolled out hospital wide. A 'Gold Standard Framework in Acute Hospitals' education and training program had been and continues to be rolled out on the two wards involved in the pilot project.
- The bereavement office staff participated in study days from funeral directors on customer service communication and supporting families. Three out of the six staff had attended this year and the other three staff were due to attend next month.
- The palliative care team told us they had regular annual appraisals.

Multidisciplinary working

- Palliative care multidisciplinary team meetings were held weekly these were attended by the palliative care team, the chaplain, social workers, allied health professionals and medical staff. We saw the team developed an audit to monitor how many meetings took place and a quarterly audit of attendance from all staff, for example we saw the chaplain attended 68% of meetings. They reviewed and discussed complex patient cases.
- All staff throughout the hospital team felt the multidisciplinary team working was excellent and they felt that the palliative team were very supportive.
- The palliative team communicated changes, updates and disseminated information to staff via senior managers briefing, the band seven and eight nursing forum, the 'Grand Round', palliative intranet page and 'all users bulletin' board.
- All palliative consultants from the local areas local areas met weekly to discuss new matters and share good practice.
- Staff told us they had good links in the community for example with coroners, hospice staff, funeral directors and religious community representatives.

Seven-day services

- The palliative team worked 8.30 -17.30 Monday to Friday and had an out of hour's system in place for staff wanting advice, across both sites. The hospice had a telephone advice system in place and local palliative consultants worked a rotation to ensure there was always a consultant available for advice. The hospital consultant told us they liaised with the team if they were concerned about anyone over night or weekend and can handover to out of hour consultants should they need to.
- The trust were aiming to open a seven day service but did not currently have formal plans in place.
- The mortuary were supported by the pathology team who managed the area in their absence. Porter staff were trained to be able to manage the mortuary out of hours. Systems were in place which ensured the safe running of the area whilst the mortuary staff were not present.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A current mental capacity assessment tool was available at the hospital via the intranet and the palliative team told us it had clear guidance on how to complete the forms. However, we reviewed the notes of four end of life patients that lacked capacity, we did not see any capacity assessments.
- We found that medical staff consistently assessed capacity with either a 'yes' or 'no' recorded on the DNACPR forms. According to the trust's policy on completing DNACPR's, the capacity assessment is to be recorded in the clinical notes. When asking staff they were not always able to locate this. We only found nine capacity assessments out of the 29 DNACPR notes reviewed.
- During our visits to the wards we saw and heard several occasions when staff sought the consent of patients before an intervention.
- We found staff were knowledgeable about deprivation of liberty and where appropriate deprivation of liberty assessments were completed with a multidisciplinary approach and families were involved.

Are end of life care services caring?

Good

Summary

We saw the 'keep sakes' as a product of the Swan Project were cherished by relatives. All relatives we spoke with as well as the palliative team confirmed all palliative patients

were checked regularly by ward staff, ensured they were comfortable, had the call bell to hand and appeared well presented at all times. However, one patient told us staff would talk over them when providing care.

Relatives we spoke with mostly felt well informed. One relative told us medical staff maintained good continuity of care and communication.

Compassionate care

- The Royal Wolverhampton NHS Hospital specialist palliative care team user satisfaction survey (March – May 2015) feedback was positive. Two individuals commented that it would have been beneficial to have had help and support from the team earlier in the admission; comments were anonymised so the team were unable to conduct a review into the comments. We saw from the 18 surveys received 15 had written very positive remarks about the staff such as: "Professional", "Wonderful", "Polite", "Answered all my questions", "Gave reassurance", "Considerate" and "Relaxed (atmosphere) and able to speak freely (with staff)".
- As part of the end of life Swan Project relatives were offered 'keeps sakes' of their relatives which included a lock of hair, handprints and photographs. When asking staff how successful this had been they told us families loved it and thought it was an excellent idea. One family told us they thought this was 'Priceless'.
- Within the Swan Project the palliative team had introduced a symbol that was used across all clinical areas to identify patients who were receiving end of life care. Privacy was maintained by keeping the curtains drawn if requested by the patient and or family and the Swan logo would be placed on the curtains to indicate an end of life patient was being nursed in the bay.
- The two palliative patients we spoke with told us that the staff were kind to them at all times.
- One patient told us staff would talk over them when providing care and told us they felt this was inappropriate.
- Relatives told us they thought it was caring that they could spend as much time with their loved one as possible.
- We were told how care after death was of a very high standard and the mortuary staff would ensure the person's dignity was maintained during the care. Mortuary staff gave us examples of assisting a mother dress her small child in clothes that the mother had picked out. The mortuary staff supported her through a difficult time and allowed her to take her time with the child and utilise the Swan suite. We could see the mortuary staff were very passionate about delivering a high standard of care after death.
- One staff member told us they had received a letter from a family thanking them for the dignified death of their relative and for being so caring.
- Staff across both sites told us they gave palliative patients their favourite drink in order to keep their mouth moist as opposed to mouth wash. Staff told us they had ordered cider for one patient.
- Staff gave us an example where the family had arranged with the ward to bring their pet to the discharge lounge after it had closed and staff facilitated this just before the person passed away.
- Staff explained how access to the mortuary was planned and ensured the dignity of the deceased. We saw the patient's privacy was maintained throughout the journey and transfer.

Understanding and involvement of patients and those close to them

- We saw in the notes that discussions with family members took place. Relatives we spoke with mostly felt well informed. However, we spoke with two families who said that communication needed to improve, and they did not feel well informed despite asking nursing staff if they could speak to the medical staff. One family told us none of the staff had updated them in the past week and they had requested to speak to the medical staff daily. We raised this to the nursing staff who told us they forgot to tell the medical staff. Medical staff responded immediately.
- One family told us that that the conversation around DNACPR was dealt with in a sensitive manner and they were taken to a private room to have the discussion which they appreciated.
- One relative told us they had seen several medical staff during their relatives care and treatment and felt that the doctors maintained good continuity of care and communication. We found the medical staff record keeping supported this process as it was consistently very detailed and holistic.
- One patient who was on the trauma ward told us the staff were very busy and they felt as though they had to wait a long time until someone came. They were upset and felt as though they were a burden on staff. We

raised this with the deputy ward manager who agreed they needed more staff. They told us they were not able to give the patient the attention they wanted to and had little time to sit and talk with them. Staff told us the palliative team were very supportive and would give attention to the patient. The patient had not been identified as needing further emotional support or counselling.

Emotional support

- We found one example of the patient not being emotionally supported. Within the 30 care records we reviewed we did not see any evidence of staff emotionally supporting palliative patients. The palliative team told us that improvements were needed to emotionally support patients on the wards. Within the care records we saw several patients suffered with anxiety and this was dealt with medication. The records lacked the details of how anxious the patient was and how often the anxiety was assessed and if they needed additional emotional support.
- The palliative team told us for cancer patients which consisted of 70% of the palliative patients, a clinical psychologist was available.
- We also saw that pre and post bereavement counselling was available for patients known to Compton Hospice.
- The mortuary staff were experienced in providing emotional support for families. We saw the staff had been recognised by the trust and won an award for compassionate care. The mortuary staff told us they would accompany deceased patients to funeral directors if they did not have a family member that would do so. They would ensure everything was seamless and the dignity of the patient was maintained.

Are end of life care services responsive?

Good

Patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available allowing for privacy. Death certificates and cremation forms were completed in a timely manner.

No religious symbols were in place throughout wards, quiet rooms or in the mortuary. Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they cared for.

The Swan logo was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible. The Swan canvas bag highlighted to all staff across the trust that the relatives have suffered a recent loss and may require extra support.

We noted there was any easy access to the palliative care team and they were responsive in supporting ward staff. Staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times across both hospital sites and were able to discharge a patient with a complex package of care within 24 hours.

The bereavement services had started to send out comment cards to all families with a freepost address to encourage feedback. The service also sent out a survey 6 weeks after death. We saw feedback from one person who said the bereavement office were helpful in providing information and said they were very grateful. Although we reviewed two complaints about insensitive/poor staff attitude towards patients at the end of their lives on two different wards and saw neither ward manager documented any lessons learnt or actions taken.

Service planning and delivery to meet the needs of local people

- There was no dedicated specialist palliative care ward across the trust. People reaching the end of their life were nursed on the main wards in the hospital. As part of the end of life plan those patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. This allowed for privacy. Almost all wards told us they always had the capacity to move a dying patient into a side room if they were not already in one. All relatives we spoke with told us they had been offered a side room and when they accepted this was organised immediately.
- We spoke with staff at the bereavement office which was on site and mainly dealt with registering a death. We found the bereavement office had systems in place if they were unable to reach a doctor to complete a death certificate. Staff told us they rarely need to use this pathway but when they did it was effective. They told us most of the doctors filled the forms in immediately and waiting over 24 hours was rarely an issue.

End of life care

- Cremation forms were filled in the same day of the death certificate to ensure they were given to the families in a timely manner. If staff were unsure if the person wished to be cremated and were unable to get a hold of the family the doctor would complete the forms and if they were not needed they would be discarded of appropriately. We saw this was also responsive in meeting the needs of the family during their difficult time.
- The palliative team were able to provide us with their demographic figures, most all of their patients were white British and 70% were cancer related deaths. The team were aware of the need to monitor these figures to ensure they were able to provide the correct care that met the needs of the local people.
- The palliative team were acting and responding to new referrals in a timely fashion with 95% of new referrals being seen within 24hours across both hospital sites.
- The 'Rapid Home to Die' audit (November 2014) which was collated prior to its implementation. The results showed that although a majority of patients (79%) have a ceiling of care documented, only 29% of these had discussions regarding their preferred place of care at the end of life, or their specific wishes regarding their end-of-life care. Of the 25 patients that were audited 25% had a discharge process commenced, none of which had a successful discharge. The rapid home to die care bundle was then implemented. We were told the audit was due to be repeated.
- The palliative team contributed to a Clinical Commissioning Group (CCG) and led the end of life care strategy group which reviewed their compliance with NICE and looked at areas where they needed to better plan and deliver the service to better meet people's needs.

Meeting people's individual needs

- Across both sites, staff told us they displayed the Swan logo which was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible.
- The Swan canvas bag was also available trust wide. This highlighted to all staff that the relatives have suffered a recent loss and may require extra support. It was more dignified to receive the deceased patient's belongings in this way rather than in a plastic bag. Staff thought this was a great idea in identifying relatives throughout the hospital.
- The chaplain services showed us their multi-faith spiritual care assessment. This assisted the staff in identifying the patient's spiritual needs. The chaplain told us they had good links in the community with a variety of religions and faiths to be able to cater to the needs of patients. Ward staff had cultural awareness training. Throughout records we noted that the spiritual needs questions in assessments and care plans were often left blank and were not completed by ward staff.
- No religious symbols were in place throughout wards, quiet rooms or in the mortuary on either hospital site. Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they care for. They were able to explain procedures for caring for patients with different religions and how they adapted the care accordingly.
- Patients were discharged with their syringe drivers in place to avoid any gaps in delivery of medicine and pain relief.
- We saw that patients who were living with a cognitive impairment had a 'This is me' document in their nursing notes. This enabled staff to better understand their communication requirements and social background to improve their experience of the hospital environment.
- Rooms were available for relatives staying overnight.
- We noted evidence of palliative staff working with the informatics department to develop a palliative intranet which would contain up to date information for staff as well as guidelines and useable documents trust wide. Although we did not see evidence of the target completion date in the specialist palliative care work programme June 2015-June 2016.
- We saw leaflets and booklets were available trust wide to relatives with practical information following a death.
- All relatives we spoke with as well as the palliative team confirmed all palliative patients were checked regularly by ward staff, ensured they were comfortable, had the call bell to hand and appeared well presented at all times.

Access and flow

- The palliative team had a telephone referral, face-to-face and a bleep referral system in place across both hospital sites. We noted the team were easily

accessible and were very supportive of ward staff. Staff told us that if they needed support immediately the palliative team were able to provide a very quick and responsive service.

- The palliative care lead nurse told us they had developed a care pathway for those patients who were in their last days of life and preferred to be cared for at home. The 'Rapid Home to Die Care Bundle' facilitated a rapid discharge. Staff told us they had used this bundle several times across both sites and on several occasions were able to discharge patients with a complex package of care within 24 hours.
- The palliative team consisted of a rapid access discharge nurse whose role it was to develop and implement the rapid access discharge. The bundle had a tear off sheet for the community staff to send feedback about the discharge to the palliative team. It reviewed the effectiveness of the discharge such as transport, equipment and communication. The rapid discharge nurse's responsibility was to support and teach staff how to execute a rapid discharge as opposed to carrying out the discharges. We saw they would go to support and teach staff on the wards. Ward staff told us the bundle had been successful however there was no audit to be able to see the results at the time of the inspection.
- Staff developed an end of life transitional care pathway for 16 – 25 year olds which ensured joint working with children's services and clarifies responsibilities of care for the patient. We saw they were recognised in 2011 and won the Black Country locality stakeholder board 'Innovation Award in Workforce Development', alongside the Royal Awards 'Partnership Working Award' for this pathway.
- Local community hospitals, West Park and Cannock Chase were both under the support of the palliative team and they told us they were aware of how to refer. They were in the process of reviewing the number of palliative patients they saw in Cannock Chase Hospital.
- Palliative patients presented in the medical admissions unit, the palliative team told us they were excellent in flagging up cases or referring to ensure the palliative team were involved from the start of admission.
- The mortuary staff had facilities and systems in place for those patients who were deceased but there was no family to collect the body.
- We were told by the mortuary staff that they had good links with funeral directors in the community and never had any issues with collection.
- Visiting times were open allowing relatives to spend as much time with their loved ones as they needed.

Learning from complaints and concerns

- From data submitted by the trust we reviewed two complaints since April-June 2015 relating to patients at the end of their lives. Both were complaints were about insensitive/poor staff attitude towards family and patients and both had personal belongings missing. Ward managers did not document any lessons learnt or actions taken.
- The bereavement office gave all families' practical information what to do after death which included information on how to make a formal complaint.
- The bereavement services had started to send out comment cards to all families with a freepost address to encourage feedback. The service also sent out a survey 6 weeks after death. We saw feedback from one person who said the bereavement office were helpful in providing information and said they were very grateful.

Are end of life care services well-led?

Good

The palliative team had a clear vision for their service. The leadership, governance and culture promoted the delivery of high quality person centred care. We saw several audits had been undertaken to evaluate and utilised to improve the service. The palliative team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.

We saw the culture was a positive energetic one. We noted staff had made efforts to engage the trust wide staff and were determined to improve care for patients at the end of the lives and better support families. We saw team members were very passionate about their job and told us they enjoyed what they did.

End of life care

We reviewed the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust. We saw they had worked on a number of areas to ensure improvement and efforts were made to ensure the sustainability of the service.

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative team members were.

Vision and strategy for this service

- The trust had a sound strategy for the service laid out in the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust and further details of the improvements made are detailed in the final subheading.
- We saw there was clear vision on where the improvement projects were going what needed to happen to ensure they took place. The palliative team developed an annual audit in which they reviewed all aspects of their work from research to national audits to improvement plans.
- We saw a strong level of commitment from all staff to all the palliative team's projects and saw the passion from the palliative care team was distributed throughout the hospital which we found was as a result of a clear vision and strategy to engage all staff.
- We saw the palliative team had a clear vision for their service such as:-additional cover for Cannock Chase Hospital and West Park Hospital, seven day face to face specialist palliative care provision, change in lead nurse professional responsibility to include acute and community setting, full implementation of Gold Standards Framework dependent on outcome of pilot, continue to embed the Swan project and introduction of new Palliative/EOLC education packages to support generalist practice.

Governance, risk management and quality measurement

- We saw matron's on the wards conducted random audits to ensure the quality of care and documentation. We noted from the last audit in May 2015 that they focused on end of life care reviewing two patients that were in the last few days of their life. We saw from feedback to the ward that staff were complimentary of a new ward manager, the Swan care plan was noted as fully completed, DNACPR forms were fully completed, the patient and family were involved in care planning, open visiting was encouraged by ward staff, staff were aware of patients wishes and relatives told the matron that staff were respectful of their wishes and responsive to their needs.
- The trust had recently implemented the 'Creating best practice' in which staff identified objectives in which they could improve practice. Objectives were in line with CQC standards, clinical outcomes, risk register, best practice, KPIs, policy and national audits. The end of life 'Creating best practice' had been completed in May 2015. The only emerging issue was that an incident must be recorded if a death certificate was signed after 24 hours of the death. The positive was the engagement from all staff across the organisation for improving end of life care. The deliverables for the next review was to look at improving parking for visitors of dying patients, a proposal for a bid with the University to look at a qualitative study reviewing the Swan Project and increase training for non-clinical staff such as porters.
- The syringe driver monitoring chart audit (February 2015) results led to an update in clinical practices and had influenced the refresher teaching, which commenced April 2015.
- We saw the trust had submitted data for the National Care of the Dying Audit (Hospital) (NCDAH) audit (May 2015).
- The Hospital has made contributions to phase one of NHS England's project to develop a national palliative care currency by collecting detailed data for analysis and have committed to further data collection in phase two. As part of the national currency development project the palliative care team have begun measuring dependency scores and patient related outcome measures of palliative patients.
- We reviewed the risk register which contained risks such:- concerns regarding the completion of all mandatory NICE audits required for the directorate, staffing levels, possibility of injury/ill health to staff and patients from the use of non-safe winged infusion sets contaminated sharps. It did not contain any details around the lack of the Swan Project being fully integrated in the organisation.

Leadership of service

- The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice. The trust had a board representative who staff told us was very engaging and pushed for palliative care to be on the agenda.
- Staff were engaging in a sponsored walk to raise money for the Swan charity. We were told they had recently received a large donation from a family after they had received good care from the hospital.
- All staff we spoke with from the palliative team thought there was excellent leadership for the service and felt well supported. Staff told us how they ensured they emotionally supported one another through difficult and upsetting situations.
- The medical staff told us they felt well supported by the consultant and had regular feedback and appraisals.
- Data submitted by the trust showed that the palliative team displayed very good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

Culture within the service

- We saw the culture was a positive energetic one. We noted staff had made efforts to engage the trust wide staff and were determined to improve care for patients at the end of the lives and better support families. We saw team members were very passionate about their job and told us they enjoyed what they did.

Public and staff engagement

- The palliative team told us they had a public representative that would support them in ratifying their ideas and had reviewed documents and policies from a patient and families perspective.
- The palliative care team had introduced a staff survey, seeking feedback from referring ward teams about the Hospital Specialist Palliative Care Team. Initial feedback (March – May 2015) has identified how approachable, supportive and informative members team were.
- Patients with cancer were invited to sit on a user group panel 'Wolverhampton Patient Advisory Cancer Team' to be able provide input in changes to the service. We saw the minutes for the February 2015 meeting where ten staff attended and three patient representatives.
- We saw staff had arranged leaflets, books, DVD's and flyers for the 'Dying matters awareness' day they had organised with the local hospice in order to engage with the public and raise awareness to the importance of end of life plans and bereavement.

Innovation, improvement and sustainability

- We reviewed the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust. The hospital highlighted areas for improvement in this document ranging from environmental challenges, hospital-wide awareness and engagement, resource capacity of specialist palliative care services, clearly defined integrated pathways to formal recording of palliative patients' wishes.
- We saw they regarded their strengths to be: - organisational leadership and commitment, a passionate and committed specialist palliative care team, person-centred care philosophy and partnership working and research leadership.
- Staff told us one improvement made by the service had been the appointment of a fixed term, rapid discharge pathway facilitator to develop a rapid home to die care bundle, and associated web resources and education programme.
- The hospital had made improvements by developing a unified Do Not Attempt Cardiopulmonary resuscitation form that travelled with the patient across services. This was supported with a newly developed e-learning package.
- Staff were currently piloting the 'Gold Standards Framework (GSF) in Acute Hospitals' on two wards aiming to improve identification of patients in the last 12 months of life and co-ordination of care across services. This focused targets of best practice for the staff to be able to audit care and develop a benchmark against these standards.
- Staff had arranged a new monthly 'Joint Advanced Respiratory Disease Clinic' for patients and a family/ friend will be invited to attend a joint clinic which will be held at the hospice to see both the respiratory and palliative medicine consultant in order to improve the continuity of care and reduce appointments for the patient. We saw the start date was June 2015.
- We saw the trust had worked in partnership with Salford NHS Trust in the implementation and piloting of an

individualised plan of care document for people thought to be in the last few days of life, with supporting education packages and champions in most wards across the hospital.

- The hospital have developed of a breaking bad news e-learning package, aligned with a revised policy and associated 'how to' guide.
- The trust had agreed in principal that an electronic palliative care co-ordination system will be implemented.
- In order to ensure the sustainability of the service the team had put forward a business case to increase the nursing and medical staffing provision of the palliative care team and added support to cover the additional community hospital sites.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Outpatients

The general outpatients department at New Cross Hospital held various clinics such as gastroenterology, renal and neurology. Other specialities such as urology, ophthalmics, cardiology, rheumatology, cancer, therapy services, orthopaedics and paediatrics held their own outpatient clinics within their department's buildings. The hospital sees an average of 650,000 outpatients per year.

We visited the general outpatients department, urology, ophthalmology, cardiology, therapy services, children's outpatients and the renal unit. We spoke with 34 staff including nurses, doctors, consultants, clinical nurse specialists, reception staff and allied health professionals. We spoke with eight patients to gain their views of the service received. We reviewed six sets of patient records along with other documents supplied by the trust. We spoke with the outpatients leadership which included the Outpatients Services Manager. Before and during our inspection, we reviewed the trust performance information. We also held listening events for the public.

Diagnostic and Imaging Services

Diagnostic and imaging services provided at New Cross included plain film radiology, emergency department (ED) radiology, computerized tomography (CT), magnetic resonance imaging (MR), ultrasound, nuclear medicine and a symptomatic breast service. The department is supported by an on-site medical physics department. The Radiation Protection Adviser (RPA) sits within the medical physics team. There are Radiation Protection Supervisors (RPS) in CT, main x-ray, ED and nuclear medicine. In addition, the department contract a mobile MR service.

We spoke with 28 staff including the clinical director, the deputy radiology manager, the group manager, radiographers, administrative staff, imaging department assistants, the clinical governance lead, medical physics staff including the RPA, radiologists, ultrasonographer and nurses. We spoke with 8 patients and reviewed 20 records.

Outpatients and diagnostic imaging

Summary of findings

Overall the services within outpatients and diagnostic imaging services required improvement. Most of our concerns related to imaging within safety, effective, responsive and well led. Outpatients was broadly satisfactory.

Within radiology there were concerns with the safety of signage, out of date clinical items and the management of controlled drugs. Clinical imaging protocols and risk assessments were not fit for purpose.

Staffing levels within the renal unit did not comply with NHS England and British Renal Society guidelines. Appointment letters and patient leaflets were only available in English. There was no method of monitoring the length of stay of patients within outpatients to ensure they were provided with food and drink.

There was not a clear vision and strategy within the outpatients and radiology departments. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to individual patient needs.

Are outpatient and diagnostic imaging services safe?

Requires improvement

The renal unit required improvement of the staffing levels for renal patients.

There were a number of safety concerns within the radiography department. There was a lack of staff feedback in relation to shared learning and changes in practice resulting from incidents.

We observed a bed blocking access to the resuscitation trolley in radiography. Call bells for patients were not fit for purpose or checked by staff. In x-ray room nine we found out of date contrast media and clinical items. Some waiting areas and cubicles had no signage requesting patients inform staff if they could possibly be pregnant. The signage on the x-ray doors did not clearly instruct patients, visitors or non-imaging staff not to enter the x-ray rooms.

Records were not adequately maintained when medicines were removed from the storage cupboard. The nuclear medicine (imaging) department did not have a written procedure for optimising/scaling children's doses of radiopharmaceuticals. In the nuclear medicine department (imaging) the main dispensary/radioactive product storage was left unsecured in the daytime.

The procedure to check whether women were pregnant prior to receiving radiography tests required improvement. The nuclear medicine (imaging) service did not have/issue 'written instructions' to females who were breastfeeding and who had undergone a radio nuclide procedure.

Within radiography and outpatients, staff were receiving their mandatory training including safeguarding vulnerable adults and children and were knowledgeable regarding safeguarding processes.

Incidents

Outpatients

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system. They knew what to report, and had reported incidents.

- A total of 606 incidents had been reported between March 2014 and February 2015. 569 of these resulted in no harm, 28 low harm and nine moderate harm. 156 of these incidents were reported as clinical assessment. 103 were reported as documentation and 78 as treatment or procedure.
- Seven serious incidents requiring investigation were reported. These included three relating to slips and trips, one confidential information leak, one grade 3 pressure ulcer and one suboptimal care of the deteriorating patient.
- Staff told us that learning from incidents was discussed at team and departmental meetings. We saw examples of minutes that demonstrated learning being discussed at meetings. For example the wrong address had been booked by the ward for patient transport. The lessons learnt included that the address should be double checked when transferring the booking from the written booking form to the electronic booking.
- There had been no 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the outpatients department during the preceding 12 months.

Diagnostic and Imaging services

- Minutes for the Radiation Committee Sept 2014 and the Clinical Governance Subgroup (Radiation) February 2015 meetings indicated that there was no trust executive present at these meetings. The Terms of Reference indicate that the Medical Director is a member of the Radiation Safety Group. The Medical Director has responsibility for implementation and review of radiation safety arrangements and IR(ME)R compliance It is best practice for a trust executive to be present or for the chief executive officer (CEO) to delegate responsibility to chair the committee. Radiation incidents were recorded at these meetings and agreed follow up actions minuted and progress against the actions monitored at subsequent meetings.
- The managers told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke with confirmed this. A band 5 radiographer described an incident on the night of 31st May 2015 – the incident form was completed immediately following the incident.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the hospital incident reporting system. Senior staff we spoke with told us that incidents were discussed at departmental governance meetings. Minutes were made available to confirm this. However, we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents with departmental staff. The Clinical Governance lead said the information was on the electronic incident reporting system and the expectation was for staff to check the outcomes themselves.
- Ionising Radiation (Medical Exposure) Regulations IR(ME)R incidents were reported to the medical physics team.

Cleanliness, infection control and hygiene

Outpatients

- Patients we spoke with felt that the areas were always clean. We observed that the waiting rooms and outpatient's clinic rooms were clean.
- We observed that all staff complied with the trust policy of being bare below the elbow.
- Hand gel was available in all clinical areas. There was not clear signage for the location of the hand gel. However, we saw staff requesting patients use the hand gel on entering the department.
- Mandatory training records showed that 100% of qualified and 80% of unqualified nursing staff had received infection prevention and control training. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Records provided by the trust demonstrated that 100% of staff had received training in hand hygiene. The hand hygiene assessment completed in November 2014 showed 95% compliance.

Diagnostics and Imaging Services

- The department overall was clean. Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. However, when visiting two rooms in the morning, there were no cleaning schedules. The information given was that records were not kept but the radiographers did clean the rooms daily.

- Personal protective equipment (PPE) equipment including lead coats were checked and were clean and of good condition.
- Clinical waste bags were used for the waste bins in the toilets. This may be expensive for the trust as not required.
- The Clinical Governance lead reported that they completed the hand hygiene audit on line. When asked what the department's performance was with regards to hand hygiene, they did know what the results were and that the department did not receive any results. Consequently the department staff were not informed of how well they were performing with hand hygiene. Records provided by the trust showed that the hand hygiene assessment completed in January 2015 was 89% compliant.
- The lead nurse in the interventional suite was unable to produce evidence of any hygiene audits or cleaning schedules being completed for the department.
- In x-ray room 9 the contrast agent warming cupboard was found to contain sticky remnants of spilled contrast, which was a high risk for microbial contamination due to the warm environment.

Environment and equipment

Outpatients

- The general outpatient waiting area was very large and well lit, mostly by natural light. All outpatient areas that we visited were tidy, including corridors. The atmosphere was generally calm, even where the clinics were very busy.
- We saw records which indicated that emergency resuscitation equipment had been checked appropriately in all areas we visited.
- We saw evidence of daily performance checks of equipment.

Diagnostic and Imaging services

- A visit to the two CT scanners on site showed that there were no Local Diagnostic Reference Levels. The CT radiographers said that they did not have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended.
- The clinical imaging protocols (operating procedures) were generic in nature. Basic scan parameters were not present that would allow an operator to follow and find operational information to be able to perform a scan safely. For example information relating to the technical settings of the scanner (scan length/mAs/kVp/slice thickness/pitch/dose modulation). This was not following best practice as recommended by the IPEM Medical and Dental Guidance Notes and IR(ME)R 2000 regulations.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- Patient call alarms were not checked to ensure that they were in working order. The cords on the patient alarms in the cubicles were not fit for purpose as they did not reach the floor. Patients that fell may not have been able to reach the alarms.
- The resuscitation equipment was checked daily and records were all up to date.
- The ward waiting area was seen to be overcrowded. It was a six bed area with one of the cubicles taken up with equipment e.g. hoists. This reduced the waiting space. We saw a very crowded waiting area with six beds in the remaining five bed areas, all squashed together. One bed was positioned in front of the resuscitation trolley which compromised access to emergency equipment and drugs. In addition there were four patients in chairs. A manager was informed that the resuscitation trolley was not easily accessible.
- The Trust presentation highlighted that obesity was a problem within the local population. It was noted that there was no provision of bariatric seating in the waiting areas.
- A clinical store room in the main department had tea, coffee and snacks on the shelves (for staff). There were also shoes on the lower shelf. There was a lack of appropriate storage for these items. This was pointed out to the superintendent.
- There was some patient signage asking patients to tell staff if they could possibly be pregnant.

Medicines

Outpatients

- Medicines were stored in locked cupboards. Controlled drugs were not stored in the main outpatient

department. We checked the controlled drugs in the renal unit and cardiology outpatients departments. Records demonstrated that daily stock checks were completed.
- Lockable medicine fridges were in place. Records showed that daily temperature checks had been recorded.
- Prescription pads were securely stored in locked drawers. Nurses signed out prescriptions.

Diagnostic and imaging services

- Medicines including controlled drugs were stored correctly and the senior nurses were responsible for medicines and medicine key controls There was no record of what drugs were taken and by whom for any medicines, including controlled drugs. The senior nurse said that staff would leave a note on her desk. The process of monitoring which drugs had been taken was by a weekly stock check. This contravened the Controlled Drugs (Supervision of management and use) Regulations 2013.
- In x-ray room 9 a container with contrast medium was found to be out of date (dated 02/15). Packs of sterile clinical items for example catheters were also found to be out of date. We informed the superintendent radiographer who immediately removed these items.
- We looked at a random sample of the medicines stored in the drug cupboard, and found all of the items looked at were in date.
- The drug fridge in the interventional suite was monitored and records were up to date on the fridge temperatures which were within normal range.
- The drug fridge in nuclear medicine imaging department did not have any recorded evidence of monitoring.
- The nuclear medicine (imaging) department did not have a written procedure for optimising/scaling children's doses of radiopharmaceuticals. Staff reported the use of a 'rule of thumb' formula for scaling doses which did not account for a child scan taking longer than an adult equivalent scan to undertake. This did not follow best practice guidelines, specifically that given by the Administration of Radioactive Substances Advisory Committee (ARSAC). It was seen that calculations on scaling dose were undertaken without written directions from the ARSAC certificate holder (practitioner) and there was no written procedure available for this.
- In the nuclear medicine department (imaging) the main dispensary/radioactive product storage (containing pharmacy only medicines and radioactive medicinal products and waste) was generally kept unsecured during the working day. Staff said that the door was locked at night. This posed a potential security and safety risk as patient's and/or visitors could obtain easy access by opening the unlocked door from the main patient corridor without restriction. Radioactive medicinal products could potentially be tampered with or stolen and this was particularly pertinent to anti-terrorism regimes.
- The radiation protection supervisor (RPS) and radiation protection adviser (RPA) were informed of this risk. The RPA said they would immediately investigate the option of swipe card entry to make access more practical for staff and also maintain security of the sources. They said they would ensure that the room was locked between use.

Records

Outpatients

- Some clinics used written patient records and some electronic records. Clinicians reported no problems accessing records.
- If patient's records were not available (which we were told was rare) a system was in place that the original referral letter from the GP had been scanned in prior to the first appointment, enabling the clerk to access it. For follow-up appointments, results and dictated letters could all be accessed on the electronic systems.
- We reviewed six sets of patient records, three paper records in general outpatients and three electronic records in rheumatology outpatients. All records were complete, with up-to-date typed letters, completed consent forms and demonstrated patient engagement.

Diagnostic and imaging services

- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- The trust had a central electronic patient records database, the Reporting Information System (RIS). We looked at a total of four patient electronic records on RIS

and saw each record included comprehensive detail of the patients imaging history. We also saw imaging request cards were also scanned into the electronic patient records.
- The quality of patient referral forms was not audited across both sites.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and in use across the trust.

Safeguarding

Outpatients

- Staff told us that they received training in safeguarding for both children and vulnerable adults. Records demonstrated that 100% of staff had completed training in children and adults safeguarding within the different speciality clinics within outpatients. The exceptions to this were: 90% of unqualified and 92% of qualified nursing staff had completed children's safeguarding training within the ophthalmology outpatients department. Within the children's outpatient department 92% of qualified nurses and 100% of unqualified nurses had completed the children's safeguarding training to the required level II. The trust target was for 75% of staff to have training.
- Staff we spoke with demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.
- Staff were able to access advice from the trust safeguarding team and the safeguarding policy was available on the intranet.

Diagnostic and imaging services

- We observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity for example name, date of birth and GP.
- Identification checks on patients were carried out according to IR(ME)R. 20 forms were checked and all had been completed correctly.
- We spoke with three staff including administrative staff and radiographers and they were aware of their responsibilities to safeguard adults and children and who to contact in the event of concern.
- Records showed that 99% of staff had received adult's safeguarding training. 99% of staff had received level I and 88% level II in children's safeguarding.

Mandatory training

Outpatients

- Staff told us that they were able to access their mandatory training such as basic life support, infection control, safeguarding and health and safety and were kept informed by their managers if training was due.
- Trust records demonstrated 94% of staff within the outpatients department had completed their mandatory training.

Diagnostic and Imaging services

- All of the staff we spoke with told us they received ongoing mandatory training and they were responsible for ensuring they kept up to date. Mandatory training included eLearning modules and face to face training.
- Records demonstrated that 94% of staff had completed their mandatory training.

Assessing and responding to patient risk

Outpatients

- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly and that staff signed to show that the equipment was checked and within the expiry dates.
- Processes were in place within the outpatients department to manage patients who presented at risk within the department. For patients in attendance who had a cardiac arrest, the cardiac arrest team would be called and if patients required transfer to the emergency Department then a 999 ambulance call would be made. If patients showed signs of rapid deterioration but were well enough to be transferred, the outpatient staff would urgently transfer the patient to the emergency department.

Diagnostic and Imaging services

- The principal function of the Radiation Safety Committee was to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and

non-ionising radiation legislation. The committee met twice each year and received reports from the appointed Radiation Protection Advisers, ensuring all recommendations were achieved.

- The manager told us that all modalities had appointed and trained Radiation Protection Supervisors (RPS), whose role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There were regular delays in paediatric reports. The Clinical Director indicated that there was not the level of interest in paediatric radiology within the consultant group to sustain effective report turnaround times. Consequently the turnaround times for paediatric reports were often several weeks.
- A receptionist in the radiology X-ray inpatient reception did not know where the patient alarm was and did not know the emergency number in the event of a clinical emergency for example cardiac arrest. (All of the other staff did know the emergency telephone number).
- The signage on the x-ray doors did not clearly instruct the patients not to enter the x-ray rooms. There was signage to indicate it was a radiation area but no instruction not to enter the room when the red light came on. This was highlighted to the radiation protection adviser (RPA) who felt that the signage was adequate. It was assumed that patients would see the light box which was above the door.
- There was no clear warning signage outside rooms 1 and 2 viewing area for staff or patients. People could enter the X-ray rooms (controlled areas) with no warning of radiation as is required by regulations. This was highlighted to the RPA who said that they would conduct an urgent review of the area.
- The service used an adapted version of the WHO surgical safety checklist, when carrying out all non-surgical interventional radiology procedures. The use of the checklist across all radiological procedures was confirmed by the Interventional Radiologist and senior nurse we spoke with.
- The department (across both sites) had a procedure in place to check whether women were pregnant. Patients were asked the last menstrual period date (LMP) and if this was within 28 days for low-dose or 10 days for high-dose procedures then they proceeded with the examination. However professional bodies (the Health Protection Agency, the Society of Radiology and the Royal College of Radiologists) recommend that LMP is not routinely asked and those patients are asked, “Are you or might you be pregnant?” This avoided assumptions that females outside their dates are pregnant. The written procedure included an instruction to proceed with exposures if the patient said their husband had had a vasectomy. This had the potential risk of irradiating a pregnant woman if she answered ‘yes’ to her husband having received a vasectomy (and she might have had sexual intercourse with another partner.)
- The nuclear medicine (imaging) service did not have/ issue ‘written instructions’ to females who were breastfeeding and who had undergone a radio nuclide procedure. This posed a risk to an infant inadvertently ingesting radioactive material. This issue was discussed with the medical physics expert who advised that written instructions were given out in the non-imaging section but they were not aware that they were not given out in the imaging section. They said that they would immediately provide a letter for staff to issue when needed.

Nursing staffing

- The general outpatients department was up to full establishment. No agency staff were used in this area. If shifts required covering for example for sickness, they used their own staff on the nurse bank.
- Some of the speciality clinics were not as well staffed. Some of the band six urology nurses were acting up as band seven felt they were provided with little support.
- The rheumatology unit manager told us that they frequently had to do clinical work due to staff shortages which detracted from her senior manager role. The staffing concerns were on their risk register.
- The renal unit required more staff to meet the needs of patients. We reviewed the nursing rotas and the dependency of the patients in the renal unit. We found that there was only one qualified staff allocated to four patients on most shifts.
- The staffing concerns had been escalated to the senior management and were on their risk register. We were told that they were actively trying to recruit more staff.

Medical staffing

Outpatients and diagnostic imaging

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Medical cover was provided without the need for locum use.

Imaging and Diagnostic services

- There were 17 radiologists and the department had five vacancies. These vacancies were being backfilled with long term locum posts.

Major incident awareness and training

- The staff we spoke with were aware of their roles in the event of a major incident.
- Major incident training was part of the trust induction mandatory training and policies were available to staff on their internal intranet.

Imaging and Diagnostic services

- Senior managers explained how table top exercises had been carried out to look at contingency plans to continue the service if the information technology systems failed. Emergency testing had been undertaken and a backup plan had been written.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There were no Local Diagnostic Reference Levels for the two CT scanners. The CT radiographers said that they did not have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended. The clinical imaging protocols (operating procedures) were generic in nature. Basic scan parameters were not present that would allow an operator to follow and find operational information to be able to perform a scan safely.

The radiation risk assessments were not fit for purpose and did not have enough specific detail for the radiation work undertaken in each area. There were no Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.

There were regular delays in paediatric reports within radiography.

Treatments were being provided in line with best evidence-based practice and NICE guidelines in both outpatients and radiography. Staff were able to access continual professional development and most staff had received appraisals. There were low rates of appraisal completion within the children's outpatient departments.

Evidence-based care and treatment

Outpatients

- We saw that treatments were being provided in line with best evidence-based practice and NICE guidelines.
- For example in the rheumatology outpatient's clinic we saw use of protocols and checklists to ensure that patients with inflammatory joint disease receiving biologic therapy were being treated and monitored in line with NICE guidance.
- We saw that a gastroenterology clinical nurse specialist was following the British Society of Gastroenterology guidance in relation to the iron deficiency anaemia clinic she was running.
- Each speciality conducted audits to assess compliance with NICE guidelines in relation to their area of clinical practice. For example, the heart failure clinical nurse specialist had audited the use of NICE recommended medication for heart failure patients. We saw an audit of 100 patients demonstrating 100% compliance.

Imaging and Diagnostic services

- NICE guidance audits were undertaken e.g. NICE guidelines for fibroid conformity.
- The department had an Annual Audit Plan which was presented to us.
- It is a requirement of the IR(ME) Regulations for audits to be carried out to ensure safe exposure and practice. The audit plan did not include reference to IR(ME)R audit. However, on examination audits had been completed to comply with IR(ME) Regulations.
- There were nine reporting radiographers who had dedicated reporting time.
- On a needs basis, some reporting was outsourced. One radiologist said that quality checks had not been carried out on the reports provided by the outsourced supplier.
- The radiology consultants had monthly discrepancy meetings which were minuted and lessons shared and learnt.

- The radiation risk assessments were not fit for purpose and did not have enough specific detail for the radiation work undertaken in each area to include: the risk issue, an assessment of the risk and barriers in place to mitigate risk.
- There were no Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
- Local Rules within the nuclear medicine imaging department dated 2010, required reviewing in line with best practice.

Patient outcomes

Outpatients

- The number of patients seen as a follow up against the number of new patients rate was worse than the England average from July 2013 to June 2014. This meant that patients may have been followed up more regularly or for longer than the average. This is measured against all other trusts in England.
- We discussed this with the divisional manager and matron for outpatients. They explained that each speciality discusses their figures at monthly governance meetings. One method they used to try and reduce this rate, was to inform patients by letter if their results were normal rather than bringing them back for another appointment. Some specialist nurses were also doing telephone follow-up appointments, for example in gastroenterology and rheumatology.

Diagnostic imaging services

- The six week Diagnostic Targets were being met. A mobile magnetic resonance (MR) unit was used to increase capacity when required to ensure optimum capacity to meet the target.
- The administrative staff check the patient tracking list (PTL) daily prior to booking. Their rule was not to book over six weeks.
- There was a service level agreement in place with the clinical commissioning group (CCG) for GP reports – 90% of exams should be reported within 10 days. This was monitored on a weekly basis. 90% of examinations had been reported within 10 days and 95% within 15 days.
- The department had set their own internal key performance indicators (KPI's) for all other reporting – three weeks for outpatients and four-six hours for ward patents. The Clinical Director said that the outpatient KPI is not always achieved due to workload and staff shortage.

Competent staff

Outpatients

- Staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs.
- Trust data demonstrated that appraisal rates were 100% in most of the outpatient speciality departments. The exceptions to this were in the children's outpatient department where 9% of qualified and none of the unqualified nurses had received their appraisal (seen in documents supplied by the trust). In ophthalmology 86% of qualified nurses and 100% of unqualified nurses had received their appraisal.
- Specialist nurses within the outpatients department provided nurse-led clinics alongside medical colleagues providing care for patients.
- In addition to mandatory training, nursing staff undertook training relevant to the clinic they were running, for example, wound care.
- Specialist nurses were given the opportunity to further develop their skills, for example the heart failure specialist nurse was going to attend a course to learn how to echo patients.
- Medical staff were given protected learning time to carry out training.

Diagnostic and Imaging services

- All of the staff that we spoke to had received their appraisal- a band 5 radiographer felt her appraisal was constructive and felt the appraiser was interested in her personal development and career progression.
- Trust data demonstrated that 86% of staff had received their appraisal.
- All staff reported that they had access to continual professional development training and that it was actively encouraged. The department held a training budget.
- The Medical Physics team annually updated IR(ME)R training for radiology staff and for new non-medical referrers.

- The Medical Physics team provided radiation protection supervisor (RPS) training for new RPS's and also update training for existing RPS's.

Multidisciplinary working

Outpatients

- There was evidence of good multidisciplinary working within different speciality clinics. For example a vascular scientist worked alongside the consultants within the varicose vein clinic. This meant that the results could be discussed and the results provided straightaway to patients.
- The ophthalmology team linked in with the diabetes and oncology teams in relation to diabetic eye disease and eye cancers.

Diagnostic and Imaging services

- Specialist radiologists were part of the multi-disciplinary teams (MDT) for example, gastrointestinal and breast MDT's.

Seven-day services

Outpatients

- Most of the outpatient clinics ran within core working hours 8-5pm Monday to Friday.
- The cardiac outpatients ran a clinic on Wednesday evening up until 9:30 pm.
- Some ad hoc weekend and evening clinics had been run to address waiting list initiatives.
- The children's outpatients department ran fortnightly Saturday clinics for their oncology patients.

Diagnostic and Imaging services

- The radiology services provided a range of services, some covering 24 hour for example emergency department x-ray, seven days a week, whilst some locations provided services within normal and or extended working hours Monday to Friday.

Access to information

Outpatients

- Electronic access was available for pathology, microbiology and radiology results.
- The rheumatology department reported receiving large volumes of paper blood results. This could result in delays highlighting and acting on significant blood test abnormalities as there was no electronic way of highlighting abnormalities. Currently the results were being reviewed by the clinical nurse specialists. The new manager was changing the system so that the requesting doctor was responsible. There were plans for a new system where significant abnormalities would trigger an email to the requesting doctor. This issue had been put on their risk register.
- Radiology reports were available electronically and results were e-mailed directly to the referring consultant.
- There was a trust target to ensure that GPs received letters within 48 hours of the patient's appointment. We saw evidence that this was being monitored and achieved within the outpatient department.

Diagnostic and Imaging services

- Radiology reports were available electronically (across both sites) and results were e-mailed directly to the referring consultant.
- Clinical Governance documents were not easily available (across both sites) to all staff as they were not filed on a shared drive. They were mostly held by the Clinical Governance lead.
- The medical physics expert reported that there were incidences where radiographers found it difficult to challenge GP referrals when incorrect or insufficient information was present to justify the request. For example poor or missing patient medical history or patient demographics missing. Examinations continued to take place where the practitioner and or operator should have been able to reject the request due to lack of information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.
- We saw examples of accurately completed consent forms in records we looked at.

Outpatients and diagnostic imaging

- Staff were aware of the Gillick competency. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Diagnostic and Imaging services

- The interventional service held a consent clinic each week for the 'major' interventional procedures which also included a comprehensive consent process which was clearly documented. For all other procedures the same forms were completed on the day of the procedure. There were a range of consent forms to meet the needs of the patient e.g. forms for patients who were unable to consent for themselves.
- Staff we spoke with demonstrated knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients receiving diagnostic procedures.
- Staff were aware of the Gillick competency with regards to gaining consent from children and young people
- The majority of general x-ray procedures were carried out using implied consent from the patient.

Are outpatient and diagnostic imaging services caring?

Good

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to patient individual needs. Patients told us they were given good explanations of their treatments and were given written information to take home.

Compassionate care

Outpatients

- We spoke with eight patients within general outpatients, children's outpatients, ENT, physiotherapy and cardiac outpatients.
- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One patient told us in relation to the physiotherapy service, "It is professional and sympathetic to patient's needs, I would be happy to recommend it." Within the children's outpatients, we were told, "the nurses are lovely I have never met a miserable face."
- All the patients told us that they were treated with dignity and respect.
- One patient told us that they had been offered a chaperone. We observed that there were chaperone posters displayed in the general outpatients waiting area.
- We observed that receptionists maintained patient's confidentiality within the reception area.
- We observed that staff were polite, courteous and friendly with patients.

Diagnostic and imaging services

- We saw staff being friendly and polite.
- Staff were courteous when caring for patients and were seen responding to patient's individual needs.
- Patients told us that they were happy with the service provided by the receptionists and nursing staff.
- One patient said, "Can't fault the service, have been treated very well."

Understanding and involvement of patients and those close to them

Outpatients

- Patients told us that they were given good explanations about their care and treatment**.**
- One patient in the cardiac clinic told us, "They explain everything; I've been given leaflets to read at home on procedures**."**
- Another patient in general outpatients told us they were very happy with the care given by all and that things were explained to them both in the clinic by doctors and also by the nurses and receptionists.
- Another patient said their care was offered with dignity and respect and staff had fully involved their partner in all communications.
- Most patients told us they were kept informed about follow-up appointments via letters.

Diagnostic and Imaging services

- One patient said, "The care and treatment is perfect, all staff are polite and explain about the results process."

Emotional support

Outpatients and diagnostic imaging

Outpatients

- We were told by patients the staff were supportive. One patient said, “The staff are friendly, caring and very helpful.”
- If patients received bad news in the gastrointestinal (GI) surgery or medical clinics, there was rapid access to the GI clinical nurse specialist who would come down and support patients.
- If cancer was detected during a cystoscopy procedure within the urology clinic, nurse specialists and senior doctors were available to see and counsel the patients there and then.
- A clinical nurse specialist was based in the main outpatient department to provide support for breast cancer patients. A health care assistant described how staff were employed for long periods of time and the staffing and clinic structure allowed them to build supportive relationships with patients.

Diagnostic and Imaging services

- We observed how a nurse clarified information to a patient until it they understood.
- One patient told us, “The staff are lovely.”

Are outpatient and diagnostic imaging services responsive?

Requires improvement

There was poor signage to both the outpatient and radiology departments. Appointment letters and patient information leaflets were only available in English. Information in other languages (to request leaflets in alternative languages) was written on the reverse of the leaflets but in tiny print that may well have gone unnoticed.

Delay times displayed in some outpatient clinics were not accurate and the delays were longer than shown.

Patients in radiography waited a long time for porters to return them to the ward. A radiographer reported that they regularly attended the department at night for emergencies and waited up to two hours for the patient to arrive from the ward.

Patients requiring ambulances often arrived in outpatients an hour before their appointment and had to wait up to an hour following their appointment to be collected. There was no method of monitoring their length of stay, to ensure they were offered food and drink. There were no vending machines available within radiology to provide food or drink. A water fountain was available but was not clearly visible.

Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first. Translation services were available for patients whose first language was not English.

A scooter service was available within outpatients for people with mobility problems to help them get from one side of the hospital to the other.

Service planning and delivery to meet the needs of local people

Outpatients

- We found there to be poor signage to the outpatients department with directions to different zones within the hospital rather than stating ‘outpatients’. Frequently patients stopped us in corridors asking for directions to different departments.
- There were three check-in desks at the outpatient’s reception. The list of which ‘window’ was dealing with which clinic was not clear as this information was on a board behind the receptionist. We observed some patients came to window one only to be told to move to window three for their clinic’s first check in. The signage could be made clearer for patients.
- There was sufficient seating within the outpatients department for patients. However, there were no diversions offered such as magazines to read whilst patients waited for their appointments.
- Vending machines were available in the hospital to obtain snacks and drinks. However, there was no free water fountain for patients.
- Appointment letters were only available in English. We witnessed a patient who spoke no English who although helped by his friends at the check-in desk appeared very confused by the process. It would have been helpful if they had received some information in their own language before they arrived at reception.
- A tuberculosis (TB) clinic had been set up in response to the local population need being identified as being a high risk of TB.

- Patients said there were always problems parking. A relative of a patient who was in a wheelchair had to park at a local supermarket as there were no spaces available.

Diagnostic and imaging services

- Imaging services were commissioned by the clinical commissioning groups (CCG's) and the radiology department provided the baseline data for the service level agreement (SLA).
- The service met with the GPs on a six monthly basis to discuss service issues.
- An overnight service was provided by an on call radiologist.
- An informal interventional radiology on call service was provided by two radiologists. A network on call service was being developed.
- It was difficult to find the way to the radiology section and to understand that the service was provided over three floors. Signs from the main corridor into the waiting area were not clear.
- There were no vending machines available within radiology to provide food or drink. A water fountain was available but was not clearly visible.

Access and flow

Outpatients

- The referral to treatment percentage within 18 weeks (between April 2013 and November 2014) was better than the England average.
- The percentage of cancer patients seen by a specialist within two weeks of urgent GP referral was better than the England average between January 2013 and September 2014.
- The percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was worse than the England average April - September 2014.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average April - September 2014.
- The "did not attend" (DNA) rate was worse than the England average. The New Cross rate averaged at 8% with the England average at 7%. The outpatient senior manager told us that they were about to introduce text messages to remind patients of their appointments to help to address this.
- There were wipe boards within the separate waiting areas in the general outpatients department which had a column for 'delays to clinics'. Delays of up to 30 minutes were displayed.
- Within the ear, nose and throat (ENT) clinic delays of 20 and 25 min were displayed on the wipe boards. However, patients reported that the delay was longer than this, up to one hour.
- There was a scooter service (0830 am to 4.30pm) available for patients who had mobility problems and needed to get from one side of the hospital to the other and also back to a car parked which was a long distance away. We saw this in operation several times and the service worked well.
- The ophthalmology department had developed an acute service for urgent eye problems, essentially an A&E for eyes. An ophthalmology outreach nurse was based in the emergency department (ED) and GPs and ED staff could refer to this specialist service as required.

Diagnostic and Imaging services

- Ward patients had long waits to return to their wards. It was reported that a ward patient had recently waited four hours for a porter to take them back to the ward. We did question as to why a member of staff had not taken the patient back and then addressed the reason for the waits. The member of staff was unsure whether an incident form had been completed.
- A radiographer reported that they regularly attended the department at night for emergencies and waited up to two hours for the patient to arrive from the ward.
- We noticed on more than one occasion many beds were blocking the CT scanning area and the main ward x-ray waiting area. This needed further management input to aid throughput of patients.
- Staff told us that inpatients were sent for on the portering system but had no control when patients arrived. This often resulted in the six bedded waiting space being overcrowded compromising patient safety, dignity and privacy.
- In response to concerns that ward patients were waiting for radiology tests, the deputy radiology manager attended the trust bed meetings twice a week and was able to identify any patient requests that needed to be fast tracked to facilitate discharge.

Meeting people's individual needs

Outpatients and diagnostic imaging

- The consultants within each speciality informed the appointments department how long was required for individual appointments depending on whether they were new or follow-up patients. The medical staff we spoke with said they were happy with the timing of the appointment slots. One consultant had requested for a longer slot due to introduction of a paperless system which was accommodated.
- Patient transport was available for patients with mobility issues. However, they frequently arrived one hour before their appointment and transport was not booked for the return journey until their appointment had concluded. This meant patients often had to wait for a further hour once their appointments had finished. The transportation was offered by another provider with an agreed contract with the trust. The service level agreement was between the clinical commissioning group and the transport provider. There was a target for 95% of patients to be picked up within 60 minutes. They had achieved 74%. This issue had been raised with the transport provider.
- The healthcare assistants told us that they offered patients drinks if they noticed they had been waiting for long periods. However, there was not a system to monitor how long patients had been present in the outpatient department.
- There was a dedicated ambulance for bariatric patients and large chairs were available within the outpatient department. There was no bariatric couch so patients remained on the ambulance stretcher until taken home. The ambulance crew remained with patients during their appointments and these patients were prioritised to avoid delays.
- Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first.
- Staff received dementia training and a consultant nurse in dementia and a lead nurse in learning disabilities were available to provide advice.
- When the outpatient reception area was refurbished, the colour scheme was designed to help orientate people living with dementia. A bid was put in last year to refurbish the rest of the department which would have included better use of colour schemes to help orientate confused patients, but this was unsuccessful in obtaining funding.
- There was an alert system on the electronic appointment system which should flag if a patient required a translator when booking their appointments. This enabled translators to be booked in advance for patients appointments. A telephone translation service was also available for staff to aid communication with patients whose first language was not English.
- All the patient information leaflets were in English. In very tiny print on the back of these leaflets was a sentence (in different languages) saying that leaflets could be requested in alternative languages. However the print was too small for most patients to notice this. This did not reflect the multicultural population that the hospital cared for.

Diagnostic and imaging services

- When information was provided at the point of booking an appointment, the booking administration team avoided early morning, late afternoon or mobile unit appointments for vulnerable adults and children, including elderly patients (across both sites).
- The trust presentation highlighted that obesity was a problem within the local population. It was noted that there was no provision of bariatric seating in the waiting areas.
- Since the trust secured the Cannock Chase imaging services, the ultrasound lists were booked at a Wolverhampton central booking centre. Wolverhampton patients were sent appointments at Cannock. An increased DNA was noted, on average 22%. This had not been investigated to see if it was attributable to the new location and distance travelled. Patients were not made aware that appointments had been made for them to attend at Cannock.
- Patients were pleased that in magnetic resonance imaging (MRI) and ultrasound, they were able to get the results there and then.
- Many waiting areas and patient cubicles did not have signage at all and where they were placed the text was very small

Learning from complaints and concerns

Outpatients

- Most patients we spoke with did not know how to make a complaint.
- Posters on how to make a complaint were displayed in the physiotherapy outpatients but not in the general

outpatients department main waiting areas. Information was provided within the clinic rooms. This may have posed a barrier to patients making a complaint. There was a comments box in the general outpatients but this was not well advertised.
- Complaints were discussed at monthly governance meetings and then fed back to staff at their team meetings. We saw minutes of these meetings and staff confirmed that learning from complaints was fed back to them. The group manager of outpatients told us they received very few complaints. Governance meeting minutes demonstrated that there were no complaints between October and December 2014 in the general outpatients department.

Diagnostic and Imaging services

- The department received a complaint regarding the lack of patient information for an appointment for a transvaginal (TV) scan. The department immediately rectified this and now sends information about the scan so that patients are aware of what to expect.
- Patients were telephoned to establish the reason for their complaint and to ensure all of their concerns were responded to.
- Complaints and outcomes were discussed at the monthly Clinical Governance meeting.
- Staff were requested to provide statements if involved or mentioned in a complaint. However, the same staff did not see the final response letter.
- Staff did not receive feedback of lessons learned from themes of complaints.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was not a clear vision and strategy within the outpatients and radiography departments.

There were no local audits of patient satisfaction for example patient surveys within radiography.

There were clear governance structures within outpatients and defined reporting systems in place. The governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Business plans and service improvements for other specialities were not shared with radiology. The department was therefore not able to plan for development of services and impacts on resource and diagnostic targets.

Staff in both departments felt well supported by their managers and were happy working for the trust. There were examples of innovative practice in both outpatients and radiography. A varicose vein clinic (within outpatients) where a vascular scientist was present with the consultant enabled discussion of the results and patients being able to receive their results on the day. The ultrasonographers were training to report plain films. This will offer more scope with regards to plain film reporting and maximise any spare capacity in the department. This was unique and a possible first in the UK.

Vision and strategy for this service

Outpatients

- There was not a clear vision and strategy for the general outpatient service. However, the group manager described their aims and objectives. These included improvements to the environment and tackling capacity issues within the department.
- Some speciality clinics were managed and held within their own outpatient areas within their department buildings. We found examples of clear strategy and vision within cardiology rheumatology and ophthalmology.

Diagnostic and Imaging services

- There was not a clear strategy and vision for the radiology service. We discussed the five-year plan for radiology with the senior managers and they were unable to respond with specific details. They told us they tend to respond to issues as they arise.

Governance, risk management and quality measurement

Outpatients

- There was a structured governance system in place.

- Monthly governance meetings took place which discussed the risk register, complaints and incidents, lessons learnt and actions to take in future and audits. We saw minutes of these meetings.
- A protocol had been introduced to ensure the right patient went into the right room as a result of an incident whereby two confused patients went into the wrong clinic room. Staff we spoke with were aware of the learning from this incident.
- Corporate governance officers also attended these meetings to share lessons learnt in relation to incidents in other areas of the trust.

Diagnostic and imaging services

- There were clear governance structures and clear defined reporting structures in the department to the trust senior management
- The risk register was well managed with regular review – however the department managers were not empowered to identify and report risks within their areas. For example the issues with patients waiting excessive times for porters to return them to the wards, was not on the risk register.
- The governance systems had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report.
- There was no ownership of who was responsible for ensuring the Department worked within best practice professional guidelines and IR(ME)R regulations. When asked staff confirmed there was no clear accountability or delegation, so could not identify who was responsible taking the lead regarding IR(ME)R and professional development for example. Although there was a written structure of roles and responsibilities within the department. The medical physics staff stated that they were not involved in the process of equipment procurement which did not allow their advice regarding dose optimisation to influence any purchasing decision.
- We informed the trust post-inspection of IR(ME)R concerns (across both sites). We have since had assurance from the trust that these matters have been addressed.

Leadership of service

Outpatients

- Staff both within the general outpatients department and the speciality clinics told us they felt well supported by their managers. The service was managed by a Outpatients Service Manager and a Matron.
- The group manager and matron of outpatients felt well supported from the executive team. They reported good two-way communication between the department and the board.

Diagnostic and imaging services

- Staff we spoke to were happy working for the trust and felt supported by the management team which included a clinical director, the deputy radiology manager and the group manager.
- One of the supervisors reported that they had requested several times the need to have team meetings with her staff. These had yet to be agreed.
- Few staff could say who the directorate management team were.
- The senior radiology management team reported that they felt really supported and listened to by the executive board. The clinical director said that the chief executive was always willing to listen with a good line of communication to the board.

Culture within the service

Outpatients

- Staff we spoke with reported a very positive, open culture where they were encouraged to report incidents.
- Staff described a good working environment where everyone worked together. One member of staff said, “It is a really nice place to work, a good team and good managers, if you knock the door there is always someone there for me.”

Diagnostic and Imaging services

- All staff that we spoke to were happy working for the trust. There was a good staff retention rate. In one year, three radiographers left the department and the same three staff returned.
- A radiologist said that they were happy that they were not involved with the management team and were allowed to focus on their clinical commitments.

Public and staff engagement

Outpatients

- The friends and family test (where patients feedback whether they would recommend the service to their friends and family via questionnaires), had only just commenced in outpatients therefore there were no results available. We observed a friends and family feedback box by the reception area.
- Staff told us they felt listened to and supported by senior managers to make changes they wanted to make.

Diagnostic and Imaging services

- The manager told us that there were no local audits of patient satisfaction for example patient surveys.
- There were no patient 'comment' boxes within the radiology departments.
- Discussions with senior staff (such as superintendent radiographers and radiologists) highlighted that they were not involved with business planning and that any plans were not shared.

Innovation, improvement and sustainability

Outpatients

- We discussed with the senior managers areas of innovative practice that had been implemented within the outpatients department.
- They were proud of their nurse led cystoscopy clinics and nurse led under 35 female and male breast clinics.
- There was also a varicose vein clinic where a vascular scientist was present with the consultant enabling discussion of the results and patients being able to receive their results on the day.

Diagnostic and Imaging services

- Business plans and service improvements for other specialities were not shared with radiology (across both sites). The department was therefore not able to plan for development of services and impacts on resource and diagnostic targets. This also applied to business cases for additional medical or surgical consultant posts.
- The ultrasonographers were training to report plain films. This would offer more scope with regards to plain film reporting and maximise any spare capacity in the department. This was unique and a possible first in the UK.

Outstanding practice and areas for improvement

Outstanding practice

Trust wide

- The trust's SimWard was being utilised to support staff competencies. Staff told us they were in the process of expanding the service externally to provide education and learning to other authorities.

Emergency Services

- We noted effective integration with the rest of the hospital. For example we observed one patient presented to ED with headache and weakness, they were received by an ED consultant and had a scan within ten minutes. They were then received by a stroke consultant and Thrombolysis (treatment to prevent blood clotting) was started in the ED within 20 minutes.

Medicine

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

Surgery

- The trust recently instituted "In Charge" initiative was welcomed by patients and relatives. This was a badge worn by the person responsible for that shift on the ward.
- The innovative system to drain chests after cardiac operations had reduced patient length of stay in hospital.
- There was a group text system in place to ensure the availability of staff and beds on the day of the operation so as to avoid any cancellation.
- The "panel meeting" concept where senior trust staff provided high challenge and high support to wards managers after investigation of incidents. This meeting enabled staff to take the learnings from such events on board and ensure systems were put in pace to prevent reoccurrence.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.

Maternity and Gynaecology Services

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

End of Life Care

- We were told how care after death was of a very high standard and the mortuary staff would ensure the person's dignity was maintained during the care. Mortuary staff gave us examples of assisting a mother dress her small child in clothes that the mother had picked out. The mortuary staff supported her through a difficult time and allowed her to take her time with the child and utilise the Swan suite. We could see the mortuary staff were very passionate about delivering a high standard of care after death.

Areas for improvement

Action the hospital MUST take to improve

Medicine

1. The trust must improve the attitude and approach of some of its staff to patients in their care.
2. The trust must improve the level of detail in patient care records, reflecting individual preferences.
3. The trust must review the amount of monitoring and supporting equipment on its wards.

Outstanding practice and areas for improvement

Surgery

1. The trust must make sure that the recruitment of additional staff that was being undertaken to resolve the transportation of blood is completed in a timely manner.

Critical Care

1. The trust must ensure that regular checks are recorded regarding the cleaning of equipment.
2. The trust must ensure that locally owned risks are identified and recorded on the risk register and have appropriate actions to mitigate them, with timely reviews and updates.
3. The trust must ensure the medicine room is locked to reduce the risk of unauthorised people accessing medicines.
4. The trust must ensure that intravenous medicines are stored correctly to reduce the risk of the administration of incorrect medicines.
5. The trust must ensure that the microbiologist input is recorded within the patient records to support their care and welfare.

OPD and Diagnostics

1. The trust must ensure that when controlled drugs are removed from the medicines cupboard in radiology, this is clearly documented at the time of administration.
2. The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
3. The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations

End of Life Care

1. Controlled medication must be labelled, prescribed to a patient and packaging must not be tampered with.

Action the hospital SHOULD take to improve

Emergency Services

1. The trust should improve staff understanding of the dementia care pathway for patients in the ED
2. Medicine fridge temperature records in the ED should be recorded daily to ensure medicines were stored safely.
3. Evidence of resuscitation status should be included in patient's records.
4. ED staff take up of mandatory training should be improved.
5. The trust should be clear about the use of the paediatric facilities in the ED
6. The trust should improve public information about making a complaint in the ED

Medicine

1. The trust should review the need to undertake transfers late at night of patients to Cannock Chase Hospital.
2. The trust should ensure sufficient and suitably skilled staff are available at all times to meet the needs of patients.

Surgery

1. The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
2. The trust should make sure that there are process in place to ensure formal "sign in" takes place in the anaesthetic room and that this is recorded.
3. The trust should make sure that a number of required policies and procedures identified from the national emergency laparotomy audit 2014 are put in place.
4. The trust should make sure that patients with bowel cancer can access appropriate clinical nurse specialist.
5. The trust should ensure there are resting seats available for vulnerable patients to avoid them to walk long intervals without resting.

Critical Care

1. The trust should ensure there are procedures in place to record the checking of the resuscitation trolley.
2. The trust should ensure that the trust's vision and strategy is cascaded to all staff.
3. The trust should ensure that all policies and procedures are up to date and have been reviewed appropriately.

Maternity and Gynaecology

Outstanding practice and areas for improvement

1. The trust should improve the quality of record keeping in maternity.
2. The trust should improve the checking of drugs and fridge temperatures where medicines are stored..
3. The trust should ensure emergency equipment is readily available to use.

OPD and Diagnostics

1. The trust should ensure that the renal unit complies with staffing requirements stipulated by the National Institute of Clinical Excellence.
2. The trust should ensure that staff in radiology receives feedback in relation to shared learning and changes in practice resulting from incidents.
3. The trust should ensure that call bells within radiology cubicles are fit for purpose and that there is clear signage outside x-ray rooms alerting patients not to enter and advising women to inform staff if they are pregnant.
4. The trust should ensure that the procedure to check whether women are pregnant prior to receiving radiography tests is improved
5. The trust should ensure that the nuclear medicine (imaging) service issues 'written instructions' to females who are breastfeeding and who have undergone a radio nuclide procedure.
6. The trust should ensure that Local Diagnostic Reference Levels are available for the CT scanners (and other diagnostic procedures) and that CT radiographers have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended and how this should be reported.
7. The trust should ensure that the clinical imaging protocols (operating procedures) are fit for purpose and that basic scan parameters are present that would allow an operator to follow and find operational information to be able to perform a scan safely and to check that recalled electronic settings within the scanning equipment is in concordance with the written protocol.
8. The trust must ensure that the radiation risk assessments are fit for purpose and have enough specific detail for the radiation work undertaken in each area.
9. The trust must ensure that there are Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
10. The trust should ensure that paediatric reports within radiography are produced promptly.
11. The trust should ensure that appointment letters and patient information leaflets are available in languages other than English.
12. The trust should ensure that there is a method of monitoring whether patients have been present in outpatients or radiology for long periods to ensure they have adequate food and drink.
13. The trust should ensure that patient feedback is received and acted upon in radiology to improve service provision.
14. The trust should ensure that radioactive medicinal products and waste are securely stored and accounted for at all times.

End of Life Care

1. The trust might like to review staffing levels in particular on the oncology ward and surgical wards.
2. The trust should develop clear guidance for staff on repositioning spinal cord compression and spinal cancer patients.
3. Spinal cord compression and spinal cancer patients must be repositioned according to their assessment and trust policy. Staff should record incidents where appropriate.
4. The hospital might like to improve on communication with families and better recording of their discussions with staff, ensuring discharge is consistently discussed and they are kept informed of patient's conditions.

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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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment** 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. How the regulation was not being met: Medications management and supply needs to improve within the trust to ensure the safety of people using the services. In particular we saw that medication packaging was used in such a way which would prevent safety checks being undertaken. Some patients did not always receive their medication as prescribed.

This section is primarily information for the provider

Requirement notices

Records of controlled drugs were not being recorded at the time of administration. We also noted that medication were not always stored securely. The storage of some intravenous medicines was in an untidy manner which could result in mistakes occurring.

All people using the service must have in place plans of care that meets all of their needs. We noted that not all patients conditions although known had an associated plan of care.

Infection control practices did not include regular checks and records of cleaned equipment. The Microbiologist input must recorded in the records to support care and treatment plans.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance** 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

This section is primarily information for the provider

Requirement notices

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a) a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

(b) any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

How the regulation was not being met:

We saw that not all of the core services used the risk register to identify locally held risks and identify mitigation actions in a timely manner.

The governance process to include shared learning needed to be improved within one of the core services, so that the onus was not on staff to identify the learning but for the local leadership to actively share the learning information.

We noted that the there was a lack of clear ownership with regard to the professional practice guidelines and IR(ME)R.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing 18**.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. How the regulation was not being met: We found that not all core services had sufficient staff to meet all the needs of patients. In addition to this existing

This section is primarily information for the provider

Requirement notices

Termination of pregnancies Treatment of disease, disorder or injury	staff were shortfalls which were having a detrimental effect on staff morale. We also noted where staff were to be supernumerary they were required at times to work clinically to boost the staffing numbers.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and Equipment 15.** —(1) All premises and equipment used by the service provider must be— (a) clean, (b) secure, (c) suitable for the purpose for which they are being used, How the regulation was not being met: People who use the services and others were not protected against the risks associated with unclean equipment in Critical care. Adequate numbers of equipment for assessment of patients should be available on all wards.

Agenda Item No. 12

Health and Wellbeing Board

7 October 2015

Report title	Safeguarding Children's Board Annual Report and Executive Summary 2014-15
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders, Community
Originating service	Children's Safeguarding
Report to be/has been considered by	Wolverhampton Safeguarding Children's Board 16 September 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

- It is recommended that Health and Well-Being Board (HWBB) receives this report in order to ensure a clear understanding in relation to the work of WSCB over the last year.
- HWBB note the range of work that is taking place to safeguard children in Wolverhampton, and the continued challenges, developments and achievements in this critical area of work.

1.0 Purpose

1.1 The purpose of this report is to provide the HWBB with a copy of the WSCB's Annual Report and Executive Summary, to inform the Board of safeguarding activity during 2014/2015 and to present the Board with progress made against the priorities for 2013-16.

1.2 The Annual Report is agreed by the WSCB and provides an overview of how partners have discharged their safeguarding responsibilities over the preceding year.

1.3 The annual report offers assurance to the HWBB that the activities of WSCB are in compliance with its statutory functions as required by legislation (Children Act 2004), and

provides a formal opportunity to ensure that practice operates accordingly. From the perspective of the Children's Safeguarding Board, it provides an arena for challenge and an opportunity to seek assurances from members of the HWBB that their constituent organisations discuss and review safeguarding at their respective Boards and, where relevant, scrutiny committees.

2.0 Background

2.1 Safeguarding Children's Boards are statutorily required to publish an annual report on the effectiveness of children's safeguarding and promoting the welfare of children in the local area. The Board is a broad partnership of key agencies with collective responsibilities for safeguarding children and providing mutual assurance that the practice of safeguarding reflects jointly agreed policies and protocols. The Board meets four times a year with much of its business conducted through a range of committees that report into the Board. In compliance with the Statutory guidance; Working Together to Safeguard Children (March 2015), which states;

"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive (Managing Director), Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board".

2.2 The annual report describes the combined activities made in respect of children safeguarded at a local level and relates to the year 2014-15. It was presented at the September Children's Board and signed off early October. As predicted in my report to this Board in January the timing of Annual report has been improved significantly and met the proposed deadline of going to the September 15 Safeguarding Children Board.

2.3 There is an executive summary which provides the key activities and highlights key achievements for the reporting year.

3.0 Progress since last report

3.1 Last year we reported on the revised priorities and Board membership, the establishment of an Executive group with each member having a lead role for each of the Board's priorities have been formalised and is now embedded within the 'Business and functions of activities.

3.2 Against each priority there is a list of achievements in the past year and priorities for the future. In particular I wish to draw your attention to the following ones:

3.2.1 Last year I drew attention to the relative paucity of information that we possessed about safeguarding of children in schools. From a point where only 10% of schools reported on safeguarding by the end of 2014-15 the figure had increased to 100%. Our challenge now is to support schools who have reported both their strengths and areas for development in ensuring they can better learn from one another in regard to best practice

and effective training. This is being supported by a Safeguarding and Schools Conference we are arranging for November.

3.2.2 We now have more effective links with young people and are better able to listen to and respond to their issues and concerns around safeguarding. This is leading to a focussed campaign this year on bullying something which is clearly something of significance for too many of our young people.

3.2.3 Wolverhampton Board has contributed to and designed up to a new West Midlands protocol relating to improved prevention and intervention in instances. Quite rightly this reflects both an increased national and regional focus on child sexual exploitation.

3.2.4 Led by West Midlands Police we have improved our partnership information gathering and sharing about children who are missing and possibly being Sexually Exploited and Trafficked. Like many other partnerships we now have a designated officer appointed to coordinate our efforts and to challenge us all to do more. But we also know there is much more to find out which is inevitably the case when so much effort is applied by perpetrators to avoid detection and prosecution. Although we do not believe Wolverhampton has repeatedly missed warnings or ignored signs of organised abuse that does not mean we are content we are doing enough to protect young people or improve our chances of prosecution.

3.2.5 The Council through their licensing responsibilities have improved their practice in terms of identify and acting on concerns about children that seem to be at risk in regulated services such as pubs, hotels, taxis and take away restaurants at licensed premises. Where there is evidence to suggest that children are in danger or at risk programme licences have been revoked.

3.2.6 In last year's report I raised concerns about the Board's funding. We have secured some additional funding for the Board in order to ensure in the short to medium term we can meet the priorities we have set ourselves. This is a continuing issue but our funding is relatively more secure than in the previous year.

4.0 Future priorities and challenges

4.1 Safeguarding children is heavily dependent on effective partnerships both in day to day operations and strategically. All agencies continue to experience frequent internal pressure on their resources which has an effect on establishing and maintaining multi-agency practice. During 2014-15 there were significant changes in the Probation Service affecting what they did and how they did it. West Midlands Police experience frequent change in the roles and responsibilities of their Officers. It is not uncommon for me to brief each year two to three new officers participating in the Boards and Committees of the Children's' and Adult Boards. It does little for consistency. The loss of Bob Jones as Police and Crime Commissioner was a significant loss for Boards across the region as he ran and supported regular conversations with Board Chairs - something which I need to encourage the new Commissioner to continue.

4.2 Issues of staff turnover also affect day to day safeguarding practice. A constant message from my meetings with front-line staff are that they all too often find that direct work with families lacks the necessary continuity due to staff shortages and relatively heavy use of agency staff. This applies in particular to social work. It is not ignored but highlights the problems that there are nationally in recruiting and retaining staff to a profession that all-too-often is identified and criticised in individual cases of child abuse or neglect.

4.3 I referred to the need to better engage GPs in the safeguarding of children. We now know that most GPs do not contribute to planning discussions either in person or in writing. We are taking steps through Wolverhampton Clinical Commissioning Group to support Doctors in making that vital contribution as well as improving their training. There is a written action plan that I am confident will lead to improved participation rates next year.

4.4 Our work on engaging Faith Groups in safeguarding has proven to be more difficult than first envisaged. We established a database of over 160 faith groups in Wolverhampton. This reflects in part the greater diversity of our local population in particular migration form Eastern Europe.

4.5 Our priorities for the year 2015-16 are outlined in the report. Above those covered in this report I would draw attention to the continued development of a new adults and children's website which, on completion, will provide substantially more accessible information not just for professionals but also the public. Of particular significance will be the section of the site designed by and for young people.

5.0 Financial implications

5.1 I have referred in 3.2.6 to the increased, but not total financial security in relation to the Children's Safeguarding Board. I am confident that for the next 12 months we shall have the necessary resources to carry out our key responsibilities.

6.0 Legal implications

6.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and Wellbeing of their local population and reduce health inequalities.

6.2 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'; the latest version came into effect from March of this year (2015).

6.3 As stipulated in the related guidance, the annual report will be submitted to the Managing Director, Leader of the Council, the local police and crime commissioner and is presented here for the attention of members of this Board.

6.4 In support of the protocol agreement put forward in January between Wolverhampton's Children's Safeguarding Board and the Health and Wellbeing Board I have supported this concept to include reciprocal relationships between the Adults' Board which I also chair. It is also intended that the report should be tabled at the Children Trust Board and Safer Wolverhampton Partnership. This extended circulation is deemed necessary in particular reference to the high correlation between domestic violence and child abuse requires us to always 'think family' in both strategy and practice I hope this will mean that excellent informal relationships will be consolidated more formally.

7.0 Equalities implications

7.1 Within this report covering the period 2014 -15, there are no specific equality implications.

8.0 Environmental implications

8.1 There are no specific environmental implications.

9.0 Schedule of background papers

9.1 Annual Report and Executive Summary of the Wolverhampton Safeguarding Children Board 2014-15

Alan Coe
Independent Chair
Wolverhampton Children's Safeguarding Board

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WOLVERHAMPTON SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2014 - 2015

CONTENTS

Chair's Foreword

This report summarises what so many of us have done in the past 12 months to better safeguard children. It tells of our successes, where we are falling short and then what we are doing about it.

All of us play a part in safeguarding children and young people. We know so well that partnership is at the heart of safeguarding. No matter what any individual or agency does it's the partnership and communication and action between all concerned that can make a difference. This does not just apply in protecting children at risk of harm; it is equally so in preventing young people being harmed in the first place. It is for that reason that I am particularly pleased for the Board to be able to report more on how we engage with young people and how we respond to their concerns. We have learnt from young people directly about anxieties surrounding bullying. Face to face discussions and local surveys tell us this. In response our plans this year include an anti-bullying campaign which will link directly with schools.

Last year I mentioned the importance of both schools and GPs in safeguarding young people. They are at the front line and should be the first to notice if things are wrong and to report it. We have made progress. This year we have found out more about how schools safeguard children than we have ever done before. This information is being applied to highlight what is working well and how better we as a Board though training and good practice examples can assist. Similarly we now have better information on where GPs might contribute more to child safeguarding. This report will tell you in the section from the Wolverhampton Clinical Commissioning Group what extra training has been provided. It will lead this year to a specific campaign which we hope will lead to further demonstrable improvements.

So many agencies work hard to protect children and it is right to acknowledge the excellent work their staff do. Inevitably media concerns highlight things that go wrong. I know that nurses, social workers, police officers, doctors and many others do much that goes unnoticed to protect children. We will never get everything right and we always want to improve further. This report tells you something about how we go about doing just that.

Alan Coe
Independent Chair

Introduction & Purpose of the WSCB Annual Report

By law we must have a Local Safeguarding Children Board (LSCB) in each local authority area. It is a partnership of the main agencies who help protect young people but also includes strong links with the community and, most importantly, young people. The government provides guidance about their role and function and it also says we must have an Annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (this is a statutory requirement under section 14A of the Children Act 2004). The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

The report provides a rigorous and transparent assessment of the performance and effectiveness of local services safeguarding arrangements and reflects multi-agency safeguarding activity across Wolverhampton, highlighting the work undertaken in the year, areas for development and board scrutiny and challenge.

This report illustrates the challenges of improving how we safeguard young people at a time of continuing high demand but reduced resources. As well as making progress in a number of areas the annual report serves to identify where we need to do more which are reflected in the 2015/16 Business Plan. In the year ahead we know that we need to clarify and strengthen links with other partnership boards, including the Health and Well Being Board (H&WBB), Safer Wolverhampton Partnership, Safeguarding Adults Board and the Children's Trust Board to make sure the work of each supports and complements each other.

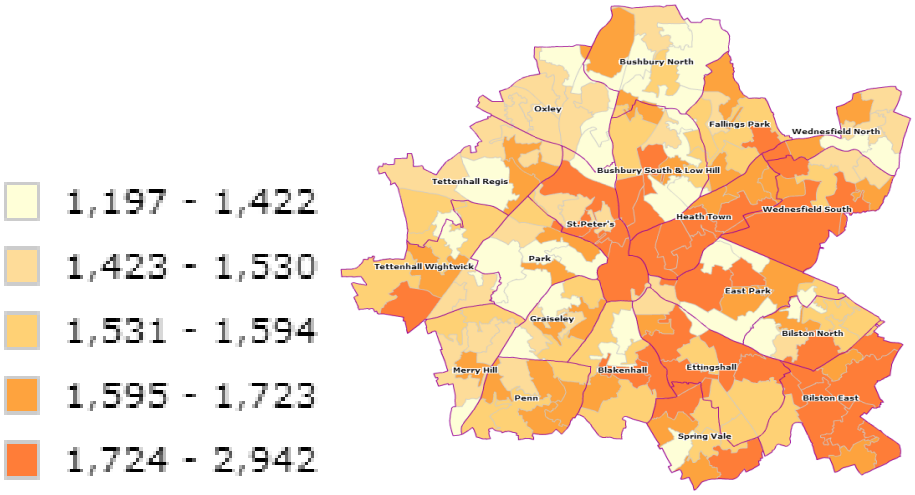
The annual report lists the contributions made to the LSCB by each partner agency and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other areas such as learning events or training. All LSCB member organisations have to provide LSCB's with reliable resources (including finance) that enable us to be strong and effective.
(Ch. 3, para. 16, 17 and 18, Working Together 2013)

The City of Wolverhampton, Local Background and Context

- Situated to the west of Birmingham, Wolverhampton is one of the 4 local authorities in the Black Country sub-region (see map)
- Rapid growth in the 19th century based on coal and manufacturing industries
- Amongst the most densely populated local authority areas in England: 251,557 people (2013 Mid-Year Pop. Est.) living in its 26.8 square miles.
- Over a third of the population are of non-'White British' ethnicity (35.5% as of the 2011 Census)

(www.bcil.org.uk/) map shows the location of the Black Country within Great Britain and is from http://www.bcll.org.uk/

Wolverhampton has a population of 251,851 and is proud of the diverse cultural richness that this encompasses, with 35% of its residents from BME.



- The greatest numbers of people are usually found in the inner city, the north-east, and the south-east

Children and Young People

a) **General:** A total of 56,353 children and young people under the age of 18 years live in Wolverhampton. This is approximately 20% of the total population in the area.

- Approximately 31.5% of the local authority's children and young people aged 0 – 18) are living in poverty; this rises to 50% in 10 LSOA's. This is higher than the national average.

- The proportion of children entitled to free school meals:

  - In primary schools (including reception) is 29.8% (the national average is 18%)
  - In secondary schools (including Academies) is 23.3% (the national average is 15%)
  - Across the total school population is 27.5%

- Children and young people from minority ethnic group's account for 44.2% of all children living in the area compared with 25.5% in England. Approximately 46.5% of school age children are from a minority ethnic group.

- The largest minority ethnic groups of children and young people in the area are Asian Indian (born in the UK).

- The proportion of children and young people with English as an additional language:

  - In primary schools is 22% (the national average is 18%)
  - In secondary schools is 17% (the national average is 14%)

Health: The health and wellbeing of children in Wolverhampton is generally worse than the England average:

- Wolverhampton currently has an **Infant Mortality** rate of 7.8 per 1,000 (2010-12) compared to 4.3 per 1,000 for England and Wales. Over the past 20 years there has been a 30% reduction in the average infant mortality rate for England and Wales, whereas in Wolverhampton the local infant mortality rate has remained static and latest data indicates Wolverhampton currently has the highest rate of infant mortality in England and Wales. Whilst it is acknowledged that year on year there is fluctuation in the infant mortality rate in Wolverhampton due to small number variation, the rate has been consistently above the average for England and Wales.

- The **Child Mortality** rate (1 – 17 years) is 13.8 per 100,000 (the national average is 12.5). This is slightly higher than the national average.

- Children in Wolverhampton have worse than average levels of **obesity**:

- Obese children aged 4 – 5 years is 12.7%; a reduction from 13.1% (March 2013), (the national average is 9.3%)

- Obese children aged 10 – 11 years is 24.1%; a reduction from 24.4% (March 2013, (the national average is 18.9%))

- Under age 18 conceptions per 1000 females age 15 – 17 years in Wolverhampton is significantly higher than the national average; although there is evidence to suggest a reducing trend.

About our most vulnerable children:

In line with Section 17 (10) of the Children Act 1989; Children's Social Care have a responsibility to safeguard and promote the welfare of Children in Need

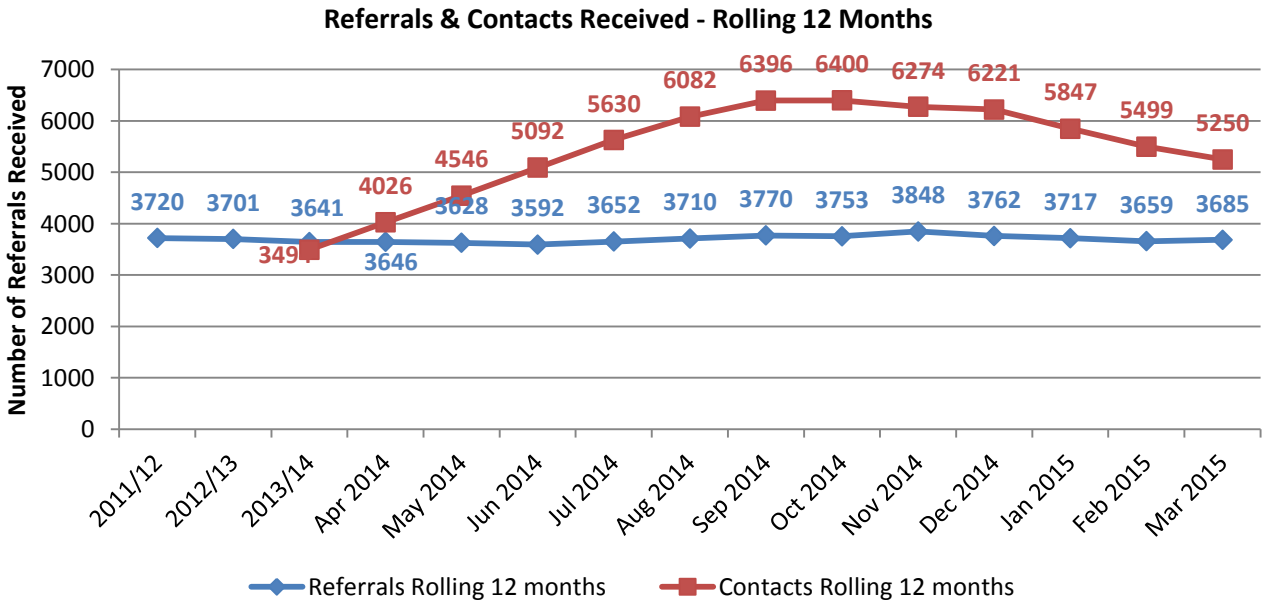
A child is a "Child in Need" if:

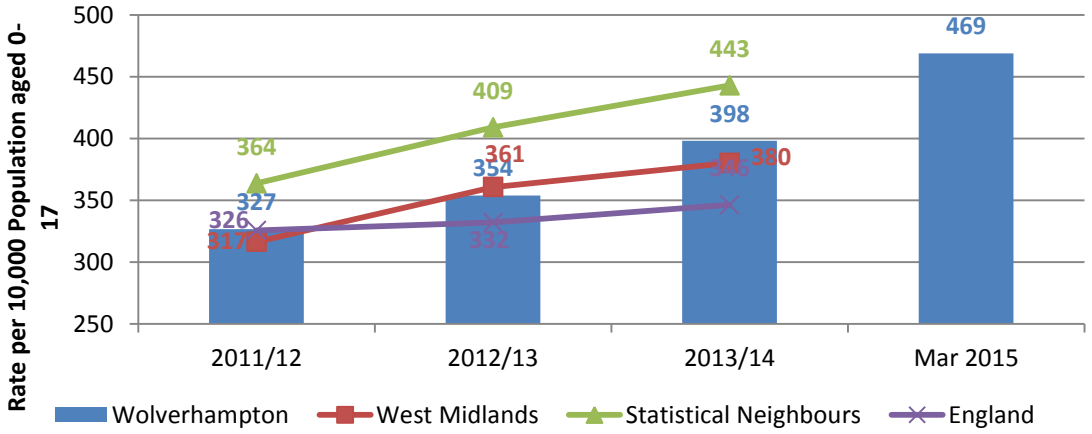
- The child is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority;
- The child's health or development is likely to be significantly impaired, or further impaired, without the provision of services; or,
- The child is disabled.

Children (under 18) may be 'looked after' by local authorities under a number of different arrangements such as care orders or emergency protection orders outlined in the Children Act 1989.

Services to Children during the reporting period:

- The chart below shows that there were 5250 contact made which transpired to 3685 children being identified through assessment as being formally in need of a specialist children's services intervention. This represents a slight increase from March 2014 (3641).



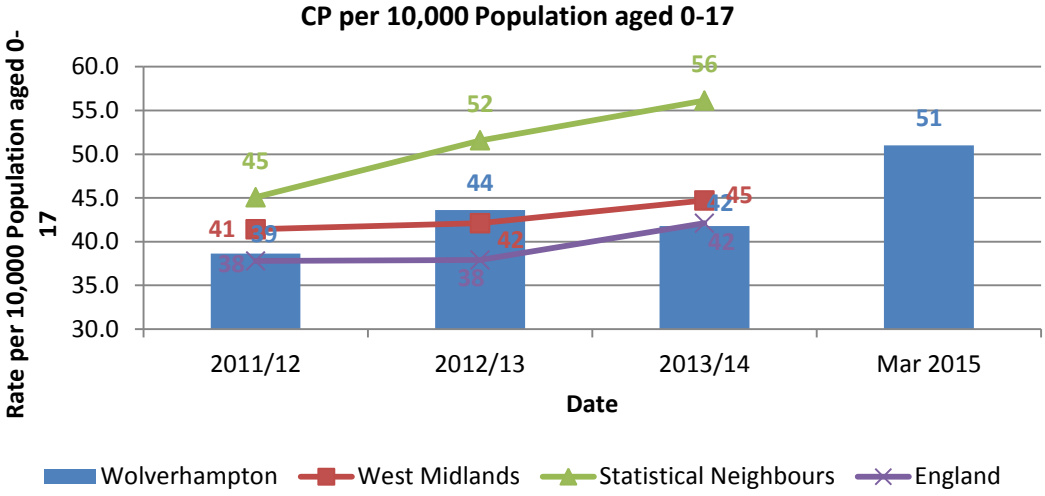


The above graph shows an increase in the rate of children in need over the past three years. The increase in Wolverhampton has been steeper than the increase in rates for England and West Midlands, but is been broadly in line with the increase seen amongst statistical neighbours.

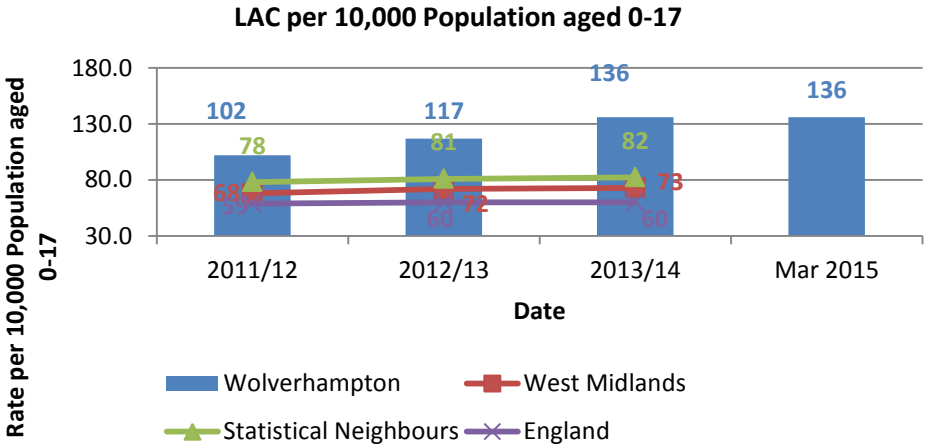
Safeguards for children suffering; or is likely to suffer significant harm.

- When a multiagency child protection case conference decides that a child or young person is suffering, or is likely to suffer, significant harm, a child protection plan is created. This is a working arrangement that enables the family of a child and professionals to understand what is expected of them and what they can expect of others.

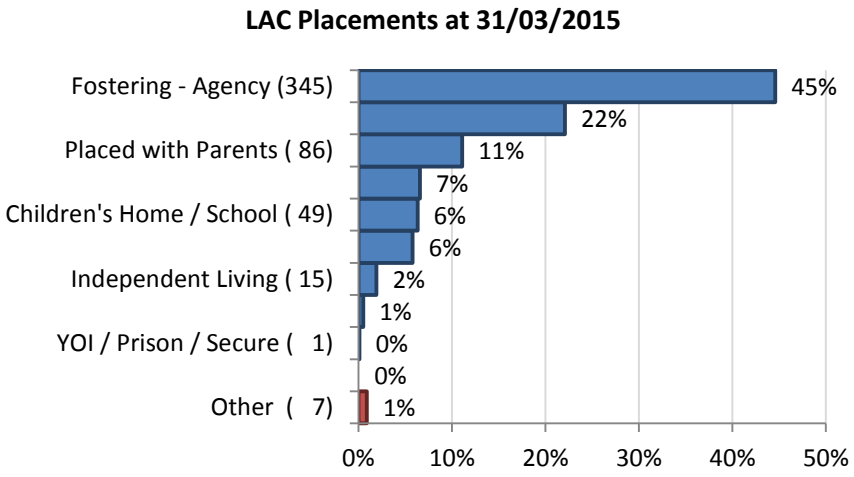
- As detailed in the chart below, the rate of children who are subject of a **Child Protection Plan** has increased in 2014/15. The rate of children subject of a child protection plan in Wolverhampton has, in previous years, been broadly in line with the England and West Midlands rates but significantly lower than the rate amongst statistical neighbours. Even with the steep increase seen in 2014/15, the rate remains below that of Statistical Neighbours in March 2014.



- As illustrated below, Wolverhampton has seen a 35% increase in the number of Looked After Children (LAC) over the last three years. This increase has been significantly higher than that of comparator groups although throughout this reporting period (2014/15) numbers have stabilised and there seems to be to a trend which indicates there may be an end to the rapid increase seen in previous years.



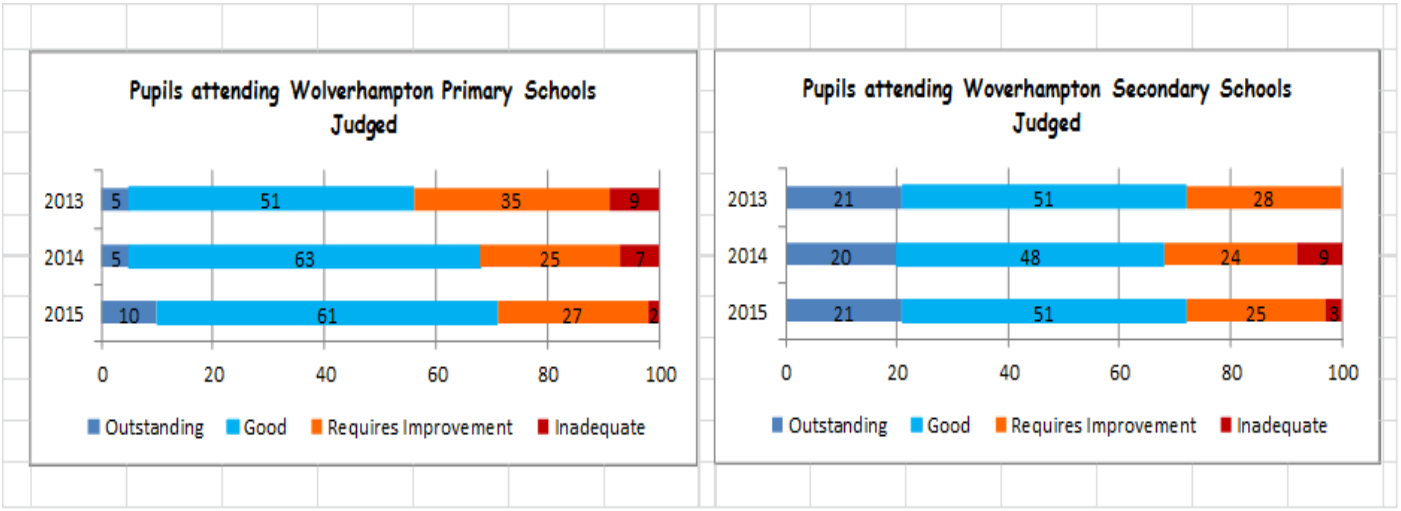
The graph below demonstrates the breakdown of LAC placements in Wolverhampton.



Education in Wolverhampton:

- In Wolverhampton 61% of children at the end of reception year achieved a "good level of development" at the end of foundation Stage Profile assessments, compared to 56% in 2014 and 44% in 2013.

- Until recently Wolverhampton was one of only three local authorities nationally where fewer than 60% of primary-age pupils attend good or outstanding schools; a recent review of Ofsted judgements has demonstrated an improved performance in this area with 71% of pupils (as at 31/03/2015) attending schools judged by OFSTED as good or outstanding. 72% of secondary-age pupils are attending schools judged by Ofsted to be good or outstanding (as at 31/03/2015) compared to 68% in 2014.



Healthy Related Behaviour Survey

What does children and young people tell us about live in Wolverhampton?

Based on a pupil lifestyle consultation exercise carried out with children and young people aged 5 – 15; ("Health Related Behaviour Survey- HRBS), children in Wolverhampton told us the following:-

In relation to Personal Safety;

- 81% of KS2 pupils said that they 'always' or 'often' feel safe during school playtimes/dinner times. 78% said they feel happy during these periods.
- 66% of secondary pupils said that their safety going to and from school was 'good' or 'very good'. 34% said that their safety going out after dark was 'good' or 'very good'.

About Internet Safety:-

- 90% of KS2 pupils had been taught how to stay safe online.
- 36% of KS2 pupils reported using social networking sites – the top reasons were for posting messages (72%), gaming (69%) and posting pictures (52%).

- 83% of secondary pupils report using social networking sites and 15% report talking to people they do not know.
- 19% of KS2 pupils had received something online that made them feel worried or upset.
- 9% of KS2 pupils said they had been bullied online, this increased to 11% in the secondary sample.

Concerns about Bullying

- 28% of KS2 pupils had been bullied at or near school in the last 12 months, of these 40% had been bullied in the last month.
- 21% of secondary pupils had been bullied at or near school in the last 12 months.
- 12 % secondary pupils had been bullied in the last month.
- 75% of KS2 said that there school deals with bullying 'quite' or 'very well', this reduced to 51% of pupils in the secondary sample.

What we were told about Abusive Relationships

- 27% of secondary pupils reported negative relationship behaviour with a current or previous partner.
- 23% of year 10s reported that they were or had been in a relationship with someone who was angry or jealous when they wanted to spend time with friends. 16% reported having their phone checked. 14% reported that a partner had used threatening language towards them. 6% had been hit by a partner.
- 20% of pupils reported shouting and arguing at home in the last month.
- 5% of secondary pupils reported physical violence.
  To view the full report, please follow the link:
  http://wolvesnet/citypeople/councilnews/2014/september+2014/260914b.htm

Private Fostering Arrangements in Wolverhampton.

Private fostering happens when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts (whether of full blood, half blood or marriage/affinity).

The Children (Private Arrangements for Fostering) Regulations 2005 sets out the legal responsibilities placed upon Local Authorities to assess and support Private Fostering arrangements. These Regulations are underpinned by the National Minimum Standards for Private Fostering (2005).

During 2014/15, the number of privately fostered carers' notifications has been very small, although it is believed there are likely to be more unknown Private Fostering arrangements. Wolverhampton seems also to be in line with other comparator local authority in how it approaches this matter. The comparator Local Authorities who have been approached for information have similar numbers of private fostering arrangements that they identify and approve.

Over the last year, five cases were brought to the attention of the Local Authority, of these; four met the criteria for private fostering assessments, which have all been completed. From these, three went on to private fostering arrangement, the fourth did not commence.

Private Fostering Activity 2014/15

	Age on 31/03/2014
1	11
2	11
3	12
4	7
5	2

- All 4 cases had action under Regulations 4(1) and 7(1) taken and completed within 7 working days
- 75% (3 / 4) had all visits completed at 6 week intervals or less
- All four children are British (Three are White British and one is Mixed – White / Asian)

There are 2 Private Fostering arrangements currently in place

Allegations against Professionals Activity for 2014 – 2015

The following detail relates to cases where it is alleged that a person **who works with** children under 18 years of age has:

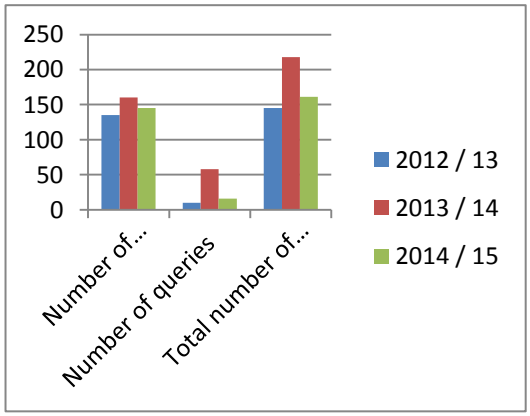
a. behaved in a way that has harmed a child, or may have harmed a child;

b. possibly committed a criminal offence against or related to a child; or

c. behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children.

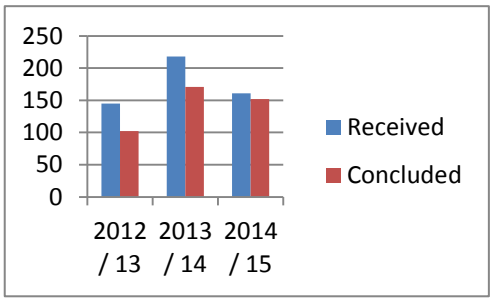
Number received over 3 years

	No of allegations	Number of queries	Total No of referrals
2012 / 13	135	10	145
2013 / 14	160	58	218
2014 / 15	145	16	161



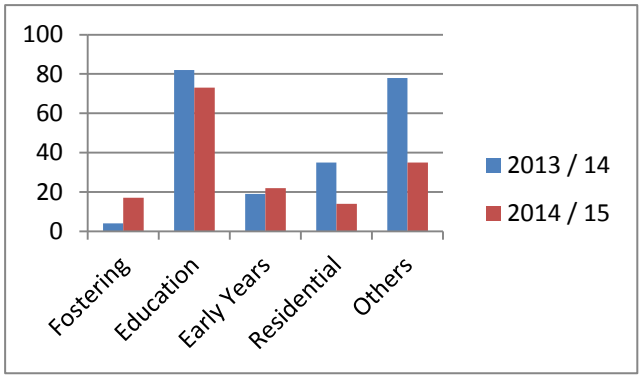
Number concluded compared to previous

	Received	Concluded
2012 / 13	145	102
2013 / 14	218	171
2014 / 15	161	152



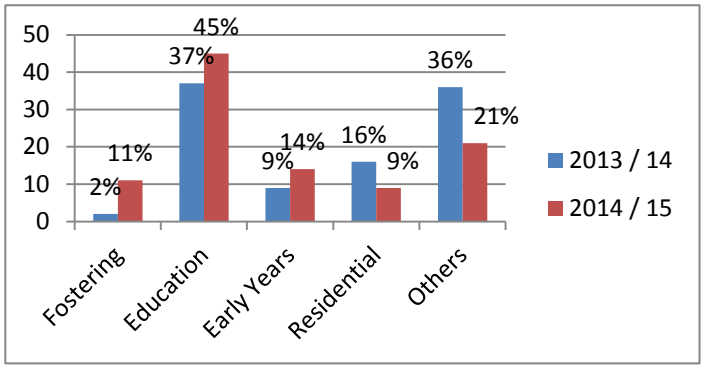
Received by service area of concern

	Fostering	Education	Early Years
2013 / 14	4	82	19
2014 / 15	17	73	22
	Residential	Others	
2013/14	35	78	
2014/15	14	35	



% received by service area of concern

	Fostering	Education	Early Years
2013/ 14	2	37	9
2014 / 15	11	45	14
	Residential	Others	
2013/14	16	36	
2014/15	9	21	



What the information tells us about managing allegations in the City:-

1. The total number of referrals received for the year has gone down by 27% compared to last year but has shown an increase of 11% compared to 2012 / 13.
2. The number of referrals concluded for 2014 / 15 was higher than those received. This reflects the higher than usual number of referrals received in the previous year and that were unresolved at the year end.
3. Referrals are categorised in to the service areas to which the concern relates, using the highest figure areas for 2014 / 15 and compared those service areas to the previous year. This clearly shows that there has been a large increase in concerns regarding fostering and a decrease in those regarding residential services. Education concerns have shown a decrease in numbers but an increase as a percentage. The 'others' category is the combination of other service areas, many of which were single referrals.

In addition, 37 of the referrals required Position of Trust (POT) meetings with 4 of these needing more than 1 POT.

The Wolverhampton Safeguarding Children Board - Statutory and Legal Context

The Wolverhampton Safeguarding Children Board (WSCB) is the key statutory mechanism for agreeing how the relevant organisations in Wolverhampton will co-operate and work together to safeguard and promote the welfare of children and for ensuring that this work is effective.
WSCB was established in May 2006 in compliance with The Children Act 2004 (Section 13) and The Local Safeguarding Children Boards Regulations 2006. The work of WSCB during 2014-15 was governed by the statutory guidance in Working Together to Safeguard Children 2013, which sets out how organisations and individuals should work together to safeguard and promote the welfare of children, and the Local Safeguarding Children Board Regulations 2006 which sets out the functions of Local Safeguarding Children Boards.

Wolverhampton City Council is responsible for establishing a Local Safeguarding Children Board (LSCB) in their area and for ensuring that it is run effectively.
The responsibility to the effectiveness of the Board rests with the Managing Director of Wolverhampton City Council.

The key objective of WSCB:

To co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Wolverhampton

We aim to do this in the following two ways:

1. To coordinate local work by:
    - Developing and maintaining policies and procedures
    - Participating in the planning of services for children young people and families
    - Communicate the need to safeguard and promote the welfare of children
2. To ensure the effectiveness of that work by:
    - Monitoring what is done by partner agencies to safeguard and promote the welfare of children
    - Undertaking Serious Case Reviews and other Multi-agency case audits to ensure that there is culture of continuous learning from practice.
    - Collecting and analysing data from Child Deaths
      Publishing an annual report on the effectiveness of local safeguarding arrangements.

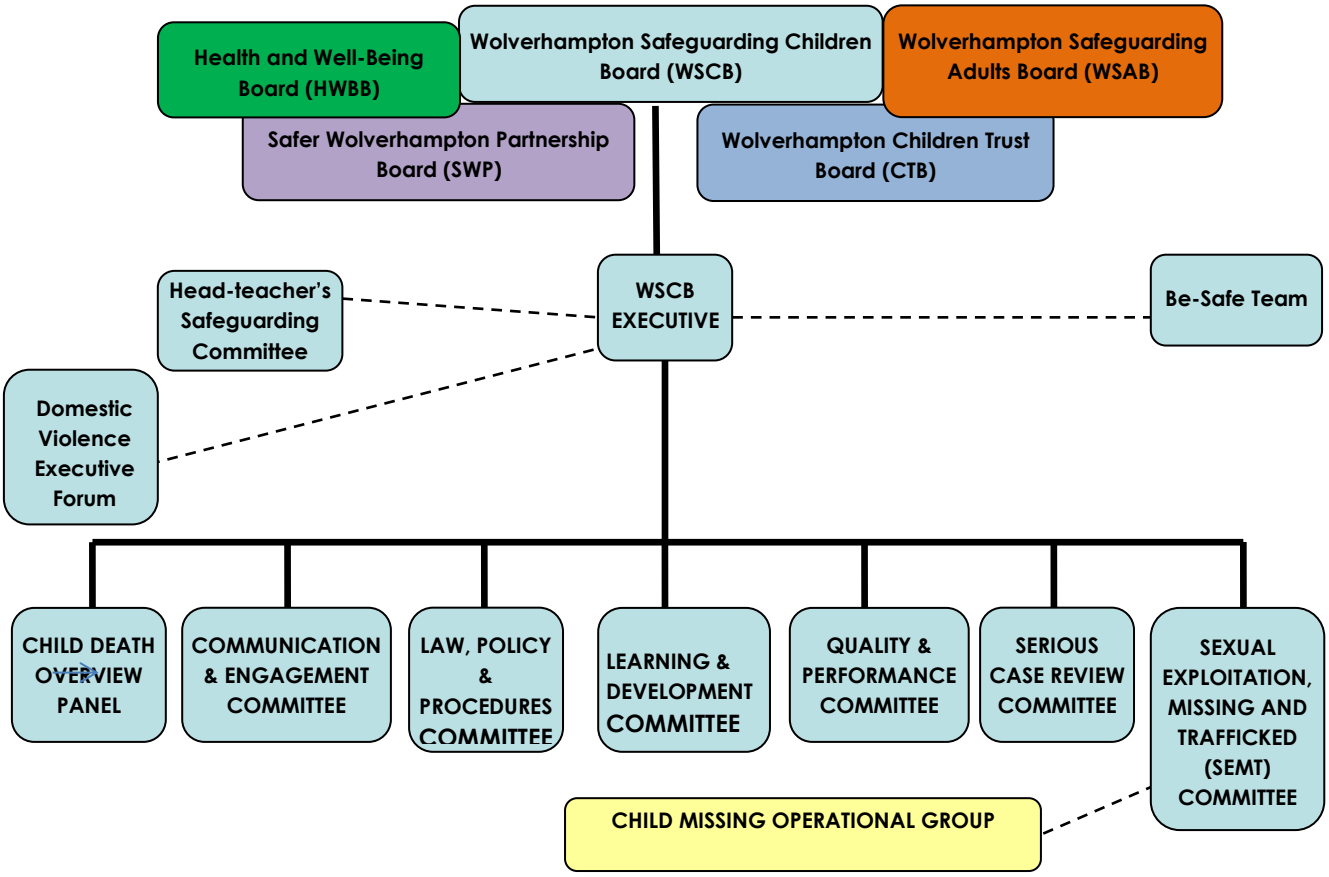
The Board is led by an Independent Chair, ensuring a continued independent voice for the Board. WSCB continues to be chaired by Alan Coe, who was appointed in February 2013. From April 2013, in line with Working Together 2013, the Independent Chair became accountable to the Chief Officer of the City Council
The Chair also works closely with the Strategic Director, People in addressing local safeguarding challenges.

Relationships between WSCB and other Strategic/Partnership Boards

The Health and Wellbeing Board (H&WBB) was established in Wolverhampton during 2013. It brings together leaders from the across the City Council, NHS and District and Borough Councils to develop a shared understanding of local needs, priorities and service developments.

All partner agencies in Wolverhampton are committed to ensuring the effective functioning of WSCB. This is supported by a constitution which sets out the governance and accountability arrangements. Members of the Board are expected to hold a strategic role within their organisation and be able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

WSCB Structure



The above chart offers the Board structure and provides in headline form the main areas of our activity. It works in alliance with other partnership boards and the structure WSCB has formulated to deliver its functions

The Board meets on a quarterly basis and has a membership made up of representatives from all statutory partners and others concerned with safeguarding children and young people.

Who makes up the WSCB?

Membership of WSCB is in compliance with section 13(3) of the Children Act 2004 which was further updated in Working Together to Safeguard Children 2013. The following organisations are required to cooperate with the local authority in the establishment and operation of the Board and have shared responsibility for the effective discharge of its functions:

- Wolverhampton City Council (incorporating children's services; adult services, the Youth Offending Team, Education and Public Health responsibilities)
- Public Protection Unit, West Midlands Police
- Local Policing: West Midlands Police
- Staffordshire and West Midlands Probation Service
- Wolverhampton Clinical Commissioning Groups
- Royal Wolverhampton NHS Trust
- Black Country Partnership Foundation Trust (BCPFT)
- NHS England
- CAFCASS
- Local school representation from: primary, secondary, special and independent schools.
- City of Wolverhampton College
- 1 Community Lay Member
- In addition to those members above as stipulated by legislation, the following organisations have also been invited to become members:
- Wolverhampton Council of Voluntary Sector (YOW is the named representative for the services providing safeguarding supports to children and young people affiliated to the voluntary sector)
- West Midlands Ambulance Service
- West Midlands Fire and Rescue Service
- The Board also have a number of standing Subject Matter Expert, who provide professional advice to the Board from the following areas:
    - Local Authority; Head of Safeguarding; Adults & Children
    - Designated Doctor for Safeguarding
    - Designated Nurse for Safeguarding
    - Wolverhampton Domestic Violence Forum
    - Safer Wolverhampton Partnership
- The Local Authority's Cabinet Member for Children and Families also attends the Board as a participating observer.

Attendance

The Board experiences good attendance from its members with representation across Board partners, lay member, voluntary sector and the involvement of other agencies and groups. Board attendance and further details of membership is outlined in appendix 1.

Contributions made to WSCB

The Board is funded by contributions from a number of partner agencies – both cash and 'in kind'. The majority of the money comes from the Council, The NHS and the Police. In the past year there was a small surplus but longer term we are predicted to have a deficit. This means we shall not be able to do all that we wish to or we find additional resources.
The full details of the income and expenditure for 2014/15 is detailed in appendix 2.

Apportioning the strategic work of WSCB

- The Board has overall responsibility for scrutinising and challenging the quality of safeguarding work by local agencies so that practice continuously improves. It does this in two ways:

- by co-ordinating the safeguarding activity of all partners; and
- for ensuring that safeguarding work is consistent, of a high quality, and effective.

As defined in *Working Together to Safeguard Children (2013), the Board has the following* co-ordinating and monitoring role:

- monitoring how effectively organisations are fulfilling their duties under Section 11 of the Children Act 2004 to safeguard and promote children's welfare, including safe recruitment practices
- promoting better understanding of children's safeguarding issues in the wider local community
- setting up and running a programme of inter-agency safeguarding training
- developing and reviewing inter-agency policies and procedures to safeguard children
- carrying out Serious Case Reviews
- taking an overview of all child deaths (under 18) in the area and identifying any potentially contributory recurrent factors, limitations or limitations in services provided by one or more agencies.

The above functions are delivered through the combined support of a range of Committees made up of nominated representatives or members of the Board. The agreed Priorities are led and monitored by members of an Executive Group made of appointed senior representatives of the main Board.

The Executive Group is chaired by the Board's Independent Chair; with the Vice being the Local Authority's Strategic Director, People and demonstrates the city's commitment to keeping children safe. Together they ensure that the focus and momentum afforded to this area of business remains undiluted and there is a strategic lead for WSCB in line with national, regional and local objectives. The role of the Executive is to determine the Boards Business Plan, with some members leading on a specific area of the Boards four Themed Priorities; and to ensure there are links with other strategic groups, including the Health and Wellbeing, Safeguarding Adults, Children's Trust, and Safer Wolverhampton Partnership Boards. The Executive monitors performance against the Business Plan, resources, and determines key issues requiring executive action by partners.

The Strategic Objective and Business themes for 2014 – 16 are as follows:-

	PRIORITY AREA	PRIORITY LEAD	ACTIVITY
1	**EFFECTIVE GOVERNANCE**	**E. Bennett** Service Director: Children and Young People	We will develop the capacity of WSCB and its infrastructure to effectively deliver the core functions of the Board to help keep children and young people in Wolverhampton safe.
2	**FRONT-LINE DELIVERY AND THE IMPACT OF SAFEGUARDING**	**M. GARCHA** CCG EXECUTIVE LEAD NURSE	We will develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding and promoting the welfare of children & young people; and will hold partners to account.
3	**SAFEGUARDING FOR PARTICULAR VULNERABLE CHILDREN & YOUNG PEOPLE**	**M. KERR** WMP: DCI - PPU	We will ensure that everything we do promotes improved practice to help safeguard and meet the needs of those children and young people who are particularly vulnerable, or are at increased risk of harm and improves outcomes for them.
4	**COMMUNICATE & ENGAGE**	**S.DODD** PROJECT COORDINATOR - YOW	We will ensure that we engage children, young people, families and communities of all backgrounds and make up, in the work of WSCB.

The combined work of WSCB is shaped from the WSCB Business Plan and the delivery against each area is deployed by its Committees, and/or Task & Finish Groups.

PROGRESS MADE AGAINST THE WSCB PRIORITIES DURING 2014-2015

PRIORITY AREA 1: Business Lead: Emma Bennett: Service Director: Children and Young People
EFFECTIVE GOVERNANCE We will develop the capacity of WSCB and its infrastructure to effectively deliver the core functions of the Board to help keep children and young people in Wolverhampton safe.

The Development of WSCB

To enable the Board to drive forward the comprehensive safeguarding agenda and be a strong and effective, the Board sees the continual development of its governance arrangements as one of the key priorities; this is led by a priority lead, Emma Bennett.

Over the reporting period the governance lead has continued to extend and strengthen the activity around governance in the following ways:

- Regularly monitored the appropriateness of representation of WSCB membership and attendance of partners at WSCB meetings and Committees to effectively deliver against the agreed business work-streams.
- Ensured WSCB presence at the appropriate level on all partnership/strategic Boards including the Health and Wellbeing Board (HWWB) and Safer Wolverhampton Partnership (SWP), Children's Trust Board (CTB), Domestic Violence Executive and the Safeguarding Adults Board (WSAB).

- Created a 'joint' working protocol between the WSCB, and a number of other local strategic partnership boards including; WSAB, SWP, HWWB and the CTB.
- Established a Head-teachers Safeguarding Committee to drive forward and strengthen communication in relation to keeping children safe across all educational establishments.
- Overseen the induction and mentoring of the Lay advisor in the first year in role.
- Formed of a task and finish group to review the discrete support to the Board. This has led to the agreement to increase the operational business support to the Board with an increase in staffing going forward in to 2015/16. This will be reviewed on an annual basis; with continuation dependent of contributions from board partners.
- Lead on the WSCB development Day
- Strengthened the attention afforded to, and oversee the Boards Risk Register
- Managed the actions arising from Executive Committee work plan
- Overseen the review of the Independent Chair's performance.
- Improve understanding of the local arrangements and service provision relating to all age disabilities.

Work in Progress going ahead in to 2015/16

At present WSCB has only one lay member who has continued to support stronger public engagement in local safeguarding children issues as he contributes to an improved understanding of the role and work of the Board within the wider community. He is a member of the Communication and Engagement committee as an additional strand to the task of actively challenging the Board on the accessibility, clarity and transparency of its plans, priorities and achieved outcomes to children and the public. The Board is seeking to recruit a further lay advisor to the board.

In compliance with Working Together to Safeguarding Children (2013), the Board has produced a Quality Assurance Framework which is currently out for consultation. This will need to be implemented throughout the coming year to assist the Board in understanding how agencies are monitoring and quality assuring the effectiveness of partner agencies safeguarding activity; including the WSCB priorities. The framework includes a multi-agency data set which reflects national indicators, local needs and WSCB priorities.

We have a Safeguarding Children in Education audit process which is distributed to all schools. We had a 100% response rate, a substantial improvement. This audit helps schools and colleges raise safeguarding children and will also include assessing the compliance of schools with safer recruitment standards. It will be used to identify targeted areas of activity for the Board and its partners to strengthen safeguarding arrangements in educational establishments. During the year ahead, the same model and process will be extended to include City of Wolverhampton College, private and independent schools and other educational providers.
Understanding and learning from practitioners is integral to the work of the Board; practitioner views are captured during training events and they are actively engaged in review learning, audit activity, communication campaigns and procedure development. This helps our partnership to identify good practice and understand frontline barriers to local safeguarding children practice. Further development is underway to capture the views of practitioners across the multi-agency workforce via a staged evaluation model to be implemented 2015-2016.

Activities for 2015/16

- Monitor the effectiveness of Early Help services and support
- Align the Board priorities to the children and young people plan
- Establish a seamless process to refer information, task request and concerns between the Board, its committees and other partnership/strategic boards
- Create a process for agencies/ front-line staff, children, young people parents and carers to refer concerns
- Review WSCB members involvement and contribution to the Board
- Review and update the Boards constitution.
- Implement an Induction programme for all new board/committee members.

A word from our Community Lay Advisor; David Perrin

"It is pleasing to see the continuous improving momentum from WSCB in the safeguarding of our children across the city. I must however hasten to add, we still have a way to go.

As a Lay Advisor my primary aim is to see every single member of the Wolverhampton community understand what safeguarding is; and believe in its principles. The Communication and Engagement Committee are vigorously working towards this end, but it must be seen as an objective for all board members and not solely the responsibility of this committee. This in turn will encourage individuals we all come into contact with to share the message with the same level of interest and application.

One of the objectives of the lay member is to raise the public profile of the Board and its work – I am actively doing this, although I think that for many, it can be difficult to take messages beyond the spheres of influence and activities.

I can see the achievements and developments of the Board in this my first year in post- I just wish that I felt more confident that the messages coming from the Board and its committee are really getting to the frontline and impacting as they should on the dedicated professionals who do their best for the young people of Wolverhampton. This remains a challenge for the Board in the year ahead.

Going forward I'd like to meet individually with the board members I've not yet met with a view of how we can better meet safeguarding needs across the city.

In closing I must applaud those individuals I have been mentored by and have worked closely with; the Independent Chair, Board Manager, Learning & Development Committee Chair and the Communication and Engagement Chair, whom have most definitely led by example in their respective areas".

Dave Perrin
WSCB Lay Advisor

What were the key achievements from the WSCB Committees against the 2014/15 Key Priorities?

PRIORITY AREA 2: Business Lead: Manjeet GARCHA; EXECUTIVE LEAD NURSE; Wolverhampton CCG
FRONT-LINE DELIVERY AND THE IMPACT OF SAFEGUARDING **We will develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding and promoting the welfare of children & young people; and will hold partners to account.**

Review of Child Deaths

In line with Chapter 5 of Working Together (2013), The Child Death Overview Panel (CDOP) is a joint statutory group for Walsall & Wolverhampton Safeguarding Children Boards. This is a cross-authority panel which consists of representatives from both Walsall and Wolverhampton Safeguarding Children Boards. This group has the responsibility for reviewing all deaths of children in both Walsall and Wolverhampton. The panel is chaired by the Executive Director Nursing & Quality, Wolverhampton Clinical Commissioning Group and its work is supported by Designated Doctors for Unexpected Death, nurse practitioners, a child death coordinator, partner representatives (including from Public Health); and the Board Managers for both WSCB local areas.

The overall purpose of the child death review process is to understand why some children die and, wherever possible, put in place interventions to protect other children and to prevent future deaths. Between 1 April 2014 and 31 March 2015 CDOP activity was as follows:-

- CDOP met 4 times in 14/15
- Reviewed 22 deaths
- 19 reviewed within the year and 3 from 13/14
- 2 with modifiable factors for 13/14 and 2 for 14/15
- 13 were male, 9 were female
- 16/22 deaths were in babies aged 0-27 days
- Zero children had child protection plans
- Zero children had statutory orders
- Ethnicities; 15 white, 0 mixed, 3 asian, 3 black carribean and 1 others
- Zero known to be asylum seekers
- Place of death; 3 emergency department, 4 NNU,7 paediatric ICU, 5 delivery ward and 2 home

The number of deaths of children normally resident in Wolverhampton reported to CDOP in 2014/2015 was the lowest number since CDOP was established in Wolverhampton since 2008. Nationally there has been a reduction also in the number of child deaths.

Achievements for 2014/15- a selection of initiatives joint with various stakeholders have been undertaken to address the wider child death issue. Whilst there will be learning from all, the

most significant initiative is the wider city multi agency steering group to address infant mortality which is multi-facetted from pre conception to post delivery.

Promotional activity 2014/15 included

- Safer sleeping
- Family nurse practitioners
- Setting up of multi-agency infant mortality steering group and agreed action plan to address infant mortality in Wolverhampton
- Stop smoking campaigns
- Review of all deaths that met the criteria within the timescales
- Learning from modifiable outcomes and share

Priorities for 2015/16
A continuing focus for the Panel is reviewing the CDOP system and processes, including how agencies can better support staff in being aware of the Rapid Response procedures and in implementing them. This will build on the training already offered, an updated guide to the process and from learning from other CDOPs.

Serious Case Reviews

A 'serious case' is one where:

- abuse or neglect of a child is known or suspected; and either –
  - the child has died; or
  - the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Local Safeguarding Children Boards must always undertake a review of these cases. These reviews are called Serious Case Reviews (SCRs).
The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

The Serious Case Review Committee (SCRC) on behalf of the Board is responsible for coordinating serious case reviews and learning reviews and for monitoring the implementation and effectiveness of all of the reviews action plans. The SCRC members act as independent panel members for serious case reviews where their agency is not directly involved with the case. The Committee is chaired by the Designated Dr for Child Death, who is also a Consultant Paediatrician for Royal Wolverhampton Trust (RWT); NHS. The group currently meets six times a year. Progress on the actions arising from serious case reviews (SCRs) and learning reviews are monitored by the SCRC. Progress and exception reports on the actions are presented to the Executive Group on a bi-monthly basis and to the WSCB on a quarterly basis as required.

During 2014-15, 9 cases were brought to the attention of the SCRC. These cases were purely Wolverhampton children. Of the 9 that have been considered by the SCRC, one met the criteria for a serious case review, which has been commissioned, one case review was undertaken by a single agency process within the Youth Offending Team (YOT), 4 are being

investigated further through the committee, and the remaining 3 did not fit within the criteria or remit of work for the SCRC, and have subsequently been forwarded to the relevant service area with advice and guidance for action.

WSCB takes seriously its responsibilities to ensure that lessons learned from serious case reviews are used to shape and improve practice and that learning is disseminated and embedded to support improvements across all partner agencies, with much emphasis on the importance of communicating, Information sharing, reporting concerns in a timely manner and on recording information. These areas are not unique to the findings of local SCR's however, they are regular recommendations threading through most SCR's. This is something that Wolverhampton are keen to improve and will monitor progression going forward, to ensure that intervention pertaining to safeguarding concerns are identified and acted upon at the right time. For 2014-15, the WSCB has included the learning from SCR's, in to its multi-agency training programme, this includes the lessons from local, regional and national SCR, to ensure the key learning s are widely shared. This will in turn enable services to be more responsive to safeguarding concerns and reinforce the message of safeguarding being everybody's responsibility.

Looking forward brief overview of work anticipated for 2015/16

We shall be publishing the findings from the SCR commissioned in 2014 in the coming year. The delay in publication is due to pending court proceedings. But we do not wait to act. In the meantime, the committee has ensured that actions from this SCR are being implemented across all the relevant partner agencies across the city.
This committee will also:

- Ensure that messages from regional and national SCR's and associated research appropriately shared to a wide audience and by way of various methods.
- Continue to scrutinise incidents which do not meet the threshold for the commissioning of a full SCR, but where there are clearly lessons for learning; in these cases, the committee will explore, identify and apply a model to conduct case reviews.
- Organise a development day in addition to the bi-monthly meetings, to evaluate progress against the board business plan and to schedule the activities going forward in to 2015/16 and beyond.

WSCB Quality & Performance Function:

The quality & performance functions of the Board spans across all priority areas, and is a key focus for the Executive Group

We collect data and performance information to tell us how well we are safeguarding children and to pinpoint where to take action if the information tells us there are problems. Through the Quality & Performance Committee (Q&PC) the Board ensures there is a clear focus on ensuring there are processes in place to improve the way the Board captures; coordinates and helps ensure the effectiveness of local safeguarding children arrangements. In response to the Department for Education's Children's Safeguarding Performance Information Framework, the Board has developed its Multi-Agency Performance Scorecard to support some of this function.
This dataset, coordinated via the Council's Business Intelligence Team, contains a number of key performance indicators covering a wide range of subject specific concerns across the broad areas of safeguarding, and child protection, activity including the provision of Early

Help. We have included new data to help us better understand how we identify how well schools and GP practices are fully-engaged in safeguarding. This has helped us get an improved response in the first instance and identify what we need to do to get this in the latter.
The WSCB Performance scorecard is under constant review and has been refreshed to reflect the requirements as outlined in Working Together 2013.

Within the remit of work for the Q&PC, is the management and oversight of the:

1. Section 11 (Children Act, 2004) audit
2. Themed/targeted Multi-agency case file audits (MACFA);

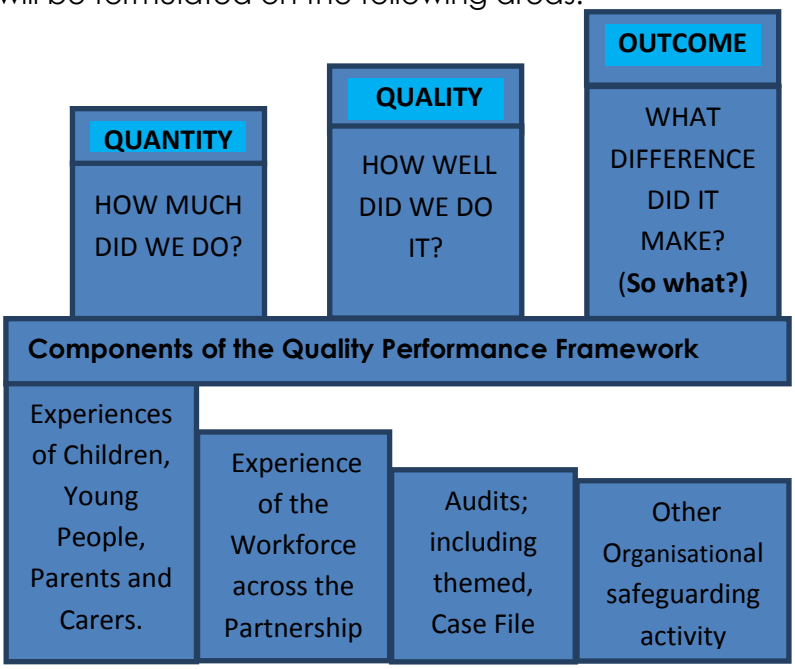
The s.11 audit was issued for completion by WSCB partners in the autumn of 2014. The Board received a summary report in December 2014 and has charged the Q&PC to further scrutinise the findings from the audit and report back to the board during 2015 - 16. It is planned that themed audits based on challenges and areas for development identified within the S.11 will be take place during 2015. The Q&PC will also draw on the findings of the s11 audits for challenge and single agency improvement plans.

During 2014-2015 the Q&PC coordinated and contributed to three children's multi-agency audits. These were undertaken via a multi-agency panel consisting of frontline workers and strategic leads. The cases were all thematic and related to the Boards priorities of adolescent neglect, child sexual exploitation and missing. The aim of this audit activity was to understand the child's journey with services and for frontline staff to improve the depth of learning achieved through contributing their own knowledge and experience of working with the child and their family. WSCB audit templates were completed and a systems approach taken to identify key learning and recommendations for improvement. The lessons arising from MACFA is shared with frontline practitioners and managers via WSCB and internal agency communication pathways. This includes sharing the learning through the Communication and Engagement monthly Newsletters; on the WSCB website; and within the delivery of single and multi-agency training.

In addition to the two functions mentioned above, the Q&PC, under the auspices of the Board is in the process of agreeing a Quality and Performance Framework to join together all quality and performance activity as required via Working Together 2013. This model will present a new range of outcome indicators that the WSCB monitors and will use to target audit activity, including:-

- The views of children, parents and carers and practitioners
- Single Agency annual reports
- Learning from serious case reviews or learning reviews
- Learning from child death reviews
- Learning from Inspections or internal audits
- Single agency performance and quality assurance activity

The model will be formulated on the following areas:



As part of the WSCB quality assurance function, we audit practice focussing on different themes on a quarterly basis. A challenge in the coming year is to involve more front line practitioners, parents and young people in the audit process. Establishing a 'scrutiny calendar' will enable the WSCB to have in place an evidence based mechanism which allows Board members to hold each other to account for their agency's contribution to the safety and protection of children and young people. This process will continue to be developed and implemented further during 2015-16.

WSCB has undertaken the required 'Section 11' audit of safeguarding arrangements across its partnership during the autumn of 2014. A final report will be presented to the Board following an analysis of agency returns to ensure that appropriate actions are being taken where shortfalls have been identified.

Schools Self- Assessment of Safeguarding arrangement under the Education Act 2002 s.175 /157

An annual audit of schools safeguarding arrangements is undertaken and reported to the Board. The audit is sent to all Local Authority Maintained Schools and Academies, The purpose of the audit is to enable establishments to:

- Assess schools safeguarding practice, identify strengths and highlight areas of development.
- Develop an action plan to address areas of development which can be reviewed on a regular basis in order to help safeguard pupils
- Have evidence of safeguarding practice available for any Ofsted inspection
- Provide statutory information to the Local Authority and WSCB.

Of the 106 educational establishments sent the audit this year, 106 (100%) establishments provided a return. This is a significant increase on previous years when less than 10% of educational establishment responded to this request.
To develop this function further, there are a number of educational establishments that have not yet been included in the activity including, Post 16 Providers and Independent Schools, who will be involved in the next cohort of distributions.

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WSCB Learning & Development Activity

In 2014-15 WSCB Training programme supported our priorities. The demand for some courses throughout the year has meant providing extra events.
Through the Learning and Development Committee, there has been a consistent multi-agency workforce streamlined programme of training activities that:

- Is informed by the Board's Learning and Improvement Framework,
- Is relevant to core business and priorities of WSCB
- Is aligned to statutory guidance, best practice and lessons learnt through the full range of reviews and audits undertaken by WSCB.

This includes reminding the Board, Partner Organisations and Practitioners of their roles and responsibilities in terms of promoting a 'learning culture' in safeguarding children.
WSCB continues to encourage partner agencies to meet their responsibilities to ensure staff receive safeguarding training by providing a varied multi-agency training programme.

'Working Together 2013' requires that Boards' monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area.
We have recognised that further work is required by the Board and partner agencies to understand what difference training is making to frontline practice. This has led to the development of new ways of evaluating training that will identify pre and post course knowledge and skills, provide evidence of the impact of the training on individuals. This in turn will improve practice and outcomes for children, young people and families. In addition

there are plans underway to develop this further to ensure feedback from both facilitators and attendees to evaluate the delivery and engagement for each session.

The findings from the previous year's annual report for WSCB training identified a high non-attendance rate for a proportion of our courses. This has an effect on the numbers of places available, and ultimately numbers of individuals trained. This was also not cost effective. To address this we now charge for non-attendance at training sessions to improve attendance rates and recoup money when people still do not come.

Highlight and feedback on WSCB training:

The provision of Safer Recruitment training, including a recently devised refresher course remains popular. WSCB has a responsibility to ensure safer recruitment practices are embedded. New guidance; 'Keeping Children Safe in Education' will lead to some updating of course material. We provide 8 events per year which are opened up to the entire workforce, both adults and children's.
The demand for the 'Working Practices; Roles and Responsibilities training was in high demand with positive feedback. It will be necessary to increase the number of courses going forward in to 2015/16.

Trafficking- Jan 2015

"Useful afternoon for gaining some insight into Trafficking
A lot of useful resources
Enjoyed training- opened eyes into what can happen if professionals do not report

DA and the impact on Families- Dec 2014

"Very good day, sensitive issue dealt with appropriately
I found the training very interesting, lots of experience in the room from different agencies.
Great to share good practice
Good delivery of training – relaxed , informative and friendly

Impact of WSCB Training

Attendees provide evidence of the impact of the training both on their practice and on children and families. It shows that the majority of attendees reported:

- increased confidence,
- improved skills
- much better informed on the knowledge base of each course;
- understood what this means for them in practice, and
- more confident that they would be better able to keep children and young people safe as a result.

Working Practices roles and Responsibilities- Nov 2014

"Very Helpful regarding personal situation and how I can now deal with my concerns"

Safeguarding Children and Young People From Self Harm- Mar 2015

"A very interesting and thought provoking training session

Joint WSCB and WSAB Annual Conference – FORCED MARRIAGE AND HONOUR BASED VIOLENCE

On 4th June 2014 a joint conference - "Forced Marriage and Honour Based Violence was held in conjunction with Wolverhampton Safeguarding Adults Board, the event was to highlight our joint safeguarding priorities and to improve the awareness of this hidden underreported issue which is of concern for both Boards. The conference attracted 126 delegates who were informed by local and national subject matter experts, including, Karma Nivarna, a national subject relation recognised charity and Home Office subject area Lead.

Going forward in to 2015/16

The Learning and Development Committee has contributed to the development of, and will lead on the implementation of the WSCB's Learning and improvement Framework. This will amalgamate and drive forward a suite of learning and development opportunities in a range of approaches to cover all aspects of the Boards work and will coordinate the dissemination of learning and messages from all WSCB Committees.

WSCB will also be exploring the implementation of a single agency training endorsement and validation scheme as a means of WSCB fulfilling its responsibilities for quality assuring training in keeping with 'Working Together 2013'.

Safeguarding Children – A Shared Responsibility- Mar 2015

"Delegates found the strategy discussion activity useful- raised awareness of decision making."

Contributing to Child Protection Case Conferences-Dec 2014

"Excellent Training, Excellent Trainer, incredibly knowledgeable and approachable when asked questions"

"Maggie is brilliant; this training needs to happen for all staff"

Developing and Maintaining Policies and Procedures

All inter-agency policies and procedures, training materials, communications and relevant documentation have been revised in line with Working Together 2013 including other national, regional or local guidance, research or learning. This includes a local threshold to support model for assessment. The 'child social work assessment' sets out clear arrangements for how cases will be managed once a child is referred to Children's Social Care (CSC) services.

The Law, Policy and Procedures Committee (LPPC) continue to develop multi-agency policies and procedures together to help to promote shared clarity and improve consistency of practice for agencies and their practitioners across the city. The most recent examples include the development of the Forced Marriage Protocol which has been recognised as the first for the region

The LPPC has been working with our IT providers to ensure the multi-agency child protection procedures and guidance can be linked via a website http://wolverhamptonscb.proceduresonline.com/

During 2014-2015 the website was redesigned in order to improve the content and accessibility of the site; there this will be further upgrades to this area during 2014-2015.

To support the Board in ensuring that safeguarding practice keeps abreast of new developments, during 2014-2015 the LPPC have reviewed, revised, devised and published policies, procedures and practice guidance in relation to:

- Children missing from home and care,
- Self Harm Protocol,
- Sexual Exploitation, Missing and Trafficked (SEMT) strategic process, Child Sexual Exploitation induction programme, Multi agency sexual exploitation (MASE) meetings; and Child Missing Operational Group (CMOG) processes.
- Unborn Baby pathway for intervention
- Supporting Children and young people vulnerable to violent extremism strategy
- Cross Border Child Protection guidance under 'Hague Convention
- Safeguards for children who may be affected by gang activity
- Threshold for support practice guidance
- Escalation Policy; and
- Information Sharing Agreement which all member agencies have now endorsed has been developed to strengthen communication between the WSCB partners

Going forward, the LPPC will:

- ❖ Continue to scrutinise and localise all Board policy and procedural guidance to increase the support of local practice
- ❖ Maintain a close eye on new ways of working alongside the introduction of 'early help' support services and the associated operating model, and ensure practice guidance, policies, procedures and protocols are revised accordingly.
- ❖ Liaise with other WSCB committees and partnership boards to ensure regular briefings and updates of new policies are widely circulated across all agencies
- ❖ To provide launch events to ensure key practice related messages involving changes in delivery are shared
- ❖ To ensure all updated policies are transferred to the Learning and Development Committee to be included in training, to ensure implementation.
- ❖ The committee has set a work-plan with timescales to review amend and/or devise policies and procedures covering the following subject areas: Children on the edge of Care, Teenage Suicide, Stateless Children, children of Detained Parents, Female Genital Mutilation; and to closely monitor and updates in relation to areas of concerns; i.e., children at risk of child sexual exploitation, practice and arrangement for Children with Disabilities, and pre-birth assessments.

PRIORITY AREA 3, Business Lead; Michaela Kerr; Detective Chief Inspector – West Midlands Police PPU
SAFEGUARDING FOR PARTICULAR VULNERABLE CHILDREN & YOUNG PEOPLE **We will ensure that everything we do promotes improved practice to help safeguard and meet the needs of those children and young people who are particularly vulnerable, or are at increased risk of harm and improves outcomes for them.**

Safeguards for Vulnerable Children and Young People; Sexual Exploited, Missing and Trafficked (SEMT) Committee

The WSCB SEMT Committee is a multi-agency partnership with a remit and duty to safeguard children and young people who may be at increased vulnerability from sexual exploitation, missing episodes and trafficking in accordance with the policies, procedures and guidance outlined in local and national guidance and that of WSCB.

SEMT Committee has been tasked with ensuring that children who are victims of Sexual Exploitation and are at risk of exploitation have their needs addressed and are effectively protected.

The group has sought to develop an improved understanding of the situation relating to Child Sexual Exploitation within Wolverhampton, and across the region. The establishment of SEMT, chaired by a senior police officer ensures information is appropriately shared regarding potential offenders and victims of particular vulnerable groups, and an effective action plan developed to protect the potential or actual victim from further harm.

The principles of SEMT which underpin our work include:

- Integrated working (e.g. co-location) – Close collaboration in multi-agency working is essential in developing 'real time' risk assessments to enhance decision making. A truly integrated approach helps to break down cultural barriers, leading to greater understanding and mutual respect among different agencies.
- Joint risk assessments – these ensure clear and sufficient information about particular cases and joint plans for individual interventions.
- A victim focused approach – the needs of the victim must be at the forefront of our approach not systems and processes.
- Good leadership & clear governance – strong leadership can often bind different organisations together to develop a shared culture.
- Frequent review of operations – to continue to drive improvement of service.

Our delivery plan for 2014/15 was built on good practice and local guidance including :-

- The West Midlands Regional framework for CSE
- Working Together to Safeguard Children (DfE 2013)
- Sexual Exploitation of Children: It Couldn't Happen Here, Could It?
- A thematic report by Ofsted, November 2014

- *See Me: Hear Me* (OCC 2013), Safeguarding Children and Young People from Sexual Exploitation (DCSF, 2009),
- Tackling Child Sexual Exploitation Action Plan (DfE, 2011)
- *I thought I was the only one in the world:* The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, (OCC 2012); and
- The recommendations made by the Association of LSCB chairs (2013)

These have all been considered alongside the revised WSCB CSE Framework adopted across the 7 West Midlands Police Force areas to manage and better safeguard children and young people at risk of sexual exploitation. This has been implemented throughout 2014/15 and will continue in to 2015/16 to include Practice Guidance and Procedure.

Achievements for 2014/15

- We obtained funding for a Child Sexual Exploitation (CSE) Co-ordinator
- Introduced Multi Agency Sexual Exploitation meetings for every child identified as at risk of CSE
- Embedded Regional CSE framework fully in Wolverhampton
- Developed and published on WSCB website CSE Induction /Awareness pack for all professionals
- Completed CSE multi-agency audit in January 2015
- Developed and delivered a multi- agency CSE training course
- Identified and implemented screening tool for CSE victims; which means we can better understand who is or is likely to be at risk and act on this
- Reviewed national guidance, reports and inspections to benchmark and improve practice in Wolverhampton
- Ensured every child is invited to participate in the multi-agency discussion around their needs.
- By auditing case files established, there was clear evidence of positive responses to the thoughts, wishes and engagement of the child needs being, prioritised and responded to.

Plans for 2015/16

- The committee has set a work-plan with timescales to review the support and services for children and young people who maybe at increased risk due to disabilities, FGM and radicalisation.

PRIORITY AREA 4: Business Lead: Stephen Dodd; Project Coordinator –
Youth Opportunities Wolverhampton (YOW)

COMMUNICATE & ENGAGE

We will ensure that we engage children, young people, families and communities of all backgrounds and make up, in the work of WSCB.

Improving Communication and Engagement

The whole purpose of the Local Safeguarding Children's Board WSCB is to ensure that children in the local area are safeguarded at every point of service delivery. Having the right level of support at the right time; is critical if children to be able to achieve their full potential. Wolverhampton recognises the fact that if children are not safeguarded they will undoubtedly be healthy, be able to enjoy and achieve, be positive and enter adulthood successfully. As such, we have established a 'Young people's forum' known as 'Be-Safe Team, to ensure children views opinions and concerns are central in the planning and delivery of our work and is used to shape how we attend to the needs of children and families in the city.

Throughout 2014/15 the Be-safe team has focused its attention on formalising the group in the following ways:

Be Safe Objectives for 2014/15

- Recruit, train and establish a dedicated group of young people as the first B-Safe Junior Safeguarding Board.
- To facilitate regular meetings and activities for the new Team, to include a combination of awareness of key safeguarding issues, training and consultation.
- To create and maintain a dedicated web presence for the B-Safe Team, including the use of social media as a communication channel to raise awareness of the Team and its activities.
- To recruit a dedicated B-Safe Team coordinator to provide additional capacity for the Team within the wider HeadStart Team, reporting to the Peer Support Coordinator.
- To give priority to bullying and online safety, coinciding with the national awareness days.
- Supporting of additional opportunities for the B-Safe Team to attend and report to the Safeguarding Board and vice-versa.

The Communication and Engagement Committee (C&EC), has a dual function to support both the Children and Adults Safeguarding Boards to:

- Improve communication to the workforces of partner agencies
- Develop city-wide communication channels (websites, social media, press coverage, leaflets posters)

- Develop constructive and mutually respectful relationships with communities; making sure that equality and diversity is appropriately considered in all communication and engagement activity.
- Liaise and collaborate with WSCB and WSAB, relevant committees, partnership forums and service users in the above activities

The monthly newsletter continues to be widely distributed to front line practitioners and managers and this promotes the WSCB priorities, the learning from serious case or learning reviews or domestic homicide reviews, as well as key national and local news relating to the safeguarding of children. This communication approach is also supported via a range of short practitioner guides and briefing papers. Managers and practitioner feedback can evidence how useful this newsletter is in keeping frontline staff up to date with national and local learning.

Activities undertaken throughout 2014/15:

- Branding inc. logo agreed for 'Wolverhampton Safeguarding' following consultation with public
- Consultation on website carried out in Oct 2014
- Website scoped and brief agreed
- 1 x public engagement activity to raise awareness of safeguarding and consult about branding and information needs carried during half term in October 2014 – Wolverhampton's Safeguarding Week
- 4 x Campaigns for 2015-16 agreed – Prevent, CSE, Violence Against Women and Girls, What does good care look like?
- Identified channels of communication available to WSCB across WSCB partners
- Undertaken work to inform future campaigns / community engagement – e.g. vulnerability of disabled children (inc. those not registered disabled), need to raise awareness of private fostering
- Established with individual faith groups, Sikh Partnership Forum and Community Cohesion Forum.
- Created and started to implement a Faith group engagement plan developed with Inter Faith Wolverhampton
- Worked to establish a greater understanding of the range and nature of faith groups in the city. – key partners have shared information about faith groups.
- Workforce communication is now clearly agreed as the responsibility of C&E committee – with all WSCB committees responsible for identifying key messages / information to share

Evidence of the Voice/Contribution of Children and Young People

Working with younger people and by accessing the Healthy Related behaviour Survey (http://wolvesnet/citypeople/councilnews/2014/september+2014/260914b.htm), we identified priorities and actions including:-

- Joint work programme
- 2014/15 agreed with B-Safe Team linking with Communication &Engagement Committee's support for B-Safe team's chosen campaigns around:
  - ✓ Bullying (in run up to and during Anti-Bullying Week in Nov 2015
  - ✓ Internet Safety in and around Safer Internet Day Feb 2016

Data from Health Related Behaviour Survey (http://wolvesnet/citypeople/councilnews/2014/september+2014/260914b.htm), also has strong bearing on choice of these 2 campaigns

Work anticipated for 2015/16:

- Develop 2 x practitioner forums to formalise workforce feedback on safeguarding progress / lack of progress
- Commission, produce, launch and develop Wolverhampton Safeguarding website
- Plan, carry out and measure impact of 4 x campaigns inc. public engagement activity around: Prevent, CSE, Violence Against Women and Girls, and 'What does good care look like?'
- Undertake an additional workforce communication campaign to promote Information Sharing
- Identify capacity to collate a list of faith groups; ascertaining up to date contact details for as many as possible; and encouraging faith groups to register on Wolverhampton Information Network and with WVSC database to receive information and support. Build working relationships with faith groups from each of major faiths inc small, unaffiliated groups
- Explore external funding opportunities for a faith group engagement worker jointly with Inter Faith Wolverhampton
- Carry out a survey to better understand safeguarding arrangements in faith groups
- Hold a city-wide high profile event for faith groups to:
  - celebrate their contributions to the city
  - listen to their needs and suggestions
  - highlight their safeguarding responsibilities and offer support to meet these;
  - connect faith groups with support from WVSC and YOW and promotional opportunities presented by Wolverhampton Information Network
  - Support B-Safe Teams campaigns around Bullying and Internet Safety

Agencies Annual Contribution to the Safeguarding of Children and Young People 2014/15

Each agency with a link to the Board produces their own summary of what they have contributed individually. People wishing to find out more about any of them can find them in Appendix 4

Summary and final remarks

The WSCB has continued to develop multi-agency arrangements in order to improve the safeguarding of children and young people in Wolverhampton over the last twelve months. The Board throughout this report has illustrated effective multi-agency working and co-operation which can be evidenced in the way in which agencies work with each other to safeguard children.

The Board through its governance structures now collaborates with other partnership/strategic boards in the city on a number of different issues including Domestic Violence, CSE, Missing, Gang activity, self- harm processes and auditing, and is making steady progress in joining the adult and children agenda at relevant points.
Appropriate arrangements are in place to ensure that the Board complies with its statutory obligations and functions as outlined in Working Together 2013, and at the point of writing this report, the release of the 2015 Working Together guidance has been released and will further strengthen the role and functions of the Board going forward.

The Board has agreed its Learning and Improvement Framework which will be implemented to ensure that where best practice and lessons are learned, these are used to drive service improvements across agencies. This will be instrumental as we are waiting to publish the findings from a SCR commissioned during this period with delayed publications pending court proceeding. It is also likely that the Board will need to consider undertaking a further SCR, or an alternative learning review having recently received a request from DFE in regards to a case of neglect that has recently reached the public domain.

The Business Plan is approaching its third year and a great deal of progress has been made towards the delivery of the plan which concludes in March 2016. The Business Plan is used by each WSCB Committee and Task and Finish Groups to identify and shape the work plans and drive priorities at both a local and regional level and has influenced the development of the Children, Young People and Families' Plan. Information sharing is an area in which the Board is striving to develop. The Board has undertaken a number of actions in relation to child sexual exploitation and to ensure members are fully engaged in driving this agenda. Over the next twelve months, the Board will give consideration to how these activities can be developed and expanded to ensure risk to children as a result of abuse can be reduced.

Overall the Board is an effective learning organisation which seizes opportunities to learn from a variety of sources in order to develop training and practice, and to ensure safety and optimal outcomes for the children of Wolverhampton.

We anticipate our challenges for the coming year include the following:

- To maintain the momentum in developing closer partnership working with other partnership/strategic boards and promote a culture of problem solving
- To ensure that all services (adults and children) embed the safeguarding of children and young people at the heart of what they do
- To improve communication across the partnership, particularly with frontline practitioners

- To further develop the coordination of safeguarding activity across the partnership and be further assured in regards to the multi-agency intervention and the quality of services through engagement with:
    - The education sector
    - Faith and community groups
    - GP's

We also need to turn attention to:-

- Recruiting a 2nd lay member to the board
- Assuring ourselves that we can respond effectively to issues relating to; Child Trafficking, Female Genital Mutilation (FGM), Stateless Children
- Increase the awareness of services and support to Disabled children and young people in the City
- Undertake an evaluation of the effectiveness of Early Help services in the City
- Ensure that the learning from the deaths of children are disseminated across the partnership and used to inform practice.

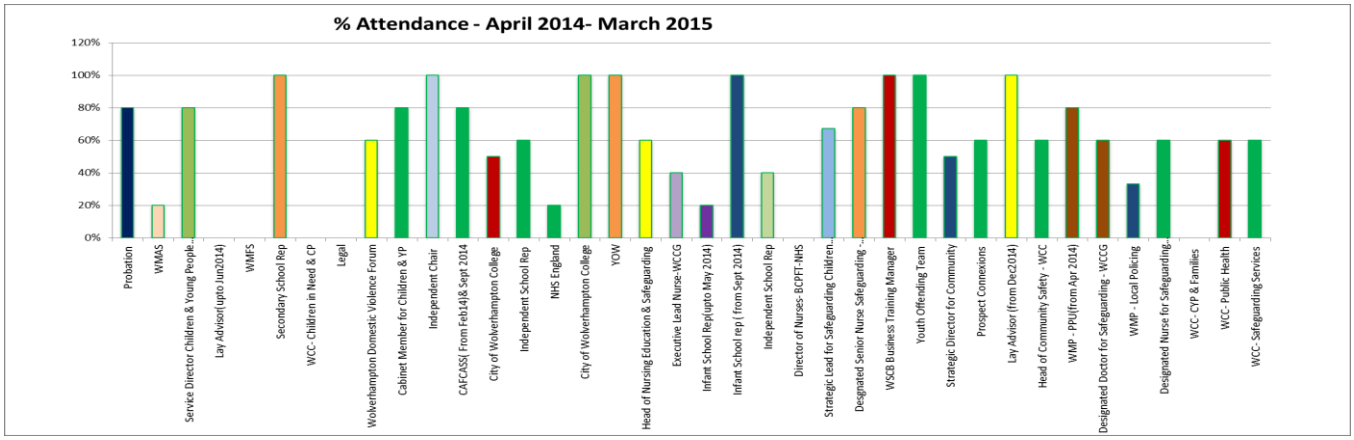
Responding to the challenges ahead the Board remains committed to:

- Ensuring the 'voice of the child' influences all that we do
- Effective partnerships in the context of change and reducing resources
- A clear focus on assuring ourselves of the effectiveness of quality of our multi-agency work with children and young people.

Appendix 1

Board Attendance

The full board meets 4 times a year. During 2014 -2015, there was also the Board Development Day; 4th April 2014.



Name	% attendance - April 2014- March 2015
Probation	80%
WMAS	20%
Service Director Children & Young People - WCC	80%
Lay Advisor(upto Jun2014)	0%
WMFS	0%
Secondary School Rep	100%
WCC- Children in Need & CP	0%
Legal	0%
Wolverhampton Domestic Violence Forum	60%
Cabinet Member for Children & YP	80%
Independent Chair	100%
CAFCASS(From Feb14)& Sept 2014	80%
City of Wolverhampton College	50%
Independent School Rep	60%
NHS England	20%
City of Wolverhampton College	100%
YOW	100%
Head of Nursing Education & Safeguarding	60%
Executive Lead Nurse-WCCG	40%
Infant School Rep(upto May 2014)	20%
Infant School rep (from Sept 2014)	100%
Independent School Rep	40%
Director of Nurses- BCPFT-NHS	0%
Strategic Lead for Safeguarding Children & Adults - BCPFT	67%
Desgnated Senior Nurse Safeguarding - WCCG	80%
WSCB Business Training Manager	100%
Youth Offending Team	100%
Strategic Director for Community	50%
Prospect Connexions	60%
Lay Advisor (from Dec2014)	100%
Head of Community Safety - WCC	60%
WMP - PPU(from Apr 2014)	80%
Designated Doctor for Safeguarding - WCCG	60%
WMP - Local Policing	33%
Designated Nurse for Safeguarding Children - WCPT/RWHT	60%
WCC- CYP & Families	0%
WCC- Public Health	60%
WCC- Safeguarding Services	60%

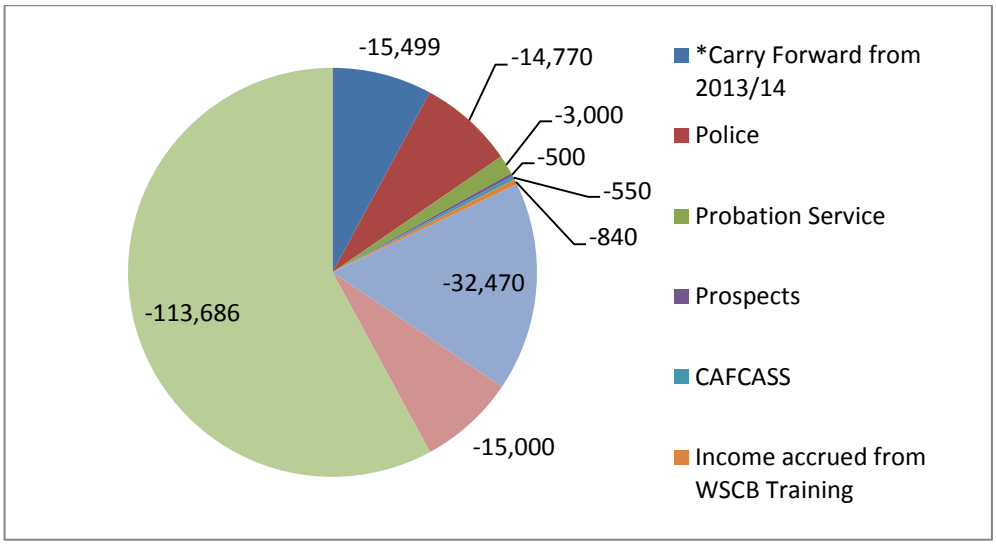
Appendix 2

Budget 2014-15

The WSCB income is largely generated from its members, with the exception of any additional carried forward from previous years, and/or income accumulated from WSCB training.

The income revenue for the period 2014-15 is detailed as follows:

Contributions	
*Carry Forward from 2013/14	-15,499
Police	-14,770
Police - One off contribution to CSE Co-ordinator	-15,000
Probation Service	-3,000
Prospects	-750
CAFCASS	-550
CCG	-32,470
CCG - One off additional contribution for 2014/15	-15,000
CCG - One off contribution to CSE Co-ordinator	-15,000
Wolverhampton City Council (WCC)	-113,686
WCC - One Off Public Health Contribution	-40,000
WCC - One off contribution to CSE Co-ordinator	-15,000
Total Contributions	**-165,226**



- The carried forward Munro initiative grant funding from 2011 is expected to be fully consumed in this financial year.
- Outlined in the details above are a number of 'one-off' contributions, most of these are additional allocated funds from key partners towards the newly created CSE Coordinator position.
- The CCG and Public Health have also allocated further amounts to support the Board to strengthen its capacity in the business unit.

The LA is the largest financial contributor to the Board totalling 58% of the combined income. The CCG is the next largest contributor providing 25% of the Boards income. The balance with the exception of the carried forward and income generated from training is funded by; Prospect, Probation and West Midlands Police which equates 9% of the total income

Expenditure 2014/15

Below is a breakdown of expenditure for the board and its related activities during 2014/15. This includes the budget projection for the remainder of the year.

Expenditure:		
	Salary Costs	69,806
	Training Expenses	31,600
	Venue Cost	2,000
	Car Allowances	2,160
	Catering	2,000
	Stationery	4,640
	Independent Chair	15,000
	Serious Case Review	9,000
	Computing - Purchase of Software	4,800
	Public Liability Insurance	220
	Payments to Walsall LA "CDOP Post	24,000
Total Expenditure Budget		**165,226**

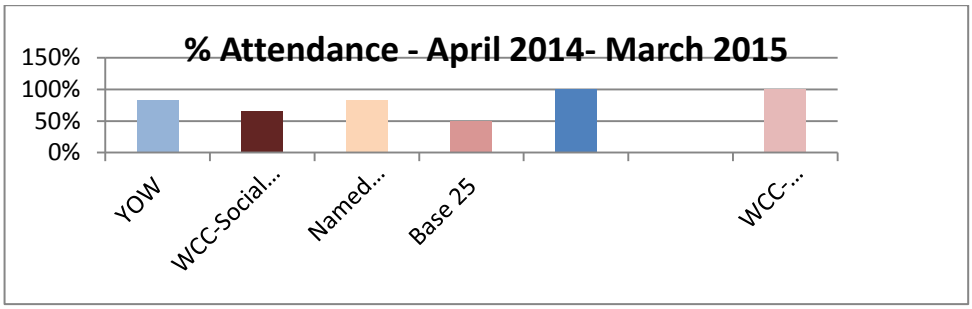
TRAINING; It is projected that there will be at least a 10% underspend in relation to training which reflects the changes to commissioning of training that has taken place throughout the year. The Underspend will be carried forward. It is intended that further savings of a similar amount will be facilitated during the 15/16 financial year.

The **CDOP Co-ordinator** is jointly funded with Walsall Local Authority. The above costs represent the **full cost** of the post.

Appendix 3

COMMITTEES ATTENDANCE 2014-15

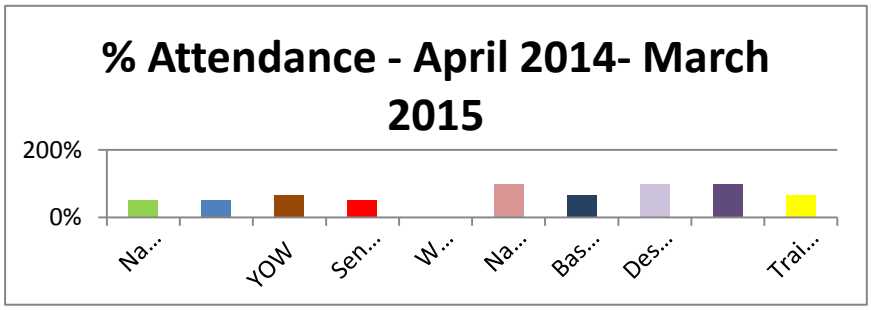
Law Policy and Procedure



Met 6 times during 2014-15

Organisation	Attendance %
WCC- Head of Safeguarding Services (**Chair**)	100%
YOW	83%
WCC-Social Inclusion and Children Centres	67%
Named Nurse for Safeguarding Children - RWHT	83%
Base 25	50%
WSCB Business & Training Manager	100%
WCC-Integrated Working	0%

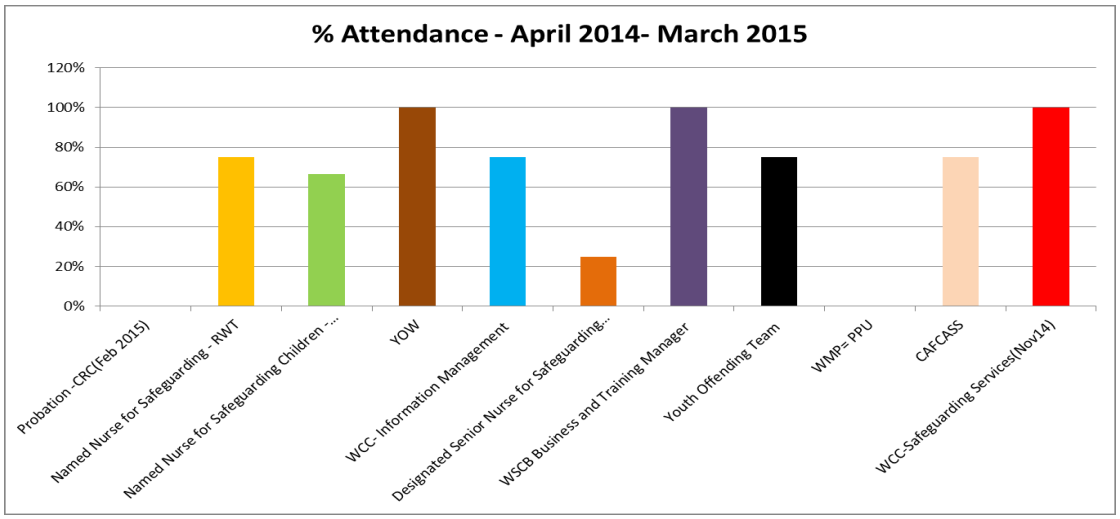
Learning and Development



Name	% Attendance
Designated Nurse for Safeguarding – WCC – **(Chair)**	100%
Named Nurse for Safeguarding - BCPFT-NHS	50%
City of Wolverhampton College	50%
YOW	67%
Senior Nurse for Safeguarding Children -RWT	50%
WMP-PPU	0%
Named Doctor for Safeguarding	100%
Base 25	67%
WSCB Business & Training Manager	100%
Training Facilitator	67%

Quality and Performance Committee

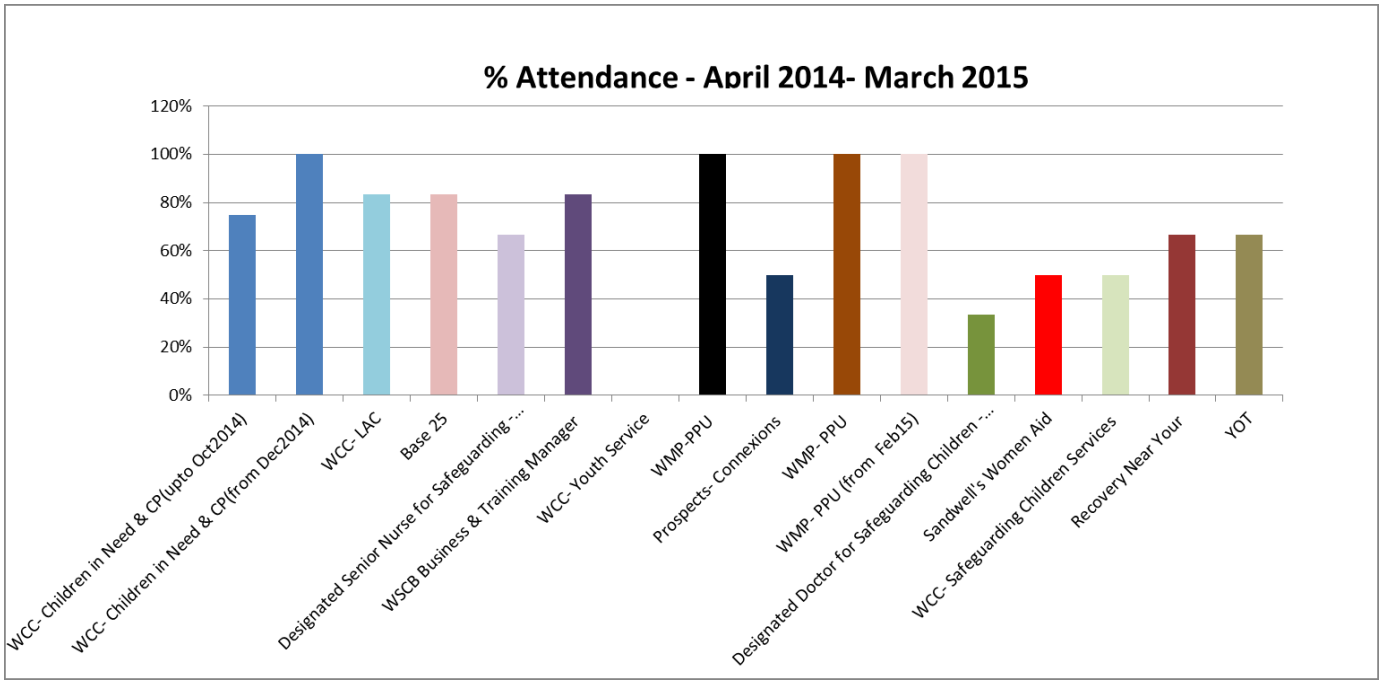
4 meetings



Organisation	% Attendance
Named Nurse for Safeguarding – RWT **(Chair)**	100%
Probation –CRC(from Feb 2015)	0%
Named Nurse for Safeguarding Children - BCPFT- NHS (Aug 14)	67%
YOW	100%
WCC- Information Management	75%
Designated Senior Nurse for Safeguarding Children - WCCG	25%
WSCB Business and Training Manager	100%
Youth Offending Team	75%
WMP= PPU	0%
CAFCASS	75%
WCC-Safeguarding Services(from Nov14)	100%

Sexual Exploitation Missing and Trafficked Committee

6 meetings



Organisation	% Attendance - April 2013-March 2014
WCC- Children in Need & CP(up to Oct2014)	75%
WCC- Children in Need & CP(from Dec2014)	100%
WCC- LAC	83%
Base 25	83%
Designated Senior Nurse for Safeguarding - WCCG	67%
WSCB Business & Training Manager	83%
WCC- Youth Service	0%
WMP-PPU	100%
Prospects- Connexions	50%
WMP- PPU	100%
WMP- PPU (from Feb15)	100%
Designated Doctor for Safeguarding Children - WCCG	33%
Sandwell's Women Aid	50%
WCC- Safeguarding Children Services	50%
Recovery Near Your	67%
YOT	67%

Appendix 4

WSCB Partners Single Agency Contributions to Safeguarding

Partner Agency	Black Country Partnership Foundation Trust (BCPFT)
What were the agreed safeguarding objectives for 2014/15? 1. Develop reliable data collection regarding children living in households where adult mental health is an issue 2. Monitor numbers of Children and Young People (CYP) where adult mental health issues have resulted in a CP Plan/CIN/CAF 3. Offer joint training/supervision opportunities for children and adult mental health services. 4. Increased involvement in early intervention and identification of CYP, who are affected by adult mental health issues. 5. To continue to raise the Toxic Trio and Hidden Harm Agenda across multi-agency partners 6. Undertake case file audit as outlined in the Safeguarding Team Audit forward Plan to ensure safeguarding children risks are identified.	**Achievements against the above Objectives :-** 1. Development of a Safeguarding Dashboard. 2. BCPFT have had Audits which supported monitoring numbers of Children and Young People (CYP) where adult mental health issues have resulted in a CP Plan/ CIN /EHA. 3. Supervision provides opportunities for reflective practice by staff, and action plans are devised. 4. BCPFT have worked in partnership with Wolverhampton CCG , Wolverhampton Safeguarding Children Board and other partners to effectively comply with the self-harm policy. 5. A number of audits have been undertaken in line with LSCB Performance Frameworks and the Safeguarding Children Team Audit 6. Plan which includes: • HV/SHA records audit (CP/CIN/LAC) • Conference Reports (quality and standards) • Quality of BAAF form • Service user feedback (LAC) • Adult Mental Health File audit

Improvement Plans where barriers have existed.	Impact for Children, Young People and Families
• A more robust system for collecting safeguarding performance data which will help the teams to review compliance with CCG and Safeguarding Boards requirements. • Additional work is required to design a safeguarding module to uncover and report on difficulties with compliance of data collection. • An internal Safeguarding Performance Dashboard will offer assurance to the Trust Board that safeguarding is meeting the required targets. • Effective engagement with the Divisions from the Named Nurse perspective.	• BCPFT needs to continue to improve in terms of developing "voice of the child" within all Divisions. Therefore, training is on-going.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

- To ensure that lessons learnt from Serious Case Reviews (SCRs), and case file audits etc. are shared with all staff
- To continue to ensure the Trust offers clear accountability; ownership and clarity around governance structures
- Increase capacity to deliver safeguarding training.
- Improve IT systems to enable sharing information with other agencies,
- Improve engagement with MARAC/DARTs by increasing capacity e.g. appointment of a Domestic Abuse nurse across adults and children.
- Review the role of the LAC and Paediatric Liaison, and the governance around Rapid Response.
- Development of Safeguarding assurance frameworks and monitoring of serious case reviews/DHR's/ CQC action plans.
- Safeguarding needs to review structure and capacity to meet demand.
- BCPFT to continue to deliver internal single agency training to all staff and also encourage our staff to attend multi agency safeguarding children training e.g. in specific areas like CSE, FGM, Forced Marriage, Modern day Slavery etc…

Robust systems of reporting out of area LAC continues to need monitoring.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Senior Leadership presence within Safeguarding Children Boards and sub-groups. Engagement with partner agencies in terms of information sharing and lessons learnt.

Agency	CHILD and FAMILY COURT ADVISORY and SUPPORT SERVICES (CAFCASS)

What were the agreed safeguarding objectives for 2014/15?

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families.

Cafcass' statutory function, as set out in the Criminal Justice and Court Services Act 2000, is to "safeguard and promote the welfare of children". Safeguarding is therefore a priority in all of the work we undertake within the family courts and the training and guidance we provide to staff reflects this.

- **Effectiveness of Safeguarding Arrangements**

A key focus during 2014/15 was continued improvement following our "good" Ofsted judgement in April 2014. Ofsted summarised that Cafcass consistently worked well with families to ensure children are safe and that the court makes decisions that are in the children's best interests. The report also highlighted areas where Cafcass should make improvements, and these areas formed a dedicated action plan which we implemented throughout the remainder of the year.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

- To undertake three thematic audits in 2015/16, focusing on further improvements required, in the joint working between the Independent Reviewing Officer (IRO) and the Guardian.
- Alongside our internal methods of quality assurance, we record and disseminate learning identified within service user correspondence, including correspondence received from children and young people. The learning points are fed back to the National Improvement Service (NIS) which maintains a national learning log, updated and disseminated throughout the organisation on a quarterly basis. The learning log sets out clear action plans designed to improve safeguarding practice and systems across the organisation, this area of work will be continued and further strengthened going forward.
- There will be further scrutiny given to our safeguarding practice and processes by the Family Justice Young People's Board (FJYPB) comprising young people with direct experience of the family court. The FJYPB contribute to our publications, review our resources for direct work with children, and are involved in the recruitment of frontline staff. Board members also review the complaints we receive from children and young people.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Cafcass is committed to joint working, as demonstrated in some of our work as recorded in the full agency report. We continue to work with partners such as the Association of Directors Children's Services (ADCS), the FYJPB and the National Family Justice Board. With ADCS in particular we will continue to work in partnership to identify and share good practice.

Cafcass also plays a strong leadership role at a local level, actively participating in Local Family Justice Boards. Cafcass chairs 10 out of 42 local Family Justice Boards and has a strong

leadership role on all others.
Number of serious incidents involving children and young people and outcomes from reviewing them
Cafcass has contributed to 26 Individual Management Reviews (IMRs), requiring a variety of methodological approaches. Of all the child deaths Cafcass has been made aware of from April 2014 – March 2015, in 52% of cases, maltreatment was suspected. This information is collated and managed nationally.
The learning from IMRs is collated and reported in an annual paper, which is disseminated nationally within Cafcass. We also publish externally a redacted version of the report, with a focus on wider learning points within the family justice system

Agency	National Probation Service

What were the agreed safeguarding objectives for 2014/15?

All colleagues must read the Working Together as part of their induction. There are resources accessible to allow staff to refresh their own knowledge of safeguarding. It also has to be seen in conjunction with other public protection practices like Multi-Agency Public Protection Arrangement (MAPPA), Multi Agency Risk Assessment Conferences (MARAC) and Safeguarding Adult arrangements.

NPS activities must reflect the importance of safeguarding children at all levels of need. This includes a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children:

- Senior Management to lead the organisation's Safeguarding Children arrangements,
- Active participation with Local Safeguarding Children Boards
- A culture that supports the child's safety and development,
- A clear process for eliciting and sharing information, in order to safeguarding children and to promote their welfare.
- Safe recruitment practices, including Disclosure & Barring Scheme.
- Supervision and support of staff (including mandatory training and learning opportunities to develop practice),

- Clear procedure and working arrangements with Local Authorities for investigating allegations against staff with regard to their work/contact with children.
- Strategic and operational involvement in multi-agency arrangements for safeguarding children, including MAPPA, MARAC, Multi Agency Safeguarding Hubs (MASH) etc.
- A clear risk escalation and transfer process for Community Rehabilitation Companies and NPS to follow when the risk towards a child/ren escalate to the level that requires management of the case by NPS (in line with the Risk Escalation Policy).
- NOMS Whistle-blowing policy must be integrated into training and codes of conduct.

NPS will:-

- Assess the risk of serious harm posed to children by offenders due to their actual offending

including targeting children or the impact it has on them, for example domestic abuse.

- Highlight concerns in relation to potential harm e.g. substance misusing parents /carers, challenging environments.
- Identify children at increased risk of exposure to victimisation including CSE, Honour Based Violence, Female Genital Mutilation, Organised Crime and Serious Group Offending as either victims or perpetrators.
- Identify children at risk of anti-social behaviour and other negative behaviour due to the behaviour of parents and others.
- Include the impact of caring responsibilities on the parents/carers ability to comply with the proposed sentence of the Court.
- Consider the impact imprisonment will have on the child/ren's welfare when custody is a stated option of the Court.
- Support families (Think Family Approach) to access services to support rehabilitation for parents/carers and positive outcomes for children and families.
- Share information to support the safeguarding, protection and welfare of children at both strategic and operational levels.
- Respond to requests for Serious Case Reviews, including archived cases, and review their involvement in the management of the cases including court process and allocation.
- Liaise directly with CRC colleagues to complete risk escalation processes and support the completion of Serious Case Reviews to include court process and allocation.

Achievements against the above Objectives :-

Despite a challenging year of flux and organisational shift the safeguarding procedures in place for staff to follow have remained constant. Staff have continued to work closely with Partners to ensure that risk assessments are completed where we are aware of children at risk of harm and that these are collectively followed through.

Staff continue to be integral to MAPPA and MARAC and through IOM arrangements work with partners to manage those offenders at highest risk to the public.

All staff have a personal development objective to keep children safe from point of contact with an adult and this is continually reviewed through the sentence.

Where recruitment has taken place, this is in line with NPS Policy and Procedure and ensures safe vetting practice.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

As above. The NPS continues to drive these objectives as an organisation through the current business year.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

- The recent organisational split has rendered both NPS and CRC's responsible authorities for LSCB's. During the past 12 months, there has been a stabilisation period of both NPS and CRC's identifying where the resource critical needs are. This has impacted on the attendance to Board and Committees for Wolverhampton however contribution to driving forward the changes has remained strong from within both NPS and CRC.
- The development of MASH is fully supported by the NPS in Wolverhampton.
- NPS has provided a financial contribution to the Board in 14/15.
  - NPS has provided attendance at committee level or has shared attendance with CRC's to ensure appropriate level of cover.

Agency	City of Wolverhampton College

How does your agency demonstrate its commitment to safeguarding children

TRAINING

- All named designated safeguarding officers have received safeguarding officer training.
- 276 staff members had attended safeguarding awareness training in 2014/15.
- 27 managers had successfully completed safer recruitment training in 2014/15.
- In 2014/15 safeguarding team have attended 6 workshops delivered by the Wolverhampton Safeguarding Board.
- Members of the safeguarding team have attended: the following multi agency training:

  - Guns and Gangs
  - Bullying
  - Young people and the internet.
  - Contributing to child protection case conferences
  - Sexual Exploitation of Children
  - Domestic abuse

- During student induction period the safeguarding team deliver 20 minutes safeguarding awareness sessions for all students.
- The College's Student Services Director is the Vice Chair for the Learning and Development Committee.

a) POLICY AND PROCEDURES

- College has a safeguarding policy in place which is updates annually and reflects the guidance provided by Department for Education – Keeping children safe in education and HR Government document Working together to safeguard children.

b) COMMUNICATION

- Termly safeguarding reports are submitted to the governing body.
- Student Services Director keeps the Executive Management Team updated on any changes in relation to safeguarding.
- Heads of school are briefed during the one to one meetings to discuss areas of student services including safeguarding.
- The College's Student Services Director is a member of the WSCB Communication ad Engagement Committee. Through this work the college's Head of Marketing has supported the development of the new logo for the safeguarding boards website.

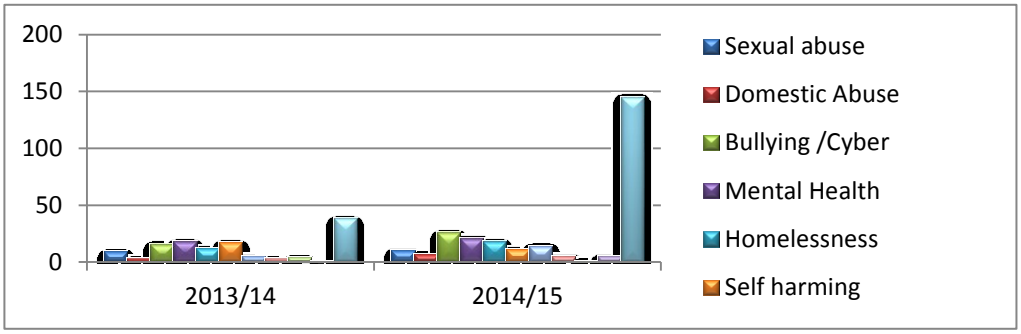
c) IMPROVING QUALITY

- College has in place safeguarding risk register action plan for 2014/15. The action plan is monitored by the Director of student services and updated on an annual basis.

d) CONTRIBUTING TO PERFORMANCE MANAGEMENT

- To date 263 safeguarding referrals made to the college safeguarding team.
- 10 referrals made to children social care and 3 referrals to adult social care in 2014/15.
- 4 referrals made to the police in 2014/15
- 246 referrals dealt by the safeguarding team as early intervention (welfare issues).
- In 2014/15 there were 170 female and 93 male safeguarding referrals made to the safeguarding team.
- There has been an increase of 88% of safeguarding referrals in 2014/15 of White British students compared to 2013/14
- In 2014/15 Indian student safeguarding referrals have almost doubled compared to the previous year.
- In 2014/15 Black & White Caribbean students safeguarding referrals have increased by 9 compared to the previous year.
- In 2014/15 there was an increase of 16-18 year old student safeguarding referrals by 80% compared to the previous year. An increase of 153% of 19+ student referrals.
- There has been an increase of 55% referrals from Essential Skills - SLDD, Pathways & Alternative Provision compared to previous year.
- There has been an increase of 127% of referrals from Creative Arts in 2014/15 compared to previous year.
- Princess Trust referrals have increased by 85% in 2014/15 compared to previous year.
- There has been an increase of 167% of learner referrals in 2014/15 from health industries compared to 2013/14.
- 100% increase of learner referrals from service industries in 2014/15 compared to previous year.
- There has been an increase of 186% learner referrals from technology in 2014/15 compared to previous year.

- There has been an increase of 171% of learner referrals from Bilston East ward in 2014/15 compared to previous academic year.
- In 2014/15 there was a sevenfold increase of referrals from Bushbury south and low hill compared to 2013/12.
- Merry hill ward had an increase of threefold of referrals in 2014/15 compared to the previous academic year.
- In 2014/15 Dudley district had seen an eleven fold increase of referrals compared with the previous academic year.
- **Nature of referrals**



- There has been an increase of 40% of referrals made to children social care services and the police in 2014/15 compared to previous academic year 2013/14.
- There has been an increase of 25% of referrals from the youth offending team compared to the previous academic year.
- In 2014/15 there has been an increase of 8% of learners who identify themselves as Looked after children compared to previous academic year.

What were the agreed safeguarding objectives for 2014/15?

Students and staff feeling safe, being able to share concerns and manage risk of harm either to themselves or others.

Achievements against the above Objectives :-

- During our Ofsted Inspection in October 2014 safeguarding was graded as Good with Outstanding features
- 30 safeguarding awareness training workshops delivered to staff.
- 8 safer recruitment workshops delivered to managers
- 96 safeguarding student inductions delivered.
- 2 PREVENT face to face workshops delivered by the police.
- Channel general awareness on line training for all staff.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

Students and staff feeling safe, being able to share concerns and manage risk of harm either to themselves or others.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The Student Services Director is a highly engaged member of both the Learning and Development Committee and the Communications and Engagement Committee.

Through the Learning and Development Committee we have supported the review of multi-agency training, evaluations and quality procedures.

Through the Communications and Engagement Committee the college has involved its marketing department to support the developments of the new joint board website. The college provided a number of ideas for a new logo layout and colour scheme and supported the committee in gaining the views of local users to identify a new logo for the site.

The Student Services Director is a member of associated boards including: Children's Trust Board and SEND Partnership Board. This ensures that the work of the board is considered in the wider remits of associated boards, ensuring that young people are safeguarded within the city.

Agency	Prospects Services [Connexions]

What were the agreed safeguarding objectives for 2014/15?

- Launch of corporate self-assessment process to inform internal risk management. Initial assessment to be launched by Autumn 2014
- Safeguarding Management group to devise and approve internal risk matrix and monitor high risk contracts more closely
- Development of procedures to bring safeguarding work into company quality procedures currently certified under ISO9001
- Review Allegation Management procedures and devise code of conduct for delivery staff by September 2014
- Embed the Early Help assessment into PA practice
- Attend relevant safeguarding training within the city

Contribute to multi-agency case file audits and any other audits/reviews/inspections.

Achievements against the above Objectives :-

- Initial assessment launched October 2014
- Internal risk matrix completed and internal safeguarding group remit redefined in light of this.
- Company quality procedures- work underway.
- Code of conduct for staff completed and launched
- Early Help embedded in service delivery
- Relevant training attended
- MASE work extended and a high level of attendance sustained by Personal Advisers.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

Not applicable-organisation is no longer on Safeguarding Board and Connexions service has been brought in house to the City Council

Agency	The Royal Wolverhampton NHS Trust [RWT]

How does your agency demonstrate its commitment to safeguarding children and the work of the Board?

The Chief Nurse who is also Deputy Chief Executive holds safeguarding in her Executive Director portfolio.

The Trust Board receives an annual child safeguarding report.

The Trust Board members receive safeguarding training on an annual basis

The Trust Safeguarding Group meets bimonthly and reports through the Trust governance structure to the Trust Board

The RWT safeguarding team has this year undergone a process of assurance using the Markers of Good Practice (DH 2008) and has a robust work-plan in place to address the key areas of risk highlighted in the assurance process. The team has undergone a process of restructuring and investment in key areas to meet the demands of the domestic violence and child sexual exploitation agenda.

The Trust has a Named Nurse for safeguarding children, a Named Midwife, a Named Nurse for Looked After Children, a Named Doctor for Looked After Children and a Named Doctor for safeguarding children

A comprehensive training needs analysis has been undertaken and all staff having contact with children, young people and parents or carers received level 2 safeguarding training (RCPCH 2014) and staff working in paediatrics, midwifery and community health undertake level 3 safeguarding training annually.

The FNP, Health Visitors, Midwives, School Nurses and Children's Nursing Service receive regular safeguarding supervision

What were the agreed safeguarding objectives for 2014/15?

- To ensure that acute and community health services in Wolverhampton develop a robust communication pathway with local authority children's centres and social care that is overviewed and transparent to the Wolverhampton Safeguarding Children Board.
- Ensure that Royal Wolverhampton Trust (RWT) provide health care services that incorporate their statutory duty as highlighted in Working Together to Safeguard Children (2013) and feedback to, contribute to and are monitored by the Wolverhampton Safeguarding Children Board.

- To ensure that community and acute health services provide a health care service that embraces lessons learnt from Serious Case Reviews and that the existing work programme reflects these values.
- RWT as the main provider of health services in Wolverhampton work closely with the Wolverhampton CCG to ensure that the rising number of Looked After Children in Wolverhampton receive Initial and Review Health Assessments as is required from the legal framework.

Achievements against the above Objectives :-

Regular communication facilitated by colocation of key professionals in the children's centres and referrals to social care are monitored and followed up by the safeguarding team

Serious case review action plans were monitored and overseen by the Joint Health Service Safeguarding Children Group

- The service for Looked after Children has worked collaboratively with the CCG to ensure services and reviews for Looked After Children are effective and timely consistent with statutory requirements

In relation to safeguarding children, what are your priorities/objectives for 2015/16

To ensure connectivity across the organisation in relation to the sharing of information for children at risk of CSE and DV

- To collaborate in the Child Protection Information Sharing programme with HSCIC and the Local Authority
- To collaborate with partner agencies in the development of the Wolverhampton MASH and ensure timely information sharing and consultation on cases of concern
- To further develop the Trust TNA and ensure that all staff working with children, young people, parents and carers receive training at level 3 (RCPCH 2014) in relation to learning from serious case reviews and domestic homicide reviews
- To work with partner agencies to develop a quality assurance framework that identifies the impact of safeguarding on children, young people and families

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The Trust has representation at a senior level on the safeguarding Board and representation at every Wolverhampton Safeguarding Children's Board Committee. Key staff Chair and contribute to the work of the Board including it's Committee's and ensures participation in regular multi-agency case-file audit and table top reviews.

Agency	Safer Wolverhampton Partnership (SWP)

What were the agreed safeguarding objectives for 2014/15?

Channel and Prevent

Raise awareness across partners of Channel referral pathways; partners need to be briefed on the current Prevent risks and feel confident in directing individuals to available support. A series of joint briefings/workshops will be held for safeguarding boards to facilitate this.

Violence Against Women and Girls (VAWG)

A revised VAWG strategy will highlight key areas of development which will reduce the risks to children and young people and where WSCB oversight is needed.

Gangs and Youth Crime

A refreshed Gangs and Youth Crime Problem Profile will inform the development of a revised strategy and targeted interventions needed to support children and young people.

Achievements against the above Objectives :-

A Channel and Prevent safeguarding awareness event was held in March 2015 to alert organisational safeguarding leads to the vulnerabilities linked to Prevent and arrangements for referring individuals needing support. The event was well attended and has provided a catalyst for an increase in referrals. Additionally, the Counter Terrorism and Security Act 2015 has introduced a statutory Prevent duty on a range of agencies and placed Channel Panel on a statutory footing.

The VAWG Strategy refresh is well underway and due for sign off in the autumn of 2015. In the interim, significant steps have been taken to improve the management of high risk domestic violence cases and embed learning from Domestic Homicide Reviews.

A refreshed gangs problem profile has been completed which is being used as a basis for developing a revised Reducing Gang Harm Strategy. This will include an enhanced focus on young people and prevention. This should be finalised by autumn 2015.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

Domestic Homicides – Shared Learning

It is proposed to host a shared Serious Case Review/Domestic Homicide Review learning event in the autumn of 2015 to disseminate findings and facilitate change within front-line services, and to ensure prompt dissemination of learning from future reviews.

Prevent duty

A key focus for 2015/16 will be on embedding changed practice following introduction

of the Prevent duty arising from the Counter Terrorism and Security Act 2015.

Youth Crime

To reduce the number of young people involved in crime either as victims or offenders.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The strengthened link between WSCB and Safer Wolverhampton Partnership enables us to collectively drive forward areas of shared responsibility. This relationship has worked well for 2014/15 and will be formalised during 2015/16 to embed that practice.

The additional focus SWP is putting into VAWG and domestic abuse in particular has a significant impact upon safeguarding children.

Agency	Wolverhampton CCG

What were the agreed safeguarding objectives for 2014/15?

WCCG fulfil their statutory duty to be members of the Local Safeguarding Children Board as the Director for Nursing and Quality for WCCG is a member of WSCB, and the Designated Doctor and Nurse for Safeguarding Children attend as advisors to the WSCB. The agreed objectives for 14/15 were:

- Chairing of 3 WSCB committees, and are active members on several committees.
- Employ services of designated professionals and a Named GP lead for Children's Safeguarding.
- Continue to make financial contribution to the safeguarding board, including an additional £15.000 (15/16) for the Sexual Exploitation Coordinator role.
- Completion of Bi Annual Section 11 audits.
- Monitoring provider compliance with nationally mandated requirements and additional local KPIs agreed in the quality schedules in each contract.
- Commission, manage and monitor LAC placements contributing to the overarching ambition to reduce the number of children in LAC placements and also to ensure placements are close to home

Achievements against the above Objectives :-

- All key designated and named professionals have been recruited and are in place
- Timely completion of reviews contributing to the publishing of SCRs. The action plans are completed with learning cascaded across primary and secondary care. Key learning is the improved collaborative working arrangements now in place between addiction services and primary care by developing a joint protocol to enable collaborative working with complex patients.
- Audits in place to monitor compliance with implementation of SCR recommendations in primary care.
- Marginal decrease in the number of reportable child deaths in Wolverhampton.

Significant improvement in reportable number of child deaths which involved co-sleeping as a modifiable factor following a sleep safe campaign launched in October 2012.

- Training plans in place for all appropriate staff and volunteers who work with or have contact with children and families (professional roles and responsibilities)
- All CCG staff is aware of their own responsibilities and those of the organisation for safeguarding and protecting children; Level 1 Safeguarding Training is included in the mandatory training for all employees.
- Engagement with children and young people
- CCG led the health component of the SEND local offer which has been recognised as best practice nationally
- Quality assessments of all External Placement Panel placements (due to be completed September 2015) and the development of a robust data base to monitor and record LAC activity.
- Enhanced and improved monitoring of provider compliance via monthly Clinical Quality Review Meetings
- CCG hosted 4 sessions of mandatory level 3 Safeguarding Children Training for GPs and their practice staff. 355 individuals attended including 134 GPs from 46 practices. Ongoing training schedules are being planned.
- Providing supervision to other health care professionals; the CCG Designated Nurse for Safeguarding Children provides supervision to the Family Nurse Practitioners. Designated Dr provides supervision for the Named Dr for Safeguarding Children and Named GP for Safeguarding Children.
- A safeguarding web page has been developed and available on the CCG Intranet
- A self-populating template is being developed to support GPs in the writing of child protection conference reports.
- Contribution to the WSCB table top review chronology reports

In relation to safeguarding children, what are your priorities/objectives for 2015/16

- Development of education and training framework
- Improved working with agencies i.e. MAPPA
- Improved compliance with education and training levels in provider contracts
- Raising awareness in primary care across GPs and practice staff
- Raise awareness for PREVENT, CSE, FGM and SEMPT
- Be integral partner for MASH
- Continue to work with GPs to improve attendance at case conferences
- Monitor action plans to assure actions completed across the provider landscape

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The CCG Governing Body are assured that WCCG are compliant of their statutory duties regarding safeguarding children and provide a high level of oversight of the quality and safety matters of safeguarding and looked after children across the city.
The Wolverhampton Safeguarding Children Board is assured that the CCG is committed to ensuring that its providers provide a safe system that safeguards children at risk of abuse and neglect, as set out in:

- Working Together to Safeguard Children 2015 Statutory Guidance on promoting the Health and Wellbeing of Looked After Children 2015

Agency	Wolverhampton Domestic Violence Forum (WDVF)

How does your agency demonstrate its commitment to safeguarding children and the work of the Board in relation to the following areas?

a) TRAINING - *Promoting, delivering and evaluating single agency & multi-agency training*

- Our funding contract, policies, procedures, and practice demonstrates that generic safeguarding training is mandatory for front line staff, as is training for subject specific safeguarding elements, for example Prevent training, etc.
- WDVF has delivered a range of subject specific safeguarding training around Violence Against Women and Girls.

b) POLICY AND PROCEDURES – *embedding policy and procedure in practice*

- Relevant policies and procedures are discussed with staff at team meetings, and raised at the multi-agency WDVF Executive Board to be embedded into practice in different organisations.
- WDVF is instrumental in developing multi-agency subject specific policies and procedures, including being instrumental as a key partner in developing the first joint adult and child Forced Marriage and Honour Based Violence Protocol together with the two Safeguarding Boards.

c) COMMUNICATION – *sharing all relevant information with the workforce*

- Information is cascaded with WDVF and partner agency staff electronically, and specific items are discussed at WDVF team meetings with a view to identifying if and how WDVF procedures and practice needs to change.

d) IMPROVING QUALITY– *single agency audit, supervision, Section 11 etc*

- Every person referred to our service is risk assessed using the national risk model, which identifies any safeguarding adult and children concerns.
- Supervision of our Independent Domestic Violence Advisers is undertaken by the Strategy Coordinator/General Manager, and these staff also receive external clinical supervision for their caseloads.
- Processes such as Multi-Agency Risk Assessment Conferences (MARAC) that WDVF coordinates and provides governance around are externally audited.
- The latest audit is wholly positive around all aspects including governance, commitment, attendance, adult and children support, and correct application of criteria.

e) CONTRIBUTING TO PERFORMANCE MANAGEMENT– *supplying performance data and commentary*

- WDVF provides Violence Against Women and Girls data and commentary to the Quality and Performance Committee to both Safeguarding Boards.
- WDVF contributes to and attends quality and performance committee meetings to critically analyse, develop, and refine performance dashboards for the Boards.
- WDVF provides update reports to the Boards from WDVF Executive Board.

What were the agreed safeguarding objectives for 2014/15?

- Increase first time reporting of Violence Against Women and Girls
- Reduce the prevalence of Violence Against Women and Girls
- Reduce repeat Violence Against Women and Girls incidents
- Increase Violence Against Women and Girls offences brought to justice
- Reduce serious harm from Violence Against Women and Girls including homicide prevention

Achievements against the above Objectives :-

- Increase in reporting of domestic violence, sexual violence, forced marriage, and honour based violence
- Increase in the number of children identified in families suffering domestic violence and jointly screened
- Increase in Violence Against Women and Girls offences brought to justice
- Increase in Multi-Agency Risk Assessment Conference (MARAC) referrals and joint action plans to reduce those at highest risk of serious harm and homicide
- Overwhelmingly positive external audit of MARAC arrangements in terms of governance, commitment, attendance, adult and children support, coordination, and correct application of criteria

In relation to safeguarding children, what are your priorities/objectives for 2015/16

- Increase first time reporting of Violence Against Women and Girls
- Reduce the prevalence of Violence Against Women and Girls
- Reduce repeat Violence Against Women and Girls incidents
- Increase Violence Against Women and Girls offences brought to justice
- Reduce serious harm from Violence Against Women and Girls including homicide prevention

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

WDVF continues to be committed to safeguarding adults and children. Our Strategy Coordinator attends and contributes to Board meetings as a professional adviser to the Board and away day events, and attends sub-group meetings both as a standing member and to make specific contributions – e.g. with new policies and procedures. WDVF ensures that information is cascaded from the Board into our organisation and to our partners, as well as providing information, guidance, and advice around Violence Against Women and Girls subjects to the Board and its committees.

Agency	West Midlands Fire Service

What were the agreed safeguarding objectives for 2014/15?

- Ensure safeguarding training is completed
- Ensure policy is up to date and reviewed to ensure the correct standard is met.

- Section 11 is reviewed

Achievements against the above Objectives :-

- All staff within Wolverhampton has received basic level safeguarding training, also all relevant information in regards to Child trafficking.
- Information around FGM, county terrorism and radicalisation has also been disseminated to staff at all levels.
- WMFS policy on safeguarding is reviewed and updated at regular intervals.
- All staff has access to safeguarding policies and are required to ensure they are up to date and also adhere to the policy.
- Section 11 is completed and reviewed 6 monthly or whenever actions have been completed.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

To ensure all relevant and up to date information is given to staff as soon as possible.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

All objectives relevant to West Midlands Fire Service have been implemented and upheld as part of the commitment from West Midlands Fire Service to assist in the delivery of the Boards objectives and effectiveness.

Agency	Youth Organisations Wolverhampton

How does your agency demonstrate its commitment to safeguarding children and the work of the Board in relation to the following areas?

TRAINING -

YOW has promoted safeguarding training opportunities through the Monthly Safeguarding Updates it has produced and circulated since May 2014.

WSCB multi-agency training (including general awareness of the WSCB multi-agency training programme, as well as notice of particular forthcoming courses, and those that are undersubscribed)

- voluntary sector specific training – Early Help, Introduction to Safeguarding to individual organisations and VCS more generally.
- external training and webinars – e.g. courses organised by Anti-Bullying Alliance, and Safe Network

POLICY AND PROCEDURES – *embedding policy and procedure in practice*

- Details of all new policies and procedures approved by WSCB have been circulated to vol orgs via the WSCB database (around 550 organisations) via the monthly safeguarding Updates and occasionally via a specific communication e.g. updated Multi-Agency Referral Form.
- A Safeguarding Forum was held in Oct 2014 - various policies and procedures were highlighted at this event too.
- The YOW Co-ordinator has also worked directly with around 10 groups to develop their safeguarding policy and practice.

COMMUNICATION – *sharing all relevant information with the workforce*

- Since May 2014 YOW has produced and circulated a monthly Safeguarding Update to all 550 voluntary and community organisations on the Voluntary Sector Database held by WVSC. This has covered safeguarding adults as well as safeguarding children topics and drawn from the following: WSAB and WSCB board meetings and committees; DfE; Safe Network; Children and Young People Now; UK Safer Internet Centre; CEOP; Anti-Bullying Alliance; NSPCC CASPAR email.
- This has been circulated to partners on WSAB and WSCB since Jan 2015.
- YOW Co-ordinator has taken a lead role in chairing the Communication and Engagement Committee.

IMPROVING QUALITY– *single agency audit, supervision, Section 11 etc*

- YOW Co-ordinator sits on the Quality and Improvement Committee and has co-ordinates Early Help Implementation under the Children's Trust Board.
- This has proved a trickier area for YOW. Having no control over what individual organisations do, the tasks around quality improvement are more around promoting and encouraging good practice.
- Engagement from VCS in Section 11 audit has been minimal although a number of groups attended the Section 11 online audit tool training in June 2014.
- A range of organisations were identified for encouragement to participate in Section 11 audit and suggestion was made to include Section 11 completion in contracts over a certain amount for VCOs from local statutory organisations – but no action has resulted from either.

CONTRIBUTING TO PERFORMANCE MANAGEMENT– *supplying performance data and commentary*

- YOW co-ordinator sits on the Quality and Performance Committee.

What were the agreed safeguarding objectives for 2014/15?

- Establish a VCS safeguarding forum
- Promoting VCS involvement in demonstrating their safeguarding effectiveness via Safe Network Standards and Section 11
- Continuing to develop and build on links with faith groups
- Improve safeguarding information to the VCS

Increase the numbers of VCS reps on WSCB committees

Achievements against the above Objectives :-

1. Establish a VCS safeguarding forum

   One meeting of the Safeguarding Forum was held in Oct 2014, with, no further progress during the reporting year.

2. Promoting VCS involvement in demonstrating their safeguarding effectiveness via Safe Network Standards and Section 11

   Development is in its infancy.

3. Continuing to develop and build on links with faith groups

   - Lists of faith groups collected.
   - Volunteer resource now secured to collate these and update contacts wherever possible. Also to connect Faith Groups up with Wolverhampton Information Network and WVSC's voluntary sector database.
   - Agreement on improving faith group engagement has been reached with Inter Faith Wolverhampton – including joint bid to Reaching Communities for Faith group engagement worker.
   - Relationships initiated with some Individual Faith groups and collaborations of faith groups.
   - Survey of Safeguarding processes in use in Faith Groups was circulated but had a poor response – maybe because relationships aren't good enough yet?

4. Improve safeguarding information to the VCS

   - Monthly Safeguarding Updates have been circulated to all VCOs (and circulated within WSCB partner organisations through the Board)
   - Feedback from all groups that have mentioned it has been positive.

5. Increase the numbers of VCS reps on WSCB committees
   - Because of lack of development of the VCS Safeguarding Forum there have been no new reps for WSCB Cttees.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

1. Establish a VCS safeguarding forum
2. Improve VCS access to key safeguarding training
3. Promoting VCS involvement in demonstrating their safeguarding effectiveness via Safe Network Standards and Section 11
4. Continuing to develop and build on links with faith groups
5. Increase the numbers of VCS reps on WSCB committees

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

YOW has been an active member of WSCB and of all the Cttees it sits on (Communication & Engagement cttee; Executive cttee; Law, Policy and Procedures cttee; Quality and Performance cttee; and Serious Case Review cttee).

In terms of effectiveness, YOW contributes a perspective which focuses on small groups and contributions to Threshold Document, Development of shared Safeguarding website (slow but now sure)

Agency	Base 25

How does your agency demonstrate its commitment to safeguarding children and the work of the Board in relation to the following areas?

TRAINING - *Promoting, delivering and evaluating single agency & multi-agency training.* Base 25 has continued to share its expertise through offering its training programme across the city. Base 25 staff has also attended relevant safeguarding training and other relevant training to ensure that staff are up to date with current standards and duties.

e) POLICY AND PROCEDURES – *embedding policy and procedure in practice.* Base 25 continues to review and update its policies to ensure their relevance. All staff and volunteers receive training and briefings around any changes in policy.

f) COMMUNICATION – *sharing all relevant information with the workforce.* Base 25 has regular meetings to ensure that information is shared. There are also internal electronic systems for effective information sharing purposes.

g) IMPROVING QUALITY– *single agency audit, supervision, Section 11 etc.* Base 25 project co-ordinators audit all case closures and cases are reviewed on a regular basis. All staff and volunteers receive the appropriate level of supervision.

h) CONTRIBUTING TO PERFORMANCE MANAGEMENT– *supplying performance data and commentary.* Through attending and contributing to EHA, CIN, CP, MASE, CMOG and Serious Case Review meetings Base 25 contributes to various plans.

What were the agreed safeguarding objectives for 2014/15?

1. To improve the early identification of young people at risk.
2. To increase self-esteem of young people.
3. To increase self-confidence and emotional resilience
4. To improve young people's ability to make informed decisions
5. To increase self-awareness and sense of identity
6. To minimise harm to self and others.

Achievements against the agreed Objectives:-

1. To improve the early identification of young people at risk:

- Increased number of referrals made to projects
- Increased number of agencies referring to projects (increase in the number of referrals from 'mothers')
- There has been an increase across the projects with regards to lower risk young people, this demonstrating that young people are being identified at an early stage of intervention. This has also enabled preventative work to be delivered with those identified and where necessary, their siblings.

2. **To increase self-esteem of young people.**

- Utilising a range of assessment tools, there has been an increase demonstrated in self-esteem with young people accessing the projects. Tools used to measure impact have included: Warwick and Edinburgh Mental Health assessment, Outcome Star, Outcome wheels and various goal setting tools.

3. **To increase self-confidence and emotional resilience**
    - Emerging themes from professionals, parents and young people involved in the projects have included: comments, observations and reflections around perceptions of the young person's level of increase in their confidence and self-esteem and what that looks like:
    - an improved ability to communicate more positively with peers, parents and professionals; Increased involvement in positive activities and an improved ability to manage emotions more effectively.
4. **To improve young people's ability to make informed decisions**
    - Reduction in the risk indicators for young people assessed now making safe/better decisions
    - Parent and/or professional perspective has shown an improvement in the decisions made by young people.
    - Increased knowledge around healthy relationships, staying safe, identifying risk and risky situations, sexual health, around protective behaviours and utilising this knowledge when making decisions.
5. **To increase self-awareness and sense of identity**
    - Through the programmes developed through the projects, concepts of self and identity have been explored at all stages across all of the thematic areas. Young people have been able to locate themselves within the context of their own lives and have demonstrated an awareness of those that have influence on them and how they influence and impact on others. This has also impacted on their confidence, self-esteem and their ability to make decisions. Young people have shown ability to empathise with others and an understanding around their own emotional literacy with regards to how others make them feel.
    - A lot of work developed with young people around de-constructing concepts around negative beliefs and values. Young people have demonstrated an understanding of the realities of negative lifestyle and have identified alternative perspectives on change.
6. **To minimise harm to self and others.**
    - Decrease in the assessed risk factors.

A lot of the thematic work has been delivered around sexual health, exploitation,

grooming, drugs and alcohol misuse, crime, violence and engaging in gang related activity. This has positively impacted on the behaviour choices of the young people involved in the projects. Most have demonstrated a change in attitude and a more confident approach towards staying safe.

Case study 1

Young person A was aged 14 and referred to the project by the Youth Offending team due to displaying a number of risk factors. At the point of referral she had been going missing and had been found in London with no explanation of why, she was believed to be in a relationship with a 19 year old male who was known for exploiting underage girls however she denied this relationship. Young person A was not in education and had a negative peer group, she would not engage in the project as she stated she did not need it. The worker had to use an assertive approach and gave her the control of when and where the sessions would take place. She eventually engaged and sessions were delivered over a 6 month period on self-esteem, grooming, healthy relationships, identifying risk and sexual health. As a result of the intervention the young person made a statement to the police as she disclosed CSE. The statement encouraged other young people to come forward and the perpetrator was convicted. Young person A is now in full time education and has had no recent missing episodes and is making positive friendships at school.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

To identify and generate new funding for projects

- To continue developing partnerships with other organisations
- To offer more external training opportunities for professionals around the thematic areas of the various projects, to raise awareness and increase referrals

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Base 25 continues to support young people in shaping their lives through the early identification of young people at risk and providing projects that offer both prevention and intervention to ensure that children and young people are safeguarded.

Case Study 2

Sally was referred to SAFE due to displaying abusive behaviour towards mum; she had previously witnessed domestic abuse from dad. Sally was controlling with mum and had previously cut up her clothes due to not wanting her to go out. At the start of the intervention Sally was reluctant to focus on making changes to her behaviour stating, "It works and gets me what I want so why do I need to change." Through the SAFE programme Sally was able to reflect on her own experiences and gain an understanding that her behaviour was learnt from what she had observed from her dad. The worker used a new tool looking at the impact of female to male domestic abuse and the consequences that her behaviour could have on her future relationships as she transitioned into adulthood.

Sally is now at the stage that she is recognising that she needs to make different choices around her negative behaviour. Mum has stated that she has begun to see changes in her daughters behaviour at home and there has been a decrease in her abusive behaviour.

Agency	West Midlands Police

Executive Summary

In June 2014 her Majesty's Inspector of Constabulary (HMIC) carried out an inspection of the West Midlands Police response to Child Abuse; the report can be found at:

http://www.justiceinspectorates.gov.uk/hmic/?type=publications&s=&cat=child-protection&force=west-midlands&year=2014

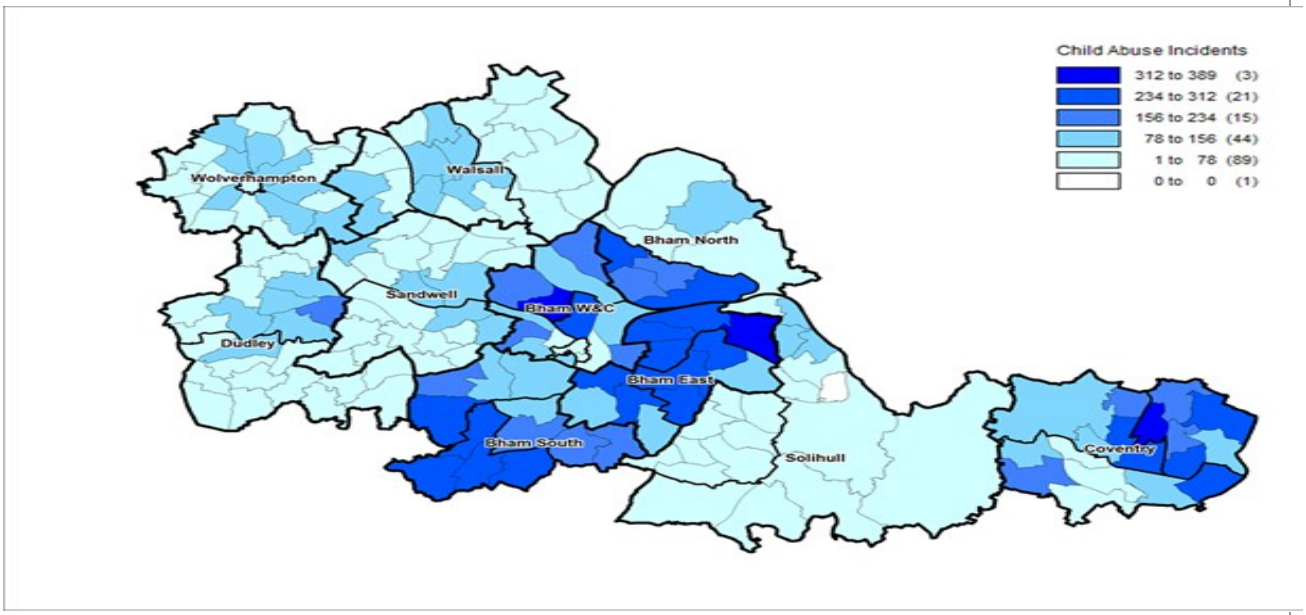
The report made a number of recommendations that were accepted by the force. An action plan was drawn up to address the issues highlighted and the work to improve the service to children in the force has continued. The updated action plan and was presented to Wolverhampton Local Safeguarding Board in February 2015

The report was independent and represents an in depth assessment into child abuse services within the force. It should be noted that the revised force structure for public protection had not been implemented at that time, have commenced implementation in late June 2014, reaching completion in November 2014.

Emerging Themes

The increase in cases (crime and 'non-crime' child abuse investigations) that have to be managed and investigated by the Wolverhampton Child Abuse Investigation Team (CAIT) has increased significantly between April 2014 and March 2015, with non – crime incidents concerning children having shown a particular increase to over 65% compared with the previous year.

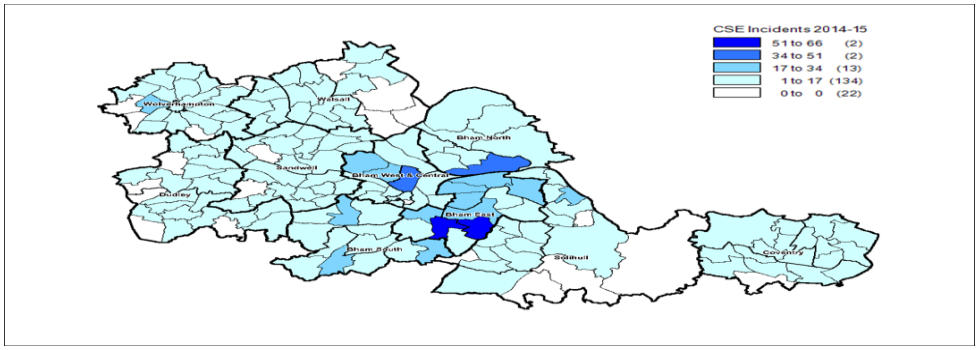
The below graphic shows the number of recorded Child abuse incidents (crimes and non-crimes) across the West Midlands Police area, including Wolverhampton between 1 April 2014 and March 31 2015



Child Sexual Exploitation cases are continuing to increase; the improved focus of all

partner agencies in this area of child abuse is leading to the early identification of victims and offenders. As a result in Wolverhampton the workload for the police CSE Coordinator has increased significantly and with it the demand from local policing colleagues and partnership teams.

The below graphic shows the number of recorded CSE incidents (crimes and non-crimes) across the West Midlands Police area, including Wolverhampton between 1 April 2014 and March 31 2015



The structure and governance for the Wolverhampton child sexual exploitation and missing group (CMOG) from a police perspective has continued to develop and improve; the volume of cases is a challenge in terms of being able to progress actions and to obtain effective updates however the excellent relationships within the CMOG and the commitment by all agencies has ensured that each child has a robust and appropriate plan in place, updates are provided by partners at each meeting and outcomes are being tracked..

Challenges

The level of resource required to review, manage and complete investigations within the child abuse investigation arena is significant.

West Midlands Police are also committed to the introduction of a multi-agency safeguarding hub for children in Wolverhampton (MASH) and to developing enhanced structures around bringing offenders to justice for CSE.

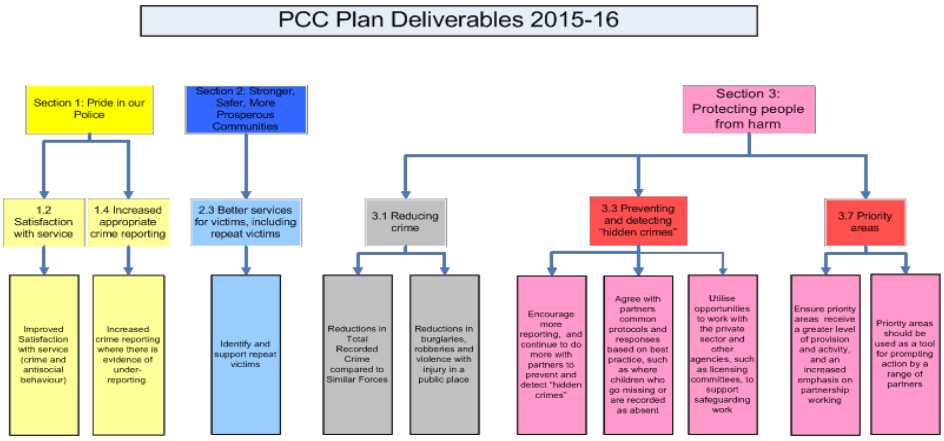
These present significant resourcing challenges which will continue to be kept under review to ensure that we are meeting the increasing demands for service in these critical areas.

West Midlands Police is still facing considerable funding reductions over the next five years and the imperative to identify a sustainable resourcing model is clear; therefore the need to work closely with partners to improve the early identification of risk and 'need' is vital to ultimately reducing the demand and volume of cases that present a greater risk.

The challenge facing West Midlands Police financially over the next five years equates to saving £25 million per year; to this end the force has developed a programme to redesign the organisation (Policing 2020).

The Policing and Crime Plan developed and implemented by the Chief Constable and the Police and Crime Commissioner (PCC) sets out the force priorities; this clearly reflects

the commitment of West Midlands Police to tackle crime against the vulnerable, reach all communities and tackle 'hidden crime' and is as follows:



TRAINING

The force has invested heavily in a structured learning and development training plan for all areas of vulnerability; this programme has now been delivered to the vast majority of operational 'front-line' police officers and supervisors.

All dedicated child abuse investigators are either experienced, trained detectives or are working towards detective status on the nationally accredited ICIDP (investigative training) programme

All CAIT officers attend the specialist child abuse investigators course (SCADIP) and supervisors the responding to child death course

All local policing officers and child abuse specialists have been given specific training on key areas of child abuse, including ensuring that the voice of every child is captured and put at the heart of our decision making, that children who are impacted on by domestic incidents are identified and referred for joint agency discussion and appropriate response, that appropriate processes used to capture evidence from children are utilised and specially trained officers deployed and that indicators of CSE are identified and referrals made accordingly.

West Midlands Police have a structure for bringing together Sergeants and Inspectors to discuss the findings of multi and police only reviews and examples of good and poor practice; this supports the development of teams.

West Midlands Police have delivered a training package to all frontline police officers (constable and sergeant level) to improve their knowledge and awareness of child safeguarding within the broader context of vulnerability.

In addition the force has developed an awareness package supported by an 'Aide Memoire' titled 'Improving our services to children'; this was developed to address the need to improve practice and recording information obtained by police officers from their interaction with children. This has been delivered by local policing senior leaders to their teams so that the commitment of local police leaders is clearly heard by frontline officers.

West Midlands Police will seek to increase the level of multi-agency training for police officers and staff within the MASH and those who require training around Strengthening Families.

Police Officers are also required to complete 'E-learning' packages that are provided through the National Centre for Applied Learning technologies (NCALT) system.

POLICY AND PROCEDURES

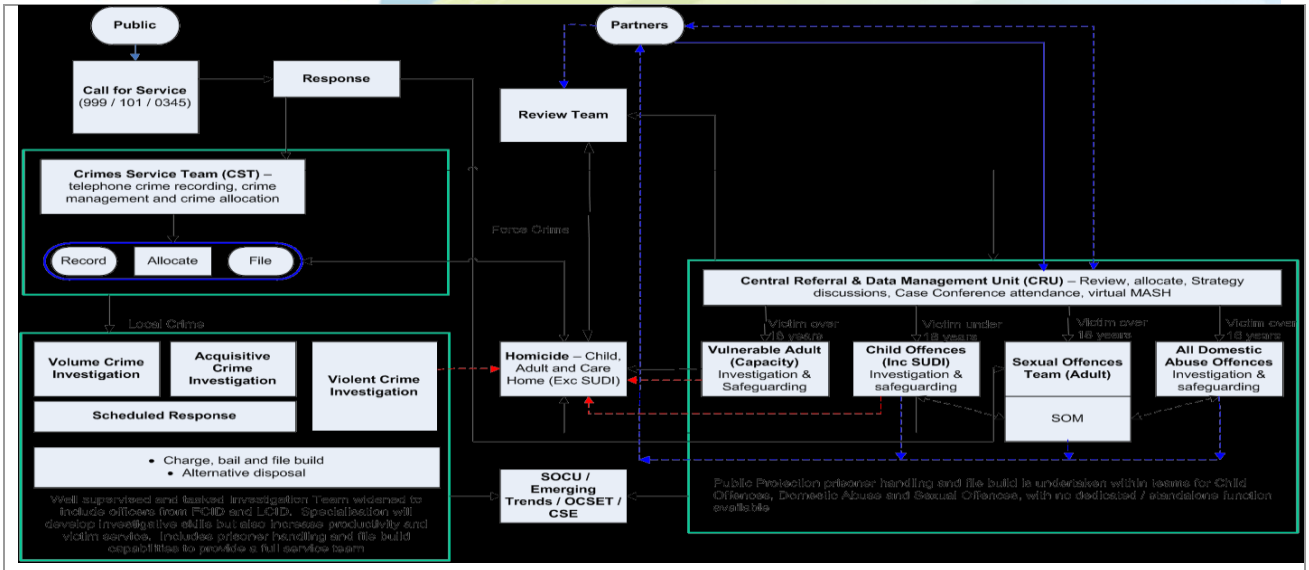
Following a review of investigative structures and processes across the force area introduced in June 2014, there are now 153 constables dedicated to local Child abuse investigations across the force, made up of 7 teams each covering a local authority area, including Wolverhampton. These are supported by a central online child sexual exploitation team (14 constables), the central CSE team (15 constables) and a central referral unit into which all referrals from partners regarding potential child protection issues are received and initially assessed before being forwarded to local CAIT for further action / strategy discussion and section 47 activity (joint agency response with children's services)

Local CAITs manage all investigations into sexual abuse of a child under 18, all neglect, physical and emotional abuse of a child under 18 where offender is inter familial, in a position of trust or by someone with responsibility for the child, all HBV, FGM, FM on a child under 18 and all SUDI and SUDC's (sudden, unanticipated death of an infant under 2(SUDI) or a child aged 2-18 (SUDC). This includes all CSE investigations with the exception of the most critical, complex and voluminous CSE investigations which are managed by the Central CSE team and allocated via force tasking processes

To support this change in the structure and processes for managing investigations across the West Midlands, clear and detailed operating principles and service documents have been developed for every team and officer working within Child Abuse which are accessible on the force intranet page.

There is a trained child abuse manager on duty between 8x4 every week day and on call from 4pm each night and at weekends. Standard operating principles have been developed determining the roles and responsibilities of all officers within child abuse, including on call functions.

The following diagram details the process for responding to and investigating child abuse / child protection issues by West Midlands Police:



WMP has fully implanted the regional framework for CSE, including the CSE risk assessment and screening tools, each CAIT DI chairing the local authority CSE and Missing multi agency operational groups and the police CSE coordinator attending each multi agency sexual exploitation (MASE) meeting.

COMMUNICATION

West Midlands Police have a comprehensive internal and external communications strategy which incorporates the West Midlands Police website (www.west-midlands.police.uk) that not only provides the public with general information regarding organisational communication and information, but includes hyperlinks to local geographic areas, including Wolverhampton Local Policing Unit (LPU) so that localised, specific information on information and police contacts unique to Wolverhampton can be assessed 24 hours a day.

West Midlands Police utilises social media opportunities to communicate with and engage our local communities both at a force and local level, including each of the neighbourhood teams in Wolverhampton having Twitter pages which daily tweet updates and local information (plus an overarching LPU twitter feed@wolvespolice and the LPU Senior Leadership team, @fraser9529wmp)), the Wolverhampton Police Facebook site (which currently has over 5000 'likes'), a Flickr and a Wolverhampton Police YouTube presence.

All West Midlands Police officers and staff have a personal email account that can receive and send internal and external email correspondence, we have a West Midlands Police intranet site which communicates force issues and information to staff, supported by a dedicated Wolverhampton LPU and PPU intranet sites where further local and Child Abuse specific information is made available to all staff.

West Midlands Police produce a daily e-bulletin called 'Newsbeat' which disseminates to all police employees daily key information, good news and updates on policy, processes and organisational structures.

Within the PPU a dedicated PPU specific newsletter is also regularly produced and made

available to all staff.

These 'electronic' communication opportunities are supported by public and partnership meetings and communication forums (further details of which can be found on the local police webpage and LSCB site), daily team briefings and a structured 'team talk' programme whereby senior managers deliver awareness raising and discussions around key topics.

IMPROVING QUALITY

West Midlands Police completes Section 11 audits for all 7 Local Authority areas, including Wolverhampton.

We are active participants in the schedule of multi – agency audits co-ordinated by the LSCB and support this with an internal programme of audit and lessons learnt within the organisation both at LPU and PPU level.

In response to the findings from HMIC and as part of our 'next steps' plans to continue to improve the service we are delivering to children, West Midland Police is seeking to strengthen its audit processes and invest in a small dedicated team of officers who will undertake regular, structured single agency audits determined by identified areas of risk and requirements that will feed into our bi – monthly Service Improvement meeting structure and allow us to conduct comprehensive analysis and develop action plans around where we can improve our service to children and vulnerable people.

CONTRIBUTING TO PERFORMANCE MANAGEMENT

Following the restructure of investigative functions an updated data set around performance management has been developed.

This provides a range of criminal justice and staffing information (including outcomes from calls for service, reported crimes, vacancy rates, outstanding suspects and timeliness of investigations).

Each LPU has monthly performance meetings where this data is considered alongside other management information (such as response times, training information) and good practice / opportunities to improve and barriers to service identified.

As referenced above, the PPU are committed to strengthening their internal audit and data management team and recognise that this is an area for development going forward, with a clear focus on agreeing consistent and appropriate data sets with all LSCBs and ensuring that we provide timely and accurate data to partners to support a fully informed and cohesive partnership approach to improving our service to children in the future

Contribution to the LSCB and sub committees

West Midlands Police is an active contributor to the LSCB and its committees and is equally held to account by the board.

Each LSCB meeting is attended by the Chief Superintendent of Wolverhampton LPU) and the DCI responsible for all Child Abuse investigations across the city.

The DCI leads on Priority area 3 for the board and is the chair of the LSCB SEMT Committee, with the DI for Child Abuse chairing the CMOG.

The DCI also sits on the Wolverhampton LSCB Chief executive group and Serious Case

Review committee with the DI being a member of the Child Death Overview panel.

West Midlands Police do not provide representation for the Quality, Performance, Communications, Learning and Development sub committees of the Wolverhampton board, however attendance and commitment to the work of the LSCB is strong and energetic and informed contributions (and challenges) to all business areas made through those and virtual forums.

Moving forward, West Midlands Police remains committed to the introduction of a Multi-Agency Safeguarding Hub and provides the post of Vice Chair to the strategic group overseeing the development and implementation of a MASH in Wolverhampton and is a member of the Operational group designing the agreed model.

Agency	Wolverhampton City Council: Children's Social Care

How does your agency demonstrate its commitment to safeguarding children and the work of the Board in relation to the following areas?

TRAINING - *Promoting, delivering and evaluating single agency & multi-agency training*

- Basic Awareness – Neglect: including two train the trainer's workshops to agree what the single agency training should consist of.
- Learning lessons from Serious Case Reviews and Audit: A series of 6 briefings were held in December 2014/January 2015
- The WSCB Multi-agency training programme: Supporting the delivery of training to ensure that the workforce maintain appropriately updated on their knowledge in respect of legislative changes; new guidance and local policies and procedures.
- Induction - A number of e-learning modules have been developed and incorporated into the Councils Induction Programme to ensure that all employees irrespective of the Directorate understand their personal responsibilities to ensure children and young people are safeguarded; including what to do if they believe a child is vulnerable to child sexual exploitation. These e-learning modules are also available for Councillors to complete.
- Social Workers have had single agency training opportunities and trained in the use of the Home Inventory (Child and Family Training) –They were also trained in Safeguarding Children: Assessment and Analysis Framework (SAAF) –

POLICY AND PROCEDURES – *embedding policy and procedure in practice*

- WSCB CSE Toolkit –Work was undertaken jointly with the West Midlands Police Constabulary PPU to agree the processes to be followed by the Police, Children's Social Care and the Safeguarding Service to ensure that children vulnerable to Child Sexual Exploitation were appropriately supported.
- Children Social Care Policies and Procedures – local policies and procedures are aligned with WSCB procedures; which are referenced to ensure front-line staff are working in accordance with the WSCB Inter-agency Child Protection and

Safeguarding Procedures. All staff are notified of new procedures as these have been authorised for publication by the Service Director (Children, Young People and Families); and case file audits undertaken by the local authority consider whether policies and procedures are being adhered to. The Children Social Care, Policy Officer is a member of the WSCB Law, Policy and Procedures committee to ensure consistency.

- Safeguarding Guidance for Councillors – This guidance is reviewed annually and briefings are offered to new Councillors as required; to ensure they are cognisant of their safeguarding and corporate parenting responsibilities.

COMMUNICATION – *sharing all relevant information with the workforce*

- Safeguarding Newsletter – The Safeguarding and Quality Service publishes a newsletter which is circulated to staff across the People Directorate.
- Children's Social Care – A quarterly newsletter is published and circulated to staff across the Children's workforce.
- Safeguarding Newsletter; compiled on a monthly basis by the Voluntary Sector Representative, is disseminates to all WSCB partners of both adults and children workforce, including Council employees.
- The Lead Member for Children, Young People and Families meets weekly with the Strategic Director (People) and Service Director (Children and Young People); which promotes robust scrutiny and challenge.
- Safeguarding Challenge Meetings are undertaken with the Lead Member, Managing Director and Leader of the Council quarterly with a focus on performance management information and safeguarding; to examine the effectiveness of service provision. The Council has a good understanding of its corporate responsibilities in regards to ensuring children are effectively safeguarded and their welfare promoted. To support Councillors the guidance in respect of their duties and responsibilities to safeguard and promote the welfare of children, young people and adults 'at risk or in need of protection' has been updated.

IMPROVING QUALITY– *single agency audit, supervision, Section 11 etc*

- Case File Audits – These have been undertaken by the Children's Social Care Management Team (including the Managing Director and Strategic Director – People) on a monthly basis. Learning from audits has been discussed at the quarterly cross-service Safeguarding Meetings to ensure learning is disseminated as widely as possible and recommendations from audit have been addressed through the development of service related actions plans. Findings from audit have contributed to the Workforce Development Programme for Social Workers and Managers.

- Health Check – the local authority is required to undertake an annual 'health check' of the organisation on a range of issues affecting the workload of social workers and to support the implementation of a set of national standards for employers and a supervision framework for practitioners. The framework identifies five key topics and areas that require improvement; as follows:
    - Effective Workload Management
    - Pro-active Workflow Management

- Having the Right Tools to Do the Job
- A Healthy Workplace
- Effective Service Delivery

The Annual Health Check Report 2014/15 for both Children's and Adults Social Care Services will be submitted to the People Directorate Social Work Development Board.

- Dip Sample Audits – In addition to the monthly Case File Audits; the Head of Service for Children in Need of Help and Protection; and the Head of Service for Looked After Children have undertaken a number of dip sample audits to ensure that changes in policy/practice directly arising from the 'monthly' audits has been embedded across Children's Social Care services.
- Supervision – Whilst supervision audits have been undertaken; these have not resulted in consolidation of learning across Children's Social Care. It has been recognised that this is an area of management oversight which requires strengthening and work will be undertaken during 2015/16 to develop a 'Competence Based Supervision and Appraisal Policy' which will include the use of reflective practice; and a report is scheduled to be submitted to the People Directorate Social Work Development Board in 2015.
- Multi-Agency Case File Audit – The WSCB undertakes quarterly multi-agency case file audits; and this process is actively supported by Children's Social Care.

What were the agreed safeguarding objectives for 2014/15?

- In order to achieve these priorities senior managers have continued to examine how to:
  - Do things differently for less
  - Manage affordable demand
  - Shift the balance of care
  - Ensure the 'Home First' principle is embedded
  - Ensure personalised approaches are embraced and services reshaped to support Asset based working
- Develop and embed whole system, corporate and integrated approaches with partners
- Further stimulate innovation and creativity
- Ensure those we serve continue to be at the heart of everything we do

There is a genuine commitment within Wolverhampton to promoting early intervention work ensuring children and families get access to early help.

Achievements against the above Objectives :-

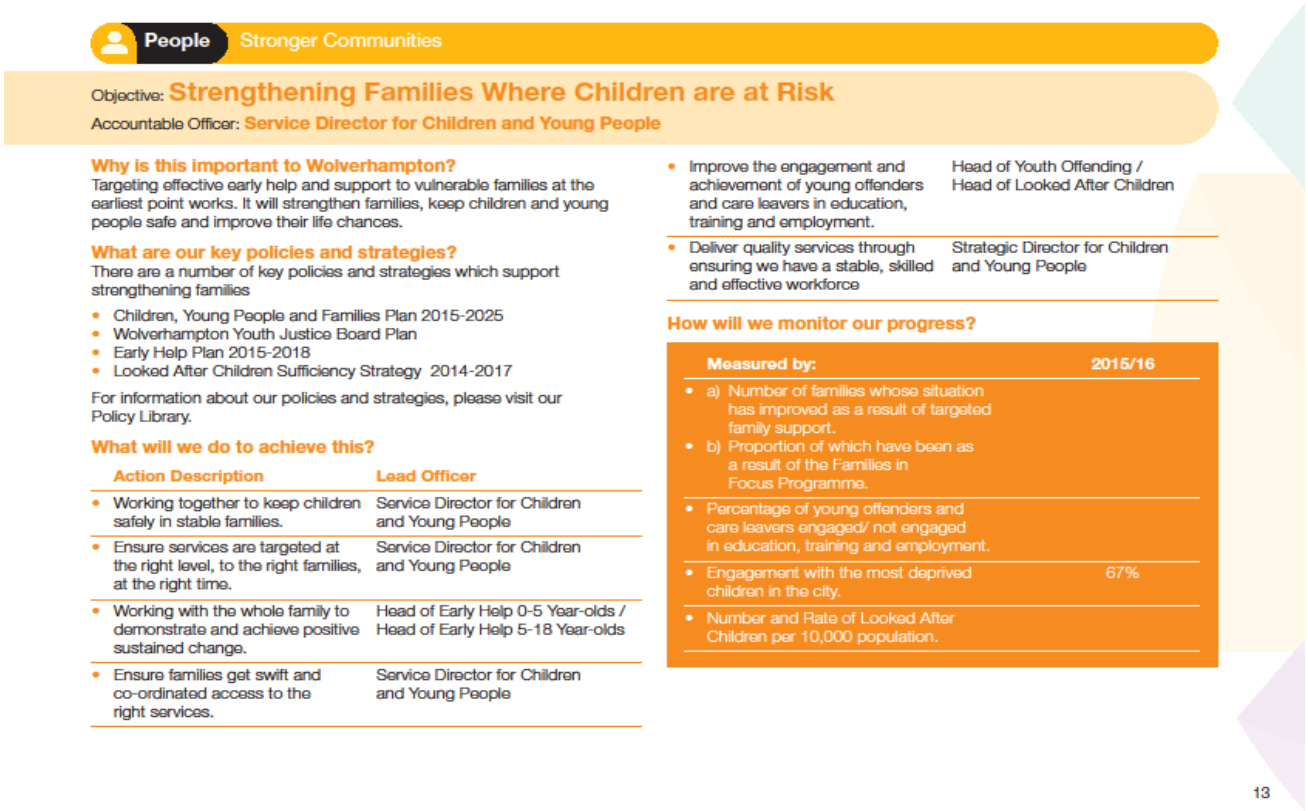
- During 2014/15 the People Directorate achievements included:
  - Implementation of new operating model integrating early help
  - Families are First programme
  - Decrease in numbers of Looked After Children
  - Transfer of Families in Focus programme into Early Help
  - DCLG funding

- The service was re-structured to align early help services and those of Children's Social Care across the City. This resulted in the creation of 18 Social Work Units,

which are co-located with early help services and Health Visitors in Children and Family Support Centres.

In relation to safeguarding children, what are your priorities/objectives for 2015/16

- The City Strategy outlines a shared partnership vision for Wolverhampton and its goal of 'prosperity for all' will be achieved through the close collaboration of partners in: encouraging enterprise; empowering people and communities and re-invigorating the city. A shared commitment to undertake early intervention and prevention is one of the five priorities within its 'empowering people and communities' theme.
- Wolverhampton's Corporate Plan confirms the Council's commitment to vulnerable families; and sets out the way in which the Council intends to develop and improve its services. It focuses on a combination of those issues that matter the most to local people, the national priorities set by Central Government and the unique challenges arising from the changing social, economic and environmental contexts.
- Strengthening Families Where Children are at Risk is the principle objective of the Children and Young People's Service for 2015/16 and aims to ensure effective early help and support is provided to vulnerable families at the earliest point possible. This is underpinned by a number of policies and strategies which support the strengthening families' agenda:
    - Children, Young People and Families Plan 2015-2025
    - Wolverhampton Youth Justice Board Plan
    - Early Help Plan 2015-2018
    - Looked After Children Sufficiency Strategy 2014-2017



People | Stronger Communities

Objective: **Strengthening Families Where Children are at Risk**

Accountable Officer: **Service Director for Children and Young People**

Why is this important to Wolverhampton?

Targeting effective early help and support to vulnerable families at the earliest point works. It will strengthen families, keep children and young people safe and improve their life chances.

What are our key policies and strategies?

There are a number of key policies and strategies which support strengthening families

- Children, Young People and Families Plan 2015-2025
- Wolverhampton Youth Justice Board Plan
- Early Help Plan 2015-2018
- Looked After Children Sufficiency Strategy 2014-2017

For information about our policies and strategies, please visit our Policy Library.

What will we do to achieve this?

Action Description	Lead Officer
Working together to keep children safely in stable families.	Service Director for Children and Young People
Ensure services are targeted at the right level, to the right families, at the right time.	Service Director for Children and Young People
Working with the whole family to demonstrate and achieve positive sustained change.	Head of Early Help 0-5 Year-olds / Head of Early Help 5-18 Year-olds
Ensure families get swift and co-ordinated access to the right services.	Service Director for Children and Young People
Improve the engagement and achievement of young offenders and care leavers in education, training and employment.	Head of Youth Offending / Head of Looked After Children
Deliver quality services through ensuring we have a stable, skilled and effective workforce	Strategic Director for Children and Young People

How will we monitor our progress?

Measured by:	2015/16
a) Number of families whose situation has improved as a result of targeted family support. b) Proportion of which have been as a result of the Families in Focus Programme.	
Percentage of young offenders and care leavers engaged/ not engaged in education, training and employment.	
Engagement with the most deprived children in the city.	67%
Number and Rate of Looked After Children per 10,000 population.	

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As part of the Service Transformation Phase 2, the Local Authority has engaged iMPOWER Consultancy Service to undertake a short term piece of work with Wolverhampton, funded through the LGA. iMPOWER's findings has resulted in a decision being made that the Council should establish an Edge of Care Service as a matter of priority due to the continued challenge it faces in relation to the numbers of children who are looked after. It is recognised that there is a need for a high quality, responsive support for families in crisis and the development of the Edge of Care Service is geared to address this gap in provision.

The current service structure for Early Help Services of a 0-5 and 5-18 service areas will as a consequence require transformation such that the proposal is for Early Help Services 0-18 to be bought under the management of a single Head of Service and the Edge of Care Service being the responsibility of a second Head of Service. All of these developments are part of a whole system review and the specific details of what the service will look like going forward will be defined over coming months.

Agency	Youth Offending Team

How does your agency demonstrate its commitment to safeguarding children and the work of the Board in relation to the following areas?

TRAINING –

Over the last year, the YOT has actively sought opportunities to train staff in Safeguarding specific issues on a multiagency basis. Key training provided included: Learning from SCRs., PREVENT training, Risk and vulnerability management training, Information sessions re MASE. The YOT has also participated in the mandatory WCC training.

POLICY AND PROCEDURES –

The YOT has redesigned its Risk and Vulnerability Strategy to ensure it is fit for current purpose and it embraces current issues such as PREVENT, MASE and other procedures. All staff have been trained in respect of this policy.

COMMUNICATION

YOT awaydays have been utilised to share all relevant information with the workforce along with other meetings such as case managers, YOT officers etc.

IMPROVING QUALITY– the YOT has undertaken a number of audits over the last year relating to a sample caseload. Learning is embedded by staff sharing in the audit process and being sighted on the findings which are followed up in supervision.

The YOT also has in place an active Section 11 audit.

All YOT Court and Panel reports are gate kept to ensure standards are maintained and Safeguarding issues are to the fore.

CONTRIBUTING TO PERFORMANCE MANAGEMENT– the YOT supplies regular returns to

the YJB , CYP, and SWP in respect of current performance. Current National Standards audit relates to victims and prevention services.

What were the agreed safeguarding objectives for 2014/15?

Our main objective for 14/15 was to ensure that our risk and vulnerability policy and procedures was modernised and embedded in the work of the YOT and that has been achieved. Two of the YOT management team were trained as PREVENT trainers. The YOT is working to embed MASE procedures as part of our mainstream work. The YOT is an active partner in WSCB committees.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

In a climate of reducing resources, the YOT strives to be an active WSCB member and contribute to the development of Safeguarding children. The YOT is active in the development of the MASH.

Acronyms Explained

A & E	Accident & Emergency
BCPFT	Black Country Partnership Foundation Trust
BME	Black and Minority Ethnic
CAFCASS	Children and Families Court Advisory Support Service
CDOP	Child Death Overview Panel
CP	Child Protection
CPP	Child Protection Plan
CiN	Child in Need
CMOG	Child Missing Operational Group
CP-IS	Child Protection Information Sharing
CRH	Central Referral Hub
CRU	Central Referral Unit
CSE	Child Sexual Exploitation
CTB	Children's Trust Board
CYPS	Children and Young People's Services
DFE	Department for Education
DHR	Domestic Homicide Review
FGM	Female Genital Mutilation
FM	Intensive Surveillance and Supervision'
HWBB	Forced Marriage
IRO	Health and Well-Being Board
IMR	Independent Review Officer
ISS	Independent Management Review
JSCG	Joint Safeguarding Children Group
LAC	Looked After Children
LADO	Local Authority Designated Officer (Allegations)
LSCB	Local Safeguarding Children Board
LSOA	Local Super Output Areas
MARAC	Multi-agency Risk Assessment Conference
MACFA	Multi-agency Case File Audit
MASE	Multi-agency Sexual Exploitation Meeting
POT	Position of Trust Meeting
PPU	Public Protection Unit
RWT	Royal Wolverhampton Trust
SWP	Safer Wolverhampton Partnership
SCR	Serious Case Review
SEN	Special Education Need
SEMT	Sexual Exploitation, Missing and Trafficked
SWMPT	Staffordshire & West Midlands Probation Trust
VAWG	Violence Against Women & Girls
VCO	Voluntary & Community Organisations
WCC	Wolverhampton City Council
WDVF	Wolverhampton Domestic Violence Forum
WIFRN	Wolverhampton Inter-Faith & Regeneration Network
WMP	West Midlands Police
WSAB	Wolverhampton Safeguarding Adults Board
WSCB	Wolverhampton Safeguarding Children Board
YOT	Youth Offending Team
	Youth Organisations Wolverhampton

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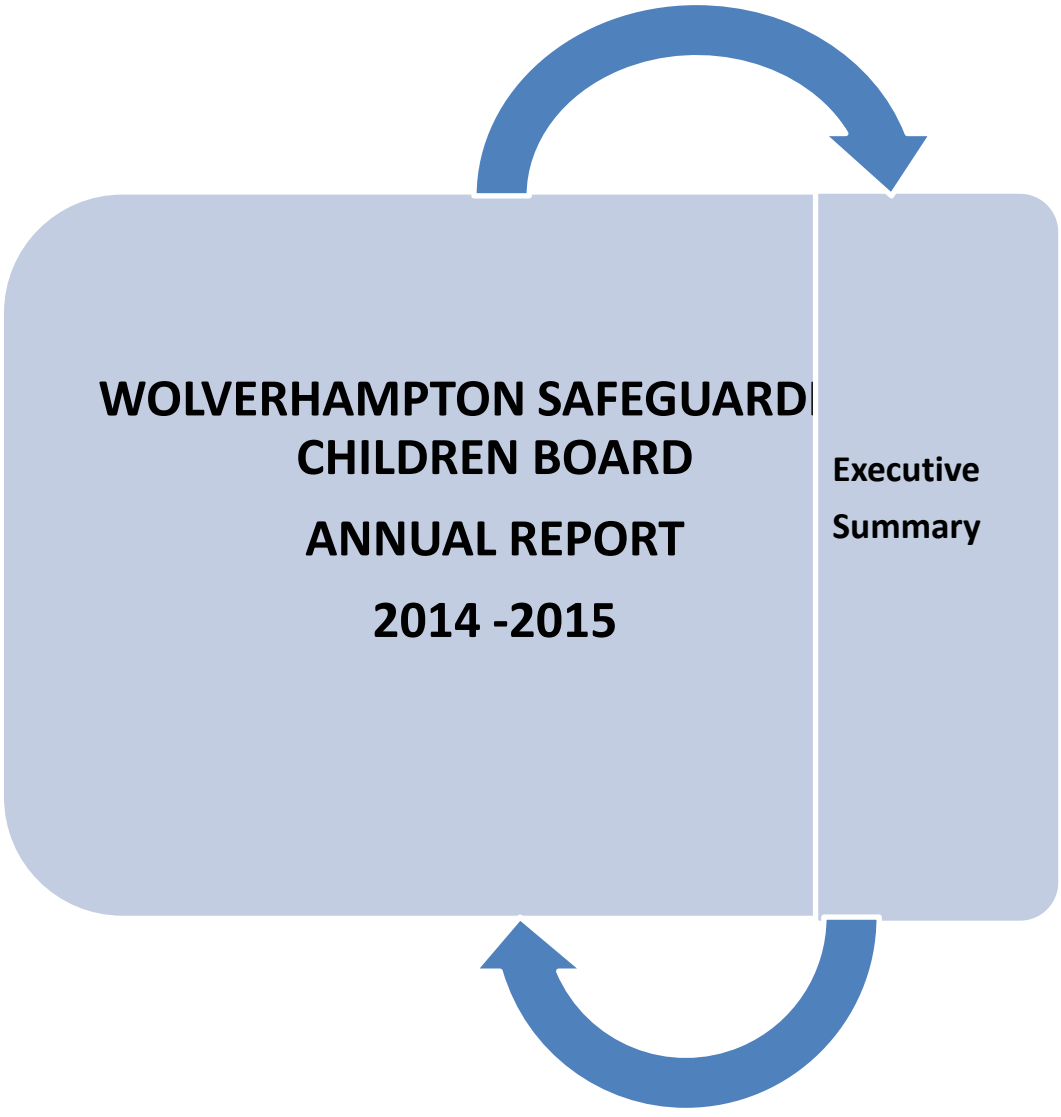
WOLVERHAMPTON SAFEGUARDI
CHILDREN BOARD
ANNUAL REPORT
2014 -2015
Executive
Summary

This executive summary highlights some of the work undertaken by the Wolverhampton Safeguarding Children Board during 2014/15. It describes the Board's structure, activity and highlights the key progress achieved against the priorities for the reporting period.

The annual report provides an analysis of the effectiveness of the Board and reflects on the activities and best approaches to ensure constant improvement.

There have been many developments and achievements during this reporting period, with this, it is hoped that you will find the annual report interesting and useful and urge you to share it far and wide so that more and more people become aware of who we are, what we do and, critically, speak to us about how we can improve the lives of our children. For a copy of the full annual report; please contact 01902 550645 or visit our website: www.wolvesscb.org.uk

In Wolverhampton, we advocate that Safeguarding is Everyone's Responsibility, this is the case whether you are a professional, a parent, a volunteer or none of those we all have a responsibility to ensure that children have the best possible start in life, growing up happy, healthy, safe and have the opportunity to access the right level of service and support, at the right time, to be able to achieve their full potential. The job of the Board is to ensure that the efforts of those agencies and groups who have contact with children work individually and collectively to ensure that children are helped, supported and protected.

Wolverhampton is the home town to approximately 56,353 children and young people under the age of 18 years, or approximately 20% of the total population in the area.

The annual report details the Boards role and function to safeguarding children in line with Section 13 of the Children Act 2004 which required each local authority area to establish a Local Safeguarding Children Board (LSCB); it also specifies the organisations and individuals that should be represented on the LSCBs. The membership of Wolverhampton Safeguarding Children Board (WSCB) complies with this requirement. Information relating to the Boards membership can be found within the appendices of the full report.

LSCB's have a range of roles and statutory functions, for the purpose of this years' annual report, the full objectives, role and functions are outline in the statutory guidance; Working Together to Safeguard Children (2013).

The current business priorities covering a three year period (2013-2016) were agreed by members' at the annual development day 2013 to help drive improvements against the core functions and requirements of the Board. These support the key objectives of the Business Plan priorities and themes which offers the underpinning framework for the work throughout this period

On the basis of all of the above, the work of the Board is informed by a set of clear priorities that is underpinned by an up to date and well-structured Business Plan.

Full information on progress against the strategic priorities can be found in the full report.

The Board's Objective and Business themes for 2014 – 16 are:-

	PRIORITY AREA	PRIORITY LEAD	ACTIVITY
1	**EFFECTIVE GOVERNANCE**	**E. Bennett** Service Director Children and Young People - WCC.	We will develop the capacity of WSCB and its infrastructure to effectively deliver the core functions of the Board to help keep children and young people in Wolverhampton safe.
2	**FRONT-LINE DELIVERY AND THE IMPACT OF SAFEGUARDING**	**M. Garcha** CCG EXECUTIVE LEAD NURSE	We will develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding and promoting the welfare of children & young people; and will hold partners to account.
3	**SAFEGUARDING FOR PARTICULAR VULNERABLE CHILDREN & YOUNG PEOPLE**	**M. Kerr** WMP: DCI – PPU	We will ensure that everything we do promotes improved practice to help safeguard and meet the needs of those children and young people who are particularly vulnerable, or are at increased risk of harm and improves outcomes for them.
4	**COMMUNICATE & ENGAGE**	**S. Dodd** PROJECT COORDINATOR - YOW	We will ensure that we engage children, young people, families and communities of all backgrounds and make up, in the work of WSCB.

The combined work of the Board is shaped from the WSCB Business Plan and the delivery against each area is driven by Committees, and/or Task & Finish Groups.

PROGRESS MADE AGAINST THE WSCB PRIORITIES DURING 2014-2015

PRIORITY AREA**: EFFECTIVE GOVERNANCE**
PRIORITY LEAD**: E. Bennett**; Service Director Children and Young People – WCC.

- Regularly monitored the appropriateness of representation of the Board and its Committees
- Increased the influence of the Board by strengthening relationships with other key strategic groups, e.g. the Health & Wellbeing Board and the Adult Safeguarding Board, Children Trust Board
- Established a Head-teachers Safeguarding Committee to drive forward and strengthen communication in relation to keeping children safe in educational establishments.
- Increase the funding stream to the Board to ensure there is capacity to deliver its core functions.
- Routinely reviewed the work of all Committees to ensure this is being effectively undertaken and where applicable influencing practice
- Reviewed the membership and Terms of Reference for each Committee
- Monitor the activities of the Boards Business Plan
- Introduced and monitor the Board's Risk Register

PRIORITY AREA**: FRONT-LINE DELIVERY AND THE IMPACT OF SAFEGUARDING**

PRIORITY LEAD: **M. Garcha**- CCG EXECUTIVE LEAD NURSE

Child Death Overview Panel (CDOP)

During 2014/15, 19 children died in our area, the CDOP reviewed each circumstance to identify any issues that could require a Serious Case Review (SCR); any matters of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; and make specific recommendation to the Board.

Serious Case Review

During 2014-15, 9 cases where brought to the attention of the SCRC. These cases were purely Wolverhampton children, one of which met the criteria for a serious case review. There is a delay in publication that is due to pending court proceedings. But we have not delayed responding, as the Committee has ensured that actions from this SCR are being implemented across all the relevant partner agencies.

Quality and Performance Functions

Quality of Performance has been a key priority for 2014/15. The Committee have throughout the year reviewed and scrutinised child protection activity performance data. Through the development of a more effective multi-agency dataset the Committee has provided written reports at each Board meeting on the analysis of data around safeguarding children.

The dataset has also been significantly improved during the year to a more multi agency tool to give the Board a picture of whether activities are making any differences to safeguard children and to adequately alert the Board of any risks in the system. Other subject areas monitored and reported on through this Committee; includes Section 11 Audits, Private Fostering, and Management of Allegations.

This Committee has also led on 3 Multi-Agency Case File Audits (MACFA) over the year. The themes; Children Missing, Self Harm and Adolescent Neglect, are summarised and findings disseminated through the partnership to frontline staff. Some of the findings from these exercises offered the assurance that practice was generally effective, there was evidence of good engagement from relevant agencies and that plans led to change in families and improvement in children's lives.

Whilst progress has been made in respect of the Quality and Performance functions of the Board, this area remains under further improvements for the Board.

Learning & Development Activities

Through this Committee there has been a consistent multi-agency programme of training that:

- Is informed by the Board's Learning and Improvement Framework,

- Is relevant to core business and priorities of WSCB
- Is aligned to statutory guidance, best practice and lessons learnt through the full range of reviews and audits undertaken by WSCB.

Highlight and feedback on WSCB training:

- Safer Recruitment training, including a recently devised refresher course remains popular.
- The demand for the 'Working Practices; Roles and Responsibilities training was in high demand with positive feedback. It will be necessary to increase the number of courses going forward in to 2015/16.

The most popular statements recorded over the year includes:

- increased confidence,
- improved skills
- much better informed on the knowledge base of each course;
- understood what this means for them in practice, and
- more confident that they would be better able to keep children and young safe as a result of the attending courses.

We held a conference with the Safeguarding Adults Board to raise awareness of Forced Marriage and Honour Based Violence

Going forward, the Committee intends to:

- further embed the WSCB's Learning and improvement Framework.
- Develop and implement of a single agency training endorsement and validation scheme to ensure the Board is fulfilling its responsibilities for quality assuring training in compliance with 'Working Together 2013'.

Law, Policies and Procedures

To support the Board in ensuring that safeguarding practice keeps abreast of new developments, during 2014-2015 this Committee have reviewed, revised, devised and published policies, procedures and practice guidance in relation to:

- Children missing from home and care,

- Self Harm Protocol,
- Sexual Exploitation, Missing and Trafficked (SEMT) strategic process, Child Sexual Exploitation induction programme, Multi agency sexual exploitation (MASE) meetings; and Child Missing Operational Group (CMOG) processes.
- Unborn Baby pathway for intervention
- Supporting Children and young people vulnerable to violent extremism strategy
- Cross Border Child Protection guidance under 'Hague Convention
- Safeguards for children who may be affected by gang activity
- Threshold for support practice guidance
- Escalation Policy; and
- Information Sharing Agreement which all member agencies have now endorsed has been developed to strengthen communication between the WSCB partners

Going forward, the LPPC will:

- ❖ To continue to scrutinise and localise all Board policy and procedural guidance to increase the support of local practice
- ❖ Maintain a close eye on new ways of working alongside the introduction of 'early help' support services and the associated 'new operating model', and ensure practice guidance, policies, procedures and protocols are revised accordingly.

PRIORITY AREA**: SAFEGUARDING FOR PARTICULAR VULNERABLE CHILDREN & YOUNG PEOPLE**

PRIORITY LEAD**: M. Kerr;** DCI West Midlands Police

<u>Sexual Exploited, Missing and Trafficked (SEMT)</u>

The WSCB SEMT Committee is a multi-agency partnership with a remit and duty to safeguard children and young who may be at increased vulnerability from sexual exploitation, missing episodes and trafficking in accordance with the policies, procedures and guidance outlined in local and national guidance and that of (WSCB).

SEMT Committee has been tasked with ensuring that:

- Children who are victims of, or at risk of CSE have their needs addressed and are effectively protected.
- Increasing the understanding of the situation relating to Child Sexual Exploitation within Wolverhampton, and across the region.
- Ensuring that information is appropriately shared regarding potential offenders and victims of particular vulnerable groups, and;
- Effective action plans are in place to protect the potential or actual victim from further harm.

This Committee also has oversight responsibility for CMOG and MASE activities and has progressed the work-stream for supporting the identification, assessment and safeguarding intervention of children at risk of sexual exploitation through the establishment of the tailored Multi-Agency Sexual Exploitation (MASE) meetings

Achievements for 2014/15

- obtained funding for a Child Sexual Exploitation (CSE) Co-ordinator
- Introduced Multi Agency Sexual Exploitation meetings for every child identified as at risk of CSE
- Embedded Regional CSE framework fully in Wolverhampton
- Developed and published a CSE Induction /Awareness pack
- Completed CSE multi-agency audit in January 2015
- Developed and delivered a multi- agency CSE training course
- Identified and implemented screening tool for CSE victims;
- Reviewed national guidance, reports and inspections to benchmark and improve practice in Wolverhampton
- Ensured every child is invited to participate in the multi-agency discussion around their needs.

PRIORITY **AREA: COMMUNICATE & ENGAGE**

PRIORITY LEAD**: S.DODD ;** PROJECT COORDINATOR - YOW

The Communication and Engagement Committee (C&EC), has a dual function to support both the Children and Adults Safeguarding Boards to:

Improve communication to the workforces of partner agencies

- Develop city-wide communication channels (websites, social media, press coverage, leaflets posters)
- Develop constructive and mutually respectful relationships with communities; making sure that equality and diversity is appropriately considered in all communication and engagement activity.
- Liaise and collaborate with WSCB and WSAB, relevant committees, partnership forums and service users in the above activities
- Promoted awareness of Private Fostering which has helped ensure that more privately fostered children and young people can be identified and supported

Oversee the activities of the B-Safe Team who this year has:

- Recruited, train and establish a dedicated group of young people as the first B-Safe Junior Safeguarding Board.
- Facilitated regular meetings and activities for the new Team, to include a combination of awareness of key safeguarding issues, training and consultation.
- Created and maintain a dedicated web presence for the B-Safe Team, including the use of social media as a communication channel to raise awareness of the Team and its activities.
- Employed a dedicated B-Safe Team coordinator
- Focused much of its attention on tackling bullying and online safety, coinciding with the national awareness days.
- Created a avenue of opportunities for the B-Safe Team to attend and report to the Board and vice-versa.

Summary of Challenges for 2014/15

In summarising, the Board can evidence that progress is being made, equally, we recognise that we have a number of challenges, these include:

We anticipate our challenges for the coming year include the following:

- To maintain the momentum in developing closer partnership working with other partnership/strategic boards and promote a culture of problem solving

- To ensure that all services (adults and children) embed the safeguarding of children and young people at the heart of what they do
- To improve communication across the partnership, particularly with frontline practitioners
- To further develop the coordination of safeguarding activity across the partnership and be further assured in regards to the multi-agency intervention and the quality of services through engagement with:
    - The education sector
    - Faith and community groups
    - GP's

We also need to turn attention to:-

- Recruiting a 2nd lay member to the board
- Assuring ourselves that we can respond effectively to issues relating to; Child Trafficking, Female Genital Mutilation (FGM), Stateless Children
- Increase the awareness of services and support to Disabled children and young people in the City
- Undertake an evaluation of the effectiveness of Early Help services in the City
- Ensure that the learning from the deaths of children are disseminated across the partnership and used to inform practice.

Responding to the challenges ahead the Board remains committed to:

- Ensuring the 'voice of the child' influences all that we do
- Effective partnerships in the context of change and reducing resources
- A clear focus on assuring ourselves of the effectiveness of quality of our multi-agency work with children and young people.

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Agenda Item No. 13

Health and Wellbeing Board

7 October 2015

Report title	Safeguarding Adults' Board Report 2014-15 Report of the Independent Chair	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders , Community	
Originating service	Adults' Safeguarding	
Report to be/has been considered by	Wolverhampton Safeguarding Adults Board	10 September 2015

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Provide assurance to Wolverhampton Safeguarding Adults Board that the respective agencies represented on the Health and Wellbeing Committee report annually to their respective boards on adult safeguarding;

2. Ensure all agencies represented at the Board have review current assurance mechanisms that they that can demonstrate their role and performance in relation to safeguarding arrangements for adults at risk.

3. To note the report

1.0 Purpose

1.1 The purpose of this report is to provide the Health and Wellbeing Board with a copy of the Wolverhampton Safeguarding Adult Board's (SAB) Annual Report and Executive Summary (**Appendix 1 & Appendix 2**), to inform the Board of safeguarding activity 2014/2015 and to present the Board with progress made against the priorities for 2013-16.

1.2 The report reminds members that Safeguarding Adults' Boards became a statutory requirement for each Council area from 1st April 2015

2.0 Background

2.1 The Chair of the Safeguarding Adults Board through the Safeguarding Manager - Adults is responsible for ensuring there is an Annual Report on behalf of the Wolverhampton Safeguarding Adults Board. The Annual Report contains contributions from the partner agencies who are members of the Board.

2.2 The report provides information regarding local safeguarding initiatives, the work and structure of the Safeguarding Board, progress against previous year priorities, partner achievements, and safeguarding data performance. An Executive Summary has also been produced, this summarises the key headlines from the full report and has been developed in recognition of the needs of the potential audience.

2.3 The Annual Report and Executive Summary is presented as a final draft at the September Board. It is a requirement that it is then presented to the Health and Wellbeing Board.

3.0 The Implications to Policy and Practice contained within the Care Act 2014

3.1 Considerable time and effort has been involved in ensuring that we have a Board, policies, procedures and practice which are compliant with the Care Act. The philosophy and legal framework are in some respects significantly different to those governing the safeguarding of children. For adults it is possible to make risky decisions which may place the adult at some risk as long as the individual has the capacity to do so. The individual perceived to be at risk is at the centre of any discussions about their safeguarding. This means that the concept of completion of any action within certain prescribed timescales is no longer a requirement. The Care Act also introduces a new and wider definition of safeguarding. Most significantly the responsibilities include the concept of Self Neglect. As one person's self neglect is another's rather eccentric lifestyle the issue of capacity remains. Where a person has capacity the role of partners may be to warn against lifestyles which could lead to physical harm or exploitation or possibly help minimise potential harm through monitoring and support. But, unlike children the power to remove is considerably more limited.

3.2 To support these changes we have reviewed Board membership. Statutory Guidance confirms that three essential members are The Police, The NHS and the local Council. They were previously well-represented and remain so. Most other members remain and we have included improved community representation through the voluntary sector. The budget to support our work is discussed under the Financial Implications heading.

3.3 Finally to support the new philosophy and expectations behind the Care Act we now have revised regional procedures – owned and endorsed by 14 Safeguarding Adults Boards in the region. This has been no small task and the lead officer for Wolverhampton, Sandra Ashton-Jones has played a prominent part in achieving this.

3.4 The Annual Report reflects the complex and wide ranging agenda that the Board, its working groups and partner organisations have been addressing throughout the year. In line with statutory guidance we now have a Strategic Plan that identifies our priorities. We have reduced our overarching priority areas from six to five by amalgamating two related areas of work. As part of what is now required we need wider community endorsement of this plan and through Health Watch we are arranging to do this. This Plan is included as **Appendix 3**

4 Progress against Priorities

4.1 The Annual Report outline our joint progress and also in an appendix to the report provides individual assurance statements from the organisations represented at the Safeguarding Adults Board. We have reviewed our 2013-16 priorities to reflect changes in legislation and guidance. More detail on both progress and future priorities can be found in the body of the Annual Report. Obtaining greater quality and consistency of those reports will be an important part of improving the report further next year. This Board agreed in January this year to do this but there is continuing evidence there is more work to be done.

4.2 For each of the Board's Priorities there is a lead who is responsible for driving the priority forward. The leads are all Board members and they report regularly to the Board on both the progress made and challenges faced. The Priority Leads make up the Board's Executive Group.

4.3 Over the past 12 months we have done more work to prevent neglect and abuse. In particular I would wish to highlight:

- We are reaching out to Faith Groups in the City to ensure that they are better aware of how to identify the signs of risk within their congregations and communities.
- Our main Social Housing providers have started their own safeguarding group to ensure there is a better understanding within housing providers of safeguarding issues and improve their response to it.
- We are also working more closely with GPs to ensure they also understand what they can do to support and protect their more vulnerable patients.
- People who have been assisted when at risk tell us that overall they feel much safer as a result of the intervention of those services that support them.
- Increased awareness of the law concerning mental capacity and deprivation of liberty has led to a massive increase in requests for assessments of people who may not have given consent for decisions to be made on their behalf or it could be argued their liberty is being compromised. This has been both a local and a national challenge.

4.4 There is more to do and this report outlines our priorities over the next 12 months and beyond. In particular I wish to highlight:

- Consulting with a wide range of local Citizens on our future plans to check what professionals believe are the main priorities are endorsed by local communities.

- Reviewing the effectiveness of the training that professionals use, ensure that all professionals are up to date and recommend improvements;
- Continuing to work with individuals at risk to ensure they feel safe and when they want us to intervene, improving the protection they are offered.
- Ensuring that we have performance data that can help us determine where we need to put more effort particularly into prevention.
- Working with faith groups by targeting those who at present are unsure how and in what ways to protect those they know work and worship with.

4.5 It is encouraging that the numbers of incidents of safeguarding that are reported continue to rise as we believe this represents greater awareness and commitment by care professionals and the public to report concerns and intervene earlier to keep people safe. It is equally encouraging that the vast people who had been subject to a safeguarding intervention felt safer as a result of this.

5 Financial implications

5.1 For the first time a range of financial and 'in-kind' contributions has formed a formal budget. It is £62,570 for the forthcoming year although the combined Probation Services are committed to increasing this by a further £3000. One of the issues for the partnership will be to consider why it is children's safeguarding has a significantly higher level of funding at £ 168,801. This significant difference reflects the national picture but has never been tested in terms of its acceptability among the members of both the children's and adults' Boards or within the Health and Wellbeing Board. During this year we need to confirm and legitimise this difference in funding levels or propose something different.

6.0 Legal implications

6.1 There are no direct legal implications arising from this report. The changes in law and guidance are covered under Section 3

7.0 Equalities implications

7.1 Safeguarding adults at risk is a concern for all communities. Improving public engagement – which includes raising public awareness about what safeguarding is and what people should do if they recognise it - is a joint priority for both the Safeguarding Children and the Safeguarding Adults' Boards. Work is currently underway to improve our links with all local communities both directly and also in part through improved links with faith groups.

8.0 Environmental implications

8.1 Comment briefly on the environmental implications of the report/proposals.

9.0 Human resources implications

9.1 There are no environmental implications arising from this report.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications arising from this report at this stage.

11.0 Schedule of background papers

11.1 Annual Report

11.2 Easy read summary

11.3 Strategic Plan

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Wolverhampton Safeguarding Adults Board

Annual Report 2014/2015

SEE Abuse STOP Abuse CALL 01902 551199

Wolverhampton Safeguarding Adults Board

Board Partners

YOW! Youth Organisations Wolverhampton

Wolverhampton Homes

West Midlands Police

Wolverhampton A Safe City

operating as Wolverhampton's Local Police & Crime Board

Staffordshire and West Midlands Probation Trust

Wolverhampton City Council

West Midlands Fire Service

The Royal Wolverhampton Hospitals NHS Trust

West Midlands Ambulance Service NHS Foundation Trust

Our Community you matter, we care

Black Country Partnership NHS Foundation Trust

NHS Wolverhampton Clinical Commissioning Group

Staffordshire & West Midlands Community Rehabilitation Company PROBATION

WDVF Wolverhampton Domestic Violence Forum

Introduction

Welcome to the 2014/15 annual report of the Wolverhampton Safeguarding Adults Board (WSAB). Anybody who has supported frail disabled or elderly relatives or neighbours will know all too well how vulnerable they can be to abuse or exploitation. This report is produced on behalf of the multi-agency Wolverhampton Safeguarding Adults Board and contains contributions from the wide range of agencies who are its members.

This year has seen a significant amount of work preparing for a change in the law in regards to protecting and supporting vulnerable people who are at risk of abuse or have been abused. From the 1st April 2015 the Government put the safeguarding of adults on an equal legal footing to that of children. The past year has been a time for preparing staff for this change and ensuring our policies and procedures reflect that. Many adults, unlike children, can choose to live in risky situations. Part of the job of the Board is to ensure staff and the public understand that although there is much they can do to support adults who may be at risk, there are times when we cannot insist they follow what to us might seem to be sound advice. It is and will remain a challenge.

Over the past 12 months we have done more work to prevent neglect and abuse. In particular we are reaching out to Faith Groups in the City to ensure that they are better aware of how to identify the signs of risk within their congregations and communities. Our main Social Housing providers have started their own safeguarding group to ensure there is a better understanding within housing providers of safeguarding issues and improve their response to it. We are also working more closely with GPs to ensure they also understand what they can do to support and protect their more vulnerable patients. People who have been assisted when at risk tell us that overall they feel much safer as a result of the intervention of those services that support them. Increased awareness of the law concerning mental capacity and deprivation of liberty has led to a massive increase in requests for assessments of people who may not have given consent for decisions to be made on their behalf or it could be argued their liberty is being compromised. This has been both a local and a national challenge.

There is more to do and this report outlines our priorities over the next 12 months and beyond. In particular I wish to highlight:

- Consulting with a wide range of local Citizens on our future plans to check what professionals believe are the main priorities are endorsed by local communities.
- Reviewing the effectiveness of the training that professionals use, ensure that all professionals are up to date and recommend improvements;
- Continuing to work with individuals at risk to ensure they feel safe and when they want us to intervene, improving the protection they are offered.
- Working with faith groups by targeting those who at present are unsure how and in what ways to protect those they know work and worship with.

It is encouraging that the numbers of incidents of safeguarding that are reported continue to rise as we believe this represents greater awareness and commitment by care professionals and the public to report concerns and intervene earlier to keep people safe. It is equally encouraging that the vast people who had been subject to a safeguarding intervention felt safer as a result of this.

Alan Coe - Independent Chair

National Developments

The Care Act 2014 sets out a clear legal framework for local authorities and other statutory agencies on how they should protect adults with care and support needs and who are at risk of abuse or neglect. New duties include the Local Authority's duty to make enquiries or cause them to be made, to establish a Safeguarding Adults Board; statutory members are the local authority, Clinical Commissioning Groups and the police. Safeguarding Adult Boards must arrange Safeguarding Adult Reviews (SARs) in circumstances where the defined criteria is met, publish an annual report and strategic plan. All these initiatives are designed to ensure greater multi-agency collaboration as a means of transforming adult social care.

Wolverhampton has remained committed to the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) Making Safeguarding Personal programme which aims to ensure the individual at the centre of any safeguarding concern has as much choice, power and control over how they are supported and protected. 2014/15 saw many more Local Authorities throughout England adopting the approach. In addition the approach can be clearly seen within the Statutory Guidance Safeguarding Adults section, which supports the implementation of the Care Act 2014.

The Supreme Court Judgement at the end of 2013-14 in relation to Deprivation of Liberty Safeguards (DoLS) widened and clarified the definition of deprivation of liberty. This has resulted in a significant increase in DoLS cases from hospitals and care homes nationally and locally. The judgement also widened the scope of DoLS to include adults living in the community requiring such cases to be put before the Court of Protection.

Regional and Local Developments

Throughout 2014-15 the Wolverhampton Safeguarding Adult Board was represented on the West Midlands Editorial Group, our safeguarding policies and procedures are used by all agencies and have been adopted by all 14 Safeguarding Adult Boards in the West Midlands region. They have been reviewed and revised to reflect the new government legislation and guidance.

Regional guidance has been developed in the areas of Self Neglect, Safeguarding Adult Reviews and Position of Trust. Work was undertaken to ensure that all the documents are both Care Act and Making Safeguarding Personal compliant. This is to secure a consistent approach to safeguarding adults across the West Midlands region.

A regional multi-agency Safeguarding Information Sharing Protocol (ISP) has also been developed and agreed by WSAB.

We have established a Housing Providers Safeguarding Forum which is a collaboration of social housing providers in Wolverhampton. It is an objective of the group and indeed the Board to receive assurances that social housing providers have robust policies and procedures in place around safeguarding and the aim is that this will ultimately be extended to private landlords and the private sector more generally. The Forum is chaired by Mark Henderson Director of Housing, Wolverhampton Homes.

In June 2014 we launched the new Safeguarding Adult DVD and workbook. The DVD features dramatized scenarios and an interview with the wife of a man who suffered abuse in an establishment in Wolverhampton. Copies of the DVD are available as a learning resource for care providers and agencies within the City. Please contact 01902 553218 if you are interested in receiving a copy.

The Structure and Work of the Board

The Wolverhampton Safeguarding Adults Board is well established and provides strategic leadership for adult safeguarding work and seeks to ensure there is a consistently high standard of professional response to situations where there is actual or suspected abuse.

The Board also oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults from abuse. The remit of the Board is not operational but one of co-ordination, quality assurance, planning, policy and development. It contributes to the partnership's wider goals of improving the well-being of adults in the City.

Alan Coe has been the Board's independent Chair since 2011. In February 2013, Alan also became the independent chair of the Wolverhampton Safeguarding Children Board. There are many advantages of having the same chairperson for the two Boards. A joint chair helps improve ways of preventative working as many issues are common to both adults and children such as domestic violence, and we have seen a greater emphasis on developing joint approaches to recognising and tackling abuse.

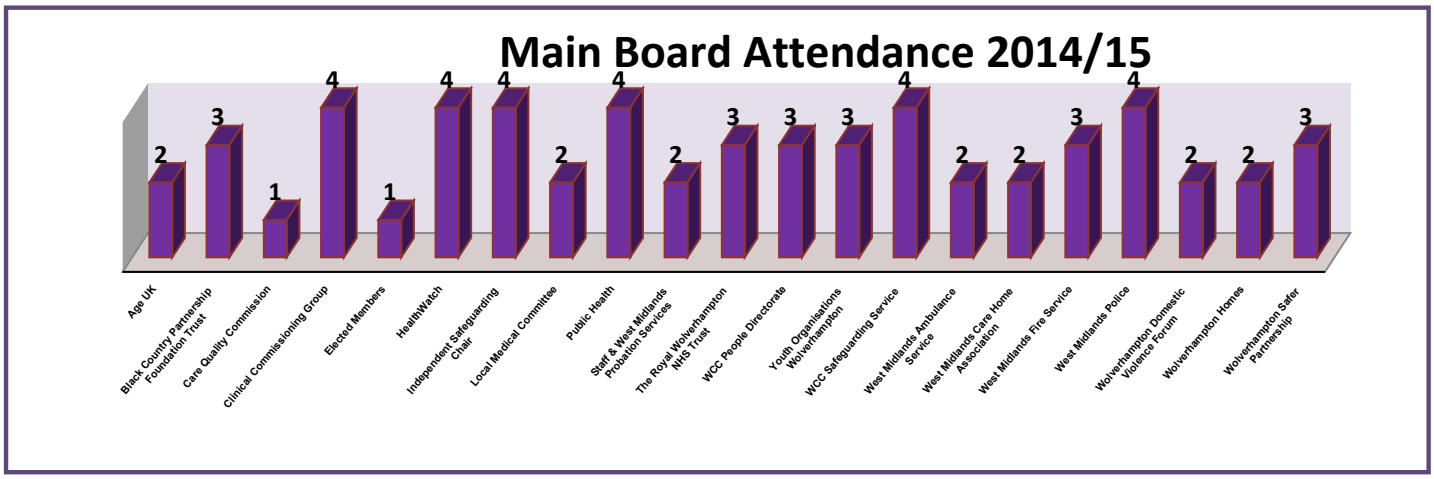
Currently, fifteen agencies are represented on the Board see Appendix 1 for list of Board members. It is agreed that the Care Quality Commission will attend and report on their activity at one Board meeting each year. The Board also has the support of an elected Council Member who attends meetings whenever he is able to do so and has participated in various adult safeguarding events.

The Board has four meetings per year; it also has one development event which usually takes place in March.

The development event this year focussed on preparations for the implementation of the Care Act and specifically reviewed the Board Priorities.

The minutes of all the open part of the meetings can be found on the Councils' Safeguarding Adults webpage: Wolverhampton City Council - Safeguarding Adults Board (SAB)

No Serious Case Reviews (now called Safeguarding Adult Reviews) were requested or undertaken during 2014/15.



The Board's Priorities

During 2014/15 we identified changes that we need to make to ensure the Safeguarding Board complied with the new legislation. This included developing a Board Constitution and Board Strategic Plan and the tightening of the Board's governance arrangements.

We have promoted the six principles that the Government expects local authorities, housing, health, the police and other agencies to follow and use for monitoring safeguarding arrangements into all Board work. The six principles are empowerment, protection, prevention, proportionality, partnership and accountability.

Summary of Progress against 2014/2015 Board Priorities

PRIORITY ONE: Better Outcomes **Service user experience and involvement in safeguarding enquiries directs improved practice**	
What did we want to achieve	**What did we achieve…..**
Ensure that the feedback and experiences of local people, who have had contact or been involved in safeguarding processes, influence and improve the way safeguarding is delivered and received **Ensure there are effective mechanisms for collating, analysing and responding to user feedback** **Ensure that we 'close the loop' by sharing how user feedback and experience has improved the way we work.**	▪ Wolverhampton Safeguarding Board partners contributed detailed information on what they do already to get feedback from people who use their service. ▪ New questions introduced on Safeguarding forms to find out what outcome is required and whether it has been achieved, also whether the person would be willing to participate in focus groups to discuss experience. ▪ Safeguarding leaflets now available and have been reviewed by service users. It is essential to continue to promote and encourage feedback through a range of methods including raising concerns with people who the individual considers can be trusted ▪ Healthwatch Wolverhampton worked in partnership with a local GP, to launch a carers corner on their website. This portal provides information for carers and professionals and was developed to be an effective citywide resource. ▪ Safeguarding week in October 2014 provided the opportunity to feedback to the public and undertake community engagement to demonstrate the importance of prioritising Safeguarding in Wolverhampton. ▪ A Making Safeguarding Personal e-learning package was developed to support social work practitioners to identify different tools and methods of working with adults at risk, maximising their involvement and ensuring they are at the centre of the safeguarding episode and that their views are heard and acted upon

Priorities for 2015/2016

- The priority for this year is to develop improved mechanisms to gather feedback and furthering the commitment to 'making safeguarding personal'.
- To undertake an advocacy feedback project, establishment of a reference group, and implementation of the user experience framework.

PRIORITY TWO: Quality Assurance Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place	
What did we want to achieve	**What did we achieve…..**
Develop multi-agency processes, including audits of shared cases, to ensure safeguarding practice is proportionate, effective and timely **Explore feasibility of identifying adults whose circumstances may make them vulnerable to abuse** **Make sure that agency learning from any Domestic Homicide Review is shared within WSAB Partner agencies** **Collate performance measures agreed by WSAB partner agencies, including those relating to service users' experiences, which gives it assurance that safeguarding processes are robust and make people feel safer.**	▪ We now have a set of performance measures for all partners on the board to contribute to rather than just the Council ▪ This information is presented at each Board. Partners are held accountable to meeting the needs of Safeguarding Board policies and procedures and provide assurance. ▪ Developed a multi- agency audit framework ▪ Domestic Homicide Reviews and Serious Case Reviews are a standing item on the Quality Assurance Committee agenda ▪ Commissioned Service User Feedback project to commence September 2015

Priorities for 2015/2016

- Collate and analyse feedback from Service User Feedback project to ensure that safeguarding processes are robust and make people feel safer

PRIORITY THREE: Information Sharing Improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk	
What did we want to achieve	**What did we achieve.....**
Ensure overall Wolverhampton Information Sharing Protocol (WISP) was adopted and embedded across partner organisations **To develop an early warning system of information sharing between partner agencies**	▪ Board agreed and signed off Wolverhampton Information Sharing Protocol ▪ Survey of partner agencies undertaken to establish Partner organisations and front line staff's understanding of Information Sharing ▪ Assessment of 'Netcall' product used to collate sensitive information held by different agencies to see if we can apply it here ▪ Support in scoping/informing the development of a Multi-Agency Safeguarding Hub (MASH) which will ensure more effective information sharing in the future

Priorities for 2015/2016

- Developing Wolverhampton MASH and ensuring adult safeguarding is effectively contained therein
- Continuation of review of most appropriate early alert systems
- This priority will now be included in the new Governance Priority detailed in the Strategic Plan 2015-18

Case Study

David's Story

David was supported by the mental health team to monitor his mental health and prevent deterioration after he had had money stolen from him by a "friend" he had met online. The team also supported him to make changes to his social media site. His Housing Association provided him with added security to his front door. David decided to buy a small safe to keep his valuables in at home.

David has remained well and been able to continue with his life in his local community.

PRIORITY FOUR: Prevention and Early Intervention **There is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups**	
What did we want to achieve	**What did we achieve…..**
Conduct a cross-agency audit to establish current delivery and gaps in service around prevention and early intervention. **Progress 'trigger thresholds' work across agencies to identify vulnerable adults at risk before safeguarding adults risk threshold is met.** **Strengthen links to Public Health and extend use of the Joint Strategic Needs Assessment to inform strategic planning for adult safeguarding.**	▪ An audit across partners has been undertaken across partners to identify current prevention and early intervention provision across the city. ▪ City-wide roll out of risk assessments which include risk to self, risk to others and a whole family assessment ▪ Development of multi-agency action plan protocol and dispute resolution process ▪ Development of joint working protocols between the children and adult safeguarding boards and other key strategic Boards ▪ Adoption of city's Overarching Domestic Violence Protocol ▪ A review of the city's Multi-Agency Risk Assessment Conference (MARAC) arrangements has been undertaken and an improvement plan developed.

Priorities for 2015/2016

- We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults.
- Partners work together to identify risks to children, young people and adults at the earliest point.
- Partners, clients and communities are aware of available prevention and early intervention support and how to access it.
- Recommended improvements in practice are embedded promptly.
- Easier access and awareness of specialist services across the city.
- Prompt multi-agency dissemination of learning from Serious Case Reviews/Domestic Homicide Reviews (SCR/DHR) for managers and front-line staff
- SCR/DHR overview forums to undertake sample auditing to ensure revised practice from is fully embedded
- Develop system for service user feedback regards prevention/early intervention improvements to be communicated to providers
- Implementation of Multi- Agency Risk Assessment Conference (MARAC) improvement plan
- Encourage reporting of hidden crimes

Case Study

Scam Mail victims – Partnership working

Wolverhampton Trading Standards have teamed up with the National Trading Standards Scams Team & Royal Mail to raise the profile on national scams. We will all have received some form of scam mail over the year, but what do we do with it

Most bin it, however a small percentage respond to that 'once in a lifetime opportunity 'And once they have made that initial response their details end up on mailing lists, often referred to as 'Suckers Lists' .The deluge then begins with the victim gradually receive more & more 'exciting opportunities to win prizes etc. As we know, the true prizes never materialise, but the victim can often get caught in a net of false hope that they will be the lucky winner.
Research has shown that the elderly, vulnerable and socially isolated are often the ones more likely to become scam victims,

Trading Standards Service receive details of scam victims identified by Royal Mail, /National Trading Standards Scams Team. Working with Adult Social Care background checks are conducted prior to personal visits being made to confirmed scam victims', where support and advice is given to help stop them handing over money for bogus lotteries, prize draws of clairvoyant scams in the future.

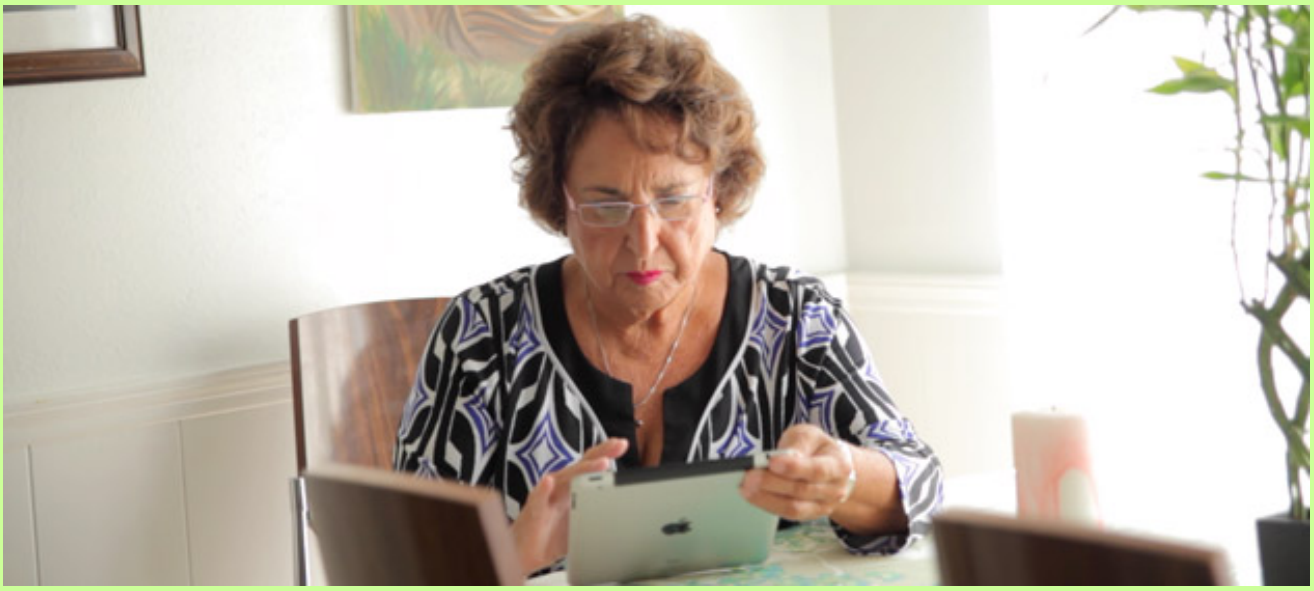
Alan's Story

Alan, 70 years old, has always been keen on purchasing collectors sets from a wide range of magazines. However, when ill health prevented him from continuing to work, the catalogues with prize draws became his focus. Gradually he had been sending increasing amounts of money to companies all over the world believing he would be entered into a lottery with a

chance to win substantial amounts of money. After a number of visits to Alan, Officers were able to make him understand he had been the victim of scams.

We were able to have his name added to the Mail and Telephone Preference Service to reduce the volume of mail and phone calls he was receiving. We also fitted a call blocking device to allow calls to be screened. Since that first visit, Alan passed the scam mail over to Trading Standards. In three months he had received £150, letters from 20 different companies, along with as many associated telephone calls and sent money in the region of £480 just on eligibility fees for the various bogus prize draws.. Now he bins the scam mail & has continued with a call blocker. The money he sent to the scammers now goes into a 'holiday fund 'for himself and his wife.

Veronica's Story



Veronica suffers with poor health which prevents her from getting out much. Receiving post is an important part of her daily routine. Veronica had responded to many prize draws over the years and to date had not received that big win. She retained all the associated paperwork for each prize draw entered all neatly filed ready for the day of that big win. Officers were able to make Veronica understand she had been the victim of various scams, and agreed to the post being handed to Officers for disposal. Officers registered Veronica with the Mail Preference Service and the reduced volume of scam mail she still receives goes in the bin.

PRIORITY FIVE: Communication and Engagement

There is a consistent and co-ordinated approach to how the safeguarding message for both adults, young people and children is disseminated to all groups and communities

What did we want to achieve	What did we achieve.....
The public and community groups are more aware of how to raise a safeguarding concern **The public and community groups are more aware of what help and support is available and have more confidence in what is available** **The public and community groups are more aware of safeguarding issues publicised** **The public and community groups are more engaged with safeguarding adults & children** **Safeguarding information is more accessible and accessed more**	▪ Improved our communication methods through the advice of specialists which is also informing a Communication Strategy ▪ A children and adult safeguarding website has been scoped and developmental work has started ▪ Held a week-long safeguarding campaign in the city centre ▪ Set up a programme of future campaigns ▪ Produced a new DVD on adult safeguarding to better inform staff and protect adults at risk

Priorities for 2015/2016

- Develop and maintain a shared public-facing safeguarding website and social media presence in conjunction with Wolverhampton Safeguarding Children Board for the public, staff and organisations

PRIORITY SIX: Workforce Development **The workforce of all partner agencies have undergone safe and robust recruitment processes and understand safeguarding issues as they relate to their role**	
What did we want to achieve	**What did we achieve…..**
Adults can have confidence that processes have been followed to ensure where possible staff and volunteers pose no risk of harm **Adults can have confidence that staff and volunteers are appropriately trained and skilled.**	▪ A range of partner agencies were contacted and 7 organisations responded and provided initial benchmarking data regarding safeguarding training undertaken within their organisations informs what more we need to do in terms of multi-agency training to support this an ▪ The four Black Country Safeguarding Boards gave commitment to a joint work programme to ensure more effective and efficient use of scarce resources

Priorities for 2015/2016

- To develop a training reporting mechanism to the Board on a yearly basis
- To pilot a cross-borough training needs analysis to further progress the collaborative work which the group can promote

Case Study

Maria's Story

A safeguarding alert was made regarding Maria, an older woman who has severe dementia. Concerns were raised by a neighbour who stated Maria lives with her daughter and grandson. The neighbour stated he could hear the daughter regularly shouting at Maria and believed she was frequently left alone and locked in the house.

Contact was made with the daughter and an advocate was allocated to support Maria. A case conference was held, Maria did not attend but the advocate attended on her behalf. Maria's daughter and grandson attended part of the meeting and a best interest decision was made regarding alternative care arrangements. Carer Support was offered to Maria's daughter as the main carer, all were in agreement with the support and care offered.

WSAB Strategic Priorities 2015/2018

From the 1st April 2015 every Safeguarding Adult Board must have a strategic plan which is consulted on with the local Healthwatch and community. These are our new strategic priorities under the new statutory arrangements. By this time next year our plan will have been shared with Wolverhampton's residents so that we can be confident that future priorities are shaped and owned by local people. We have reduced our overarching priority areas from six to five by amalgamating two related areas of work.

Effective Governance	**We will develop the capacity of WSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Wolverhampton safe.**
Performance & Quality	**We will ensure that there are effective multi-agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account.**
Prevention	**We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults.**
Communication & Engagement	**We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities in Wolverhampton, and we will ensure that we engage children, young people, families, adults and communities of all backgrounds and make up in the work of WSAB.**
Workforce Development	**We will ensure the workforce of all partner agencies have access to and have undergone robust training relevant to their role and understand how to apply it to their role.**

Wolverhampton Safeguarding Adult Budget

For 2014/2015, the financial contributions for the work of the Board came from Wolverhampton City Council, Wolverhampton Clinical Commissioning Group, West Midlands Police.
The total budget was £60,782, comprising of £30,889 Wolverhampton City Council, £15,000 Wolverhampton Clinical Commissioning Group and £ £14,873 West Midlands Police.

The contributions made by the above agencies have covered:

- **the general expenses of Board business**
- **the work of the Independent Chair of the Board**
- **9.25 hours per week for the Board Manager**
- **18.5 hours for the Board Administrator**
- **the costs of multi- agency safeguarding training during 2014/15**
- **production of new Adult Safeguarding DVD and Workbook which was launched June 2014**

Board Members Reports 2014/2015

Copies of individual Board Members reports relating to their respective organisation's safeguarding activity can be found at **Appendix 1.**

Safeguarding Performance Data 2014/2015

Appendix 2 provides a range of data to demonstrate safeguarding activity in Wolverhampton from all agencies; this data is collected by Wolverhampton City Council as the lead agency for safeguarding adults.

All data is scrutinised and used to inform prevention work and reviews of guidance and policy. Wolverhampton's data collection meets the requirements of the annual Health and Social Care Information Centre (HSCIC) Safeguarding Adults Return

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Feedback Form

Can you please help by providing us with feedback on the content of this report. You may wish to print off this page and return this in the post to:
Safeguarding Service, Priory Green, Whitburn Close, Pendeford, WV9 5NJ
or alternately contact the Safeguarding Adult Board Manager on 01902 553218/553259 to give verbal feedback.

To improve the report next year, can you please specify what areas you would like included**:**

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WHO CAN I TELL MY CONCERNS TO?
To make a referral ring Adults Social Care Services on 01902 551199.

If you would like any advice before contacting the number above, please ring 01902 553218.

In an emergency, ring 999.

APPENDIX 1

Board Members Reports 2014/2015

Wolverhampton Homes

Mark Henderson

What were the agreed safeguarding objectives for 2014/15?
The Care Act 2014 places adult safeguarding on the same footing as children's safeguarding. The Act is specific in its reference to the duties on housing providers and Wolverhampton Homes needs to respond appropriately to the safeguarding provisions contained within the legislation to ensure compliance.

The need to meet these requirements and also to ensure that both adult and children's safeguarding processes and procedures are well embedded will require on-going commitment from the company on a strategic and operational level, with financial resources needing to be identified, where necessary, to ensure effective management and legal compliance and accommodate staff training.

Agreement to raise awareness among tenants and service users generally in relation to safeguarding will need to be done in a sensitive manner, ensuring that information is provided in appropriate language and in relevant formats.

Achievements against the above Objectives:-

Information sharing – Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision to children and adults in relation to their safeguarding.

Awareness of safeguarding and improving our response to children and adults at risk – Raising awareness of our responsibility to respond to safeguarding issues when identified has been, and remains a priority.

Improvement Plans where barriers have existed.

A particular challenge remains with effective information sharing. Consequently we will be actively supporting the development of a Multi- Agency Safeguarding Hub (MASH) and will be members of the Operational and Strategic Group to see its development.

Impact for Adults

An increasing number of our customers display and present with safeguarding issues and we believe that a more informed and equipped workforce enables us to respond with effective interventions and referrals.

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

a) Ensure Board and the company generally have an understanding of our duty in relation to the Care Act by providing appropriate training/awareness raising sessions.
b) Continue to recognise that housing staff have a key role to play in safeguarding and promote this role at every available opportunity (e.g. Safeguarding Adult Board, Wolverhampton Information Sharing Group, Housing Provider Safeguarding Group, Early Intervention Board);
c) In conjunction with partners, continue to research the potential for the development of either a real or virtual MASH to improve information sharing across and between partner agencies.
d) Continue to learn from Domestic Homicide Reviews and Safeguarding Adult Reviews where appropriate and amend working practices as a result where necessary.

We believe that safeguarding has become more embedded within the Company, our Board and Senior Managers have received awareness training and made a commitment to ensuring that safeguarding is considered a priority and regarded as everyone's business.

The development of a Housing Providers Safeguarding Group continues and a number of social housing providers commit to sharing knowledge and experiences through regular meetings and a social media 'yammer' site.

Our Director of Housing has been involved in national safeguarding events and used the opportunity to raise awareness and profile of work being undertaken by WSAB.

Furthermore Wolverhampton Homes is committed to multi agency working and will offer its full support to the WSAB in its attempts to ensure adults within the city are safe and where necessary protected.

West Midlands Police

Chief Superintendent Simon Hyde

What were the agreed safeguarding objectives for 2014/15?

West Midlands Police are committed to engaging with our partners, providing a joint approach to safeguarding those members of our community who are the most vulnerable.

In January 2013, West Midlands Police responded to the national concern of adults at risk of abuse by piloting a Vulnerable Adult Abuse Hub for a six month period. The pilot provided the basis for an established and dedicated team of officers covering the seven Local Authority areas of the West Midlands; the Adult at Risk Team is based at West Bromwich Police Station in Sandwell operating within the Public Protection Unit. Our objective for 2014 /15 was to strengthen and further develop the Team.

The Adult at Risk Team provides a point of contact for vulnerable referrals and work with partner agencies in regards to multi-agency strategy meetings, case conferences and information sharing. The team consists of 18 experienced police officers and four members of business support staff, supervised by three Detective Sergeants and a Detective Inspector. The team work 7 days a week between 08:00 – 20:00 providing a service both internally to West Midlands Police colleagues and externally to victims of abuse. The team are responsible for both safeguarding and investigating all vulnerable adult crime and non-crime incidents where the perpetrator is in a relationship with the vulnerable adult or a position of trust. The offences include:

- Domestic abuse
- Financial abuse
- Physical abuse
- Suspicious death
- Sexual offences committed against a vulnerable adult that has been committed by an offender who is a family members or in a position of trust or a vulnerable adults themselves.
- West Midlands Police adopts the 'No Secrets' definition of vulnerability, namely:
- A Vulnerable Adult is any person aged 18 or over who is or may be in need of community care services, by reason of mental, physical or learning disability, age or illness and is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or exploitation. The definition applies to people with mental health, sensory or other physical impairments, learning difficulties, frailty or confusion, who, as a consequence, are unable to protect themselves and are in need of community care.
- West Midlands Police are one of the only forces in the country to have a dedicated Adult at Risk Team and will work on average with 100 open incidents at any one time across the force area. These incidents can range in severity from low level crime through to high profile, complex investigations. Earlier this year the Adult at Risk Team were responsible for securing a conviction of a 23 year old care worker for the attempted murder of three elderly residents of a care establishment in the West Midlands. Adult at Risk Officers have received training from the Office of Public Guardian, the Crown Prosecution Service, Coroner's Office and have attended multi-agency training on domestic abuse, financial abuse and the Winterbourne View investigation.

Achievements against the above Objectives:-

All West Midlands Police officers and staff have completed comprehensive training in which safeguarding is paramount; the mission statement for West Midlands Police is 'to protect and serve'. All policies and guidance are easily accessible by all members of staff from any workstation within a police station and all staff have access to advice on-line. Safeguarding inputs form part of initial police training which are regularly updated on designated training days. In addition, Operation Sentinel is West Midlands Police's response to increasing the awareness of vulnerability for all frontline staff which has included the training of all supervisors in recognising vulnerability.

In March 2015, the Adults at Risk Team hosted a Social Care Awareness Event for partners, focusing on the concepts of 'best evidence' and 'criminal threshold' with the aim of improving assessment of concern. The event received positive feedback from partners who could take the learning back into their workplace in order to enhance their safeguarding procedures.

A comprehensive training plan with a layered approach has been put in place for the force in light of The Care Act. Whilst The Care Act is predominantly Local Authority driven, there are many aspects that can be supported within policing which are being linked and picked up through our 'WMP 2020' change programme around the 'Geared to Prevent Harm' strand of this five year programme of work. The training is not mandatory but will give West Midlands Police staff the knowledge to approach vulnerability with confidence.

The training plan consists of bespoke training for the Adults at Risk Team such as external speakers around Mental Capacity Act and dementia training, amongst others to provide them with enhanced knowledge enabling them to offer support and advice to others. There is also a front facing response and contact driven training through Continuous Professional Development days and we are working at a video box delivery with our Learning & Development Department. West Midlands Police are also arranging training sessions with Local Authorities to inform them of Criminal Threshold and Best Evidence to assist them when they are directing a Section 42 enquiry under the Care Act.

There is also a strand that is being developed with partners which assists care establishments professionalise themselves, thus preventing further harm. All the above is supported by West Midland Police's internal web site and we are currently scoping a link to the external site for reference of Local Authority practitioners.

West Midlands Police have a force wide Review Team that reviews all cold cases, undertake Independent Management Reviews (IMRs) for any Serious Case Reviews involving children (SCRs), Domestic Homicide Reviews involving adults (DHRs) and Vulnerable Adult Serious Case Reviews. There is developing a work plan for disseminating learning from across the West Midlands.

Victims and witnesses are contacted through our dip sampling policy of which is governed through our 'Contact Counts' policy. The new 'Victims Code' ensures West Midlands Police understands the victim's perspective and how our service can be improved.

All West Midlands Police officers and staff are vetted to the required standards and is a requisite condition to their employment within West Midland Police. DBS/Vetting is not renewed, however should an officer or member of staff breach the Police Code of Conducts or commits a criminal offence they will be subject internal disciplinary proceedings. Part of the proceedings is consideration as to the role/function carried out by the officer/member of staff and a full suitability and risk assessment is conducted. Officers or staff who are subject to gross misconduct proceedings can be removed from the workplace when the circumstances dictate.

West Midlands Police is committed to partnership working and offers attendance at all seven Local Safeguarding Adult Boards across the region. The Care Act states that attendees must be someone who can speak with authority, can commit resources and agree actions on behalf of their organisation and must be an 'Executive Member'. Each Local Policing Unit Commander has agreed for a member of their Command Team to be present at each Local Safeguarding Adult Board (LSAB), supported by a dedicated member of the Adults at Risk Team. Due to the

Adults at Risk Team servicing all seven Local Authority LSAB meetings, it is not possible to provide the same commitment to sub-group attendance. West Midland Police 'match funds' the same donations to Adults Board that it does annually to each Local Safeguarding Children's Board across the force area.

In Wolverhampton there were 63 crimes in 2014/15 which carried the 'vulnerable adult' incident marker. There were 331 incidents that attracted the "VA" non- crime marker.

Challenges

West Midlands Police are in a similar position to other partners in relation to future budgetary challenges. We are in a position where budgets are reducing at a level never seen before, technology is advancing and society is changing. At the end of summer 2014, West Midlands Police entered a partnership with Accenture to help us transform how we deliver policing across the West Midlands by 2020. This work will help us tackle the spending gap of £120 million over the next five years by allowing West Midlands Police to develop new ways of working supported by modern technology.

Complimentary to this work is a 'Zero Based Budgeting' exercise whereby the Public Protection Department will define service levels in line with the future financial outlook. Throughout both of these programmes of work, West Midlands Police will continual to consult with key partner agencies to maintain excellent working relationships.

Royal Wolverhampton NHS Trust (RWT)

Lynne Fieldhouse represented RWT to Dec 2014, Jane O'Daly Dec 2014 onwards

The Royal Wolverhampton NHS Trust has undertaken a comprehensive assurance review of safeguarding in the year 2014-15, restructured the team and located them in the Corporate Division and recruited additional staff to work in the field of safeguarding adults and Domestic Violence.

All policies have been updated in the light of The Care Act 2014, case law in relation to DoLS and new policies are being developed to address issues of managing allegations against staff and Domestic Violence for example. An audit schedule has been developed and will be implemented over the coming year.

All training has been updated to address The Care Act 2014 and other developments and training compliance is monitored at the Trust Safeguarding Group. The Annual Report has been presented to the Trust Safeguarding Group and through the governance structure.
Performance data is regularly reported through the governance structure at all levels and also in our regular meetings with the CCG.

A comprehensive work-plan is in place and progressing to timescales.

Black Country Partnership Foundation Trust

Tabetha Darmon

What were the agreed safeguarding objectives for 2014/15?

1. Data collection system and the monitoring of adult safeguarding activity;
2. Establishing a robust training programme for staff that is sustainable with existing resources;
3. Raising awareness within the organisation that Adult Safeguarding is everyone's business;
4. Increased activity within Domestic violence, e.g. Multi Agency Risk Assessment Conference (MARAC) and Multi- Agency Safeguarding Hub (MASH);
5. Capturing service user's experience of Adult Safeguarding.

Achievements against the above Objectives:-

Our performance system Datix now collects all the Adult Safeguarding activity and other adult concerns; and are shared Trust wide through the introduction of an incident conference call every Tuesday. A review of all safeguarding incidents is still on-going and this data needs to be cross referenced with the information held by local authorities so a more structured system can be developed to ensure all information is captured in a timely manner. Safeguarding Adults Return, Annual Report, England 2013-14, experimental Statistics provides an annual national report (Appendix 3) Figures for 2014/15 are not available until October 2015. Reporting for the trust is in keeping with national averages and increased reporting expected to continue due to increased awareness and improved reporting systems.

There is a Safeguarding Training strategy in place for 2015/16. Monitoring and assurance is in place through a safeguarding dashboard. All staff received basic awareness of adult safeguarding training (Level 1) within the induction programme and the annual Mandatory training. Induction and mandatory training content and quality are audited annually with learning and development. There has been a significant investment in training for adult safeguarding level 2 and 3 adult, Domestic Violence and Deprivation of Liberty/Mental Capacity via external trainers. To enable training levels to be sustained beyond 2015 Train the Trainers has been commissioned. Our Local Authority partners also provide training in specific areas of Adult Safeguarding which are available for staff to attend as appropriate. The 4 Adult Safeguarding Boards have created a Regional Training Group to seek to develop collaborative training events.

Health WRAP training has been delivered to 208 frontline staff and awareness raising provided at mandatory and induction training days. Raising awareness has also been provided through the e-bulletin, intranet and attendance at local authority awareness raising events. Moving forward to 2015/16 BCPFT is further developing training in line with NHS England Competency framework.

1. This is being achieved within BCPFT from the training as stated above and also Safeguarding Teams engaging with the divisional teams for e.g. Safeguarding workshops and meetings. Additionally the Safeguarding Team uses e-bulletin to inform trust wide staff around new legislation, training, policies and much more.

2. The Multi Agency Safeguarding Hub (MASH) was launched in Sandwell on the 18th November 2013. Domestic abuse screening is incorporated into the MASH arrangements. All domestic abuse cases which have been reported to the Police are submitted to the MASH for multi-agency screening. This enables information to be shared by agencies which is used to assess the level of risk to adult and child victims and determine the most appropriate response. Agencies involved in MASH screening include Police, Children's Social Care, Sandwell Women's Aid, Housing, Health, Probation, Community Safety, Early Help, Adult Social Care and Education.

3. The Black Country Partnership Foundation Trust recognises the impact of domestic violence on its service users, whether they are the victim, perpetrator or children. Adult Safeguarding represents BCPFT at 2 MARACs, Sandwell and Wolverhampton. MARAC workload is increasing and this has been raised by many of the agencies attending. Wolverhampton MARAC now meets weekly as a result of the increases in activity. There is a raised awareness with agencies regarding Domestic violence and the role of MARAC and recent changes to the structure within West Midlands Public Protection Unit and the formation of a multi-agency shared hub (MASH) in Sandwell are possible contributing factors and this is being monitored.

Improvement Plans where barriers have existed.

Following the Supreme Court judgement on 19 March 2014, health and social care staff must be aware of how to judge whether a person might be deprived of their liberty. It is clear that the intention of the majority of the Supreme Court was to extend the safeguard of independent scrutiny.

BCPFT have taken legal advice , and followed guidance from West Midlands Regional DoLS Group and the Care Quality Commission which are consistent in their interpretation and application.
An action plan to address the challenges that the legal Supreme Court judgement brings has been taken forward through the Quality and Safety Steering Group.
200 staff received DoLS/Mental Capacity Act awareness training between September and January. In addition local authority provided support and advice to individual teams.
BCPFT is engaged in a project in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards, the project is hosted by Birmingham South Central CCG and works across Sandwell and West Birmingham CCG.
The project aims to identify local, issues, barriers and challenges, as well as looking at creative ways to share and promote best practice and improve service delivery for people and patients who experience the Act.
BCPFT has got an implementation plan to ensure the requirements of the Care Act 2014 which came into effect in April 2015 are met.

Impact for Adults

Adult Safeguarding team has evolved significantly in the past 2 years which evidences BCPFT commitment to keeping adults at risk safe from harm. The team is making a difference through

its engagement with teams across the organisation and externally through its partnership working with other agencies.

We have vacancies within the adult safeguarding team which we need to recruit to for Mental Capacity Act/Deprivation of Liberty (MCA/DoLS) Lead and Domestic Abuse Nurse, to ensure adults are safeguarded effectively.

In relation to safeguarding adults , what are your priorities/objectives for 2015/16

- Implementation of the Care Act 2014, making adult safeguarding personal and capturing service user's experience of Adult Safeguarding.
- Continue to provide a robust training programme for staff that is sustainable with existing resources.
- Raising awareness within the organisation that Adult Safeguarding is everyone's business.
- Meeting the expectations of external partners through full participation in Adult safeguarding boards, Domestic Violence Forums and related sub groups.
- Increasing awareness and expertise for Deprivation of Liberty Safeguards and Mental Capacity Act.
- PREVENT: expected statutory requirements through the Counter-Terrorism and Security Bill. Action plan required to meet needs for PREVENT agenda.
- Action Plan required to reflect increase in activity with domestic violence e.g. MARAC and MASH.
- Improving practice through lessons learnt from Domestic Homicide Reviews and Serious Case Reviews.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Senior Leadership presence within Safeguarding Adults Boards and sub-groups. Engagement with partner agencies in terms of information sharing and lessons learnt.

Healthwatch

Maxine Bygrave

What were the agreed safeguarding objectives for 2014/15?

The objective was to support collating information from other agencies about their methods of gathering feedback from service users in relation to vulnerable adults and the safeguarding process.

Achievements against the above Objectives:-

We have clarified what needs to be done to get better information from people who have been at risk and who can tell us whether our intervention has made them feel safer, whether they feel they have been given choice and control and whether people have confidence that they are listened to. We are well on the way to getting that and we can make improvements based on the feedback we receive.

We have also ensured our staff understand sharing information with other agencies when adults may be at risk of harm.

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

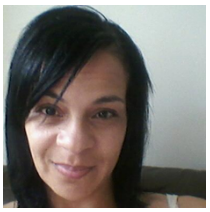
The priority for this year is to develop improved mechanisms to gather feedback - mechanisms included questionnaires to service users during safeguarding process, review of user complaints from all agencies if they related to safeguarding, commitment to 'making safeguarding personal'.

Future plans also include advocacy feedback project, establishment of a reference group, and implementation of the user experience framework.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

A designate member from the Healthwatch Board has been identified and they regularly attend meetings and share information especially around our Enter and View programme which is one of our statutory functions.

Safer Wolverhampton Partnership



Karen Samuels

The Safer Wolverhampton Partnership did not set any objectives for 2014/2015.

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

Domestic Homicides – Shared Learning
It is proposed to host a shared Serious Case Review/Domestic Homicide Review learning event in the autumn of 2015 to disseminate findings and facilitate change within front-line services, and to ensure prompt dissemination of learning from future reviews.

Prevent duty
Building on work completed so far, following successful delivery of a Channel and Prevent safeguarding awareness event held in March 2015, which alerted organisational safeguarding leads to the vulnerabilities linked to Prevent and arrangements for referring individuals needing support), a key focus for 2015/16 will be on embedding changed practice following introduction of the Prevent duty arising from the Counter Terrorism and Security Act 2015.

Violence Against Women and Girls (VAWG)
Develop a revised VAWG strategy focussing on domestic and sexual violence, honour based violence, forced marriage and female genital mutilation which will reduce the risks to vulnerable adults and families and highlight areas where WSAB oversight is needed.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

The strengthened link between WSAB and Safer Wolverhampton Partnership enables us to collectively drive forward areas of shared responsibility. This relationship has worked well for 2014/15 and will be formalised during 2015/16 to embed that practice.

The additional focus SWP is putting into VAWG and domestic abuse in particular has a significant impact upon safeguarding adults and protecting families.

Wolverhampton Clinical Commissioning Group (CCG)


Manjeet Garcha

What were the agreed safeguarding objectives for 2014/15?

Implementation of the Care Act 2014

- Empowerment – presumption of person led decisions and informed consent
- Prevention – it is better to take action before harm occurs
- Proportionality – proportionate and least intrusive response appropriate to the risk presented
- Protection – support and representation for those in greatest need
- Partnerships – local solutions through services working with their communities
- Accountability – accountability and transparency in delivering safeguarding

Incorporate safeguarding into provider contract schedules.

Improve MCA/DOLS training across the health and social care sector

Improve outcomes for patients and service users in nursing and residential homes, identify safeguarding and strengthen reporting and mechanisms for monitoring key themes

Develop a schedule of quality visits.

The Counter Terrorism and Security Act 2015 (CTSA 2015) seeks to place a statutory duty on NHS organisations, under S24, to have “due regard of the need to prevent people from being drawn into terrorism”. This becomes statute in July 2015.

Develop monitoring/audit tools for provider education and training specific to adults safeguarding at appropriate levels

Develop CCG safeguarding training at minimum level 1 for all staff as part of mandatory annual updates.

Instill a recognition that safeguarding is everyone's business from board down.

Achievements against the above Objectives:-
The CCG has reviewed its internal processes for recording all requests for safeguarding enquiries and information regarding safeguarding concerns, and has utilised the Datix system to capture this (since February 2015).

The West Midlands Multi Agency Policy and Procedures for the protection of adults with care and support needs in the West Midlands has been revised in line with the new statutory legislation and is currently in a working draft format.

Development of local practice guidance

As now required by law we now have a Designated Adult Safeguarding manager who will oversee our approach to adult safeguarding.

Agreed quality schedules into contracts for 2015/16

MCA/DOLS training across Black Country in collaboration with NHSE and Walsall CCG

Close working with LA to identify homes with safeguarding concerns via wider working and via Root Cause Analysis of avoidable pressure ulcers
Schedule of quality visits completed in 14/15, improvement plans in place and large scale strategy meetings have improved quality and safety of care

CCG PREVENT Strategy and web page in operation

Contribute to Domestic Homicide Reviews monitor action plans and provided primary care awareness sessions at Team W event

Monthly monitoring of provider education and training target v plans to ensure all staff are accessing appropriate training according to their individual role.

Improvement Plans where barriers have existed.

Improved collaboration with wider agencies to address barriers. Improved communication.

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

Continue and build on the work above

Contribute to the Board's Strategic Plan 2015/18

Contribution to the MASH

Improved guidance on DASM role to ensure CCG is well placed

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?
The CCG Governing Body are assured that WCCG are compliant of their statutory duties regarding safeguarding adults and provide a high level of oversight of the quality and safety matters of safeguarding and vulnerable adults across the City.

The Wolverhampton Safeguarding Adults Board is assured that the CCG is committed to ensuring that its providers provide a safe system that safeguards all adults at risk of abuse and neglect, as set out in the Care Act 2014.

West Midlands Care Association (WMCA)


Trisha Haywood

What were the agreed safeguarding objectives for 2014/15?

During 2014/2015 West Midlands Care Association continued to support and encourage members to work on previous objectives in relation to training re: DOLs and Safeguarding

The manager and team members of WCC Safeguarding have been regular speakers at our meetings, offering advice and clarification for homes, keeping us informed of changes and the specific parts care homes need to prioritise.

Employment and Recruitment remained a key item on our agenda as prioritised by the CQC.

Achievements against the above objectives?

Attendance at WMCA Meetings to hear presentations on the Care Act and especially the changes to safeguarding under this act were excellent.

The issue of References under the Employment and Recruitment objective remains a problem, many organisations refusing to give more than a generic reference confirming dates of employment.

Improvement Plans where barriers have existed

The major barrier for WMCA Wolverhampton branch has been the removal of funding for training to homes, so this is having to be sounded and funded by homes themselves.

There is some training available re: DOLs during July, August & September 2015.

Impact for Adults

Care Homes and their staff having an increased knowledge of safeguarding, DOLs and should translate to a greater understanding by staff on which will enrich their day to day working practice with service user.

In relation to safeguarding adults, what are your priorities for objectives for 2015 / 2016?

The Care Act - Understanding thresholds.

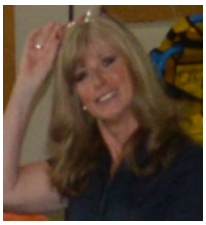
New Safeguarding Policy - Referral pathways, MASH, POWE HUB.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

WMCA Director for Wolverhampton attends the safeguarding board meetings, facilitates two way information sharing, ensures that changes are passed onto members and facilitates key speakers to come to WMCA meetings to inform / advise members.

We support national safeguarding days e.g. Elder Abuse.

Wolverhampton Domestic Violence Forum (WDVF)



Kathy Cole-Evans

How does your agency demonstrate its commitment to safeguarding adults and the work of the Board in relation to the following areas?

a. **TRAINING - Promoting, delivering and evaluating single agency & multi-agency training**

Our funding contract, policies, procedures, and practice demonstrates that generic safeguarding training is mandatory for front line staff, as is training for subject specific safeguarding elements, for example Prevent training, etc.

Wolverhampton Domestic Violence Forum (WDVF) has continued to deliver subject specific safeguarding training around Violence Against Women and Girls, for example Domestic Abuse Stalking, Harassment and Honour Based Violence, Risk Assessment training to Children and Adult Social Workers and newly qualified workers, Family Support Workers, Housing Options and Wolverhampton Homes staff; Multi-Agency Risk Assessment Conference (MARAC) training to 30 agencies; Training and coaching around Domestic Homicide Reviews.

b. **POLICY AND PROCEDURES – embedding policy and procedure in practice**

Relevant policies and procedures are discussed with staff at team meetings, and raised at the multi-agency WDVF Executive Board to be embedded into practice in different organisations.

WDVF is instrumental in developing multi-agency subject specific policies and procedures, for example Wolverhampton's - Over-Arching Domestic Violence Protocol, Multi-Agency Risk Assessment Conference (MARAC) and Information Sharing Protocol, and was a key partner in developing the first joint adult and child Forced Marriage and Honour Based Violence Protocol together with the two Safeguarding Boards.

These policies and procedures are embedded by partners who are held accountable through inclusion of policy requirements through Section 11 and other Safeguarding audit processes, and the Domestic Homicide Review Standing Panel.

c. COMMUNICATION – sharing all relevant information with the workforce

Information is cascaded with WDVF and partner agency staff electronically, and specific items are discussed at WDVF team meetings with a view to identifying if and how WDVF procedures and practice needs to change.

d. IMPROVING QUALITY– single agency audit, supervision, Section 11

Due to the nature of our work, every person referred to our service is risk assessed using the national risk model, which identifies any safeguarding adult and children concerns. Supervision of our Independent Domestic Violence Advisers is undertaken by the Strategy Coordinator/General Manager, these staff also receive external clinical supervision for their caseloads. Processes such as Multi-Agency Risk Assessment Conferences (MARAC) that WDVF coordinates and provides governance around are externally audited. The latest audit is wholly positive around all aspects including governance, commitment, attendance, adult and children support, and correct application of criteria.

e. CONTRIBUTING TO PERFORMANCE MANAGEMENT– supplying performance data and commentary

WDVF provides Violence Against Women and Girls data and commentary to the Quality and Performance sub-groups to both Safeguarding Boards. WDVF also contributes to and attends quality and performance sub-group meetings to critically analyse, develop, and refine performance dashboards for the Boards. WDVF provides update reports to the Boards from WDVF multi-agency Executive Board.

What were the agreed safeguarding objectives for 2014/15?

Increase first time reporting of Violence Against Women and Girls

Reduce the prevalence of Violence Against Women and Girls

Reduce repeat Violence Against Women and Girls incidents

Increase Violence Against Women and Girls offences brought to justice

Reduce serious harm from Violence Against Women and Girls including homicide prevention

Achievements against the above Objectives:-

Increase in reporting of domestic violence, sexual violence, forced marriage, and honour based violence

Increase in the number of children identified in families suffering domestic violence and jointly screened

Increase in Violence Against Women and Girls offences brought to justice

Increase in Multi-Agency Risk Assessment Conference (MARAC) referrals and joint action plans to reduce those at highest risk of serious harm and homicide

Overwhelmingly positive external audit of MARAC arrangements in terms of governance, commitment, attendance, adult and children support, coordination, and correct application of criteria

Improvement Plans where barriers have existed.

Safer Wolverhampton Partnership has agreed a funding plan for 2015/16 for resources:
- for multi-agency training and awareness raising around Violence against Women and Girls subjects, including female genital mutilation for which there have been no reports to West Midlands Police
- a resource to raise external funding around Violence Against Women & Girls
- increase capacity for Independent Domestic Violence Advisers to meet demand for victims & their children at high risk of serious harm/homicide
- improvements to governance and operation of the Barnardo's joint screening of children and pregnant women in domestic violence cases
- embed learning from domestic homicide reviews

Impact for Adults and their Families

Increase in identification of victims of Violence Against Women and Girls and their children, and signposting and provision of early help and support, and child in need and protection services leading to:
- reduced repeat victimisation
- reduced serious harm
- increased reporting and help-seeking

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

Increase first time reporting of Violence Against Women and Girls

Reduce the prevalence of Violence Against Women and Girls

Reduce repeat Violence Against Women and Girls incidents

Increase Violence Against Women and Girls offences brought to justice

Reduce serious harm from Violence Against Women and Girls including homicide prevention

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

WDVF continues to be committed to safeguarding adults and children. Our Strategy Coordinator attends and contributes to Board meetings as a professional adviser to the Board and away day events, and attends sub-group meetings both as a standing member and to make specific contributions – eg with new policies and procedures. WDVF ensures that information is cascaded from the Board into our organisation and to our partners, as well as providing

information, guidance, and advice around Violence Against Women and Girls subjects to the Board and its sub-groups.

West Midlands Fire Service

WEST MIDLANDS FIRE SERVICE

How does your agency demonstrate its commitment to safeguarding adults and the work of the Board in relation to the following areas?

f. TRAINING - Promoting, delivering and evaluating single agency & multi-agency training

All personnel receive on-going safeguarding training. Radicalisation training has also been delivered to all staff in Wolverhampton in the last year delivered by WMP. Sessions are evaluated. Vulnerable Persons Officers (VPOs) receive higher level training in safeguarding and also attend additional more specific training in areas such as drugs and alcohol awareness and mental health.

g. POLICY AND PROCEDURES – embedding policy and procedure in practice

WMFS has an embedded Standing Order Safeguarding Policy 17/12 which lays out the responsibilities of staff in relation to the protection of children, young people or adults with whom they come into contact through **their work and details the reporting mechanism and procedures.**

h. COMMUNICATION – sharing all relevant information with the workforce

Information is conveyed to all personnel via WMFS Intranet, Routine Notices, email, various meetings, communication briefings and management briefings.

i. IMPROVING QUALITY/ SERVICE USER EXPERIENCE– single agency audit, supervision, annual assurance statement etc

WMFS's The Plan 2015 – 18 sets out the priorities of the organisation over the rolling three year period. The priorities, objectives and outcomes set out in The Plan are informed by our Community Safety Strategy which sets out in detail how we will meet our legal responsibilities to provide an efficient and effective fire and rescue service. The Community Safety Strategy provides the risk analysis and tells us what resources we need and where they are required in order to reduce risk to our community through the delivery of prevention, protection and response services. Following a serious incident (fire death or injury) a Serious Incident Review is undertaken and any learning from this is conveyed to all staff and departments.

j. CONTRIBUTING TO PERFORMANCE MANAGEMENT– supplying performance data and commentary

WMFS provides, periodically, data on the work it undertakes – number of Home Safety Checks carried out and number of VPO visits made.

What were the agreed safeguarding objectives for 2014/15?

Further and on-going training around safeguarding and extremism.

Achievements against the above Objectives:-

Safeguarding and extremism training was carried out for all personnel.

Improvement Plans where barriers have existed.

A plan to offer more support to VPOs to ensure they are able to keep the most vulnerable people safer and healthier in their own homes.

Going forward, and as a result of the Comprehensive Spending Review, operational staffing is at a minimum and all on duty crews are now always available to attend incidents (previously they were 'off the run'. This is now not an option and means that attendance at community events or training will be carried out 'on the run' and if a 999 incident occurs then they will have to respond to the emergency.

Impact for Adults

WMFS's Service Delivery Model sets out the 5 minute attendance time for category 1 incidents (risk to life or property). Whilst attendance at incidents is the priority, our prevention work and work with vulnerable people will continue to be carried out by support staff and operational personnel when available.

In relation to safeguarding adults, what are your priorities/objectives for 2015/16

Reduce number of accidental fires in dwellings by targeting our most vulnerable working with the voluntary sector and other partner agencies.
Delivery and support of national DCLG and CFOA campaigns that are aligned to local risk, priorities and objectives.
All staff will engage with partners and citizens to develop and support healthy and sustainable communities by championing healthy lifestyles through exercise and reduction in obesity.

Provide a statement on the effectiveness of the contribution made by your organisation/service to the Board and/or its committees?

Working with our partners will enable us to target communities and individuals who are more at risk from safety related issues at home, including fire. We will respond to issues such as healthier living, anti-social behaviour and safer business premises, through a multi-agency approach enabling us "To Make West Midlands Safer".

West Midlands Ambulance Service

Andy Proctor

West Midlands Ambulance Service NHS Foundation Trust (WMASFT) has continued to ensure the safeguarding of all vulnerable persons remains a focal point within the organisation and the Trust is committed to ensuring ALL persons within the region are protected at ALL times.

West Midlands Ambulance Service NHS Foundation Trust serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Warwickshire, Staffordshire and the Birmingham, Solihull and Black Country conurbation.

The safeguarding team provides expert evidenced based clinical leadership on all aspects of the safeguarding agenda. The team have a responsibility for the development of systems and processes, working with partner agencies in line with local and national standards and legislation.

All Staff are required to act at all times to safeguard the health and well-being of children and vulnerable adults. All operational staff within WMASFT are issued key rings with the Safeguarding Referral line number and are expected to carry them whilst on duty. All staff and volunteers are expected to be able to recognise and respond to safeguarding concerns.

General Overview

The Referral Process

A single point of contact (SPOC) was created in July 2009. It was designed so that crews can make safeguarding referrals quickly and efficiently to a single point without the need for unnecessary paper trails and complex processes. All staff working within the SPOC have received training in both safeguarding adults and children.

Achievements

All members of the safeguarding team have attended multi-agency safeguarding education with the Local Safeguarding Boards. Study days have included identification of sexual exploitation, female genital mutilation, serious case reviews and safeguarding law updates during 2014/2015.

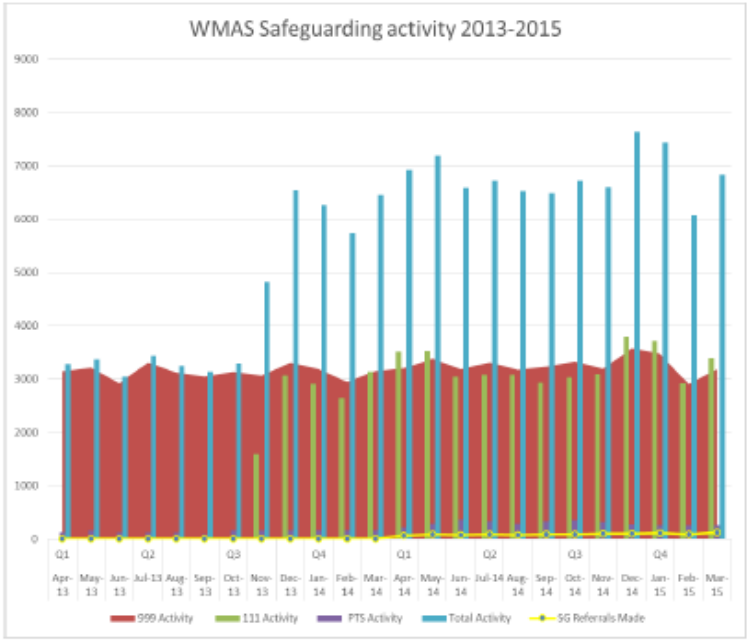
The safeguarding team provide support to the Education & Training Department for delivering safeguarding training. In 2014/2015 training programmes were developed for Ambulance Support Officers (ASO's) and Emergency Operation Centre (EOC), Call Handlers and Dispatchers and the Head of Safeguarding gave an update on safeguarding, the child death process and domestic homicides.

All staff within WMAS have received safeguarding training as part of their mandatory corporate induction.

The 2014/2015 mandatory training for all clinical staff included training on domestic abuse. This will also be complimented by a domestic abuse question set for the safeguarding referral line enabling staff to appropriately refer concerns. Close ties with all Police forces in the West Midlands have also been developed for reporting domestic abuse.

Safeguarding Activity in Wolverhampton

		SG Referrals Made	999 Activity	111 Activity	PTS Activity	Total Activity	% Total (Number of Referrals against activity)	Average for month
Apr-13			3148		128	3276		
May-13			3211		154	3365		
Jun-13	Q1		2919		125	3044		
Jul-13			3309		128	3437		
Aug-13			3120		126	3246		
Sep-13	Q2		3044		86	3130		
Oct-13			3134		154	3288		
Nov-13			3062	1597	163	4822		
Dec-13	Q3		3307	3065	157	6529		
Jan-14			3187	2909	157	6253		
Feb-14			2946	2638	157	5741		
Mar-14	Q4		3151	3136	158	6445		
		SG Referrals Made	999 Activity	111 Activity	PTS Activity	Total Activity	% Total (Number of Referrals against activity)	Average for month
Apr-14		59	3202	3507	214	6923	0.85%	0.93
May-14		83	3381	3523	283	7187	1.15%	1.01
Jun-14	Q1	77	3184	3036	361	6581	1.17%	1.00
Jul-14		83	3311	3075	327	6713	1.24%	1.00
Aug-14		76	3174	3071	279	6524	1.16%	1.05
Sep-14	Q2	87	3231	2928	326	6485	1.34%	1.03
Oct-14		89	3330	3082	350	6712	1.33%	1.67
Nov-14		98	3192	3090	314	6596	1.49%	1.11
Dec-14	Q3	97	3576	3783	268	7627	1.27%	1.09
Jan-15		110	3473	3713	254	7440	1.48%	1.17
Feb-15		93	2906	2915	252	6073	1.53%	1.13
Mar-15	Q4	124	3183	3392	258	6833	1.81%	1.19
					Total %		1.32%	1.11%



Wolverhampton City Council

Linda Sanders

How does your agency demonstrate its commitment to safeguarding adults and the work of the Board in relation to the following areas?

Many parts of the council contribute towards helping adults who may be at risk of harm keep safe. This includes services as diverse as Public Health,Trading Standards, Licencing, Homeless Families, the council's Workforce Development Services through to social work operational teams who undertake direct enquiries when a concern about abuse is received.

a. TRAINING - Promoting, delivering and evaluating single agency & multi-agency training

The council delivered the following programme of safeguarding training over the course of 2014/15:

Course name	Number completed
Basic Safeguarding Awareness Level for Adults and Children and Awareness Level CSE	970
DoLs	220
Domestic Violence (Adults)	210
Domestic Violence (Children)	120
Introduction to Adult Safeguarding for Social Workers	15
Legislation & Partnership Working for Social Workers	6
Multi-Agency Forums for Social Workers	6
Safeguarding for Adult Social Care Workers	176
Sexual Abuse	27
Role of the Social Worker in Child Protection	10
Role of the Social Worker in Adult Safeguarding	7
MCA / Dols Face to Face attended	120
Marac Face to Face attended	38
Care Act Implications for Safeguarding Face to Face Briefings	50
Making Safeguarding Personal – e-learning	72

Evaluation of face to face delivery of Safeguarding and the Care Act training:

Overall increase in knowledge 10%
Overall increase in skills 9%
Overall increase in confidence 8%

b. POLICY AND PROCEDURES – embedding policy and procedure in practice

Following the recommendations arising from the Adult Safeguarding Peer Review conducted by the Local Government Authority (LGA) in September 2013 the council updated its Constitution; this now provides clarity of roles and responsibilities of individual Members and officers within the council, in terms of their specific duty to safeguarding adults.

The council also produced a specific guide to safeguarding adults for Councillors to help raise their awareness of the types and symptoms of abuse, legislative requirements and local points of contact.

The council's Safeguarding Service has continued to be instrumental in driving the development of the regional West Midlands Safeguarding Adults Policy and Procedures to reflect the requirements of the Care Act 2014, in readiness for April 2015. The Safeguarding team has been developing local Practice Guidance, which reflects the requirements of the Care Act and will help support staff with new ways of working which came into force April 2015.

The council's CareFirst system has also been updated to ensure electronic records enable practitioners to capture/record information in line with the changes introduced by the Care Act 2014 and MSP.

Wolverhampton has also continued its commitment to the LGA's Making Safeguarding Personal (MSP) agenda, ensuring practitioners adopt an outcomes focused and person centred approach when dealing with incidents of safeguarding. MSP training was delivered to frontline practitioners and an e-learning package developed, which was made mandatory for all ASC staff.

The council's Adult Disability Team also developed the role of Advanced Social Work Practitioner who has responsibility for receiving and responding to safeguarding alerts and monitoring the progress of referrals and investigations. Liaison with the Police and other key agencies is an imperative part of this role.

k. COMMUNICATION – sharing all relevant information with the workforce

Staff briefing sessions have been delivered to the children's and adult's workforce to share key learning from serious case reviews.

Safeguarding newsletters have also been developed and circulated across the council to help raise safeguarding awareness and share key learning from serious case reviews; provide examples of case studies and insights into specific areas of safeguarding work undertaken by safeguarding staff.

A series of workshops facilitated by Research in Practice for adults (RiPFA) have also been provided to staff from across Adult Social Care to brief them on the implications of the Care Act 2014; and requirements for implementation with effect from April 2015. These have been further reinforced through mandatory on-line training provided through the council's Learning Hub.

l. IMPROVING QUALITY/ SERVICE USER EXPERIENCE– single agency audit, supervision, annual assurance statement etc

A pilot case file audit process was rolled out across the Directorate as part of the newly developed Quality Assurance Framework to assess the quality of safeguarding practice and compliance with the West Midlands Safeguarding Policy and Procedures. The process involved both strategic and operational staff completing one audit per month using newly developed audit tools and safeguarding standards.

A total of 81 case files were audited over a three month period of which 70% were found to be of a good/excellent quality, suggesting that safeguarding standards were being consistently met by practitioners.

The case file audit tools and corresponding quality standards will now be reviewed to reflect the changes introduced by the Care Act 2014; and the revisions to the local policy and procedures before being reintroduced across the Directorate. Any areas of underperformance will be shared with Workforce Development to inform future training provision.

The council's Place Directorate have established a 'Safeguarding Partnership Forum' which involves strategic and operational representation from across Regulatory Services i.e. Licensing, Private Sector Housing, Wolverhampton Homes and Fleet Management. The forum meets on a bi-monthly basis and looks to raise safeguarding awareness, identify possible resolutions to complex scenarios and improve referral pathways between services and share learning from good practice.

The Quality Assurance and Compliance team have been relocated out of the Safeguarding Service to Commissioning to provide increased assurance of internal/external provider services and help better inform future commissioning decisions.

What were the agreed safeguarding objectives for 2014/15?

Training Objectives

- Mandatory Safeguarding Adults, Safeguarding Children and Child Sexual Exploitation Awareness level e-learning for all employees
- Delivery of Councillor Safeguarding awareness level face to face sessions
- Workforce Development Leads to meet across the Black Country (Dudley, Walsall, Sandwell & Wolverhampton) to plan for some joint delivery in 2015 / 2016
- Launch of Safeguarding Adults DVD & Workbook to internal employees and external providers – copies of DVD one per establishment
- Care Act Safeguarding face to face sessions in preparation of implementation April 2015 for internal employees and external providers
- e-learning Care Act Awareness raising available for internal employees and external providers
- Develop Safeguarding Against Violent Extremism e-learning module for launch in 2015

In relation to safeguarding adults, what are your priorities/objectives for 2015/16?

1. Ensure the principles of the Care Act and Making Safeguarding Personal are embedded in social work practice.
2. Develop a Safeguarding Forum for staff within other directorates and sections of the Council to ensure best practice is disseminated.
3. Promote awareness and commitment to safeguarding vulnerable people within the City through the Council's Corporate Plan.
4. Increase awareness, reporting and recording of domestic violence.
5. Undertake review of commissioned services in line with personal choice agenda.

APPENDIX 2

Safeguarding Performance Data 2014/2015

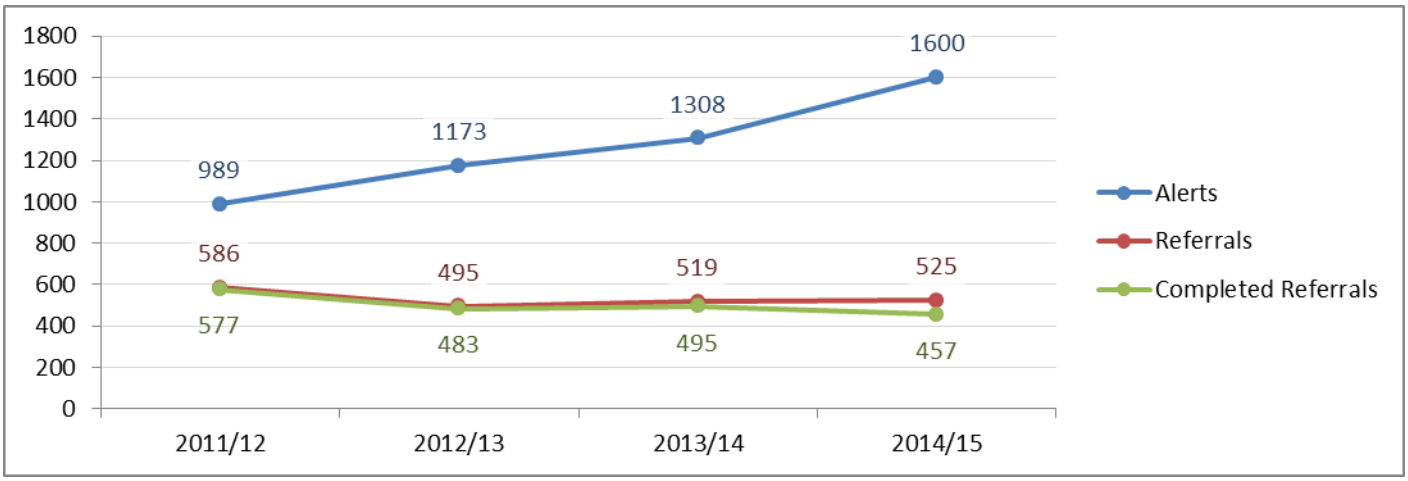
This section details a range of data to demonstrate safeguarding activity in Wolverhampton from all agencies. The majority of data is collected by Wolverhampton City Council as the lead agency for safeguarding adults, but this year includes data from other agencies to demonstrate their commitment to safeguarding adults and is taken from the Boards Performance Report. (Appendix 2) It tells us that there is a greater number of initial alerts suggesting greater public and professional awareness of safeguarding. This is encouraging. Secondly the figures provide evidence that for the vast majority of people who have been subject to multi-agency safeguarding intervention felt safer as a result of this,

All data is scrutinised and used to inform prevention work and reviews of guidance and policy. Wolverhampton's data collection meets the requirements of the annual Health and Social Care Information Centre (HSCIC) Safeguarding Adults Return

Alerts and Referrals

The number of alerts has risen significantly from 1308 in 2013/14 to 1600 in 2014/15. The number that precede to referral has not increased. This decreased conversion from alert to referral suggests that the increase in referrals is due to either cases that are not safeguarding related or do not meet the threshold for investigation.

	2011/12	2012/13	2013/14	2014/15
Alerts	989	1173	1308	1600
Referrals	586	495	519	525
Referrals as a % of Alerts	59%	42%	40%	33%
Completed Referrals	577	483	495	457



Alerts and Referrals by Age and Gender

The charts below show the proportion of alerts in the centre circle and the proportion of referrals in the outer band.

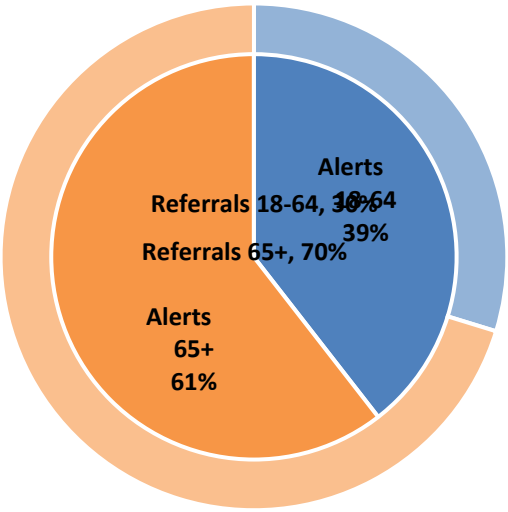
The alerts / referrals by age shows that 39% of alerts received relate to adults aged 18-64 although only 30% of referrals relate to the same age group. This shows that, in general, referrals for the 18-64 age group are less likely to be investigated or, conversely, that referrals for the 65+ age group are more likely to be investigation. This suggests that more alerts for 65+ age group are correct and suitable for investigation whereas alerts for the 18-64 age group are more likely to be inappropriate or not safeguarding issues.

The alerts referrals by gender breakdown does not differ by a significant amount and indicates that gender does not affect the likelihood of investigation.

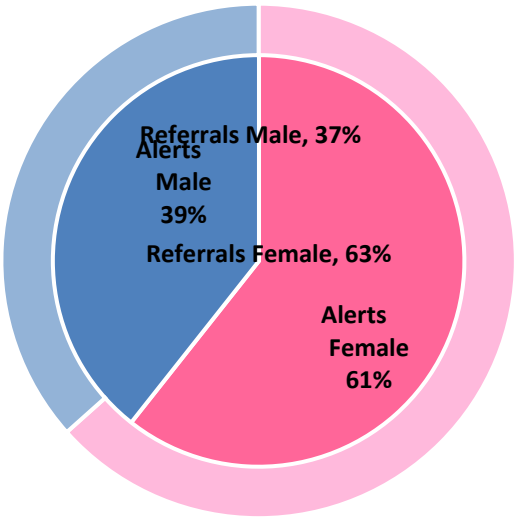
	By Age	
	18-64	65+
Alerts	606 39%	929 61%
Referrals	152 30%	359 70%

	By Gender	
	Male	Female
Alerts	604 39%	931 61%
Referrals	187 37%	324 63%

Alerts / Referrals by Age Group



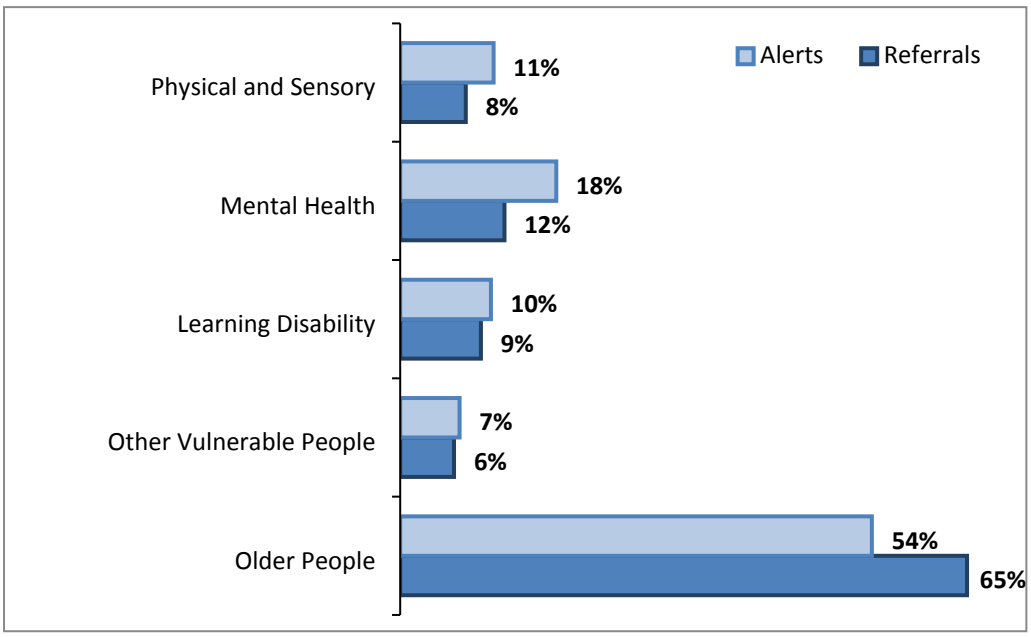
Alerts / Referrals by Gender



Alerts and Referrals by Primary Client Group
Alerts and referrals by Primary client group does not show any significant causes for concern. As previously noted in the age breakdown the older people category is more likely to proceed to investigation.

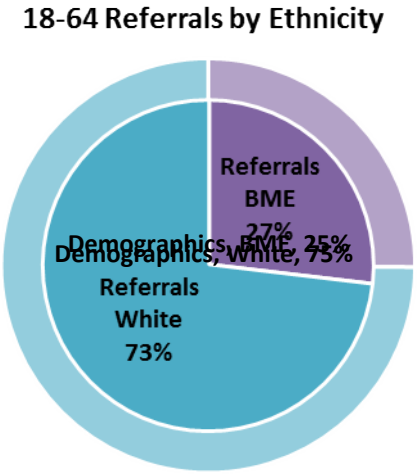
The only point which shows a discrepancy is that of the Mental Health primary client group. Although 18% of alerts relate to Mental Health only 12% of referrals are for Mental Health clients. This again, implies that there is either concerns being raised that are not safeguarding issues relating to Mental Health clients or part of this may be due to the complexity of Mental Health cases.

	Alerts		Referrals		% of Alerts that proceed to Referral
	Number	%	Number	%	
Physical and Sensory Disability	163	11%	32	8%	28%
Mental Health	226	18%	66	12%	27%
Learning Disability	157	10%	47	9%	35%
Other Vulnerable People	119	7%	20	6%	36%
Older People	933	54%	360	65%	48%



Referrals by Ethnicity – 18-64

The table below provides figures and the chart to the right shows the proportion of referrals in the centre compared with the demographic breakdown of Wolverhampton in the outer ring. Ideally both inner and outer should match.

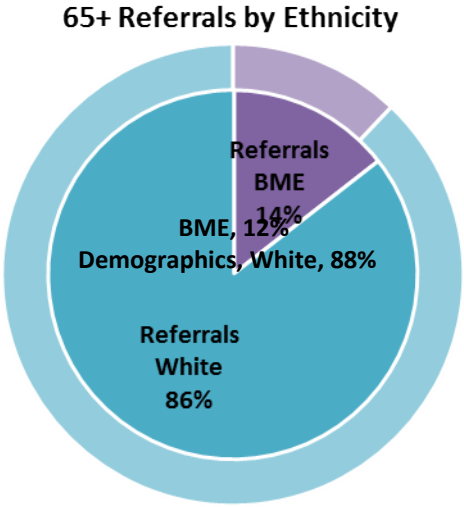


The breakdown of referrals by ethnicity for the 18-64 age group show that investigations broadly matched the local authority demographic. The biggest anomalies are that there is an over representation of referrals for Black clients and a smaller under representation of Asian clients. This can be explained by the fact that these over and under representations are generally true of the service user demographic.

	2012/13		2013/14		2014/15		Demographics
	Number	%	Number	%	Number	%	
White	91	71%	117	73%	109	71%	75%
Asian	19	15%	25	16%	16	10%	15%
Black	16	12%	14	9%	18	12%	6%
Mixed	3	2%	1	1%	6	4%	2%
Other	0	0%	3	2%	4	3%	2%

Referrals by Ethnicity – 65+

The table below provides figures and the chart to the right shows
the proportion of referrals in the centre compared with the demographic breakdown of Wolverhampton in the outer ring. Ideally both inner and outer should match.



The breakdown by ethnicity for 65+ shows that again the figures broadly match the local authority demographic. The biggest anomaly is again that black clients are over represented but as before this is also true of the service users. This discrepancy continues to decreased year on year.

	2012/13		2013/14		2014/15		Demographics
	Number	%	Number	%	Number	%	
White	260	82%	284	86%	300	85%	88%
Asian	23	7%	17	5%	26	7%	7%
Black	31	10%	30	9%	23	7%	4%
Mixed	0	0%	0	0%	1	0%	0%
Other	2	1%	1	0%	1	0%	0%

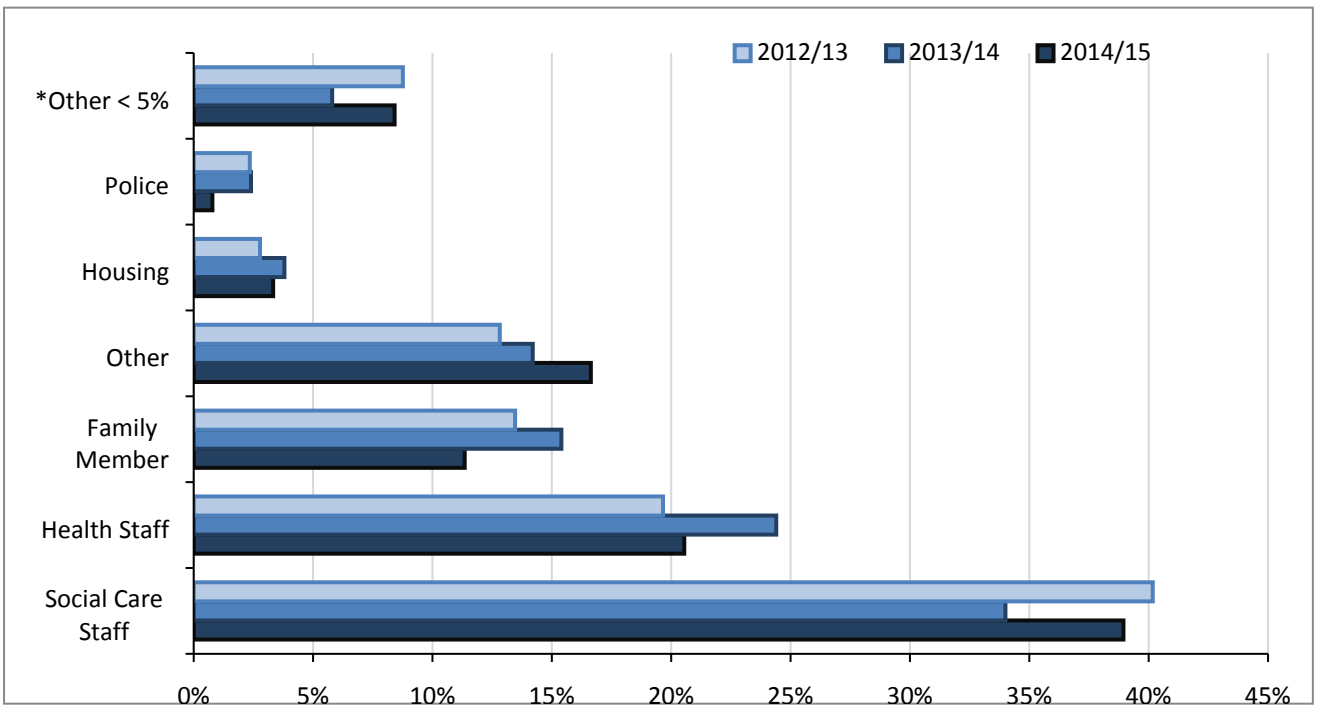
Sources of Referral

In 2014/15, as in previous years, the highest percentage of referrals came from Social Care Staff with 39% followed by a further 21% of referrals from Health Staff.

The proportion of referrals from 'Other' sources has increased to 17% which suggests that there may be other unlisted sources which could be added to the possible options.

*Sources marked with a * have less than 10% of referrals in all years and have been combined in the bar chart.

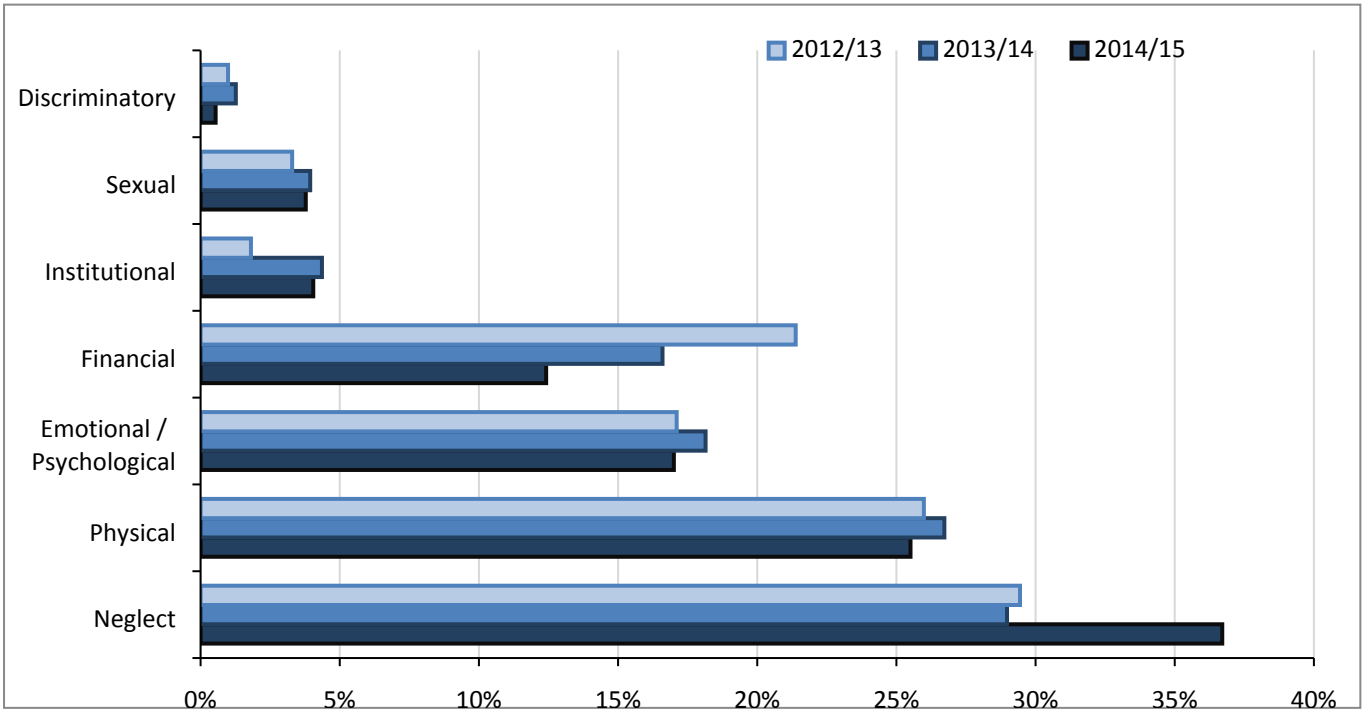
	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
Social Care Staff	179	40%	170	34%	199	39%
Health Staff	92	20%	122	24%	105	21%
Self Referral*	9	2%	3	1%	4	1%
Family Member	61	14%	77	15%	58	11%
Friend / Neighbour*	9	2%	7	1%	3	1%
Other Service User*	0	0%	0	0%	2	0%
Care Quality Commission*	17	4%	16	3%	33	6%
Housing	13	3%	19	4%	17	3%
Education / Training / Workplace Establishment*	3	1%	3	1%	1	0%
Police	11	2%	12	2%	4	1%
Other	56	12%	71	14%	85	17%
Overall Total	450		500		511	



Referrals by type of Alleged Abuse
Referrals may contain more than one type of alleged abuse and therefore the numbers are greater than the number of referrals.

The type of abuse breakdown remains relatively similar for most types of abuse. The main exceptions are that the proportion of cases with Neglect has increased significantly from 29% to 37% and the proportion with financial abuse has fallen to 12%. The increase in cases of neglect may in part be due to better recording as multiple items can be recorded against each investigation.

	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
Neglect	179	29%	206	29%	272	37%
Physical	158	26%	190	27%	189	26%
Emotional / Psychological	104	17%	129	18%	126	17%
Financial	130	21%	118	17%	92	12%
Institutional	11	2%	31	4%	30	4%
Sexual	20	3%	28	4%	28	4%
Discriminatory	6	1%	9	1%	4	1%
Overall Total	608		711		741	

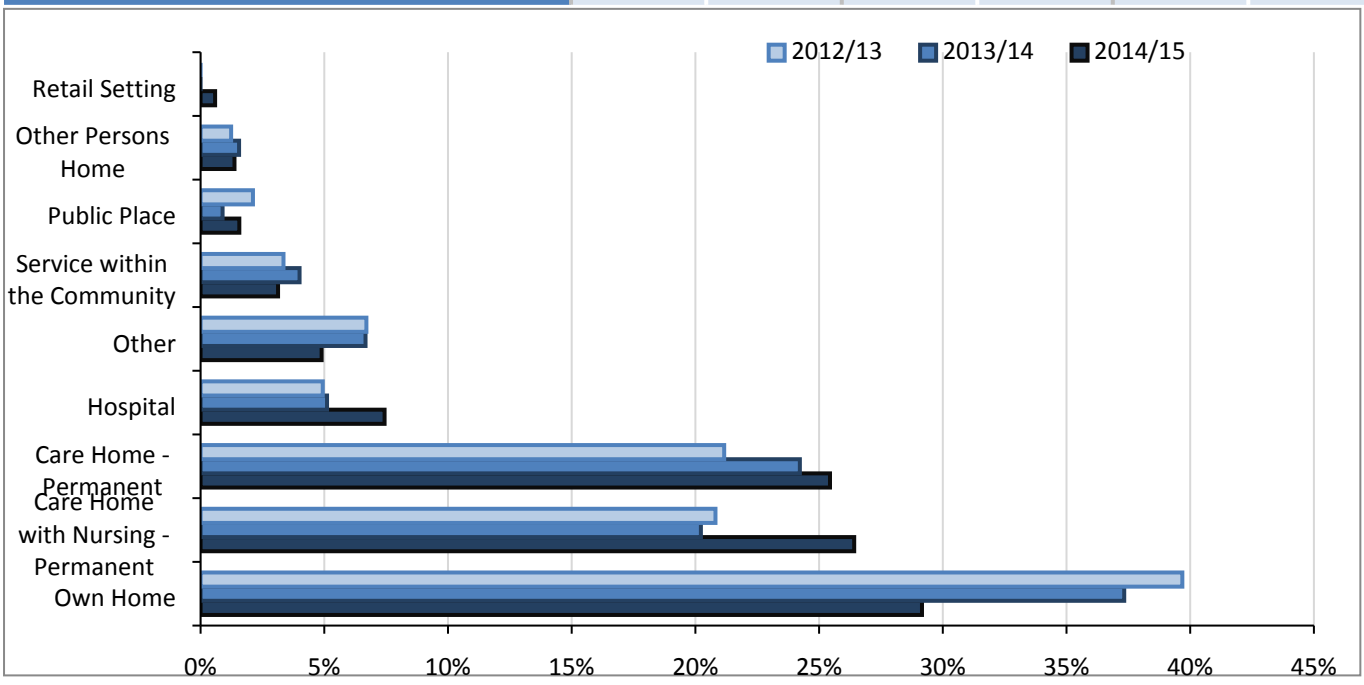

2012/13
2013/14
2014/15
Discriminatory
Sexual
Institutional
Financial
Emotional / Psychological
Physical
Neglect
0%
5%
10%
15%
20%
25%
30%
35%
40%

Location of Alleged Abuse

The most common location of abuse is care homes with 51% of all referrals relating to a residential or nursing care home. The second most common location is the person at risk of harm's own home with 29% of referrals.

The most significant changes this year are that the proportion of referrals relating to care homes continues to increase whilst the proportion of referrals around the persons own home continue to fall. This suggests that, given the increased number of alerts, there continues to be increased awareness of safeguarding resulting in more cases from care homes being referred.

	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
Own Home	225	40%	168	37%	149	29%
Care Home with Nursing - Permanent	118	21%	91	20%	135	26%
Care Home - Permanent	120	21%	109	24%	130	25%
Hospital	28	5%	23	5%	38	7%
Other	38	7%	30	7%	25	5%
Service within the Community	19	3%	18	4%	16	3%
Public Place	12	2%	4	1%	8	2%
Other Persons Home	7	1%	7	2%	7	1%
Retail Setting	0	0%	0	0%	3	1%

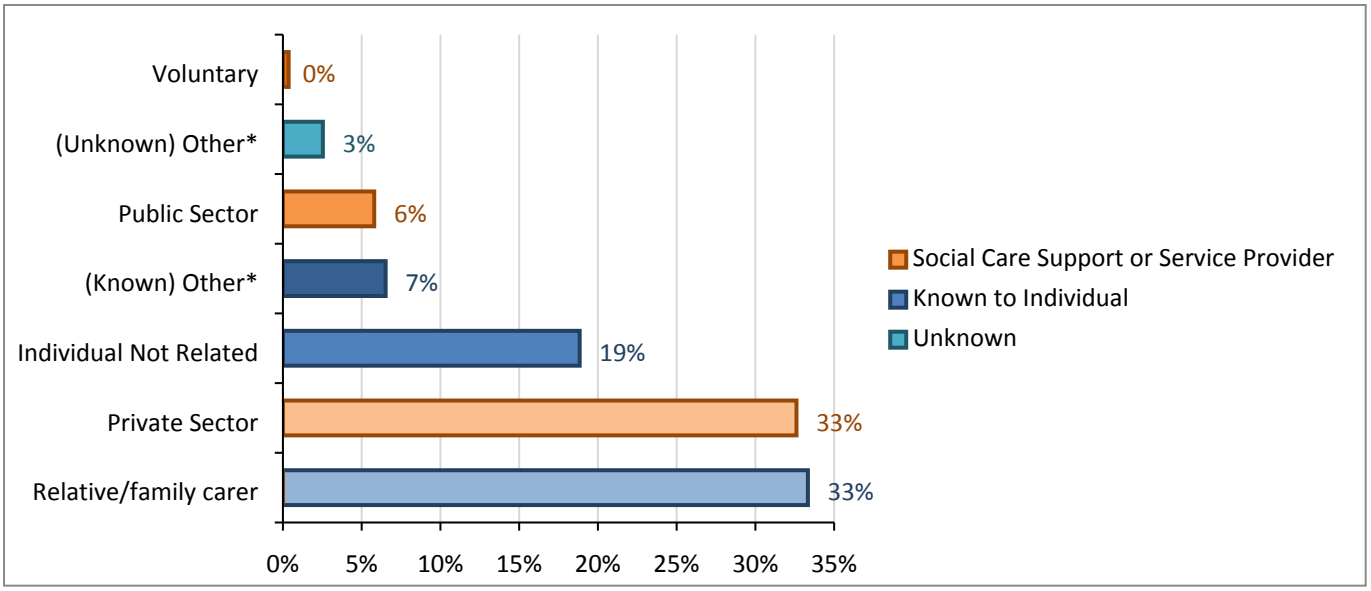


Relationship with Person Suspected of Causing Harm

The relationship data has changed significantly in this year's return and therefore it cannot be directly compared to previous data.

Where the relationship is recorded the two most common people alleged to be causing harm are relatives / family carers or private sector staff who account for 33% of all referrals each. The figures show that in 97% of cases the person alleged to be causing harm is known to the person at risk of harm.

		2014/15	
		Number	%
Social Care Support or Service Provider	Private Sector	90	33%
	Public sector	16	6%
	Voluntary	1	0%
Known to Individual	Relative / Family Carer	92	33%
	Individual Not Related	52	19%
	Other*	18	7%
Unknown to Individual	Other*	7	3%
Overall Total		276	

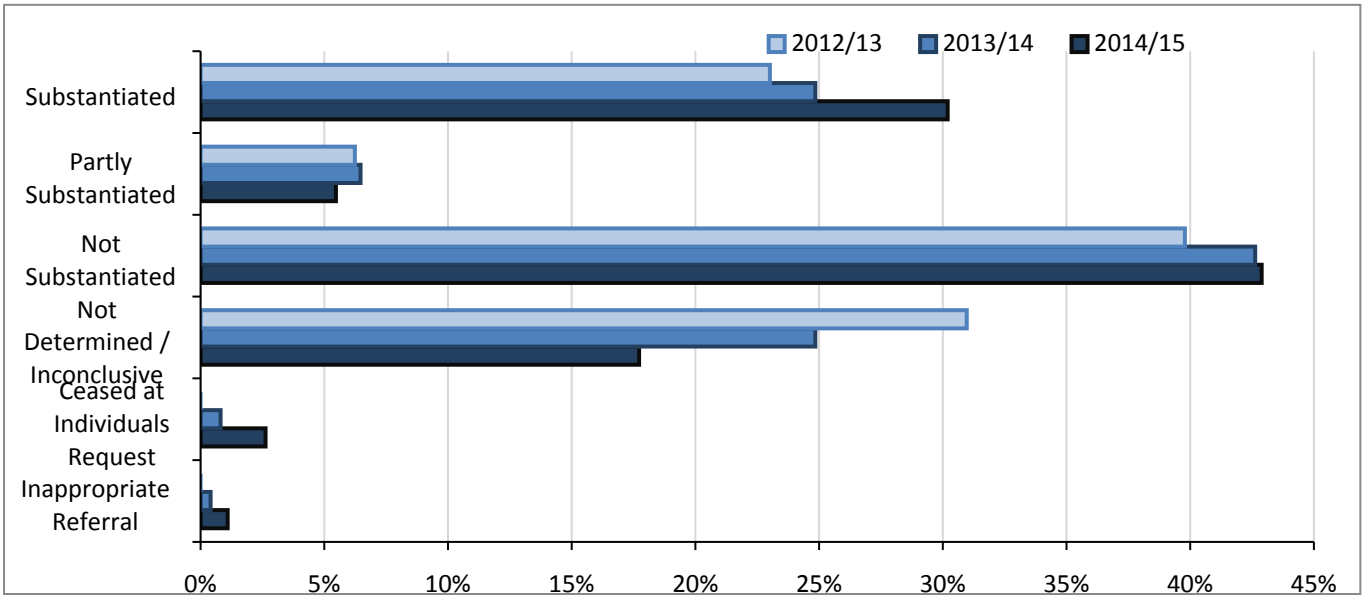


Case Conclusion
In 2014/15 30% of cases were substantiated and 5% were partly substantiated.

The overall proportion of substantiated or partly substantiated has increased marginally from 2013/14 from 32% to 35%.

The proportion of cases not determined has decreased from 25% to 18% which suggests that investigations are more likely to arrive at a conclusion although at least part of this increase may be due to a small increase in the portion that ceases at the individuals request.

	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
Substantiated	107	23%	123	25%	138	30%
Partly Substantiated	29	6%	32	6%	25	5%
Not Substantiated	185	40%	211	43%	196	43%
Not Determined / Inconclusive	144	31%	123	25%	81	18%
Ceased at Individuals Request	-	-	4	1%	12	3%
Inappropriate Referral	-	-	2	0%	5	1%
Overall Total	465		495		457	

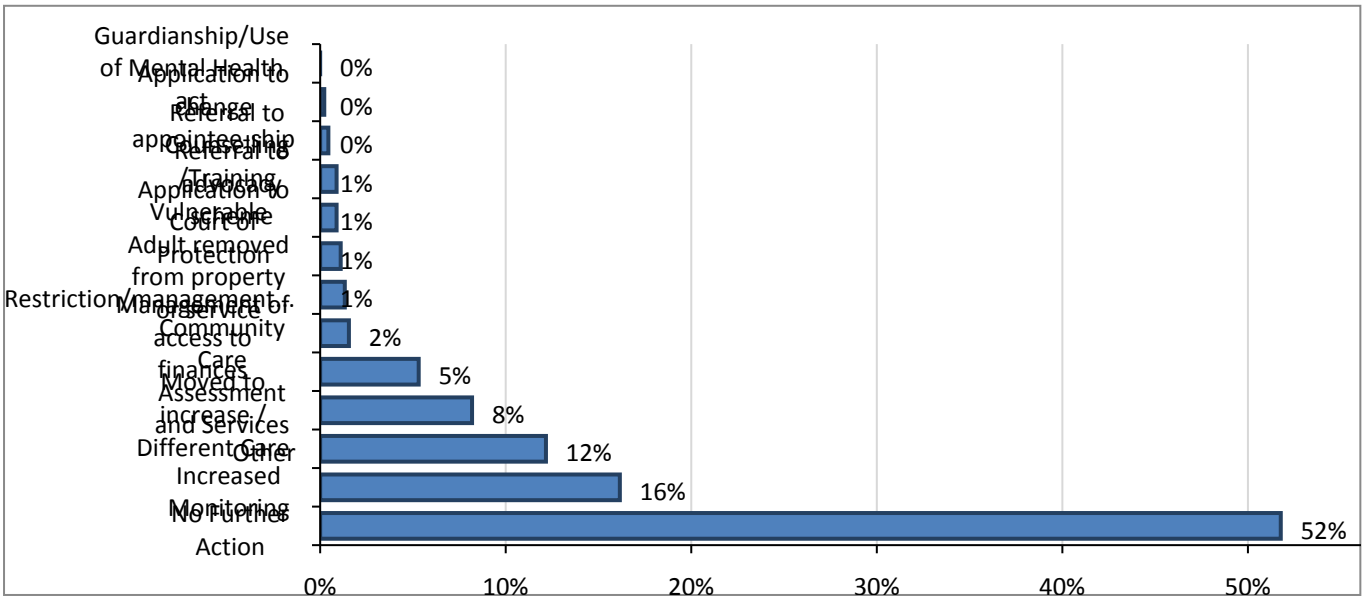


Outcomes for the Person at Risk of Harm

The proportion of cases where the outcome was 'No further action' ended at 52% which is only a marginal increase from the 2013/14 result of 51%. This is largely expected due to the high proportion of unsubstantiated cases along with the possibility that the investigation itself is likely to have an impact on reducing or negating the risk of future abuse.

The main outcome after this is 'Increased Monitoring' at 16%. All of the outcomes remain relatively static over all three years.

	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
No Further Action	234	50%	251	51%	234	52%
Increased Monitoring	85	18%	82	17%	73	16%
Other	37	8%	40	8%	55	12%
Moved to increase / Different Care	43	9%	42	8%	37	8%
Community Care Assessment and	22	5%	28	6%	24	5%
Restriction/management of access to	11	2%	18	4%	6	1%
Vulnerable Adult removed from property	7	2%	14	3%	5	1%
Management of access to finances	8	2%	8	2%	7	2%
Application to Court of Protection	7	2%	4	1%	4	1%
Referral to Counselling /Training	1	0%	3	1%	2	0%
Guardianship/Use of Mental Health act	1	0%	3	1%	0	0%
Application to change appointee-ship	5	1%	1	0%	1	0%
Referral to advocacy scheme	3	1%	1	0%	4	1%
Overall Total	465		495		452	

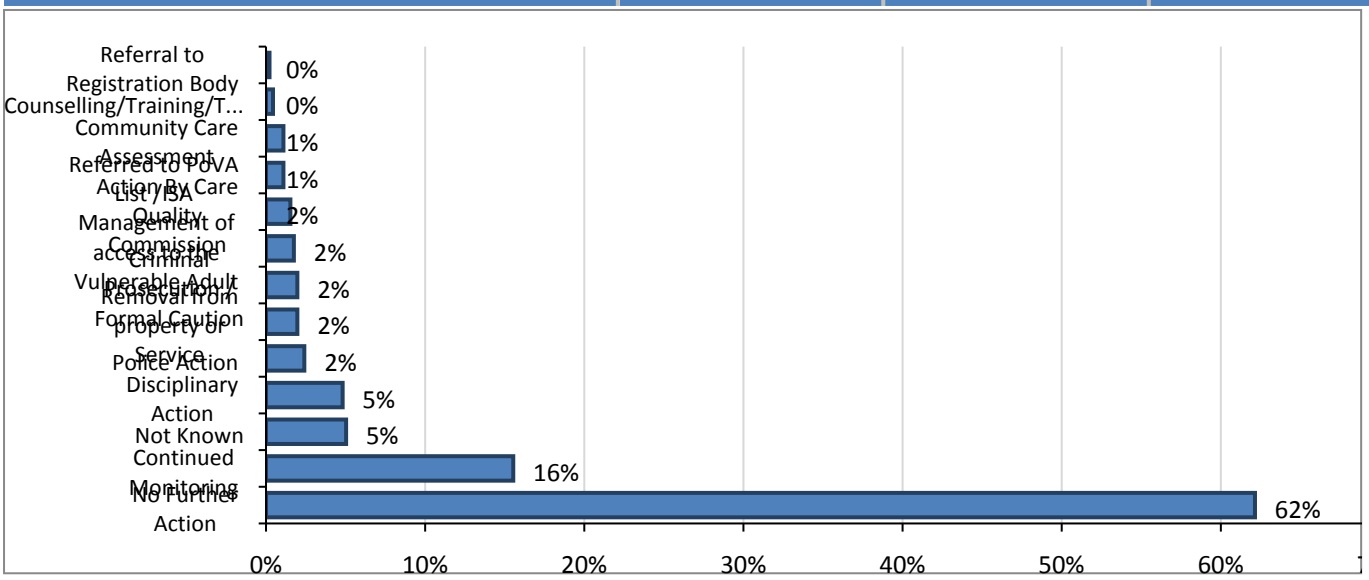


Outcomes for Person Alleged to be Causing Harm

The proportion of cases where the outcome for the person alleged to be causing harm was 'No Further Action' remains high at 62%. This is largely expected due to the high proportion of unsubstantiated cases along with the possibility that the investigation itself is likely to have an impact on reducing or negating the risk of future abuse.

The most common action taken is 'Continued monitoring' with 16% of outcomes in 2014/15. All of the outcomes remain relatively static over all three years.

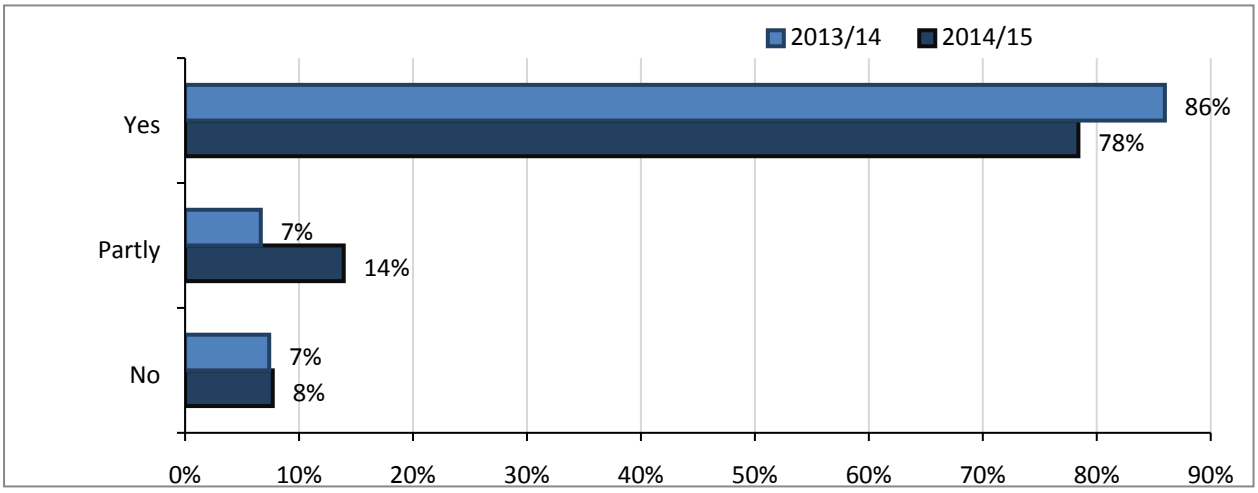
	2012/13		2013/14		2014/15	
	Number	%	Number	%	Number	%
No Further Action	273	59%	265	54%	284	62%
Continued Monitoring	84	18%	91	18%	71	16%
Not Known	14	3%	35	7%	23	5%
Disciplinary Action	23	5%	22	4%	22	5%
Police Action	12	3%	18	4%	11	2%
Removal from property or Service	11	2%	13	3%	9	2%
Criminal Prosecution / Formal Caution	12	3%	11	2%	9	2%
Management of access to the Vulnerable Adult	7	2%	10	2%	8	2%
Action By Care Quality Commission	0	0%	10	2%	7	2%
Referred to PoVA List /ISA	2	0%	9	2%	5	1%
Community Care Assessment	6	1%	5	1%	5	1%
Counselling/Training/Treatment	4	1%	3	1%	2	0%
Referral to Registration Body	6	1%	2	0%	1	0%
Exoneration	3	1%	1	0%	0	0%
Action by Contract Compliance	7	2%	0	0%	0	0%
Action under Mental Health Act	1	0%	0	0%	0	0%
Overall Total	465		495		457	



Were the Expectations of the Adult at Risk Achieved?
The results show that in 92% of cases the person at risk of harm's outcomes are at least partly met. This result appears to be very good and shows that the large majority of safeguarding investigations result in a satisfactory outcome for the adults at risk.

However, it should be noted that 184 cases (40%) are not measured as the outcome was recorded as not applicable. Much of this is where the client is unaware of the safeguarding issue or unable to comprehend the fact that they were at risk. These cases have not been included when calculating the results and may require further investigation.

	2013/14		2014/15	
	Number	%	Number	%
Yes, expectations were achieved	233	86%	214	78%
Expectations were partly achieved	18	7%	38	14%
No, expectations were not achieved	20	7%	21	8%
Not applicable	213	-	184	-
Overall Total	495		457	

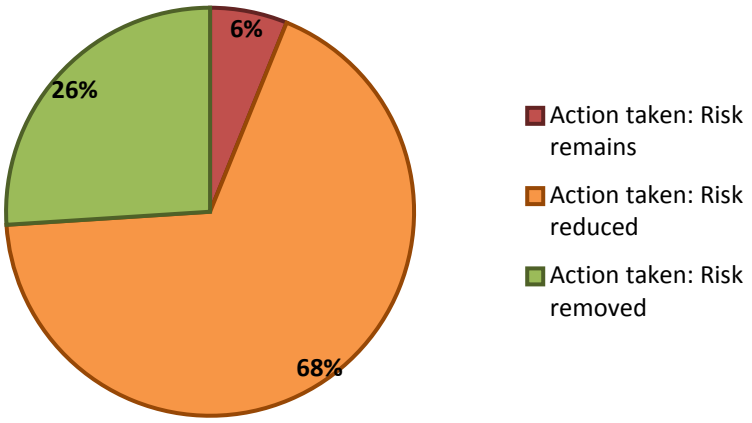


Was the risk reduced or removed
This is a new indicator for 2014/15.

The result shows that in 94% of all cases where action is taken the risk is at least reduced with 26% of cases having the risk removed altogether. This is a very positive result and shows that safeguarding has been extremely effective.

However, it should be noted that in 56% of cases no action was taken under safeguarding which is primarily due to immediate steps already being taken by other parties, such are care homes, to remove the risk before the safeguarding investigation is completed.

	2014/15	
	Number	%
No action taken	250	-
Action taken: Risk remains	12	6%
Action taken: Risk reduced	133	68%
Action taken: Risk removed	51	26%
Overall Total	446	



Deprivation of Liberty Safeguards Summary

The Mental Capacity Act 2005 - Deprivation of Liberty Safeguards came into force in England and Wales in April 2009. The Safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty in a care home or hospital, within the meaning of Article 5 of the European Court of Human Rights, whether placed under public or private arrangements.

The Board monitors the numbers of DoLS referrals and authorisations so as to be assured Wolverhampton is meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards especially following the Supreme Judgement on 19th March 2014.

The number of DoLS requests received in 2014-15 is significantly higher than in previous years following the Supreme Court Judgement on 19th March 2014.
Due to a ten-fold increase, there are a high number of assessments and authorisations outstanding. All DoLS requests are screened and urgent requests, including those in hospital and those where there seems to be doubt or controversy, are prioritised. Cases where people are in a care home where they have been for some time and there is no controversy are not given a high priority. Additional resources have been allocated for 2015 to significantly reduce the number of unallocated requests for assessment.

Year	2011/12	2012/13	2013/14	2014/15
No. of new Referrals	53 referrals	74 referrals	75 referrals	427 referrals

APPENDIX 3

Wolverhampton Safeguarding Adult Boards Partner Organisations - Members & Their Representatives 2014/15

Alan Coe – Independent Chair

Chief Supt Simon Hyde/DI Julie Woods — West Midlands Police

Tabetha Damon — Black Country Partnership NHS Foundation Trust

Manjeet Garcha – Wolverhampton Clinical Commissioning Group

Dawn Williams — Wolverhampton City Council, Head of Service Safeguarding & Quality

Sandra Ashton-Jones—Wolverhampton City Council, Adult Safeguarding and Quality Service

Lynne Fieldhouse/Jane O'Daly —Royal Wolverhampton Trust

Karen Samuels — Wolverhampton City Council, Safer Wolverhampton Partnership

Jamie-Ann Edwards/Jas Pejetta — West Midlands Probation Service

Mark Henderson — Wolverhampton Homes

Kathy Cole-Evans — Wolverhampton Domestic Violence Forum

Councillor Steve Evans — Wolverhampton City Council

Sarah Norman/Linda Sanders — Wolverhampton City Council, Strategic Director

Brian Pearce/Kate Houghton — West Midlands Fire Service

Andy Proctor — West Midlands Ambulance Service

Fiona Davis — Wolverhampton City Council, Legal Services

Trisha Haywood — Wolverhampton Branch, West Midlands Care Association

Anthony Ivko — Wolverhampton City Council, Service Director Older People

Susan Spencer — Age UK

Dr Miles Manley — Local Medical Council

Payal Patel – Care Quality Commission

Ros Jervis - Public Health

Maxine Bygrave – Wolverhampton Healthwatch

Stephen Dodd – YOW (Youth Organisations Wolverhampton)

Councillor Ian Claymore – Wolverhampton City Council

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Safeguarding Adults Strategic Plan 2015-18: Working Together to Keep People Safe.

Contents

Foreword

Living a life that is free from harm and abuse is a fundamental right of every person. However, when abuse does take place, it needs to be dealt with swiftly, effectively and in ways which are proportionate to the issues, where the adult in need of protection stays as much in control of the decision-making as is reasonably possible. The right of the individual to be heard throughout this process is a critical element in the drive towards a more personalised care and support. It remains the job of Wolverhampton's Adult Safeguarding Board to make sure all the partner organisations work together to prevent abuse and also to protect people if they are harmed or exploited.

In Wolverhampton, partners work together both to promote safer communities to prevent harm and abuse and to deal effectively and efficiently with suspected or actual cases. Together we have co-produced our *Safeguarding Adults Strategic Plan 2015-18: Working Together to Keep People Safe*. It is our firm belief that adults are best protected when our strategy for improving adults safeguarding is consistent across the city.

From the 1st April 2015 every Council area in the country must have a Safeguarding Board and it must have a strategic plan. In Wolverhampton we have had a Board for some years and we have also had a list of priorities which has helped plan our work. This is our new version and our first under the new arrangements. One particular priority for the next 12 months will be to ensure by this time next year our plan will be one that we know has been shared with Wolverhampton's residents so that we can be confident that future priorities are shaped and owned by local people.

Alan Coe- Independent Chair

1. Introduction and vision

Introduction- why do we need a strategy?

Safeguarding is everyone's business, and it is important that organisations work together to protect people who need help and support. People and communities have a big part to play in preventing, identifying and reporting neglect and abuse, and measures need to be in place locally to protect those least able to protect themselves.

The development of an Adult Safeguarding Board in Wolverhampton followed as a result of the "No Secrets‟ guidance published by the Department of Health in 2000. This guidance focused on ensuring vulnerable adults receive protection and support through the development and implementation of multi-agency policies and procedures.

The implementation of the Care Act 2014 places our Safeguarding Adults Board on a statutory footing from April 1st 2015. This will strengthen, through legislation, the Board's partnership work already in existence and will hold agencies to account.

Whilst WSAB has a role in coordinating and ensuring the effectiveness of work being done by local individuals and organisations in relation to safeguarding and promoting the welfare of adults, it is not accountable for their operational work. Each Board Partner has their own existing lines of accountability for safeguarding and promoting the welfare of adults by their services. The Board does not have the power to direct other organisations.

The Board will receive and scrutinise regular quality-assurance reports by individual agencies annually (as a minimal requirement) to identify good practice and highlight any shortcomings within agencies. If shortcomings are identified the Board and the agency in question will agree a remedial action plan. The implementation and resulting impact of the action plan will be reviewed by the Board.

We will use the following six core principles set out by the Government to measure existing adult safeguarding arrangements and to measure future improvements.

- Empowerment - person led decision making and informed consent

  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens"
- Protection - support and representation for those in greatest need

  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want"

- Prevention - taking action before harm occurs

  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help"
- Proportionality - proportionate and least intrusive response, appropriate to risk

  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed"
- Partnership - local solutions through services working with their communities

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best results for me"
- Accountability - accountability and transparency in delivering safeguarding
  "I understand the role of everyone involved in my life and so do they"

The Principles are not in order of priority; they are all of equal importance. However, the government highlights the importance of prevention and proportionate responses. Prevention of harm is always better than investigating harm that individuals have experienced, after the event. Empowerment and proportionality are critical in ensuring

that individuals have the best experience possible when they are involved in safeguarding.

Our local vision
In Wolverhampton our vision is based not only on the six core principles set out by the government but also on five priorities which underpin the work of the Safeguarding Board.

2. Strategic Priorities 2015- 2018

We strive to continually improve how we work with people to safeguard them from abuse and neglect and want to further understand whether we are making a positive difference to the lives of the people who use, or who are in contact with our services. We will use the six key principles as a focus for our strategic priorities.

The Wolverhampton Safeguarding Adults Board will make sure that actions happen to meet our priorities. Actions identified in Appendix B will be the work plan in order to ensure that the Board can deliver its vision. The Board has nominated Priority leads to ensure that the actions are implemented and delivered within agreed timescales. Progress will be reviewed and reported at each Board meeting.

The Board is not an operational body, nor does it deliver services to adults. Its role is a co-ordinating one, to ensure the effectiveness of what each member organisation does and good collaborative working between agencies to keep adults safe from harm.

This approach to delivery and performance management supports us to be clear about what is working and what is not working, providing greater transparency and accountability for the people of Wolverhampton. It will also enable us to monitor our vision closely, ensuring actions are appropriate and progress is timely

WSAB
Strategic Priorities 2015 – 2018

Effective Governance	We will develop the capacity of WSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Wolverhampton safe.
Performance & Quality	We will ensure that there are effective multi-agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account.
Prevention	We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults.
Communication & Engagement	We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities in Wolverhampton, and we will ensure that we engage children, young people, families, adults and communities of all backgrounds and make up in the work of WSAB.
Workforce Development	We will ensure the workforce of all partner agencies have access to and have undergone robust training relevant to their role and understand how to apply it to their role.

Appendix A sets out the Board's Priorities Action Plan and sets out the specific activities that will be undertaken each year to deliver the Board's Strategic Plan. The Priorities Action Plan will be presented to each Board meeting. These meetings take place four times a year. In addition, the Board's Executive Committee will receive a Priority update at each meeting; this will include any action taken. The Executive Committee will also identify areas of risk for the Board and will review and update the Board's Risk Register.

3. Understanding the effectiveness of safeguarding arrangements

The Board will develop its understanding of work on safeguarding and the effectiveness of not only interventions following the discovery of abuse, but also the effectiveness of early intervention and prevention. The Board is therefore keen to understand:

- Not only the outcome of enquiries but also the experience of those who use safeguarding services and how those experiences have been used to improve services.

- Whether there is effective involvement from those requiring safeguarding support? Does their sense of being in control increase and do they sufficiently influence and determine the outcome?

- How effective is the support provided for carers.

- Whether there is effective application of the Mental Capacity Act and appropriate use of advocacy?

- How commissioners are developing and procuring services with contracting arrangements that ensure the provision of personalised services and whether providers respect people's dignity ensure that safeguards are in place that protect their human rights

4. Accountability

The Board will report against the delivery of the Strategic and Priority Action Plans in the WSAB Annual Report. The Annual Report in accordance with the Care Act 2014 will be presented to;

- The Managing Director and Leader of Wolverhampton City Council;
- The West Midlands Police Commander;
- The Chair of the Health and Wellbeing Board and
- The local Healthwatch
- The general public- it will be placed on the Wolverhampton Safeguarding website.

The roles and responsibilities of Board members are set out more fully in the Board's constitution. Appendix B sets out the Board structure and relationship to other Boards.

Appendix A

1. EFFECTIVE GOVERNANCE – Lead Anthony Ivko

We will develop the capacity of WSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Wolverhampton safe.

What we need to achieve is:

- ✓ A strong Board where each member agency makes a robust, equitable and proportionate contribution.
- ✓ A Board where individual members play a full part and are fully accountable.
- ✓ Governance arrangements between the Board and key partners that is transparent and understood by all stakeholders.

Key to BRAG Rating

Blue = Timetabled for the future
Red = Not on track and /or deadline passed
Amber =On track but not yet completed
Green = Completed

Ref	What we will do	When	Who	Progress Update	RAG
1	Review the level of resource available to the Board and ensure that all partners make an equitable and proportionate contribution. Ensure the Board budget is managed effectively.	By Dec 2015	Chair, Board manager	Meeting taken place with finance department, Report to go to Board Sept 2015	
2	Clarify governance arrangements between the WSAB, WSCB, the Health and Well-Being Board, and Safer Wolverhampton Partnership in the light of local changes and national guidance. Ensure WSAB representation membership on	By Dec 2015	Board Manager, Priority Lead	Safeguarding Partnership Arrangements Protocol developed to outline the relationship between Wolverhampton Safeguarding Children	

Appendix A

Ref	What we will do	When	Who	Progress Update	RAG
	relevant partnership Boards			Board (WSCB), Wolverhampton Safeguarding Adults Board (WSAB), the Health and Wellbeing Board (HWBB), the Children Trust Board, and Safer Wolverhampton Partnership (SWP).	
3	Establish an Induction Programme at the appropriate level for new Board and Committee members to ensure they are briefed in relation to the area of business.	By Dec 2015	Board Manager, Priority Group	Board Constitution includes Job role, induction programme to be developed with Safeguarding Children Board	
4	Review the membership and attendance of each WSAB Committee, to ensure that they correct representation to contribute adequately to the area of business concerned.	Sept 2015	Executive Committee	Constitution agreed and signed off	
5	Ensure consistent attendance, at the appropriate level of seniority, at all Board meetings, including the Executive Committee and Priority meetings.	March 2016	Priority Lead, Board Manager, Chair	Attendance at Board and Committees monitored quarterly	

Appendix A

Ref	What we will do	When	Who	Progress Update	RAG
	Monitor and report on attendance to the main Board and through the annual report.				
6	Ensure that there is a system for all agencies to raise any issues about safeguarding in their organisation with the Board. This to include providing opportunities at Board meetings for individual agencies to report on the quality of safeguarding practice within their organisations and adults experiences of their services.	Dec 2015	Executive Committee	A reporting timetable to be established	
7	Ensure that all agencies complete the Annual Assurance Statement and contribute to the annual report which demonstrates a broad evidence base and clear evaluative narrative which reflects the local safeguarding landscape.	Dec 2015	Governance Lead, Board Manager	Limited response to Annual Assurance Statement, contributions from Partner Agencies included in Annual Report	
8	Review and update Board Constitution and seek all members' sign up for 2015/16.	Sign up by Dec 2015	Executive	Reviewed at June Executive , members to have all signed up by December Board	

How we will know we have been successful:

- ✓ We will have an effective Board, the Strategy and Constitution will be reviewed at least annually and will be fit for purpose
- ✓ All Board members will have agreed the Strategy and will be involved in its development and delivery.
- ✓ All agencies represented on the Board will have contributed to the Annual Report.

Appendix A

Ref	What we will do	When	Who	Progress Update	RAG
✓ All agencies represented on the Board will complete the Annual Assurance Statement.					

Appendix A

2. PERFORMANCE & QUALITY – Tabetha Darmon, Lead

We will ensure that there are effective multi-agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support need and will hold partners to account.

What we are aspiring to achieve:

- ✓ A Board that knows it is effective.
- ✓ A Board that has set priorities with systems in place to measure progress.
- ✓ A Board that has a clear and consistent focus on its core safeguarding business.
- ✓ A Board that is effectively challenging areas of practice where necessary.

Key to BRAG Rating

Blue = Timetabled for the future
Red = Not on track and /or deadline passed
Amber =On track but not yet completed
Green = Completed

Ref	What we will do	When	Who	Progress Update	RAG
1	Establish a Multi-agency quality assurance process, including audits of shared cases to ensure safeguarding practice is proportionate, effective and timely.	Sept 2015	Priority Lead, Priority Group , Board Manager	Multi Agency Audit Tool developed	
2	Identifying from audits and available data trends and research of adults whose circumstances may make them vulnerable to abuse.	March 2016	Priority Lead, Priority Group , Board Manager	Production of report for Board members and other priority Leads with recommendations.	
3	Make sure that agency learning from Safeguarding Adult Reviews (SAR) and	On completion	Priority Group	Specific DHR recommendations	

Appendix A

	Domestic Homicide Review's (DHR) are implemented within WSAB partner agencies.	of DHR's		included in the Annual Assurance Statement. Followed by specific DHR audits.	
4	Collate performance measures agreed by WSAB partner agencies, including those relating to service users' experiences which give assurance that safeguarding processes are robust and make people feel safer.	March 2016	Priority Group in conjunction with Sandra Jones (Healthwatch)	Priority leads need to agree performance measures to inform Dashboard.	

How we will know we have been successful:

- ✓ People can expect to receive good quality experiences of safeguarding by services improving compliance with the six safeguarding principles – Empowerment, Protection, Prevention, Proportionality, Partnership & Accountability
- ✓ Vulnerable identification
- ✓ Prevention
- ✓ Awareness training
- ✓ Engagement
- ✓ Protection
- ✓ Empowerment
- ✓ Learning is embedded in improved practice
- ✓ Safeguarding policies and procedures are fit for purpose, person centred and being compiled with partners
- ✓ Service users' experiences contribute to the Board's priorities and work plan

Appendix A

3. PREVENTION – Karen Samuels, Lead

We will ensure there is a coherent, inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults.

What we intend to achieve:

- ✓ Improved safeguarding practice that keeps children, young people and adults safe from harm.
- ✓ Effective safeguarding for particularly vulnerable groups of children, young people and adults.
- ✓ Thresholds for early help and safeguarding services that are clearly articulated and understood by staff in all agencies.

Key to BRAG Rating

Blue = Timetabled for the future
Red = Not on track and /or deadline passed
Amber =On track but not yet completed
Green = Completed

Ref	What we will do	When	Who	Progress Update	RAG
1	Partners, clients and communities are aware of available prevention and early intervention support and how to access it.	December 2015	Priority Lead and members	Improved access and awareness of specialist services across the City	
2	Recommended improvements in practice are embedded promptly.	September 2015	Priority Lead/ SAR Committee Chair and Board Manager	SAR Committee established, links developed with WSCB Serious Case Review Committee and Domestic Homicide Review Panel	
3	Provision is in place for monitoring, oversight and review of the plan.	Dec 2015	Priority Lead and members		

Appendix A

4	Progress 'trigger thresholds' work across agencies to identify adults at risk before safeguarding adults risk threshold is met	April 2016	Priority Lead and members		

How we will know we have been successful:

- ✓ Earlier identification of clients in need
- ✓ Reduced demand for crisis intervention
- ✓ Improved communication between partners
- ✓ Faster resolution of disputes
- ✓ Improved co-ordination of early help delivery
- ✓ Increased awareness of available services
- ✓ Increased access and take up of early help and prevention services
- ✓ Increased reporting of 'hidden' crimes
- ✓ Improved communication with partners, clients and communities
- ✓ Improved service delivery
- ✓ Improved implementation of revised practice
- ✓ Reduced risks and incidents of abuse, neglect, serious harm and homicide
- ✓ Improved delivery of specialist Domestic Abuse support interventions
- ✓ Improved monitoring of early intervention and prevention delivery
- ✓ Earlier identification of improvements in practice
- ✓ Good and emerging practice is identified

Appendix A

COMMUNICATION & ENGAGEMENT – Stephen Dodd, lead

We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities in Wolverhampton, and we will ensure that we engage children, young people, families, adults and communities of all backgrounds and make up in the work of WSAB.

What we intend to achieve:

- ✓ Greater public awareness of safeguarding and how to respond to any safeguarding concerns.
- ✓ Improved participation of individuals (children, young people, adults in need of care and support, parents and carers), families and communities in raising awareness of safeguarding and shaping services.
- ✓ Better services based on listening to the views and experiences of those who have received support from safeguarding and care services.

Key to BRAG Rating

Blue = Timetabled for the future
Red = Not on track and /or deadline passed
Amber =On track but not yet completed
Green = Completed

Ref	What we will do	When	Who	Progress Update	RAG
	COMMUNICATE				
1	Develop and maintain a shared public-facing safeguarding website and social media presence in conjunction with Wolverhampton Safeguarding Children Board for the public, staff and	10-09-15 (originally 30-06-15)	C&E cttee and Board managers	• Website commissioned June 2015 • Layout for testing finalised 17-08-15 • Plan to launch at WSAB & WSCB Board meetings on	

Appendix A

	organisations.			10-09-15 and 16-09-15 respectively	
2	Develop and run PREVENT campaign in 2015-16	30-11-15 (originally Apr – Jun 2015)	*Comms leads from a WSAB/WSCB partner agency; Karen Samuels; all WSAB/ WSCB partners support*	• Scope and responsibilities of this campaign agreed 29-07-15 • Campaign outline in development to share with Comms leads before next mtg on 14-09-15 • Comms lead from a partner agency needs to be identified at next C&E mtg on 14-09-15	
Page 445	Develop and run Child Sexual Exploitation campaign in 2015-16	31-03-16 (originally July – Sept 2015)	Comms lead; See Me Hear Me Campaign; all WSAB/WSCB partners to support	• Ian Fegan WCC comms lead agreed to lead on CSE campaign 18-05-15 • CSE Digital Comms plan and resources produced and agreed with Dawn Williams July 2015 • Digital comms plan commenced August 2015 • Partner engagement Aug - Sept	
4	Develop and run Violence Against Women & Girls campaign in 2015-16	Oct – Dec 2015	*Comms leads from a WSAB / WSCB partner agency; Kathy Cole-Evans / WDVF, all WSAB/WSCB partners to support*	• Initial scoping mtg has taken place between Kathy Cole-Evans and Priority 4 lead • Campaign outline needed • Comms lead from a partner agency needs to be	

Appendix A

				identified at next C&E mtg on 14-09-15	
5	Develop and run "What does good care look like?" campaign in 2015- 16	Jan – Mar 2016	*Comms lead from one WSAB / WSCB partner agency; Wton Care Homes Assoc / Age UK Wton / B-Safe Team; all WSAB/WSCB partners to support*	• None to date	
	Produce regular updates to staff in all partner agencies on local and national safeguarding developments	Dec 2015	Priority 4 lead; Board managers; Comms leads	• Need for more systematic join up between comms leads agreed at C&E mtg 18-05-15 • However, we're sill reliant on Board members circulating individual ad hoc emails and VCS safeguarding update	
7	Establish twice yearly multi- agency practitioner forums to feedback safeguarding issues from front-line staff to Board representatives	March 2016	C&E Cttee; Board managers; all partners to support	• No progress to date	
	ENGAGE				
8	Identify and use specific opportunities to engage with individuals and communities to increase public involvement in raising awareness of	31-03-16	C&E cttee; Comms leads for each campaign	• A range of opportunities have been identified – some for individual	

	safeguarding			campaigns ; and some for general awareness raising • Next C&E mtg on 14-09-15 to decide how to use these in period Sept – Dec 2015	
	Develop and implement a Faith Group Engagement plan	31-03-16	Priority 4 lead; WVSC; InterFaith Wolverhampton; lay reps	• Plan in development with InterFaith Wolverhampton • Faith group list has been produced 10-08-15 • Faith groups being contacted individually by phone to ascertain correct contact details wherever possible • Survey being promoted through individual contact • Application to BIG Lottery's Reaching Community being developed for next closing date	
10	Listen to and involve children, young people and adults who have experienced safeguarding services and act on their suggestions for improvements.	31-12-15	HealthWatch; B-Safe Team; Age UK Wton; WCC Safeguarding Service; partner agencies	• B-Safe Team have been engaged to support Prevent campaign • B-Safe team have been promised support for their first campaign around bullying in Anti-	

				Bullying week (Nov) • HealthWatch have been commissioned to get 'customer feedback from adult service users and carers with experience of safeguarding support	

How we will know we have been successful:

- ✓ A range of tools are used by the Board to inform the public, organisations and their staff about safeguarding issues and developments
- ✓ The Board examines feedback from children, young people, adults, families and communities and there is evidence that it takes action in response to this feedback
- ✓ There is greater awareness amongst staff in agencies, children, young people, parents, adults and communities of key safeguarding messages and the role of WSAB partners in keeping children and young people safe from abuse and neglect

Appendix A

5. WORKFORCE DEVELOPMENT – Jane O'Daly, lead

We will ensure the workforce of all partner agencies have access to and have undergone robust training relevant to their role and understand how to apply it to their role.

What we intend to achieve:

- ✓ The Board, partner agencies and the public can have confidence that staff and volunteers are appropriately trained

Key to BRAG Rating

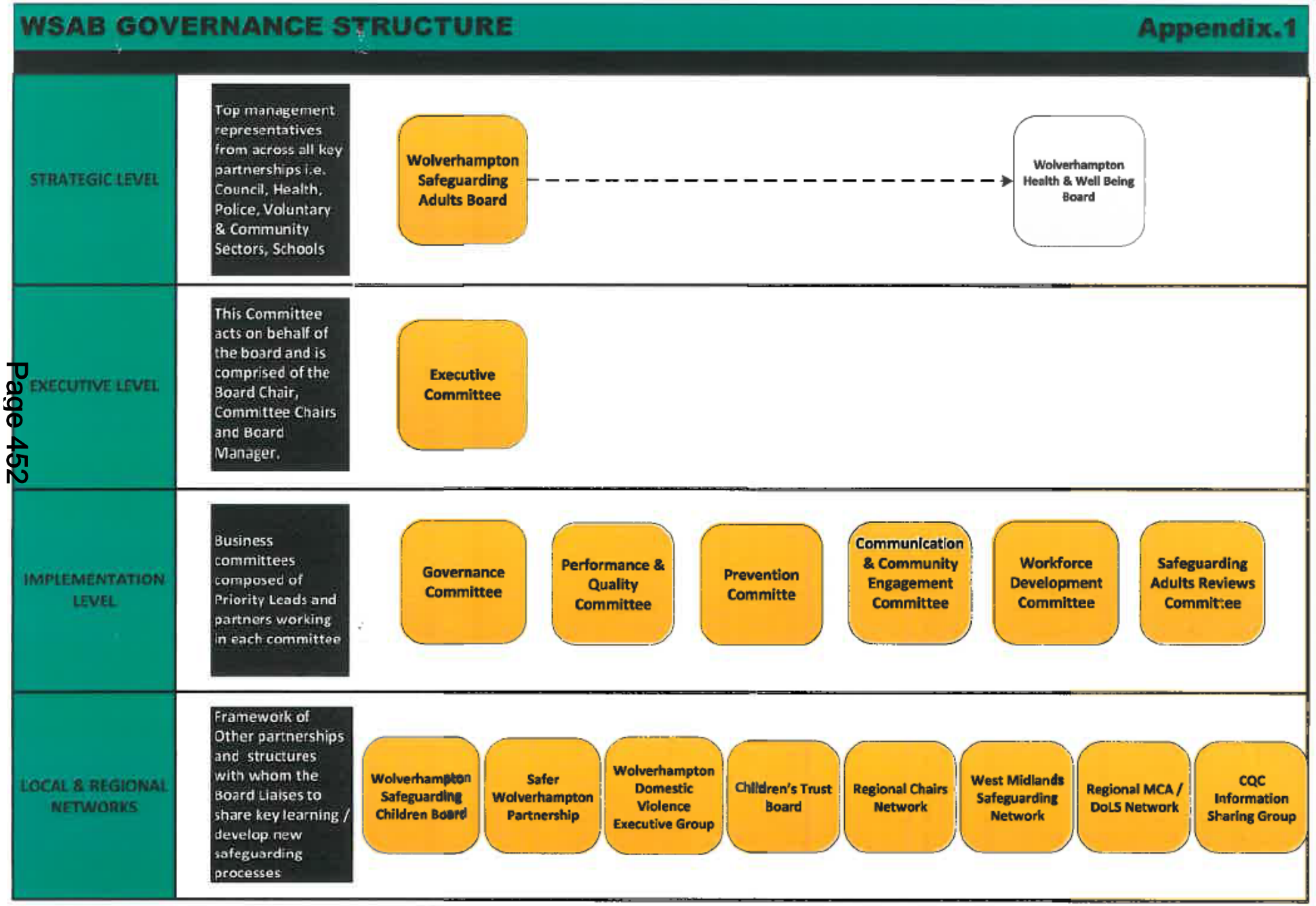
Blue = Timetabled for the future
Red = Not on track and /or deadline passed
Amber =On track but not yet completed
Green = Completed

R	What we will do	When	Who	Progress Update	RAG
1	Identify that Board member Organisations deliver safeguarding adult training including all necessary elements to their workforce at levels appropriate to contact with adults and responsibility in the organisation	Dec 15	The Workforce Development Group	Meeting held with group members and training content mapping tool discussed and developed	
2	To develop training reporting mechanism to the Board on a yearly basis .	November 2015	The Workforce Development Group	Once tool finalised – to be sent to all member agencies for return by October 1st 2015	
3	Explore the role of WSAB in provision of training based on the findings of training content mapping	February 2016	The Workforce Development Group	Not yet commenced	

How we will know we have been successful:

- ✓ Employers can access training relevant to their needs
- ✓ The efficiency of training is measured and reported

Appendix B


WSAB GOVERNANCE STRUCTURE
Appendix.1
STRATEGIC LEVEL
Top management representatives from across all key partnerships i.e. Council, Health, Police, Voluntary & Community Sectors, Schools
Wolverhampton Safeguarding Adults Board
Wolverhampton Health & Well Being Board
EXECUTIVE LEVEL
This Committee acts on behalf of the board and is comprised of the Board Chair, Committee Chairs and Board Manager.
Executive Committee
IMPLEMENTATION LEVEL
Business committees composed of Priority Leads and partners working in each committee
Governance Committee
Performance & Quality Committee
Prevention Committe
Communication & Community Engagement Committee
Workforce Development Committee
Safeguarding Adults Reviews Committee
LOCAL & REGIONAL NETWORKS
Framework of Other partnerships and structures with whom the Board Liaises to share key learning / develop new safeguarding processes
Wolverhampton Safeguarding Children Board
Safer Wolverhampton Partnership
Wolverhampton Domestic Violence Executive Group
Children's Trust Board
Regional Chairs Network
West Midlands Safeguarding Network
Regional MCA / DoLS Network
CQC Information Sharing Group

Safeguarding Activity

The total number of alerts received this year was 1600, a marked increase from last year which totalled 1308.

It is unclear why there has been such an in-crease in the number of alerts, although there has been an increase every year for the last three years. It may be attributed to the increased public awareness through media coverage and locally through safeguarding awareness raising sessions delivered on behalf of the Wolverhampton Safeguarding Adult Board and partner organisations.

	2011/12	2012/13	2013/14	2014/15
Alerts	989	1173	1308	1600
Referrals	586	495	519	525
Referrals as a % of Alerts	59%	42%	40%	33%

Risks Removed

The result shows that in 94% of all cases where action is taken the risk is at least reduced with 26% of cases having the risk removed altogether. This is a very positive result and shows that safeguarding has been extremely effective.

	2014/15	
	Number	%
No action taken	250	-
Action taken: Risk remains	12	6%
Action taken: Risk reduced	133	68%
Action taken: Risk removed	51	26%
Overall Total	446	

Our Priorities for 2015-2018

Going forward we have reduced our priorities to five by merging two areas of work. These five areas the Board think are very important and will be working towards with our partner agencies over the coming three years.

Priority One	We will make sure all the people on the Safeguarding Board **know what they should do** to keep people in Wolverhampton safe.
Priority Two	We will make sure all the people on the Safeguarding Board **do what they should** to help keep people in Wolverhampton safe.
Priority Three	We will make sure that we all work together to reduce risk of harm to **children, young people and adults**.
Priority Four	We will **share information** about safeguarding with the public.
Priority Five	We will make sure that staff have the **proper training** so they know how to keep adults safe from abuse and neglect.

WHO CAN I TELL MY CONCERNS TO? To make a Safeguarding Referral ring Adults Social Care

Services on 01902 551199. If you would like any advice before contacting the number above, please ring 01902 553218.

In an emergency, ring 999.

Wolverhampton Safeguarding Adult Board

Annual Report 2014-15

Executive Summary

SEE Abuse STOP Abuse CALL 01902 551199

Wolverhampton Safeguarding Adults Board

Introduction

This summary highlights some of the work undertaken by the Wolverhampton Safeguarding Adults Board during 2014/15. The Board ensures all partner organisations work together to prevent abuse and to protect people if they are harmed or exploited.

15 agencies are represented on the Board and there are four meetings a year.

There have been many developments and achievements in the last year and details can be found in the full Annual Report. For a copy please contact 01902 553218 or visit our website.

Preparation for the Care Act 2014

This year has seen a significant amount of work preparing for a change in the law in regards to protecting and supporting vulnerable people who are at risk of abuse or have been abused. From the 1st April 2015 the Government put the safeguarding of adults on an equal legal footing to that of children, our policies and procedures have been updated to reflect the changes.

Board Priorities 2014-15

What did we achieve against our priorities in 2014-2015?

Priority One: Better Outcomes

Service User experience and involvement in safeguarding enquiries directs improved practice.

- Safeguarding week in October 2014 provided the opportunity to feedback to the public and undertake community engagement to demonstrate the importance of prioritising Safeguarding in Wolverhampton

Priority Two: Quality Assurance

Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place.

- We now have a set of performance measures for all partners on the board to contribute to rather than just the Council

Priority Three: Information Sharing

Improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk.

- Safeguarding Adults Information Sharing Protocol developed and adopted at September 2014 Board.

Priority Four: Prevention

There is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect dis-advantaged groups

- A review of the city's Multi-Agency Risk Assessment Conference (MARAC) arrangements has been undertaken and an improvement plan developed

Priority Five: Communication and Engagement

There is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities.

- A children and adult safeguarding website has been scoped and developmental work has started

Priority Six: Workforce Development

The workforce of all partner agencies have undergone safe and robust recruitment processes and understand safeguarding issues as they relate to their role.

- The four Black Country Safeguarding Boards gave commitment to a joint work programme to ensure more effective and efficient use of scarce resources

An example of the positive impact that Safeguarding can have on a person's life:

David's Story

David was supported by the mental health team to monitor his mental health and prevent deterioration after he had had money stolen from him by a "friend" he had met online. The team also supported him to make changes to his social media site. His Housing Association provided him with added security to his front door. David decided to buy a small safe to keep his valuables in at .

David has remained well and been able to continue with his life in his local community.

NHS
Wolverhampton
Clinical Commissioning Group

Integrated Commissioning and Partnership Board
Thursday 17 September 2015 at 12.30pm
in the CCG Main Meeting Room,
Wolverhampton Science Park

Present

Steve Marshall (SM) (Chair)	Director of Strategy and Transformation, Wolverhampton CCG
Viv Griffin (VG)	Service Director, Wolverhampton City Council
Ros Jervis (RJ)	Service Director, Wolverhampton City Council
Andrea Smith (AS)	Interim Head of Delivery BCF, Wolverhampton CCG
Tony Marvell (TM)	Programme Manager, Wolverhampton City Council
Emma Bennett (EB)	Service Director, Wolverhampton City Council
Paul Smith (PS)	Interim Manager for Commissioning, Wolverhampton City Council
Manisha Patel (MP)	Administrative Support Officer, Wolverhampton CCG

1.0 Apologies **Action**

1.1 Apologies were received from Helen Hibbs, Linda Sanders, Claire Skidmore, Donald McKintosh, Tony Ivko

2.0 Minutes and Action Log From 13 August 2015

2.1 The minutes from the meeting held on the 13 August 2015 were agreed to be a true record.

Under the section **Sexual Health**, RJ queried the date (14 August 2015) for which the sexual health contract was going out to tender. RJ to check and advise so that the minutes could be updated with any change.

Action
RJ to check and advise of the date that sexual health contract was sent out to tender. **RJ**

The action log was discussed, updated and will be circulated with the minutes.

3.0 Consultation on Joint Special Educational Needs and Disabilities Strategy

3.1 VG presented to the group a paper regarding the Joint Special Educational Needs and Disabilities Strategy. The paper was a high level vision statement. VG welcomed any comments/amendments from the group regarding the document.

The document would be being going to the Council Cabinet on the 21 October 2015 for permission to send out for consultation. VG asked that following approval from the cabinet that this would be added as an agenda item at Wolverhampton CCG's Governing Body Meeting for comments/ratification at the November 2015 meeting by the Governing Body. Following the consultation period a final document would then be taken back to the Cabinet for ratification in February 2016.

The group also discussed the autism strategy and SM highlighted that it was important that autism in adults was also picked up as part of the strategy as this currently did not seem to be incuded. Children and adults should be discussed jointly. Sarah Fellows would be the point of contact with regards to adult's autism and the new appointment for the Whole System Transformation Director would pick up the children's element of autism.

Action

VG to ask Karen Garbutt for Consultation on Joint Special Educational Needs and Disabilities Strategy to be added as an assurance item to November 2015 Governing Body agenda for initial ratification and discussion. **VG**

Named people would be identified to attend a group to discuss the autism strategy for adults and children. **SM/VG/ EB**

4.0 Assistive Technology

PS presented a document related to Assistive Technology on behalf of AI and Nathan Downing from NDI Consulting Ltd.

The Council was embarking on a programme to increase the use of better care technology across Wolverhampton to support people to remain as independent as possible in their own homes and communities.

The enhanced and approved Telecare strategy went to the Cabinet in July 2015 and permission to progress a pilot was approved. A consultation was currently underway until the 26 October 2015.

A current Telecare service was currently in operation but had relatively low user figures at 950. It was hoped that this would increase to 3000 users with a long term target of 6000.

Tunstall would be undertaking a 12 week redesign of the service.

Action

A refresh to be bought back to this meeting in November 2015. **AI**

5.0 BCF Planning 2016/17

5.1 The group had a general discussion around BCF Planning for 2016/17. VG spoke of a document that SM had worked on regarding his five year vision for Commissioning and felt that it would be useful to take to the Health and Wellbeing Away day to use alongside the visions of the Council.

The importance of Integrated working was pressed upon.

Action

SM to send document on his five year vision to VG for the next Health and Wellbeing Away day. **SM**

6.0 Any Other Business

6.1 VG asked TM to ensure that the BCF Update Report was ready for the next Health and Wellbeing Board on the 7 October 2015.

7.0 Date and time of next meeting

7.1 Thursday 8 October 2015 at 11.30am, People Board Room, Civic Centre

ACTIONS LOG **[Appendix.1]**

Summary of key Actions

Date	Action	Owner	Status	Notes
11.06.15	Further work is needed on the structure chart, although too much detail would make the chart too complex. Detail around the layer below the People Leadership Team and more integrated groups is required, as well as ensuring both logos appear on the chart.	VG	OPEN	VG, EB and AI have completed their areas of the chart and recently forwarded to SM. 17.09.15 – SM to chase and update at the next meeting.
11.06.15	A full review of children being placed out of the city is required, to look at their social, health and education needs, to lead to a reconfiguration and formalisation of future funding arrangements.	EB	OPEN	For next meeting. 17.09.15 – This would be bought back to the 12 November 2015 meeting after it had been discussed at the 5 November 2015 MSMG Meeting. This would be in relation to pooled funding.
11.06.15	SF and AI will prepare a paper to seek approval around a potential opportunity to transfer financial resource, to deliver services in a new way and to accommodate individuals in pathways more innovatively.	SF & AI	OPEN	For next meeting. 17.09.15 – SM to chase and confirm action with SF and TI.
11.06.15	Further information about the Discharge to Assess model to	SM & AI	CLOSED	17.09.15 – This had been circulated

	be shared with the group to aid the decision making process.			and discussed.
11.06.15	AI will talk to a colleague in Walsall about their research into delayed discharge. SM and AI to look into possible solutions.	AI & SM	OPEN	17.09.15 – PWC work was ongoing. Discussion at next meeting.
11.06.15	Briefing note regarding the ILF to be circulated.	VG	OPEN	17.09.15 – VG to chase and discuss at next meeting.
13.08.15	Public Health Commissioning Strategy to be presented to the Commissioning Committee.	JG	CLOSED	17.09.15 – Virtual Commissioning Committee had taken place in September 2015.
13.08.15	AS and AI to meet with DMcI to brief him about the status of the BCF with regards to understanding the changes around service provision.	AS, AI, DMcI	CLOSED	17.09.15 – Completed.
13.08.15	DMcI will produce a communication on behalf of Healthwatch.	DMcI	OPEN	17.09.15 – DMcI had written to LS. To be discussed at next meeting.
13.08.15	TM to facilitate a meeting with Paul Smith.	TM	CLOSED	17.09.15 – Completed.
13.08.15	LS to progress check meeting to be set up in first week of September 2015 with HH, LS, SM, AI regarding the PWC report which is nearly completed and is to be reviewed.	LS	CLOSED	17.09.15 – Completed.
17.09.15	RJ to check and advise of the date that sexual health contract was sent out to tender.	RJ	OPEN	

17.09.15	**VG to ask Karen Garbutt for Consultation on Joint Special Educational Needs and Disabilities Strategy to be added as an assurance item to November 2015 Governing Body agenda for initial ratification and discussion.**	**VG**	**OPEN**	
17.09.15	**Named people would be identified to attend a group to discuss the autism strategy for adults and children.**	**SM/VG/EB**	**OPEN**	
17.09.15	**A refresh of Assistive Technology to be bought back to this meeting in November 2015.**	**AI/ND**	**OPEN**	
17.09.15	**SM to send document on his five year vision to VG for the next Health and Wellbeing Away day.**	**SM**	**OPEN**	

Minutes of Public Health Delivery Board 28 July 2015

Time: 10.00 **Public meeting? No** **Type of meeting: Internal**

Venue: Committee Room 3

1. **Present:** Andrew Wolverson(AW), Andy Jervis(AJ), Chris Hale(CH), Donald McIntosh (DMc), Glenda Augustine (GA), Ian Darch (ID), Jo Birtles (JB), Juliet Grainger (JG), Karen Samuels (KSa), Katie Spence (KSp), Neil Rogerson (NR), Richard Welch (RW), Ros Jervis (RJ) (Chair), Sue McKie (SMc), Sheila Collett (SC), Sharon Sidhu (SH)
Notes: Sarah Capewell

Apologies: Neeraj Malhotra, Jane Fowles

Item No.	Agenda Heading	Action
3.	**Approval of minutes of previous meeting and matters arising.** *Approval of minutes of meeting 3rd February, 2015 with the following amendments:* • *Sue McKie Job Title – Health Improvement principal* • *Page 2 paragraph: 3.1 add: Community Safety and Resilience are service areas which are now part of the public health and wellbeing portfolio.* *RJ felt that the Public Health Delivery Board should extend its remit to bring in health elements of Children's Services and to determine priorities for decision making, driving through key issues to improve health across the city.*	Minutes approved Decision to bring Children's health into the Board remit from the next meeting scheduled for 15th September

4.	**A. 2015/2016 Corporate Plan Priorities: Presentations and discussions:-** (v). **Children, Young People and Families** (This item brought forward to accommodate AW leaving meeting early). AW presented an update on the restructuring of the Children, Young People and Families service over the past 12 to 18 months and the new operating model being adopted. This model was being co-located across geographical areas and was based on delivery of 0-5 and 5 – 18 services and the development of the MASH strategy. RJ commented that Children, Young People and Families work was crucial in improving health and gaining health improvement. In order to prevent duplication the board will need to consider the work could be driven through on Public Health Delivery Board. (i) **Promoting and Enabling Healthy Lifestyles** GA's presentation included updates on Smoking in Pregnancy Programme and the Stop Smoking programmes commissioned to target 9 - 11 year olds, and secondary school children, Smoke Free Campaign across the city to be delivered in conjunction with STOPTOBER and March No Smoking day. RW reported that the council will consider the adoption of the workplace well-being Charter as part of the obesity call to action. In addition, Wolverhampton University and RWT will be encouraged to adopt the charter with wider adoption across the City in 2016. SMc highlighted the increasing number of alcohol related admissions. There is a need to look at supporting GP's to identify alcohol related problems. Uptake of NHS health checks can be improved. Making Every Contact Count across all services to identify alcohol related, and other health issues needs to be promoted. RJ commented that three board priorities last	Decision to include Children, Young People and Families in Public Health Delivery Board. Identify from the presentation 3 main areas to drive through for Board, with a focus on outcome measures. Intention to adopt Charter to be reported to Cabinet Resources in Oct 2016. Target of Public Health Delivery Board to support Making Every Contact Count

	year were Infant mortality, Obesity call to action and continued effort on alcohol and substance misuse. Future reporting on these areas would be by exception. (ii) **Keeping the City Safe** KSa presented the key developments in Community Safety. Mandatory Prevent Training now features on the learning hub. There is on-going work around female victims of crime such as domestic violence and female genital mutilation. (iii) **City Assets** Presentation by CH on Housing Offer and work being done to provide new safe, secure, appropriate housing. There are strategies on reducing homelessness by highlighting risk of homelessness at an earlier stage. Support will be provided for households in vulnerable situations, such as risk of fuel poverty. The potential for housing need displacement towards Wolverhampton from Birmingham city council highlighted. (iv) **City Environment** AJ presented how the City environment contributes to Public Health with a review of the Service Dashboards, work plans and programmes on key issues and KPI's to measure targets. This clearly highlighted how a cleaner, healthier environment can contribute to positive health benefits and mental health wellbeing which impact on quality of life. RJ stated that there are opportunities to do more with this agenda and introduce mainstream Public Health outcomes into every service. The Board will need to consider where value could be added. (v) **City Economy** SC highlighted to the Board that nationally Wolverhampton, as a city, was amongst the worst	

	for adults with no qualifications (22.9%) and 59% of the local adult population have the numeracy skills expected of an 11 year old. It was noted that a combination of issues contributed to these outcomes, but school issues were a major factor. There are a number of models in place to address the issues of economic inclusion in various targeted neighbourhoods. A consistent common theme of mental health, alcohol and substance misuse contributed to a lack of literacy skills. A number of schemes were in place to assist people into work. Newly formed YOO Recruit gave individuals the opportunity to work at all levels. RJ requested that the RICH profiles are shared with public health. Closing comments from RJ (Chair) *The Board to reflect on the presentations at today's Board to identify and 'tease out' recurring themes in order to bring to next Board meeting for consideration for programme of work for next year.*	RICH profiles to be shared with Public Health
13.	**Any Other Business**	None
14.	**Date of Next Meeting** **15th September, 2015 at 10.00 am** **Committee Room 1 – 3rd Floor, Civic Centre**	

Minutes of Public Health Delivery Board 15 September 2015

Time: 10.00 **Public meeting? No** **Type of meeting: Internal**

Venue: Committee Room 1

1. **Present:** Ros Jervis (RJ) (Chair), Joanne Birtles (JB), Glenda Augustine (GA), Ian Darch (ID), Karen Samuels (KS), Andy Jervis (AJ), Neeraj Malhotra (NM), Donald McKintosh (DM), Andrew Wolverson (AW), Juliet Grainger (JG), Kerry Walters (KW), Tara Ajimal (TA), Kam Banger (KB)

Apologies: Richard Welch, Katie Spence, Chris Hale, Sharon Sidhu

Item No.	Agenda Heading	Action
2.	**Minutes of last meeting and matters arising** DM felt that the minutes from the last meeting held on 28th July 2015 did not reflect all the issues discussed and that it is important that these are captured. It was agreed that going forward the minutes would include key issues and discussion points. The minutes of the meeting held on 28th July 2015 were agreed as a true and accurate record.	
3.	**Recap of presentations made at the last Public Health Delivery Board (PHDB)** Group noted the contents of the paper produced by RJ highlighting the key points and recurring themes emerging from the PHDB meeting held on 28th July 2015. RJ asked group for any further comments to be added and the group discussed the following areas;	

	Children, Young People and Families RJ informed that due to re-configuration, the 'health' elements of Children, Young People and Families plan will sit under the PHDB. The Key Performance Indicators from the Children and Young People's Families plan will be shared with the group to define and measure progress towards key outcomes in relation to health related matter. DM felt that there was a gap in terms of single point of access for children and talked about the co-ordination of services working together at the GEM Centre to provide holistic care for children and their families. The group discussed prevention and early intervention by raising the health profile. It was noted that AW presentation focused on this area and group recognised that this was a priority area moving forward. ID highlighted that this could be a challenge and reasonable confidence is needed in order for an impact to be made. GA informed that Public Health has provided information on prevention in terms of lifestyle choices. Promoting and Enabling Healthy Lifestyles The 3 sub-groups; Wolverhampton Tobacco and Substance Misuse Alliance, Infant Mortality Working Group and Obesity Call 2 Action Programme Board reporting to PHDB provide a firm mechanism to deliver against these priority areas. Keeping the City Safe It was noted that this is in line with the Community Safety Plan. City Assets Group discussed the Syrian refugee crisis and acknowledged that this could have an impact across many areas of Public Health. Group agreed that this is an area the board needs to focus on. ID highlighted the new legislation for landlords in relation to people not eligible to live in Wolverhampton could have an impact on their mental and physical health. It was noted that the Inclusion Board will be prioritising this but there was recognition that there are links to be made	**RJ/JB**

	with this board. City Environment Group discussed the links with air quality and ill health/death. AJ informed that the Local Authority is undertaking work around air quality in terms of PM 2.5 and PM10. AJ added that there is a definite link to ill health but more monitoring is required to understand the detail and the scale of the problem in Wolverhampton. DM informed that is important to raise people's awareness of the issues around air quality and also what choices they can make to improve it. City Economy The board discussed the issues around Wolverhampton being amongst the worst nationally for adults with no qualifications and low numeracy skills. NM informed that Public Health is commissioning a school nursing service to provide health care for children at school and this service can contribute to supporting the skills and education agenda. ID talked about city economy and highlighted that mental well-being is more than just financial inclusion and that there is also a need to promote social inclusion and being valued.	
4.	**Presentations:Business as usual** **i) Commissioning** JG reported the commissioning team work programme and the contents of the slides were noted by the group. The following points were discussed further by the group: • New services or market tested arrangements to be in place by April 2016 • Business planning sessions to review NACRO contract. JG informed that that a report will be presented to the board in December 2015. • Tender : sexual health portfolio. • Healthy lifestyles services – it was noted that a report will be presented to cabinet this evening and JG will update board at the next meeting. The group discussed flexibility within contracts (in	**JG** **JG**

year) and JG clarified that upon awarding the contract, the specification can be tweaked and amended but once contracts are awarded making changes can be difficult because of legal arrangements. However it was noted that there are opportunities to go back and have open discussions with any service provider.

NM questioned the links between the PHDB and Commissioning Oversight Group and JG reported that the Commissioning Oversight Group is an internal group.

ii) Healthcare Public Health

RJ reported on the healthcare action plan and the contents of the presentation were noted by the group. The following points were discussed further by the group:

- RJ informed that following the transfer to the Local Authority, Public Health continues to work with the CCG to deliver a core offer. It was noted that this is a statutory requirement.
- Migrant health –clear processes are in place and a lot of good work has taken place in Wolverhampton. However it was noted that the funding for this scheme with the RMC is non-recurrent from the transformation fund and sustainability of this workstream needs to be discussed.
- Pharmacy work stream – it was discussed that to improve health we need to work more closely with pharmacies to promote and deliver public health campaigns and services.

iii) Health Protection/EPRR

- Health Protection work plan – RJ informed that this work is a statutory requirement.
- TB – RJ informed that considerable amount of work is being undertaken both regionally and nationally. Group discussed that testing for latent TB can help prevent the disease. The pilot undertaken in Wolverhampton showed that from those tested, 33% tested positive and nationally there has been interest in the Wolverhampton model.
- Flu – It was noted that this is a high risk on

	the national risk register. • Immunisations – NHS England commission this service and Public Health scrutinise but it was highlighted that this can be difficult due to on-going issues around data access. **iv) Process, Quality and Governance** KW went through the process, quality and governance work plan and the contents of the slides were noted by the group. The following points were discussed further by the group: • Governance Framework – To be supported by the wider PH team as well as WCC • Workforce Development Plan – It was noted that this was an on-going process. RJ informed that this was a priority for the board last year.	
5.	**Discussion and identification of priorities and work programme for 2015/2016 onwards** The group discussed the key issues to take forward as a board over the next 12 months. Following this discussion the board agreed to focus on following key principles on themes and identify priority areas to develop as work streams- <u>Principles/Themes</u> • Prevention/Behaviour change • Partnership • Effective engagement and building trust <u>Priority areas</u> • Mental Health and Wellbeing • Healthy lifestyle (Choices) • First year of life • Targeted work of at risk groups e.g. new communities and migrants RJ informed that this work will be further developed and a process map will be shared with the board for review. It was highlighted that there are some gaps in terms of representation on the board and group agreed that a representative from mental health, new communities and CCG commissioning is required to drive forward this work.	**RJ** **RJ/JB**

6.	**AOB** NM clarified time of next meeting is 1.00 pm – 3.00 pm.	
14.	**Date of Next Meeting** **15th December, 2015 at 1.00 pm** **Committee Room 3 – 3rd Floor, Civic Centre**	

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