Care Quality Commission

Wye Valley NHS Trust

Hereford Hospital

Quality Report

County Hospital
Union Walk
Hereford
HR1 2ER
Tel:01432 355444
Website:www.wyevalley.nhs.uk

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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	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
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

Wye Valley NHS Trust was established in April 2011 and provides hospital care and community services to a population of 186,000 people in Herefordshire and a population of more than 40,000 people in mid-Powys, Wales. The trust also provides a full range of district general hospital services to its local population, with some links to larger hospitals in Gloucestershire, Worcestershire and Birmingham. During this inspection we only inspected the services provided by Hereford Hospital. We did not inspect community services provided by the trust. Therefore, the overall rating for community services remains as requires improvement, as per the September 2015 inspection.

There are approximately 236 beds of which 208 are general and acute, 22 maternity and six critical care beds within Hereford Hospital. The trust employs 2,601 whole time equivalent staff as of June 2016.

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 5 to 8 July 2016 and unannounced inspections on 11, 17 and 18 July 2016.

Overall, we rated Hereford Hospital as requires improvement with four of the five questions we ask, safe, effective, responsive and well led being judged as requiring improvement.

We rated caring as good. Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support.

Our key findings were as follows:

Safe

- There was a high vacancy rate which meant an increased use of agency and bank staff. The safer nurse staffing levels were planned in line with the national recommendations. The trust fill rate for registered nurses did not always meet the 95% target, ranging from 74.5% on Wye ward to 109.4% on Monnow ward for June 2016. The trust strategy was to cover unfilled registered nurse shifts with a health care assistant where appropriate, to help mitigate staffing level risk. For June 2016 the hospital health care assistant fill rate was 116% for day shifts and 122% for night shifts. We found actual staffing levels met planned staffing levels on most wards during our inspection. We found no incidents relating to staff shortages directly affecting patient care at ward level.
- Mandatory and statutory training compliance for June 2016 was at 86% which although had improved from 78% in July 2015, did not meet the trust target of 90%.
- Patients' weight was not always recorded on patients' prescription charts, which could potentially lead to the incorrect prescribing of the medicine.
- In maternity, the anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby.
- Staff were aware of their responsibilities regarding safeguarding procedures.
- Staff understood the importance of reporting incidents and had awareness of the duty of candour process.
- Staff understood their responsibility to report concerns and to record safety incidents and near misses. Staff received feedback on all incidents.
- Ward and clinical areas were visibly clean and staff were observed following infection control procedures.
- There were systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.

Effective

- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated more patients were dying than would be expected. This had been reported to the trust board and an action plan was in place to understand and improve results.

Summary of findings

- The caesarean section rate was significantly higher (worse) than the national average and the deteriorating rate was not recorded on the risk register.
- Most care was delivered in line with legislation, standards and evidence-based guidance. However, some trust guidelines needed updating.
- The service had a series of care bundles in place, based on the appropriate guidance for the assessment and treatment of a series of medical conditions.
- The trust had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. Performance in national audits had generally mixed results compared to the national average. Actions plans were in place to address areas needing improvement.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Caring

- Staff were observed being polite and respectful during all contacts with patients and relatives. Staff protected patients' privacy and dignity.
- Patients felt involved in planning their care.

Responsive

- The emergency department consistently failed to meet standards in terms of the amount of time patients spent in the department and waited for treatment.
- Bed occupancy was consistently worse than the national average.
- Patients were unable to access the majority of outpatient services in a timely way for initial assessments, diagnoses and/or treatment. The trust had put a system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- The trust did not consistently meet all cancer targets for referral to treatment times.
- Overall referral to treatment indicators within 18 weeks for admitted surgery patients was worse than the England average.
- The percentage of patients that had cancelled operations was worse than the England average.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches on the intensive care unit each month.
- The trust did not have an electronic system in place to identify patients living with dementia or those that had a learning disability.
- Staff adapted care and treatment to meet patient's individual needs.
- We saw examples of services planning and delivering care to meet the needs of patients.
- Systems and processes were in place to provide advice to patients and relatives on how to make a complaint.

Well-led

- The trust had governance oversight of incident reporting and management. Some local risks had not always been identified on risk registers.
- Local leaders demonstrated good understanding of the risks, issues and priorities in human resource management. However, overcoming some of these issues, such as recruitment, remained a significant challenge.
- The trust had a vision, their mission and their values. However, these were not fully embedded or understood by staff.
- Following the trust being placed into special measures in October 2014, a comprehensive quality improvement plan was developed, which included a number of projects and actions at local level. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.

Summary of findings

- The trust implemented a new structure in June 2016, with three service units reduced to two divisions, medical and surgical. Although staff felt the reconfiguration was positive and provided more support we were unable to assess the sustainability and effectiveness of the restructure as this had not yet been embedded into the trust.

We saw several areas of outstanding practice including:

- Services for children and young people were supported by two play workers (one was on maternity leave at the time of inspection). The play workers regularly made arrangements for long term patients to have days out to different places, including soft play areas or bowling. An activity was arranged most months and the play workers sourced the activities from local businesses who donated their good and/ or services. This meant that patients with long term conditions could meet peers who also regularly visited the hospital. Patients found this valuable and liked the opportunity to meet patients who had shared experiences.
- There was a children's and young people's ambassador group which was made up of patients who used or had used the service. We spoke with some members of the ambassador group who told us that they were involved in the service redesign when developments took place and improving the service for other patients.
- The respiratory consultant lead for NIV had developed a pathway bundle, which was used for all patients requiring ventilator support. The pathway development was based on a five-year audit of all patients using the service and the identification that increased hospital admissions increased patient mortality. The information gathered directed the service to provide an increased level of care within the patient's own home. Patients were provided with pre-set ventilators and were monitored remotely. Information was downloaded daily and information and advice feedback to patients by the medical team. This allowed treatments to be altered according to clinical needs. The development had achieved first prize in the trust quality improvement project 2016.
- The newly introduced clinic for patients with epilepsy had enlisted the support of a patient with epilepsy; their views had helped the clinic develop so that the needs of patients were met.
- Gilwern assessment unit was not identified as a dementia ward, however, this had been taken into consideration when planning the environment. The unit had been decorated with photographs of "old Hereford" which were used to help with patients reminiscing. Additional facilities included flooring that was sprung to reduced sound and risk of harm if patients fell, colour coded bays and wide corridors to allow assisted mobility. Memory boxes were available for relatives to place personal items and memory aids for patients with a history of dementia, and fiddle mittens provided as patient activities. The unit provided regular activities for patients, which included monthly tea parties and games.

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

Importantly, the trust must:

- The trust must ensure that all staff receive safeguarding children training in line with national guidance, in particular in the emergency department.
- The trust must ensure that enough staff are trained to perform middle cerebral arterial Doppler assessments, to ensure patient receive timely safe care and treatment.
- The trust must ensure there are enough sharps bins available for safe and prompt disposal of used sharps.
- The trust must ensure that patients' weight is always recorded on patients' prescription charts, to ensure the correct prescribing of the medicine.
- The trust must ensure that medicine records clearly state the route a patient has received medicine, in particular, whether a patient has been given the paracetamol orally or intravenously.
- The trust must ensure all medicines are stored in accordance with trust polices and national guidance, particularly in outpatients.
- The trust must ensure that all patients receive effective management of pain and there are enough medicines on wards to do this.

Summary of findings

- The trust must ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust must ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- The trust must ensure staff receive appraisals which meet the trust target.
- The trust must ensure that patients are able to access surgery, gynaecology and outpatient services in a timely way for initial assessments, diagnoses and/or treatment, with the aim of meeting trust and national targets.
- The trust must continue to take action to address patient waiting times, and assess and monitor the risk to patients on the waiting list.
- The trust must ensure the time taken to assess and triage patients within the emergency department are always recorded accurately.
- The trust must ensure effective and timely governance oversight of incident reporting and management, particularly in children and young people's services.
- The trust must ensure all policies and procedures are up to date, and evidence based, including the major incident policy.

The trust must ensure that all risks are identified on the risk register and appropriate mitigating actions taken.

In addition the trust should:

- The trust should ensure all vacancies are recruited to.
- The trust should continue to complete mortality reviews with the aim of reducing the overall Summary Hospital-level Mortality Indicator for the service.
- The trust should ensure patient records are stored appropriately to protect confidential data.
- The trust should ensure all patient records are fully completed, including stroke pathway documentation and communication detailing interactions and treatments provided within the care plan evaluation sheets.
- The trust should ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for emergency departments.
- The trust should ensure delays in ambulance handover times are reduced to meet the national targets.
- The trust should ensure initial patient treatment times are reduced to meet the national target for 95% of patients attending the emergency department to be admitted, discharged or transferred within four hours.
- Ensure that each service has a local vision and strategy which is disseminated and understood by all staff so that it is embedded within the service.
- The trust should ensure that systems and processes are in place to ensure cleanliness of equipment within the emergency department.
- The trust should ensure that systems are in place to provide adequate nutrition and hydration to patients in the emergency department and clinical assessment unit.
- The trust should ensure treatment bays in the emergency department resuscitation area protect patients' privacy and dignity.
- The trust should review staff safety and provision of an alarm call system in the rapid assessment area.
- The trust should review its arrangements for transporting patients home if they need to travel on a stretcher, with emphasis on improving patient flow.
- The trust should ensure that electronic discharge letters are completed in a timely manner to prevent delays in the preparation of patient's medication to take home and delays in patient discharge.
- The trust should ensure where possible, patients are placed in the most appropriate clinical area.
- The trust should consider implementing a checklist for transferring patients between wards, to ensure transfer is appropriate and maintains patient safety.
- The trust should consider implementing a risk assessment for the admission of medical patients to outlying wards, to ensure admission is appropriate and maintains patient safety.

Summary of findings

- The trust should ensure unnecessary patient moves are minimised at night.
- The trust should continue to work with local stakeholders to improve the discharge pathway and facilitate timely patient discharge.
- The trust should ensure mixed sex breaches are prevented.
- The trust should consider employing a lead nurse for learning disabilities to support patients.
- The trust should ensure that all staff are aware of the trust structure and who their managers are.
- The trust should ensure that patents privacy and dignity is protected at all times, in particular during handover on Leadon ward.
- The trust should ensure that there are action plans as a result of audits, to promote improvements.
- The trust should ensure that cancelled operations are prevented; and if cancelling an operation is essential, patients are then treated within 28 days as per NHS England standard.
- The trust should ensure staff are aware of the trust mission, vision, and strategic objectives.
- The trust should consider a follow-up clinic for patients discharged home after an intensive care unit admission, as recommended in National Institute for Health and Care Excellence guidance.
- The trust should ensure that flow is maintained throughout the hospital to ensure there is capacity to admit patients that required critical care services and discharge patient in a timely manner.
- The trust should ensure there are systems and processes in place to keep patients safe, particularly in maternity services where, the anaesthetic room used as a second theatre on the delivery suite was not fit for purpose.
- The trust should ensure there is clear oversight of outcomes and activity in maternity services.
- The trust should ensure measures are in place to reduce the caesarean section rate.
- The trust should ensure that meeting minutes clearly record recommendations and lessons learnt from incidents.
- The trust should ensure that appropriate transition arrangements for children are clearly defined.
- The trust should ensure there is an acuity tool to be used to determine patient dependency levels and staffing requirements in paediatrics.
- The trust should ensure that there is oversight of the service arrangements for the mortuary team to ensure that staff training and supervision is in place.
- The trust should ensure that effective information on the percentage of patients who were discharged to their preferred place within 24 hours is collected.
- The trust should ensure that corridors where patients wait for their consultation and treatment in the Victoria Eye Unit do not pose a risk to patients with visual difficulties.
- The trust should ensure there is signage on the doors to indicate if a compressed gas is stored in the room, in line with the Department of Health guidance (Medical gases. Health Technical Memorandum 02-01: Medical gas pipeline systems. Part B: Operational management, 2006).
- The trust should ensure that complaints are responded to within the trust target of 25 days.
- The trust should minimise the percentage of outpatient clinics cancelled.
- The trust should ensure all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to, particularly in outpatients, the emergency department and the intensive care unit.

The trust was placed into special measures in October 2014. Due to the improvements seen at this inspection, I have recommended to NHS Improvement that the special measures are lifted.

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	Requires improvement 	We rated urgent and emergency services as requires improvement overall. We found urgent and emergency services required improvement to be safe and responsive. However, it was good for being effective, caring and well led. We found that: • Systems, equipment and standard operating procedures were not always reliable or appropriate to keep patients and staff safe. For example, there was not an effective system in place for staff to identify deteriorating patients in the waiting room. • Waiting times for ambulance handovers were worse than the England average, with over one hour 'black breaches' being reported most weeks. • Patients were unable to access services in a timely manner for assessment, diagnosis or treatment. Action to address this was not always timely or effective. Lack of available capacity caused overcrowding in the emergency department (ED). • The trust was not meeting the 95% Department of Health target for patients being seen within four hours of arriving in ED. • The times patients were assessed by a triage nurse were not always recorded accurately. • Systems and processes were not always in place to ensure cleanliness of equipment within the ED. • In ED's resuscitation area we saw two instances of unsafe management of used sharps. • Staff were aware of their responsibilities regarding safeguarding procedures however, the trust did not meet intercollegiate guidance for safeguarding training, which states all doctors and qualified nurses should be trained to level 3. Only 71% of nursing staff and 63% of medical staff in ED had completed level 3 safeguarding children training.

Summary of findings

- We saw incidents reported in ED related to nursing staff shortages. However, none resulted in impact to patient care.
- Triage times were not always recorded correctly so data about how long patients waited to be seen by a nurse could not be assessed accurately.
- Patients who could take fluids orally did not always have a drink within reach in the emergency department and staff reported that meals in the clinical assessment unit were often cold when served to patients.
- Nursing appraisal rates did not meet the trust target. However, medical staff appraisal rates did meet the trust target.
- The trust did not provide evidence to show that a nurse trained in paediatric immediate life support was on shift at all times.
- Treatment bays in the ED resuscitation area did not have effective screens or curtains to protect patients' privacy and dignity.
- There was no divisional strategy in place.

However, we also saw:

- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so.
- Medications were stored and administered safely.
- Patient risk assessments were generally well completed.
- Staff had awareness of major incident planning.
- A freestanding hand wash station had been installed in the ambulance corridor in response to an area for improvement identified in our September 2015 inspection.
- The trust had systems in place to meet patient's individual needs. Particularly for paediatric patients.
- Patients, their relatives and carers told us staff treated them with dignity and respect, and involved them in decisions about their care.

Summary of findings

- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored to ensure consistency of practice.
- Most medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Consent to care and treatment from patients aged 16 and over was obtained appropriately under the Mental Capacity Act 2005 and by making a Gillick competency assessment of children.
- The trust had systems in place to identify and monitor risks. Performance issues were escalated to relevant senior managers through clear structures and processes.
- Managers were knowledgeable about quality issues and priorities, understood the service's challenges and took action to address them.
- The division had a robust audit calendar, which was used to monitor services and compliance against national and local standards.
- There was a children's and young people's ambassador group that had assisted the redesign of the paediatric ED area.

Medical care (including older people's care)

Requires improvement

We rated medical services (including older people's care) as requires improvement. We found medical services required improvement to be effective and responsive. However, it was good for safe, caring and well led

We found that:

- The new sepsis bundle was not fully implemented or used across the organisation during our announced inspection. This was brought to the trusts attention and during our unannounced inspection the new sepsis methodology had been fully implemented.
- There was no hospital at night service, with separate handovers for medical, nursing and surgical teams. There was no additional nurse support for clinical tasks out of hours.
- There was limited seven-day working across the organisation.

Summary of findings

- The trust has an elevated Summary Hospital-level Mortality Indicator (SHMI) rate of 115.
- The trust had an elevated Hospital Standardised Mortality Ratio (HSMR) of 113.
- The service reported variable performance in a number of national audits relating to patient safety and treatment. Including, the national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) were the service was rated in band D; the trust performed worse than the national average in 12 out of 15 domains in the National Diabetes Inpatient Audit (NaDIA) 2014/15; and there were variable results within the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit.
- Patients were not always placed in the most appropriate clinical area, and general medical patients were often moved to facilitate patients admitted with a clinical speciality. An increased number of mixed sex breaches were reported because of speciality bays for clinical conditions, such as stroke and ventilator support.
- There was no formal risk assessment in place for transfers between speciality wards, or outlying patients. The surgical day case unit was used to facilitate additional bed spaces for medical patients pending discharge.
- The medical admissions area was used by all specialities, which increased patient flow through the department and increased patient bed moves.
- Delays in completing discharge letters delayed patients discharge.
- Divisions were not fully established, and as a result, there was limited evidence of division functioning.

However, we also found that:

- There was a positive culture regarding the management and shared learning of complaints and incidents.
- All clinical areas were clean and there were appropriate systems in place for the monitoring and surveillance of hygiene, equipment and staff compliance.

Summary of findings

- Medications were stored safely, and the service had systems in place to reduce errors and omissions.
- Patient records were completed with evidence of ongoing monitoring and detailed risk assessments.
- Staff were aware of their responsibilities regarding safeguarding procedures and met targets for adult safeguarding training.
- Despite significant nursing staff vacancies, patients were managed safely with appropriate mitigation implemented to prevent patient harm.
- Medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- There was a proactive attitude towards the use of agency staff that were trained with additional skills to meet the demands of the service, or utilised for their speciality knowledge to assist with staff development.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Staff understood the Mental Capacity Act 2005 and we saw evidence of appropriate mental capacity assessments and Deprivation of Liberty Safeguard assessments and referrals.
- All teams reported effective multidisciplinary team working and delivered coordinated care to patients.
- Patients were treated with dignity, respect and kindness. Patient satisfaction was generally high.
- Patients told us they felt supported and stated staff cared about them.
- Staff were observed encouraging patients living with dementia to participate in activities to occupy their time.
- The service had introduced a system of monitoring patients requiring non-invasive ventilation to promote care in the community and avoid admission to hospital.
- The trust had visions and objectives, which were displayed at ward level.

Summary of findings

- All staff spoken with reported that the new division structure was a positive step in moving services forward.
- Staff were dedicated, and proud of the service they provided.
- The service had a robust audit calendar, which was used to benchmark services against other wards and hospitals.

Surgery

Requires improvement

We rated surgery services as requires improvement overall. We rated the service requires improvement for effective and well-led; inadequate for responsive; and good for safe and caring because:

- Between March 2015 and February 2016, the overall referral to treatment (RTT) within 18 was significantly worse than the England average.
- There was an electronic system to monitor and record waiting times for treatment. It was unclear what measures the trust were taking to reduce waiting times. We asked the trust to provide evidence of measures taken but this was not provided.
- Capacity was an issue at the hospital.
- Most staff we spoke with were unaware of the trust's vision and mission.
- There was a strategy for delivering care to patients. The strategy mirrored national performance targets. However, the trust acknowledged within the strategy that demand was outweighing capacity and there were insufficient clinicians to meet this demand.
- There was a new governance structure. However, staff were unaware of the structure and who their line managers were.

However, we found that:

- We saw that all policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence (NICE).
- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes identified shared learning from incidents.
- The environment was visibly clean and staff followed infection control policies.

Summary of findings

- Patient notes had documented risk assessments undertaken.
- The surgical team used the Five Steps to Safer Surgery checklist. The hospital audited and monitored the checklist to ensure any harm caused to patients was avoidable.
- The service assessed the nursing staffing numbers using the national safer nursing tool in order to identify the planned staffing levels.
- There were competency frameworks for staff in all surgical areas.
- Patients told us staff requested their consent to procedures and records seen demonstrated clear evidence of informed consent.
- Staff were clear about their roles and responsibilities around the Mental Capacity Act 2005 and had an awareness of the Deprivation of Liberty Safeguards.
- Staff were caring and compassionate to patients needs and treated patients with dignity and respect.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- Length of stay was better than the national average for elective and non-elective general surgery, urology, non-elective upper gastrointestinal surgery, and trauma and orthopaedics. However, elective trauma and orthopaedic length of stay was worse than the England average.
- There was a sense of pride amongst staff working in the hospital.
- The hospital recognised the views of patients and carers.
- Staff working within the service felt supported.
- Ward sisters had access to leadership programmes.

Critical care

Good

We rated critical care services as good overall. We rated critical care services good for safety, effective, caring and well-led and requires improvement for responsive.

We found:

Summary of findings

- We found an active patient safety incident reporting culture and evidence of learning from incidents.
- There were low infection rates and good adherence to infection prevention and control policies and use of handwashing and personal protective equipment.
- Patients' pain was regularly assessed and pain relief was provided.
- Staff acted in accordance with the Mental Capacity Act 2005 when treating patients on the ICU and requested Deprivation of Liberty Safeguards authorisations when necessary.
- Patients were treated with dignity, respect and kindness during interactions with staff.
- Staff responded compassionately when patients needed support and helped them to meet their personal needs.
- During the inspection, patient's privacy and confidentiality was respected at all times.
- The unit worked hard to meet individual patients' needs and accommodate preferences.
- The staff accessed use of translation services appropriately during our inspection.
- The service had a low formal complaint rate.
- Members of the multidisciplinary team worked well together on the unit.
- The overall mandatory training compliance met the trust target (90%).
- 60% of trained nursing staff on the ICU held a post registration award in critical care nursing, which met guidelines for the provision of intensive care services (GPICS) 2015.
- The ICU was performing as, or better than expected (compared to other similar services) in seven out of eight indicators used in the ICNARC report (2015/16).
- There was an improvement in the minutes of mortality and morbidity meetings, with ongoing actions to improve care.
- We found evidence that staff regularly discussed new guidance and presented patients clinical cases in meetings, which resulted in recommendations and changes in practice.
- The unit engaged in the hospital bed capacity meetings.

Summary of findings

- Leadership of the unit was in line with guidelines for the provision of intensive care services (GPICS) 2015.
- The unit had a risk register which contained relevant risks. There was evidence of frequent discussions and reviews of the risks and leaders were all aware of them.
- There were regular meetings including at unit and clinical leader level. The minutes of these demonstrated that quality, risks, incidents, mortality and morbidity were discussed and ongoing actions were monitored.
- The intensive care unit (ICU) team had been nominated by theatre staff to receive the trust's 'going the extra mile' award for their dedication and hard work.

However, we also found:

- The Intensive Care National Audit and Research Centre (ICNARC) 2015/16 report showed that the unit was performing worse than expected for transferring patients out of hours to a ward and this had increased from the previous year.
- There was no follow-up clinic for intensive care unit (ICU) patients following discharge home from hospital, which was recommended in National Institute for Health and Care Excellence (NICE) guidance and guidelines for the provision of intensive care services (GPICS) 2015.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches each month. There were 27 instances of mixed sex occupancy reported from January to June 2016.
- There had been 22 cancellations of on the day of surgery due to lack of ICU beds in 2015/16, which was significantly worse than the previous year.
- In the six months ending April 2016, there were 14 critical care patients who were ventilated outside the unit and eight patients transferred to another hospital for non-clinical reasons (in the three months ending April 2016) due to bed pressures.
- NHS Safety Thermometer data was not on display and staff were unaware of the results.

Summary of findings

- Antibiotic stewardship audits showed that improvements were required in documenting when an antibiotic prescription required review.
- We found there were many local policies and guidance that were beyond review date.
- There was not always a consultant anaesthetist that specialised in intensive care covering the ICU because the on call rota was split between critical care and anaesthetics.
- The ICU nursing staff appraisal rate was 76% and did not meet the trust target of 90%. However, this was an improvement from the September 2015 inspection when 50% of staff had an annual review.
- There was unclear understanding of a vision and strategy for critical care services.

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology services as requires improvement overall. We rated maternity and gynaecology services as requires improvement for safe, effective, responsive and well-led. We rated the service as good for caring.

We found:

- Systems and processes in maternity were not always reliable or appropriate to keep patients safe. The anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby, and injury to staff from moving and handling within a small space. the trust had implemented mitigating actions to reduce the risk. However, the environment did not meet patient demand and could impact on patient care.
- The caesarean section rate for 2015/16 was 30.3% which was worse than the national average of 26.5%. The caesarean section rate had risen to 42.9% in April 2016. This was worse than the caesarean section rate in the two previous years. The deteriorating caesarean section rate was not recorded on the risk register.
- The midwife-to-birth ratio was 1:30 (one midwife to 30 births).
- 95% of women received one to one care in labour.

Summary of findings

- Root cause analysis demonstrated detailed investigations of incidents. Recommendations and lessons learnt were recorded within the documentation. However, we did not see evidence of these always being followed up.
- There were gynaecology patients on surgical wards due to lack of gynaecology beds. This meant that gynaecology patients were not always cared for on the most appropriate ward.
- 39 operations were cancelled on the day of surgery between March 2015 and April 2016, 18 of those were due to lack of beds.
- Lack of medical staffing resources to deliver the gynaecology cancer pathway meant there was a number of women breaching referral to treatment times.
- There was no dedicated bereavement room.
- Compliance with mandatory training did not meet the trust target.
- Two documents were used to monitor outcomes: the quality report obtained from the maternity information system and the dashboard. This meant there was no clear oversight of outcomes and activity.
- Although staff we spoke with understand their role and responsibilities regarding the Mental Capacity Act 2005. The trust did not provide data to demonstrate that staff had the appropriate skills to care for patients under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

However, we also found:

- Patients, partners and relatives felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- Women's privacy and dignity were protected.
- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- Staff were aware of their responsibilities regarding the duty of candour and we saw those involved in incidents were offered an apology.

Summary of findings

- Staff we spoke with demonstrated an understanding of the arrangements in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- The gynaecology ward displayed quality data that demonstrated the ward had been free for pressure ulcers, falls and MRSA bacterium for over 1000 days.
- The planned and actual staffing levels were displayed and met on the gynaecology ward.
- All areas of the service were visibly clean and well maintained with display boards detailing cleanliness and safety information.
- Equipment was maintained and was safe for use.
- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- Women we spoke with felt that their pain and analgesia administration had been well managed.
- Staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Appraisal rates met the trust target.
- There was a statement of vision and strategy.
- There was an active women's forum that met regularly and provided input into projects in the maternity services.

Services for children and young people

Requires improvement

We rated services for children and young people as requires improvement. We rated the service requires improvement for effective and well-led. We rated the service as good for being safe, caring and responsive.

We rated the service as requires improvement because:

- There was not always effective and timely incident reporting and management.
- Lessons learned from incidents were not always shared and understood by staff.
- Not all risks were identified on the risk register, such as ligature risk. However, mitigating actions had been taken.

Summary of findings

- The trust's mandatory training target of 90% had not been achieved although there had been some improvement since the September 2015 inspection.
- The trust did not use an acuity tool to assess whether additional staff were required depending on the acuity and age of patients present on the ward. However, we saw staffing levels met patient need.
- Procedures and guidance available to staff were not always up-to date. This had been identified in September 2015 but action had not been taken.
- Audits were undertaken to monitor compliance. Audit aims and objectives were clearly defined. However, audit plans did not define clear timescales, were not always assigned to a lead, actions and recommendations were not always documented and there was no evidence of discussion around the audit findings.
- Intended Patient outcomes were either in line with the national average or worse than the national average. The trust had developed action plans to make improvements.
- The transition arrangements for conditions, with the exception of diabetes, were not clearly defined.
- The service did not have a clear vision.
- Objectives in the business plan had been set but were not supported by actions, timescales or accountability.
- Some risks we identified during our inspection had not been included on the risk register, we also highlighted this in the September 2015 inspection.
- Risks were overdue their review date.
- Governance processes were not in place to assess and review policies and care pathways.

However, we also found:

- Patients and stakeholders were involved in service development, including a children's and young people's ambassador group.
- Play workers arranged activities for patients, to provide patients with the opportunity to meet peers who had similar patient experiences.

Summary of findings

- Patients and / or their relatives were informed when things went wrong.
- Good standards of cleanliness and hygiene were maintained on the paediatric ward and special care baby unit (SCBU) which was an improvement since September 2015.
- There was adequate equipment to meet the needs of patients.
- There were suitable arrangements in place for management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Patient's individual medical records were written and managed in a way that kept patients safe.
- Staff were clear about their roles and responsibilities around the safeguarding children.
- Patient risks were managed appropriately and their risks were assessed on admission; observations were made in line with their risk assessment.
- Medical staffing levels and skill mix were planned so that patients received safe care and treatment.
- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.
- Most staff had the right qualifications and experience to carry out their role.
- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner patients could understand.
- There were facilities to engage and occupy young children and teenagers admitted to the ward.
- There were overnight facilities for parents to stay on both the paediatric ward and SCBU.
- Leaders were visible and approachable; ward managers understood the challenges at a local level.
- Staff felt well supported and listened to, there was a strong culture of putting the patient first.

Summary of findings

End of life care

Good

We rated end of life care services as good. The service was safe, effective, caring, responsive and well led because:

- Care records were maintained in line with trust policy.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of their life.
- The trust had a replacement for the Liverpool Care Pathway (LCP) called the multidisciplinary care record for adults for the last days of life (MCR). The use of this document was embedded in practice on all of the wards. The MCR was also used in community based care homes in the area.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed had been signed and dated by appropriate senior medical staff. There was a clear documented reason for the decision recorded. This included relevant clinical information.
- Policies and procedures were accessible and based on national guidance. We saw improvements since the September 2015 inspection, with regard to only one DNACPR policy being accessible to staff on the intranet.
- We found the trust had addressed maintenance issues affecting the mortuary body storage units (fridges), that we had identified on the September 2015 inspection. We also saw a new governance structure in place. The mortuary staff had a clear reporting structure.
- Patients were happy with the care they had received. Relatives were happy with the care their relatives had received.
- Patients were involved in making decisions about their care. Staff carried out care in a respectful and careful manner.
- Care and treatment was coordinated with other services and other providers. The specialist palliative care team (SPCT) had good working relationships with their community colleagues, which ensured when patients were discharged, their care was coordinated.

Summary of findings

- 100% of patients were seen by the SPCT within 24 hours of referral.
- The trust had an executive and a non-executive director on the trust board with a responsibility for end of life care.
- The risks regarding the mortuary were identified on the support services risk register.
- Risk associated with SPCT were on the divisional risk register. The staff had taken action to mitigate against risks.

However:

- The acute SPCT were not collecting information on percentage of patients that had been discharged to their preferred place of death within 24 hours. Without this information, the service was unable to monitor if they were able to honour patients' wishes and assess if they needed to improve on this. This had not improved since the inspection in 2015.
- We did not see evidence of a hand hygiene audit being completed in the mortuary.
- The mortuary team did not have oversight of the service arrangements for mortuary equipment so were unable to assure us that this was completed in a timely manner.
- The facilities management company provided staff training, while it did not specifically include safeguarding training. However, it identified the need to raise any concerns about the treatment or condition of deceased patients to the mortuary staff and their line manager.
- The service did not provide face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday. This did not meet the recommendation from the National Institute for Health and Care Excellence (NICE) guidelines for 'End of life care for adults'.
- Medical staffing did not meet the NICE guidance for end of life care staffing, that recommends there is one whole time equivalent consultant/ associate specialist in palliative medicine per 250 hospital beds. However, in addition to the

hospital based medical cover, an out of hours consultant led palliative care advice service was available through the local hospice 24 hours a day, seven days per week.

Outpatients and diagnostic imaging

Requires improvement

Overall, we rated the outpatients and diagnostic imaging services as requires improvement. We rated the service inadequate for being responsive, requires improvement for being safe and well-led, and good for caring. CQC do not have the methodology to rate the effective domain. The service was judged to be requires improvement overall because:
We found:

- There were long waiting lists for the majority of specialities and the trust had not met all cancer targets for referral to treatment times.
- Although the trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list, we saw there were approximately 28,000 open patient pathways still to review. Therefore, there continued to be a risk that the trust did not have full oversight of the risk to patients on open pathways.
- Mandatory and safeguarding training levels did not always meet the trust's target and not all staff had received an annual appraisal.
- We could not be assured that learning from incidents was cascaded to all staff within the outpatient department.
- Patient records were not always stored securely in some areas of outpatients.
- Whilst the formal complaint rate for outpatients was low, complaints were not always responded to in a timely way.
- The outpatients department had been restructured within the surgical division and whilst governance systems were in place to monitor and manage risks identified within the department, these were not yet established within the new structure.
- The trust had developed a comprehensive quality improvement plan in order to improve

Summary of findings

the patient experience and reduce waiting times. However, the trust had not yet met the majority of objectives and actions it had set and had fallen behind the completion schedule.
- There were effective systems in place for the management of medicines throughout the outpatient department, although not all medicines were stored in accordance with trust polices and national guidance.

However, we also found:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Incidents were investigated and patients were informed when things went wrong. This had improved since our September 2015 inspection.
- The trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- All clinical areas we visited were clean and there was good adherence to infection control policies and personal protective equipment.
- Patient records were generally stored securely and effective systems were in place to ensure clinicians had access to appropriate and up to date patient information.
- The diagnostic and imaging service had systems in place to ensure the safe administration of ionising radiation for staff and patients and these systems were regularly audited and reviewed.
- We saw effective multidisciplinary working across outpatient and diagnostic services.
- Patients were treated with kindness, dignity and respect and spoke positively about the care they had received.
- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- The outpatient department was well represented at board level and leadership within the department was strong, supportive and visible. Staff felt confident to report concerns to senior management.

Hereford Hospital

Detailed findings

Services we looked at
Urgent & 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 & Diagnostic Imaging

Detailed findings

Contents

Background to Hereford Hospital

Wye Valley NHS Trust was established in April 2011 and provides hospital care and community services to a population of 186,000 people in Herefordshire and a population of more than 40,000 people in mid-Powys, Wales. The trust also provides a full range of district general hospital services to its local population, with some links to larger hospitals in Gloucestershire, Worcestershire and Birmingham. During this inspection we only inspected the services provided by Hereford Hospital.

There were approximately 236 beds of which 208 were general and acute, 22 maternity and six critical care beds within Hereford Hospital. The trust employs 2,601 whole time equivalent staff as of June 2016.

For 2016/17 the trust's predicted revenue was £184,377k. The trusts forecast deficit was £31.5m. At the end of June 2016, the trust reported a deficit of £8,154k, this was £1,132k worse than plan. There was a cost improvement programme in place, the trust was cumulatively £587k behind the programme at the end of June 2016.

We inspected Hereford Hospital as part of our programme to re-visit acute trusts that are in special measures.

We held focus groups, drop in sessions and held a stall within the reception area of the hospital to capture feedback from patients, family members and representatives visiting the hospital. We spoke with a range of staff, including black and minority ethnic staff, nurses, junior doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professions, porters and the estates team. We also spoke with staff individually as requested.

The inspection team inspected the following eight core services at Hereford Hospital

- 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

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Detailed findings

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission (CQC)

The team included 11 CQC inspectors, two assistant inspectors, one CQC pharmacist inspector and a variety of specialists including governance leads, a safeguarding lead, a critical care consultant and nurse, a midwife, a consultant obstetrician and gynaecologist, medical consultants and nurses, a surgical nurse, allied health professionals, a junior doctor, a palliative care nurse, a consultant neonatologist and an expert by experience who had experience of using services.

How we carried out this inspection

To get to the heart of patients' experiences 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 of people's needs?
- Is it well-led?

We carried out this inspection as part of our comprehensive programme of re-visiting trusts which are in special measures. We undertook an announced inspection from 5 to 8 July 2016 and unannounced inspections on 11, 17 and 18 July 2016.

Before visiting, we reviewed a range of information we held about Wye Valley NHS Trust and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Health Watch.

We talked with patients and staff from all inpatient areas and outpatients departments.

We held an engagement stand within the reception area of Hereford Hospital where people shared their views and experiences of services provided by Wye Valley NHS Trust. Some people also shared their experience by email, telephone or completing comment cards

We held focus groups and drop in sessions with a range of staff. The focus groups included nurses, junior doctors, consultants, health care assistants, allied health professionals, administrative and clerical staff, porters and the estates team, and black and minority ethnic staff. We also spoke with staff individually as requested.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Wye Valley NHS Trust.

Facts and data about Hereford Hospital

Wye Valley NHS Trust employs 2,601 whole time equivalent staff as of June 2016. The trust had a planned nursing staffing level of 2,844 whole time equivalent for this period. This meant there was a shortfall of 224 whole time equivalent staff as of June 2016.

For 2016/17 the trust's predicted revenue was £184,377k. The trusts forecast deficit was £31.5m. At the end of June 2016, the trust reported a deficit of £8,154k, this was £1,132k worse than plan. There was a cost improvement programme in place, the trust was cumulatively £587k behind the programme at the end of June 2016.

Activity

The trust informed us that in 2014/15, they admitted 43,000 patients. They also saw 239,026 attendances in outpatients and 51,717 to the emergency department. Alcohol-specific hospital stays among those under 18s is 56.5%, worse than the average for England. The rate of alcohol related harm hospital stays, rate of self-harm hospital stays and the rate of smoking related deaths, is better than the average for England.

The first quarter of 2016/17 the bed occupancy at the hospital was 95%. For 2015/16 the bed occupancy was

Detailed findings

94%, this was worse than the national average (88.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of a hospital.

Population served

The trust provides hospital and community care to a population of 186,000 in Herefordshire and a population of more than 40,000 in mid-Powys, Wales. Herefordshire had the fourth lowest overall population density in England at 85 people per square kilometre/220 per square mile.

Deprivation

The health of people in Herefordshire is varied compared with the England average. Out of 326 authorities, Herefordshire is ranked 193th most deprived authority in England. In the 2015 Indices of Multiple Deprivation, Hereford Unitary Authorities were ranked in the second quintile for deprivation. Deprivation is better than average, however, about 13% (4,000) of children lived in poverty. In year 6, 17% (264) of children are classed as obese which is worse than the England average. Life expectancy for both men and women is better than the England average. The rate of statutory homelessness is worse than the England average. Rates of violent crime, long term unemployment, drug misuse and early deaths from cancer are better than average.

Population age

The average age of the population is older than the national average and there is a continuing trend of an increasingly ageing population.

Our ratings for this hospital

Our ratings for this hospital are:

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

Detailed findings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Urgent and emergency services

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

Information about the service

Urgent and emergency care at Hereford Hospital is provided 24 hours a day, seven days a week through the emergency department (ED) and clinical assessment unit (CAU). The trust also has minor injury units and 'walk-in' centres at Ross Community and Leominster Hospitals. However these were not inspected or rated as part of this inspection.

ED provides 10 'majors cubicles', where seriously ill patients can be seen, three 'minors' cubicles for those with minor injury or illness, two paediatric cubicles and five rapid assessment cubicles. CAU had 12 trolley spaces, one triage trolley and eight chairs.

ED had a total of 54,269 attendances from April 2015 to March 2016, 23% of which resulted in admission to the hospital. This was worse than the England average admission rate of 21.6%.

We carried out an announced inspection at Hereford Hospital from 5 to 8 July 2016, and an unannounced inspection of the ED on 11 July 2016. During the inspections, we spoke with 73 members of staff including medical staff, trainee doctors, different grades of nurses, allied health professionals, healthcare assistants and support staff. We also spoke with 14 patients and their visiting relatives and friends. We checked the clinical environment, observed nursing and medical staff handovers and assessed patients' healthcare records. We reviewed the trust's performance data.

Summary of findings

We rated urgent and emergency services as requires improvement overall. We found urgent and emergency services required improvement to be safe and responsive. However, it was good for being effective, caring and well led.

We found that:

- Systems, equipment and standard operating procedures were not always reliable or appropriate to keep patients and staff safe. For example, there was not an effective system in place for staff to identify deteriorating patients in the waiting room.
- Waiting times for ambulance handovers were worse than the England average, with over one hour 'black breaches' being reported most weeks.
- Patients were unable to access services in a timely manner for assessment, diagnosis or treatment. Action to address this was not always timely or effective. Lack of available capacity caused overcrowding in the emergency department (ED).
- The trust was not meeting the 95% Department of Health target for patients being seen within four hours of arriving in ED.
- The times patients were assessed by a triage nurse were not always recorded accurately.
- Systems and processes were not always in place to ensure cleanliness of equipment within the ED.
- In ED's resuscitation area we saw two instances of unsafe management of used sharps.

Urgent and emergency services

- Staff were aware of their responsibilities regarding safeguarding procedures however, the trust did not meet intercollegiate guidance for safeguarding training, which states all doctors and qualified nurses should be trained to level 3. Only 71% of nursing staff and 63% of medical staff in ED had completed level 3 safeguarding children training.
- We saw incidents reported in ED related to nursing staff shortages. However, none resulted in impact to patient care.
- Triage times were not always recorded correctly so data about how long patients waited to be seen by a nurse could not be assessed accurately.
- Patients who could take fluids orally did not always have a drink within reach in the emergency department and staff reported that meals in the clinical assessment unit were often cold when served to patients.
- Nursing appraisal rates did not meet the trust target. However, medical staff appraisal rates did meet the trust target.
- The trust did not provide evidence to show that a nurse trained in paediatric immediate life support was on shift at all times.
- Treatment bays in the ED resuscitation area did not have effective screens or curtains to protect patients' privacy and dignity.
- There was no divisional strategy in place.

However, we also saw:

- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so.
- Medications were stored and administered safely.
- Patient risk assessments were generally well completed.
- Staff had awareness of major incident planning.
- A freestanding hand wash station had been installed in the ambulance corridor in response to an area for improvement identified in our September 2015 inspection.
- The trust had systems in place to meet patient's individual needs. Particularly for paediatric patients.
- Patients, their relatives and carers told us staff treated them with dignity and respect, and involved them in decisions about their care.
- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored to ensure consistency of practice.
- Most medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Consent to care and treatment from patients aged 16 and over was obtained appropriately under the Mental Capacity Act 2005 and by making a Gillick competency assessment of children.
- The trust had systems in place to identify and monitor risks. Performance issues were escalated to relevant senior managers through clear structures and processes.
- Managers were knowledgeable about quality issues and priorities, understood the service's challenges and took action to address them.
- The division had a robust audit calendar, which was used to monitor services and compliance against national and local standards.
- There was a children's and young people's ambassador group that had assisted the redesign of the paediatric ED area.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated urgent and emergency services as 'requires improvement' for being safe because:

- Systems, equipment and standard operating procedures were not always reliable or appropriate to keep patients and staff safe. For example, there was not an effective system in place for staff to identify deteriorating patients in the waiting room.
- Waiting times for ambulance handovers were worse than the England average, with over one hour 'black breaches' being reported most weeks.
- The times patients were assessed by a triage nurse were not always recorded accurately.
- Regular checks were not completed to ensure intravenous fluid warming equipment in ED's resuscitation area was working properly.
- Systems and processes were not always in place to ensure cleanliness of equipment within the ED.
- In ED's resuscitation area we saw two instances of unsafe management of used sharps.
- Staff were aware of their responsibilities regarding safeguarding procedures however, the trust did not meet intercollegiate guidance for safeguarding training, which states all doctors and qualified nurses should be trained to level 3. Only 71% of nursing staff and 63% of medical staff in ED had completed level 3 safeguarding children training.
- We saw incidents reported in ED related to nursing staff shortages. However, none resulted in impact to patient care.
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However, we also saw:

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- Medications were stored and administered safely.
- Patient risk assessments were generally well completed.
- Staff had awareness of major incident planning.
- A freestanding hand wash station had been installed in the ambulance corridor in response to an area for improvement identified in our September 2015 inspection.

Incidents

- The trust reported no 'never events' in the emergency department (ED) or clinical assessment unit (CAU) from March 2015 to February 2016. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Sixteen serious incidents were reported from March 2015 to February 2016. 56% of serious incidents were due to 12-hour trolley wait breaches in ED.
- From November 2015 to April 2016, ED staff reported 263 incidents. One 'severe' incident reported a delay in response from another department in the hospital. Seventeen 'moderate' incidents had been reported: three delayed diagnoses, four relating to staffing issues, five about problems with other providers, four regarding patients observations, documentation and treatment and one delayed discharge. The remaining 245 incidents were all graded as 'low harm' or 'no harm'. Each incident included a record of action taken as a result of the report. We saw appropriately rigorous investigations and learning outcomes recorded for all grades of incidents, and saw examples of learning that had been put into practice in the department.
- Clinical and non-clinical staff we spoke with told us they knew how to report incidents and were able to give appropriate examples of incidents they would report. They told us incident reports were always acknowledged by email and when the investigation was completed a manager gave them feedback on the outcome.
- ED produced a leaflet and held feedback sessions, called 'Feedback Friday'. We were given copies of the leaflets from several weeks, and saw it included information on trends and learning associated with incidents that staff had reported.
- We observed one 2pm meeting in ED, which was attended by five staff nurses, three sisters, one agency nurse, one healthcare assistant and one student nurse. The meeting covered updates from concerns and incidents, new equipment in ED, new guidance from the

National Institute for Health and Care Excellence, improvements in medicine documentation and safety improvements. Staff were positive about the meetings and felt they were worthwhile and useful.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff we spoke with were aware of their responsibilities and principles with regard to duty of candour regulation. However, no formal training had been provided. Staff were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives, made an apology and explained to them how the trust had responded.
- Managers in ED discussed mortality and morbidity incidents during their monthly clinical governance meetings. We saw copies of the minutes of these meetings, which were also made available to staff in the department.
- A consultant paediatrician led a formal debrief and review of any child death in ED, to identify good practice and areas for improvement.

Cleanliness, infection control and hygiene

- Data provided by the trust for the period April 2015 to March 2016 as part of their urgent care service unit dashboard showed no cases of MRSA or Clostridium difficile within ED. One case of hospital acquired bacteraemia was reported in May 2015.
- Cleaning audits showed the trust had not met its cleaning targets from April 2015 to October 2015 for the areas of 'estates' and 'cleaning' within ED. No data had been submitted to this audit from November 2015 to March 2016.
- Audits of hand hygiene compliance showed 100% compliance from April to December 2015. No data was submitted to this dashboard from January to March 2016.
- The trust audited infection prevention standards within ED in November 2015. The audit outcome stated cleanliness "could be improved". Action points included the use of 'I am clean' stickers to indicate which pieces of equipment had been cleaned after use; and to ensure hand hygiene posters were located in appropriate places, such as above wash basins. One area highlighted was over spilling sharps bins with open, blood stained, sharps and equipment protruding. This was reinforced by dashboard results which showed five sharps injuries sustained in ED from April 2015 to March 2016. During our inspection, we saw staff had to share one sharps bin between two or three bays in the ED's resuscitation area. This meant sharps bins were not always readily available for safe, prompt disposal of used sharps.
- During our inspection of ED's resuscitation area, we found dried blood on top of a phlebotomy equipment trolley and another equipment trolley with rust on its surface. We brought these to the attention of a nurse in the department and they were dealt with immediately. However, we were not reassured processes to maintain equipment in a safe and clean condition were effective.
- While observing a patient's treatment in ED's resuscitation area, we saw a consultant disposing of a used sharp which a doctor from the medical team had left on a work surface. We raised this with the ED matron who told us they would report it as an incident and include it in the trust's 'Safety Bites' newsletter. We attended one of the department's 2pm briefing sessions later in the week, and the nurse taking the session mentioned this incident and the need for safe disposal of sharps.
- In the ED 'majors' area, we saw staff cleaning cubicles effectively between patient use. Staff wore disposable aprons, were bare below the elbow and cleaned their hands before and after dealing with each cubicle.
- On 11 July 2016, the ED cleaning check record for 10 July 2016 indicated several areas in the department had not been cleaned, as there was no tick in the relevant boxes on the sheet. These areas included the ambulatory care corridor and resuscitation room; commodes/toileting areas; toilets; kitchen; medical equipment; and monitoring equipment.
- On 11 July 2016 we saw two bins and two hand hygiene dispensers in the rapid assessment area (RAA) that had 'I am clean' stickers dated 8 July 2016. However, the equipment was being used on a regular basis and should have been cleaned at least daily. In the paediatric cubicles, we saw one bin with an 'I am clean' sticker indicating it was last cleaned on 4 July 2016 and

another on 5 July 2016. We saw two hand hygiene dispensers that had 'I am clean' stickers on dated 5 July 2016. We were not reassured the use of 'I am clean' stickers was routine or embedded among cleaning staff.

- The trust carried out an audit of infection prevention standards within the clinical assessment unit (CAU) in December 2015. This demonstrated a 96% compliance rate, which was better than the 90% target rate. Actions for improvement were identified, and an action plan recorded how and when these points had been achieved.
- In the September 2015 inspection, we found there were no handwashing facilities in the ambulance corridor. During this inspection we saw the trust had installed a freestanding warm water hand wash station to address this. The station provided adequate facilities for hospital staff and ambulance staff to wash their hands.
- Handwashing facilities were also available in ED's and CAU's treatment rooms and cubicles.
- In the rapid assessment area (RAA) we saw a paper notice attached to the top of an electrocardiograph machine with sticky tape. The tape was dirty and split and could harbour harmful organisms.
- The trust's November 2015 audit of infection prevention standards within ED found they had achieved 'partial compliance' (82%). Many of the subsequent action points related to the environment and equipment within ED. We saw that actions had been initiated through facilities to upgrade and improve upon the environment, and major buildings works were in progress at the time of the audit.

Environment and equipment

- The RAA in ED had space for up to five patients. It was staffed with one nurse and one doctor, however, we saw times when one or the other was alone in the area. The RAA, its patients and staff were not visible from the main ED environment. There was no panic alarm system in the RAA and we were not assured staff were always safe. We raised this concern with the ED matron during our inspection. During one of ED's 2pm briefing sessions later in the week we heard the practice development nurse telling staff about new safety measures that were planned for staff in the RAA.
- We inspected equipment in ED's resuscitation area, and found staff regularly checked equipment, such as stroke and myocardial infarction ('heart attack') kits, airway trolleys, defibrillators and ventilation in line with best practice guidelines. Staff who completed the tests recorded results on equipment checklists. However, we also found there was no checklist for equipment kept in transfer packs (used when transferring unwell patients to other departments in the hospital), and fluid warmers (equipment used to warm intravenous fluids to body temperature) had not been checked consistently. Fluid warmer checks had not been completed on 13 out of the preceding 28 days, including six consecutive days. This meant that staff were not completing regular checks to ensure equipment was working properly.
- We inspected a random selection of disposable items on each resuscitation trolley in ED and CAU. All items were properly packaged and in date. Records showed staff performed daily checks on equipment and stock in each trolley.
- Staff in ED had access to appropriate safety equipment and clothing for protection from radiation. They used this equipment when radiology staff carried out diagnostic imaging, such as x-rays, in the department's resuscitation area.
- We were shown ED's major incident equipment room, where decontamination tents and equipment, personal protection equipment and action cards were stored. We saw records of regular equipment checks and found equipment to be neatly and safely stored, of sufficient quantity and available for use at short notice.
- ED reception had a separate waiting room for paediatric patients, which kept children and their parents or carers separate from adults waiting to be seen. The paediatric waiting room had a transparent wall facing the reception desk, allowing receptionists to see into the room and ensure children were safe.
- One bay in the ED resuscitation area was allocated as a paediatric bay and contained a range of appropriately sized equipment.
- ED had a 'quiet room' where patients suffering mental health problems could be assessed and treated. When the quiet room was not in use, it was kept locked to prevent anyone going in there unnoticed by staff. The room was compliant with Royal College of Emergency Medicine (RCEM) guidance that requires assessment rooms to have an alarm system, two doors and no ligature points or object that can be used as missiles.
- Any paediatric patient using the quiet room had one-to-one supervision from a member of staff.

- A ligature cutter was available and stored in an easily accessible location in ED. This meant staff would be able to deal with incidents of deliberate self-harm involving ligatures quickly.
- The hospital did not have any security staff. ED staff told us the porters supported them if any patients or visitors became violent or aggressive. The police would be called if required. Porters did not have any specific training to deal with aggression or violence, and we were not assured the hospital had appropriate measures in place to ensure its staff were kept safe. At the time of our inspection ED managers were conducting an audit of incidents of violence, abuse or aggression against reception staff.
- Reception staff told us they had discovered their panic alarm was not working a few weeks before our inspection, and they were not sure if it had been repaired. We raised this with senior managers during our inspection and they tested the alarm and confirmed it was working.
- The switchboard was contacted if the ED reception panic alert was activated. In response the switchboard would phone the reception to enquire if any assistance was needed. However, there was a risk that if reception staff were intimidated that assistance would not be called or that assistance would be delayed due to the call.
- At night, the door giving access from the ED waiting area to the rest of the hospital was kept locked. For part of each night, reception staff worked alone and told us staff from other wards or departments sometimes asked them to go out and let patients or visitors into the hospital. This put the receptionists at potential risk of harm. Reception staff told us there was no formal risk assessment or plan for this process.

Medicines

- ED was trialling an automated electronic medicine dispensing system, which staff operated by fingerprint recognition. This meant staff no longer had to find keys when they needed medicines, and accurate records of access and stock were maintained.
- Agency nurses had access to the medicine dispensing equipment according to their skill levels and competency. Senior nurses in the department could authorise new and temporary users to allow agency nurses access to medicines without asking substantive staff for help.
- We found that medicines were stored securely in ED and CAU. Controlled drugs were stored following safe and good guidance procedures.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators and records showed that they were kept at the correct temperature.
- Staff recorded medicine incidents on a dedicated electronic recording system. Pharmacy managers cascaded learning from incidents to staff in a monthly 'MedsTalk' newsletter. We were shown copies of 'MedsTalk' from May, June and July 2016 which included information and reminders about safe medicine checks, refrigerator temperature checks, sepsis and safe administration of insulin.
- We were told the department worked closely with the medicine safety officer about any medicine related issues in order to ensure safe use of medicines. We were given two example of shared learning about safe medicine administration that had improved patient safety.

Records

- ED reception staff printed out wristbands as soon as patients booked in at the department, and gave them to patients to take in to their assessment with the triage nurse.
- Nursing and medical records for patients seen in ED were held electronically. This meant they were secure and could be accessed by any staff that needed to while creating an audit trail. The electronic record could be transferred to other wards or departments if patients were admitted.
- However, the computerised patient admission system was not always kept up to date. We found that 15 of the 41 patients on the system at 12.55pm on 11 July 2016, had the same registration and triage times This meant the triage time was not always being recorded correctly so data about how long patients waited to be seen by a nurse could not be assessed accurately.
- During our inspection, staff in ED and CAU always locked computer screens when they left them unattended. This meant no-one without legitimate access could view confidential personal information.

- We looked at 18 sets of electronic patient notes. We saw they were completed to a good standard, including assessments, reviews, treatment and discussions with patients and families or carers. Each entry included the name and grade of the staff member involved.

Safeguarding

- Staff we spoke with in ED and CAU gave us examples of situations they would report as safeguarding issues, and demonstrated an understanding of what immediate action they should take if they considered a child or adult to be at risk of harm.
- Healthcare assistants in ED and CAU completed level 2 safeguarding children training.
- The trust's target for mandatory training was 90%. Data from July 2016 showed 83% of nursing staff in ED and 75% of nursing staff in CAU, and 56% of medical staff in ED had completed level 2 safeguarding children training. 71% of nursing staff and 63% of medical staff in ED had completed level 3 safeguarding children training. This did not meet intercollegiate guidance which states 100% of staff in these groups should be trained to level 3 safeguarding children.
- Safeguarding adults training levels stood at 84% for ED nursing staff, 100% for CAU nursing staff and 94% for ED medical staff. The department's practice development nurse had plans in place to train at least the target number of staff from each group by the end of the 2016/17 financial year.
- As part of the triage system used when children arrived at ED, staff used the 'CWILTED' (condition, witness, incident, location, time, escort, description or disability) mnemonic. This helped staff to explore the reasons for the child's attendance at the hospital and highlight possible child protection issues.
- We saw information about safeguarding children displayed on the wall in the paediatric bay of the ED resuscitation area.
- A sister in ED told us they had attended a multi-agency safeguarding meeting regarding a child living with a mental illness who had been seen in the department. They fed back details of lessons learnt from the incident through the department's 'Feedback Friday' programme. The sister also told us they had regular email feedback from the trust's safeguarding team following any referrals they made.
- When necessary, a nurse from the trust's safeguarding team attended ED to debrief staff or discuss individual cases.

Mandatory training

- Mandatory training for ED and CAU staff comprised of dementia awareness; equality, diversity and human rights; fire safety; health and safety; infection control; information governance; and moving and handling.
- Data from July 2016 showed, on average, 84% of clinical staff and 93% of non-clinical staff in ED and CAU had completed their mandatory training. Plans were in place to ensure training levels for clinical staff met the trust's 90% target by the end of the 2016/17 financial year.

Assessing and responding to patient risk

- From April 2015 to March 2016, 27% of ambulance turnarounds took longer than the national target of 30 minutes. Of these, 8% were over 60 minutes and 92% were between 30 and 60 minutes.
- From April 2015 to March 2016, 285 'black breaches' were reported. This was where the time from ambulance arrival to the patient being handed over to ED staff took longer than 60 minutes. Monthly totals varied between a low of seven in June 2015 and a high of 60 in March 2016.
- In addition to the hospital-wide escalation plan, ED managers had written a specific escalation system for the department. This was in response to feedback from staff who said the hospital-wide system did not always accurately reflect the pressures in ED due to the nature of patients they looked after. We were shown the ED escalation plan, which included triggers and actions specific to the department, such as delayed ambulance handover and turnaround, breaches of the four-hour target, reviews of staffing and escalation to senior managers in the trust. Managers and staff told us the system gave a better indication of the stress ED was under and helped to communicate the situation to other departments in the hospital and to senior managers. They told us they used the plan to assess and reassess the department's capacity on an ongoing basis and discussed the escalation level at their twice-daily capacity meetings.
- In addition to the trust wide capacity meetings each morning, ED managers, senior doctors and nurses held a second capacity meeting at 4pm each day. If necessary a third at a later time to review their internal

escalation level and assess what actions were necessary to keep the department safe. This demonstrated that risk and capacity was being continually reviewed and managers were kept aware of any capacity issues in the department.

- ED used the 'Manchester triage system', an internationally recognised process, to prioritise patients who arrived in the department, whether by ambulance or through reception. This ensured patients were seen in order of clinical need and high-risk patients were identified quickly.
- ED reception staff had two specialist 'bleep' numbers to call, one for the paediatric assessment nurse if a patient aged under 18 attended and one to contact specialist staff immediately if a patient displays signs of suffering a suspected stroke or chest pain. However, reception staff had not had any training or formal guidance on recognising stroke symptoms. They told us they knew what to look for from experience and from the Department of Health's 'When stroke strikes, act F.A.S.T.' television advertisement campaign. This meant that there was not an effective system in place for reception staff to identify and respond to patient who may need immediate medical attention
- ED and CAU used the National Early Warning Score (NEWS) to monitor deteriorating patients and trigger appropriate referrals to senior staff. Staff automatically escalated any patient whose observations triggered a NEWS of two or greater to the nurse in charge.
- Part of the escalation process for patients with a NEWS of two or greater was an automatic sepsis screen.
- Medical and nursing staff from the hospital's paediatric ward attended ED as part of the 'crash call' system when seriously ill or injured children came in to the department. ED staff told us they had good and timely support from paediatric ward staff when this happened.
- During the inspection we saw three patients brought in by ambulances under emergency conditions, suffering suspected strokes. All three patients were assessed by a consultant within five minutes of arrival, had 'computerised tomography' (an imaging procedure that uses special x-ray equipment to create detailed images of areas inside the body) scans within twenty minutes and, where appropriate, had thrombolytic ('clot busting') treatment within half an hour of arrival. This exceeded the National Institute for Health and Care Excellence's minimum standard for treatment of an acute stroke.
- During our unannounced follow-up inspection, we checked six cubicles in ED and saw call bells were within reach of patients in each of them. This enabled patients to alert staff for help if required.

Nursing staffing

- The trust's director of nursing (DoN) used the 'safer nursing care tool', which was developed in 2010 by the NHS Institute for Innovation and Improvement, to assess and review nurse staffing levels in ED. The DoN reviewed nurse numbers twice a year against patient attendances and acuity in the department.
- Data provided by the trust in March 2016 reported that ED nursing staffing rates were significantly below the planned resources required. The department's nursing establishment was 54.3 whole time equivalent (WTE) registered nurses, however, only 39.3, 72% of that figure, were in post. Staff recruitment was recognised as a significant risk throughout the trust.
- Staffing fill rates for the ED were not stipulated within the trust board papers fill rate indicator.
- ED used bank and agency nurses to fill vacant shifts each day. Information provided by the trust showed 'minors' and 'majors' nursing staffing met national guidelines such as the National Institute for Health and Care Excellence 'Safer Staffing' guidance, and the Safer Nursing Care Tool, which was developed by the NHS Institute for Innovation and Improvement. However, staffing numbers in the department's resuscitation area did not meet guidelines. The hospital had a workforce development plan for ED to address staffing issues, and had recorded this as a 'moderate' risk on its risk register. We saw no evidence of patient impact.
- ED had three full time equivalent registered sick children's nurses (RSCN). This was not sufficient to provide 24-hour cover and meant ED sometimes did not have an RSCN on duty. ED staff contacted the hospital's children's ward for support if a paediatric patient attended the department while no RSCN was on duty. We saw no evidence of patient impact.
- We asked the trust twice for data on the number of nursing hours filled by substantive, agency and bank staff, and the number of hours left vacant. However, the figures the trust provided did not provide the information we requested. We were not confident the trust was monitoring their use of agency and bank staff in ED, and how many shifts were left vacant.

- From November 2015 to April 2016, 12 of the 263 incidents reported in ED related to staff shortages. Most raised issues with staff being under pressure and unable to take breaks due to shortfalls. None resulted in any patient harm.
- CAU had 3.5 WTE registered nurse vacancies against an establishment of 17.36 WTE. This represented a vacancy rate of 20%. Rota shortfalls were covered by a mixture of bank and agency nurses.
- ED employed a team of 10 emergency nurse practitioners, who cared for patients in the minor injuries treatment area.
- A mixture of substantive and bank advanced nurse practitioners (ANPs) provided 24 hours a day, seven days a week cover in CAU. At the time of our inspection the trust has recently appointed three new ANPs in CAU, bringing the establishment to eight, which reduced the number of shifts covered by bank staff.
- We spoke with eight agency nurses in ED, all of whom had experience of working in emergency departments at Hereford or other hospitals. All of the agency nurses had appropriate experience for the roles they were fulfilling at the hospital. All of them told us they had had a thorough induction on first working in the department, regardless of their previous experience and knowledge, and completed the same induction folder as substantive staff. We saw examples of completed induction folders for agency staff.
- ED managers had agreed training requirements for agency nurses with the hospital's staff bank and all agencies they used. These included paediatric immediate life support and appropriate levels of safeguarding for adults and children.
- We observed a senior nurse carrying out an induction for an agency nurse who had not worked in the department for several months. The induction was thorough, and followed a checklist to ensure uniformity and that no areas were overlooked.

Medical staffing

- ED had three full time consultants in post, and funding for two further consultants. ED managers had submitted a business case to the trust board for two more consultant posts.
- From January to June 2016, 24% of medical shifts in ED were covered by agency or locum doctors. During this period, 4.5% of middle grade shifts, 2.6% of junior doctor shifts and 1% of consultant shifts in ED were not filled.
- Consultants were on site in ED from 8am to 7pm Monday to Friday, and from 9am to 2pm on weekends. Outside those hours, consultants were available on call.
- Speciality and junior doctors provided 24-hours a day, seven days a week medical cover in ED. From Tuesday to Thursday, night cover was provided by one middle grade and one junior doctor. From Friday to Monday night cover consisted of two junior and one middle grade doctor.
- Two full time and two part time consultants provided medical cover in CAU, from 8am to 8pm Monday to Friday. Outside those times, middle grade doctors provided cover with consultants available on call if required.
- The department did not see over 16,000 paediatric patients a year so was not required to have a consultant with sub-specialist training in paediatric emergency medicine in line with the 2012 Intercollegiate Emergency Standards.
- The trusts quality improvement plan included service planning to improve urgent and emergency services. An independent review was being commissioned to look at rotas further to maximise job plans against clinical need and best practice standards.

Major incident awareness and training

- Wye Valley NHS Trust's major incident plan was written in October 2013, and was overdue for review which should have happened in October 2014. We spoke with the trust's emergency planning manager who had been appointed after the plan's review date. They told us they had reviewed the existing plan and deemed it to be safe to remain in operation until a new version was written, rather than simply amending the existing plan.
- We were shown a copy of a staff leaflet on emergency planning, produced in May 2016 and due for review in May 2017. The leaflet was attached to all staff members' payslips in May 2016 and gave them key information about major incidents. Details included: what a major incident is, how it is declared, who has responsibility, who may be 'called out', and what action on and

off-duty staff should take in the event of a declared major incident. It also gave details of important locations to be used during a major incident and contact details for the emergency planning manager.

- The emergency planning manager had produced a folder, entitled 'major and critical incident immediate response plan' for each unit and ward in the hospital. The folder, which was bright red to aid identification, contained simple action cards detailing what staff in each area should do in the event of a declared major incident.
- We were given a copy of the trust's emergency planning, resilience and response (EPRR) core standards document. This document listed 37 key areas of EPRR and rated each as red, green or amber. The trust submitted the document to the local health resilience partnership annually. The version of the trust's EPRR core standards document at the time of our inspection had 31 of the 37 items showing 'green' (completed) and six showing 'amber' (in progress). None were rated as 'red'.
- Copies of the most recent chemical, biological, radiological, nuclear and explosive (CBRNe) and major incident plans were held in ED reception and at the ED nurse base.
- Nursing staff in ED told us they had annual training days on major incidents, including practical sessions using mass casualty and CBRNe equipment. We spoke with the practice facilitation nurse who told us the training days consisted of CBRNe familiarisation and kit practice, followed by a major incident table top exercise based on the layout of the department, and triage practice.
- An emergency planning manager from a local ambulance trust audited the hospital's CBRNe equipment in May 2016 and graded every area as 'green' on a red, amber, green scale.
- ED had a policy in place for treating patients suspected or confirmed as suffering with Ebola or Middle East respiratory syndrome coronavirus. Staff were able to tell us their responsibilities in the event of a patient with these conditions arriving.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated urgent and emergency services as good for being effective because:

- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. It was used to improve care and treatment and patients' outcomes.
- Most medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Consent to care and treatment for patients aged 16 and over was obtained appropriately under the Mental Capacity Act 2005 and for children by making an assessment of Gillick competence.
- Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. When people aged 16 and over lacked the mental capacity to make a decision, 'best interests' decisions were made.
- There was effective management of pain.
- All teams reported effective multidisciplinary team working and delivered coordinated care to patients.

However, we also saw:

- Patients who could take fluids orally did not always have a drink within reach in the emergency department and staff reported that meals in the clinical assessment unit were often cold when served to patients.
- Nursing appraisal rates did not meet the trust target. However, medical staff appraisal rates did meet the trust target.
- The trust did not provide evidence to show that a trained in paediatric immediate life support nurse was on shift at all times.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Medical and nursing staff in ED provided care and treatment which followed guidance published by the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine.
- Staff checked pressure areas on patients' skin according to patient risk, and completed a 'Waterlow' score, a nationally recognised pressure ulcer risk tool. If staff found pressure areas on a patient's skin, they took photographs on a trust-owned camera and completed an incident report. As soon as doctors made a decision to admit a patient who had pressure ulcers, emergency department (ED) staff informed the receiving ward to ensure they had a pressure-relieving mattress available.
- Staff we spoke with were all aware of care bundles for patient conditions such as sepsis, and stroke. We heard staff referring to treatment from the relevant bundles when caring for patients suspected of suffering each condition.
- Staff in ED were participating in 13 audits at the time of our inspection. These included Waterlow assessments and the 'SSKIN' bundle (which highlights five areas of care: surface, skin inspection, keep your patients moving, incontinence and moisture and nutrition and hydration to prevent pressure damage), waiting times for children in ED, assessment of patients presenting with symptoms suggestive of stroke and record keeping in the department.

Pain relief

- Staff updated wipe-clean boards in each ED and clinical assessment unit (CAU) cubicle with details of what pain relief patients were receiving, including the time last administered.
- Nurses working on triage in ED had patient group directions (PGD) in place to allow them to administer pain relief such as paracetamol and ibuprofen. PGDs provide a framework that allows some registered health professionals to administer a specified medicine to patients without them having to see a doctor. This meant nurses could minimise patients' pain while they waited for assessment and further treatment.
- We looked at 18 sets of patient records in ED and CAU. All had pain scores recorded and showed staff had offered pain relief where appropriate. If patients refused pain relief staff recorded that in the notes.
- Patients' notes we looked at in ED consistently recorded prompt administration of pain relief medicine.
- Nursing staff told us that patients could be referred to the pain control specialist nurse if pain management was difficult to control.

Nutrition and hydration

- Patients' nutrition and hydration information, including details for those who were 'nil by mouth', were displayed on wipe-clean boards in each cubicle in ED and CAU. Because of this, staff knew patients' dietary needs and restrictions without having to refer to patients' notes.
- We saw colour-coded equipment in use to alert staff to patients who required extra assistance with eating or drinking.
- Patients and, in the case of paediatric patients, their parents and carers, told us they had been offered food and drinks regularly while in ED.
- On several occasions in ED and CAU, we saw staff providing drinks for patients within a few minutes of being asked.
- However, during our unannounced follow-up inspection on 11 July 2016, we checked six patients who could take fluids orally in the department and saw only two of them had a drink within reach. The ward manager told us that there was usually a drink round every couple of hours but there was nothing formal in place to initiate or monitor this. We were in ED for three hours on that day and during that time no drinks round was completed.
- Staff in CAU told us the hospital's system for ordering patients' meals did not work well on the unit. Due to the unpredictable nature of their patient types and numbers, staff had to guess how many meals they would need for lunch and dinner and order them in the morning. When meals arrived on the unit, they were on an unheated trolley and were often cold by the time staff could serve them to patients. As a result, patients often did not eat the meals and they ended up being thrown away.

Patient outcomes

- From March 2015 to February 2016, the trust's rate for unplanned re-attendances to ED within seven days averaged 7.2%. This was worse than NHS England's target of 5% but was comparable to the England average for the same period.
- In the Royal College of Emergency Medicine (RCEM) 'Mental Health in the ED' audit for 2014/15, the trust scored better than the England average for four, worse than the England average for two and in line with the England average for two of the eight measures.
- In August 2015, the trust developed an action plan to manage the risks to patients presenting with mental health concerns within ED. Several actions mentioned in the plan had been completed at the time of our inspection. For example, the trust had assessed all ligature points in the assessment area and minimised risk, and provided staff with training on 'SADPERSONS' (sex, age, depression, previous attempts, excessive alcohol or drug abuse, rational thinking loss, separated, divorced or widowed, organised or serious attempt, no social supports and stated future intent), a mnemonic-based assessment of the risk of suicide in adults. One identified action "improve access to mental health assessment", was not marked as 'completed' as it was an ongoing process rather than one with a defined finish point.
- The trust met three of the six RCEM standards in the 'assessment for cognitive impairment in older people' 2014/15 audit. Their scores were better than the England average for three measures and in line with the England average for three measures.
- In the 'initial management of the fitting child' 2014/15 audit the trust met three of the five RCEM standards. The trust's scores were in line with the England average for four and below the England average for one measure. We were shown an action plan for improving the initial management of a fitting child. The plan showed a clear identification of an area for improvement (documentation of eyewitness accounts), and named a person responsible for this improvement. The document confirmed ED had achieved the improvement by November 2015 by adding an 'eyewitness account' section to the computer system to prompt and record this information.
- The trust took part in the trauma audit and research network (TARN), a national project to improve care for trauma patients. A clinical report published in April 2016 showed the trust submitted 225 cases from April 2014 to March 2015, and 90 from April to December 2015. Data provided showed the trust had a good level of record keeping for those patients whose details had been submitted to TARN: scoring 96% for the earlier dates and 97% for the latter. Results showed that for Hereford Hospital, from April 2014 to December 2015, survival rates of patients who had experienced major trauma at either discharge or 30 days was within the expected range.
- The trust held trauma group meetings at six monthly intervals. We saw minutes of the February 2016 meeting which showed reviews of unexpected deaths to find out what could be improved. The team shared good practice and reinforced important points when dealing with trauma patients. The meeting also highlighted ongoing training and meetings to support the work of those dealing with trauma patients.

Competent staff

- Nurses working in ED were given an orientation pack when they started, providing details on shift times, roster planning, leave and shift swaps, the makeup of the ED team and personal safety advice. The pack also included a four-week competency-based induction programme covering ED equipment, procedures and familiarisation with other departments and wards who worked closely with ED. We were shown a copy of the induction pack which was clearly written and simple to use.
- ED's practice facilitator managed a well-organised resource room, in which they displayed information on changes to and developments in practice, 'hot topics' about care and treatment and details of training courses available to staff. They also provided training sessions, made learning materials available for loan and stored and monitored nurses' competency folders.
- We were also shown a copy of an ongoing competency programme of skills used by nurses when they worked in ED. Skills in the document were separated into basic ones, requiring a one-stage sign-off by a trainer, and more advanced skills. The programme split competency in the more in-depth skills into five levels, based on an internationally recognised skills development concept, Benner's 'Novice to Expert'.
- In addition to general ED competencies, ED nurses completed a separate portfolio of skills specific to caring for paediatric patients, through training provided by a practice facilitator in paediatrics. The training and

self-study aimed to support nursing staff in a number of areas, such as to be aware of their own skills and development needs; to recognise children who were sick or at risk of deterioration; to understand the differences in anatomy and physiology at different ages; and to understand common childhood illnesses and their treatment.

- The practice facilitator in paediatrics held monthly 'get togethers' to monitor and support new nurses and to allow nurses to discuss any related subjects they wished to.
- Nurses' training folders contained formal certificates and their individual competency plans. The practice facilitation nurse had colour-coded nurses' individual competency plans so nurses could easily see what they were expected to complete during their induction, and by three, six, nine, 12 and 24 months in the department. One newly-qualified band 5 nurse told us it helped them understand what competencies they were expected to achieve during each time period.
- All band 6 nurses in ED were trained in paediatric immediate life support. Nurses who held the ED paediatric 'bleep' were qualified in advanced paediatric life support. We requested evidence to show that a trained in paediatric immediate life support nurse was on shift at all times, but this was not provided.
- Staff described the practice facilitation nurse as "amazing". Staff told us they knew what courses were available for them and were able to submit suggestions about training they were interested in.
- We spoke with a student nurse in ED who told us they had regular, named 'buddies' and a mentor who set and helped them to achieve their learning outcomes. They also told us their buddies and mentor supported them through difficult times and helped them talk through any issues that arose.
- When starting work in ED, all doctors completed a training needs analysis in which they graded their competency in 28 different skills or abilities, such as assessment of different types of patients, communication and management of a variety of injuries.
- Senior ED doctors held weekly training sessions for junior colleagues. The training programme for August to December 2016 included teaching on a range of medical and trauma situations, delivered by staff with specialist knowledge in each field.
- Two medical students who had recently started their rotation in ED told us their induction had included a tour of the department, access to IT systems, introductions to staff and a description of their role. The hospital's postgraduate medical centre had given them copies of relevant policies and procedures however they told us they had not been given any literature specifically relating to ED.
- ED consultants held regular weekly departmental teaching sessions for junior doctors. Junior doctors told us the sessions were well-attended and they found them useful and informative.
- Records of doctors' training needs and competencies were held in each of their personnel files, and were updated during annual reviews.
- In August 2016, 77% of ED nurses and 55% of ED emergency nurse practitioners, and 59% of CAU nurses had had an annual appraisal. Appraisals were scheduled for staff that had not yet had one.
- In 2015/16, 100% of substantive medical staff had an appraisal. We asked the trust for the figures for 2016/17, but they were not provided.

Multidisciplinary working

- The trust was a member of the West Midlands trauma network and operated as a trauma unit. As part of the network the hospital had formal arrangements with the local ambulance provider and regional trauma centre for the management and transfer of patients who had suffered major trauma.
- Managers from ED and CAU attended the daily morning trust wide capacity meetings to ensure they were aware of pressures elsewhere in the hospital and other managers understood the situation in ED and CAU.
- CAU staff provided a proactive in-reach service to ED. They monitored the patient records system to identify patients in ED who were suitable for CAU and liaised closely with ED staff to improve patient flow when possible. Advanced nurse practitioners from CAU attended ED when suitable patients were in the department to start their assessment, even if space was not yet available in CAU.
- CAU staff told us they had a good working relationship with the hospital's diagnostic imaging department and were able to refer patients to the service quickly and easily.

- A hospital ambulance liaison officer us they had a good working relationship with the ED staff and they felt they worked together as one team to manage and minimise ambulance handover delays.
- Staff were able to refer patients to an out of hours GP service, also based in the hospital, if that was the best pathway of care for them. Staff spoke positively about this service and its benefits for the department's flow and for patients.
- Staff were able to refer adult and paediatric patients to mental health services when needed. This process was supported and promoted by the department's registered mental health nurse.

Seven-day services

- A team of ten emergency nurse practitioners provided cover from 8am to 9.30pm, seven days a week, in the ED minor injuries area.
- The department had access to diagnostic treatment services such as computerised tomography (CT) scans and x-rays 24 hours a day, seven days a week.
- We looked at nursing and medical staff's rotas for three months leading up to our inspection. Staffing levels were at similar seven days a week; there was no reduction in cover over weekends.

Access to information

- ED staff had access to a folder of policies and procedures. We were shown the folder and found its contents were up to date and relevant to the department.
- Two junior doctors in ED told us they knew where to find care and treatment guidelines on the trust's intranet, and were able to show us quickly and easily when we asked.
- Wipe-clean boards in each cubicle in ED and CAU gave staff information about the patient in that area. The boards displayed details such as pain relief, nutrition and hydration, care bundles (for example, diabetes, sepsis and dementia), and the nurse and doctor in charge of caring for the patient. The boards also had a 'forget-me-not' symbol to identify patients living with dementia. When patients moved between cubicles or were admitted to a ward, staff took their board from the cubicle and kept it with the patient, which helped ensure continuity in care across different parts of the hospital. The boards were positioned so that they were not visible from outside the cubicle so patients' personal information was protected.
- In the ED resuscitation area, we saw a dated list of on-call staff from each specialty displayed. The list changed daily and was regularly updated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of nurses' skills workbook. We were shown hand-outs and aides memoire that ED's registered mental health nurse had produced for staff to help them make decisions and assessments under the MCA and DoLS.
- The trust's safeguarding team had held an MCA study day for registered nurses in ED and further days were planned. The team provided MCA awareness for healthcare assistants through online training on the trust's intranet.
- We asked 12 nurses in ED and CAU about the MCA and DoLS. All of them demonstrated a good understanding of the processes involved and the reasons behind them. Three nurses in ED showed us the department's MCA checklist and an example DoLS application form.
- We spoke with five nursing staff regarding consent in children. They were able to describe the key elements of Gillick competence and gave recent examples within their clinical practice. A capacity policy was in place and staff we spoke with knew how to access this as required, and capacity training formed part of the paediatric competency training for nurses in ED.

Are urgent and emergency services caring?

Good

We rated urgent and emergency services as good for being caring because:

- Feedback from patients, their families and carers was positive about the way staff treated people. Patients were treated with dignity, respect and kindness during almost all interactions with staff. Patients said staff cared about them.

- Patients and their families or carers were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to people, or those close to them. Patients received information in ways that they could understand.
- Staff responded compassionately when patients needed help and supported them to meet their basic personal needs as and when required.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

However:

- Treatment bays in the ED resuscitation area did not have effective screens or curtains to protect patients' privacy and dignity.

Compassionate care

- A patient and their parent in the clinical assessment unit (CAU) told us all the staff who had looked after them in the emergency department (ED) and CAU were kind and genuinely caring. They had explained everything they were doing and reassured both the patient and their parent throughout their time in the hospital.
- A patient in CAU described the medical and nursing staff as "first class" and told us they were impressed with the way in which they had been looked after. Another patient told us staff were friendly, polite and kind.
- We saw medical and nursing staff treating patients with respect and obvious compassion in ED and CAU, and respecting their dignity.
- We heard staff speaking to patients in a compassionate way, asking patients if they could do anything more for them.
- We saw a junior doctor ask a patient if they could speak with them before closing the door to ensure privacy.
- In the rapid assessment area we heard staff introduced themselves to patients and their family, saying 'Hello, my name is…'.
- We observed a nurse practitioner treating a four-year-old patient. The nurse explained things in simple language the patient was able to understand and displayed a caring, empathetic manner.
- However, one patient told us some staff in ED spoke very bluntly and abruptly and did not display care and compassion. They also said, "some staff are great, make you feel comfortable, are friendly and try to help".
- Treatment bays in the ED resuscitation area did not have effective screens or curtains to protect patients' privacy and dignity. Fixed screens were present between the bays, however there were no curtains to draw around the ends of the bays. Staff used a free-standing, concertina-style fabric screen to try to maintain patients' dignity however, the screen was not as wide as the bays and it left gaps at each end through which the patient could be seen. Patients were visible from the ambulance corridor when staff entered and left through the doors to the resuscitation area. We saw staff trying to use the screen to shield a patient who was undergoing an urgent, intimate procedure. Staff tripped over the feet of the screen twice, knocking it over on both occasions.
- From June 2015 to May 2016, the ED scored worse than the England average in the NHS 'Friends and Family' Test. Over that period, 80% of respondents said they would recommend the unit compared to an England average of 87%, and 11% said they would not recommend it compared to an England average of 7%. In October and November 2015 ED scored better than the England average in the survey, with positive results of 94% and 93% compared to averages of 87% for both months and negative results of 2% and 3% compared to averages of 7%. The average response rate over the period was 12.4%, which was slightly worse than the England average of 13.5%.

Understanding and involvement of patients and those close to them

- We spoke with a parent of a young patient who had attended ED as an emergency. The parent was living with multiple sclerosis and, on hearing that, staff in ED had obtained a reclining chair to allow them to rest in comfort while their child was assessed and treated in the department.
- We spoke with a teenaged patient and one of their parents in ED. They told us staff had kept them informed about every stage of their assessment and treatment, and the patient told us they felt staff respected their ability to make their own decisions rather than referring questions to their parent.
- We saw interactions between doctors and patients in ED, during which staff explained details of assessments and the results of investigations, answered patients' questions and involved them in decisions about their care and treatment.

Urgent and emergency services

- A patient in CAU told us staff had explained the results of their investigations and told them what treatment was planned. They said staff had been polite and courteous, and very helpful.
- We observed a patient living with dementia who was brought into the ED resuscitation area by ambulance, having suffered a suspected stroke. The patient was accompanied by their spouse, and we heard a consultant explaining the situation and what treatment was proposed to them as the patient could not understand. The consultant told the patient's spouse all decisions would be made with them as part of the discussion.
- However, one patient told us staff had given them mixed messages about their treatment plan, depending on which staff member they spoke with.

Emotional support

- Staff understood and showed how they would support the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- Staff could access the trust's chaplaincy service if patients or their relatives needed support. Chaplains and religious leaders from other faiths were available 24 hours a day, seven days a week.

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

Requires improvement

We rated urgent & emergency services as requires improvement for being responsive because:

- Patients were unable to access services in a timely manner for assessment, diagnosis or treatment. Action to address this was not always timely or effective. Lack of available capacity caused overcrowding in the emergency department (ED).
- The trust was not meeting the 95% Department of Health target for patients being seen within four hours of arriving in ED.
- The trust performed worse than the England average for patients waiting between four and 12 hours to be admitted to hospital after doctors in ED made the decision to admit them.
- The trust performed worse than the England average for the percentage of patients leaving the hospital's ED before being seen. However, rates of patients leaving without being seen were within the 5% level considered a risk by the Royal College of Emergency Medicine.
- The hospital did not have any arrangements for transporting patients needing to travel on a stretcher home after 11pm. This meant patients who were fit for discharge sometimes had to stay in ED overnight and discharged the following morning.

However, we also saw:

- The trust had systems in place to meet patient's individual needs. Particularly for paediatric patients.
- Processes were in place for patients to make complaints locally and at trust level.
- The trust performed better than the England averaged for attendances that resulted in admission.
- The trust performed similar to the England average for the total time each patient spent in ED.

Service planning and delivery to meet the needs of local people

- The trust's corporate risk register, reviewed on 30 March 2016, highlighted that lack of available capacity caused overcrowding in the emergency department (ED). The risk register stated it was unable to maintain the urgent care pathway and breached four-hour waits during the year 2014/15, which had an adverse effect on patients' experiences and outcomes. There was a risk that the trust would fail to maintain the urgent care pathway during the year 2015/16 due to demand for services potentially being greater than the capacity to supply but there was no updated to state if this had happened or not. Although control measures had been implemented this remained the highest risk on the register.
- Each cubicle in ED and CAU had a wipe-clean board on the wall, giving patients, relatives and carers the names of members of staff responsible for looking after them.
- We spoke with a patient and their parent in the clinical assessment unit (CAU), who had originally attended ED as an emergency. After their condition had been stabilised they were offered a choice of a course of follow-up treatment as an in-patient or discharge home

and appointments in CAU. They had chosen the latter as it was better for them. They told us their follow-up appointments had been arranged quickly, at times to suit them and they were never kept waiting.

Meeting people's individual needs

- Services were delivered in a way that took into account the needs of different patients, including in relation to age, disability, gender, race and religion, with reasonable adjustments made to accommodate patients during their care and treatment.
- Following feedback from teenage patients and their parents, ED provided Wi-Fi access in its paediatric waiting area. The password was held by the ED receptionists and the service was provided free of charge.
- ED used a nationally-recognised series of posters and activity packs featuring a toy animal to reduce anxiety for children attending the department, and explain things that were happening in child-friendly terms.
- Doors from the paediatric waiting room in to the two treatment cubicles showed a variety of photographs of children undergoing different procedures and having observations taken, to try to reassure children and allay their fears.
- The ED registered mental health nurse had devised two leaflets for patients, on 'safe self-harm' and 'anxiety'. They had also provided an information leaflet for patients who were suffering a mental health crisis, explaining the process in ED and the reasons why the police may have to be informed if the patient left the department against the advice of staff.
- We saw a patient admitted who required psychiatric care. The patient was cared for in the quiet room in ED, which had an alarm system, two doors and no ligature points. The patient received one to one care from trust staff before and during the mental health team assessment.
- ED and CAU had access to translation services, either over the telephone or face to face. Staff who were multilingual also assisted with translation when needed. We spoke with one patient whose first language was Polish, who had had an interpreter while in ED. They told us they understood all the treatment and care they had been given.
- Hearing loop facilities were available throughout the hospital.
- Staff in ED used 'twiddle mitts' (sometimes called 'memory mitts'), simple knitted tubes with items such as buttons, beads and ribbons attached, to ease anxiety and promote calm for patients living with dementia. In addition to providing a focus for patients, the mitts had an added benefit of keeping patients' hands warm. Each of the mitts used in ED were only used for one patient, and staff knitted the majority of them, in their own time.
- Seats in the ED waiting area were grey metal, against a grey background. This may cause difficulties for visually impaired patients as the seats did not stand out from the background.
- Patient information boards in ED cubicles included a 'forget-me-not' symbol to identify patients living with dementia.
- Staff gave relatives and carers of patients living with dementia a printed pass allowing them access to the hospital at any time of the day or night.
- We saw ED staff caring for a patient living with dementia who was confused and trying to leave the department unescorted. Staff demonstrated an attentive and supportive manner and clearly had an understanding of dementia and how patients are affected by it.
- Patients had access to a chapel and multi faith room on site.

Access and flow

- ED had a total of 54,269 attendances from April 2015 to March 2016, 23% of which resulted in admission to hospital. This was worse than the England average admission rate of 21.6%.
- In every month from April 2015 to March 2016, the trust did not meet the 95% Department of Health target for patients being seen within four hours of arriving in ED. Percentages at the hospital ranged from a low of 84% in March 2016 to a high of 91% in June 2015, and averaged 89% for the whole period.
- From February to July 2016, the trust performed worse than the England average for patients waiting over four hours to be admitted to hospital after doctors in ED made the decision to admit them. On average, 31% of the 2,649 patients admitted from ED at Hereford Hospital fell into this category compared to 14% nationally. The trust showed an improving trend in these figures from February to July 2016.
- From May 2015 to April 2016, 3.1% of patients left the hospital's ED before being seen. This was worse than the England average of 2.9%. Overall, the rates of patients

leaving without being seen were below the 5% level considered a risk by the Royal College of Emergency Medicine (RCEM). The trust performed better than the 5% level every month from May 2015 to April 2016.

- The trust performed similar to the England average for the total time each patient spent in ED from May 2015 to April 2016. On average, patients spent 2 hours and 34 minutes in ED at Hereford Hospital compared to 2 hours and 23 minutes for all hospitals in England.
- The ambulance triage areas in ED had access to the local ambulance service's dispatch computer system. This meant staff working on triage knew how many ambulances were on their way in to the department at any time and could plan the best use of their available space accordingly.
- ED did not have access to the Welsh ambulance provider's dispatch system so could not anticipate the arrival of ambulances from Wales in same way. However, a triage nurse told us the ambulance service had recently agreed to install their system in the ED.
- The hospital did not have any arrangements for transporting patients needing to travel on a stretcher home after 11pm. This meant patients who were fit for discharge sometimes had to stay in ED overnight and discharged the following morning. Whilst this was sometimes a clinical or patient safety decision, the lack of a suitable transport facility meant patients who could have been discharged home sometimes blocked cubicles in ED.
- When we carried out our unannounced follow-up inspection, on a Monday, a nurse told us patients had been cared for overnight on the ambulance corridor because the department had been full.
- A patient flow manager told us patient safety was paramount and staff would keep a patient in ED overnight rather than make an unsafe move to another ward or unit in the hospital.
- A senior doctor in ED told us flow problems often occurred on Mondays because of discharge issues over the weekend. They cited social services' need for two working days' notice to arrange support for patients in their own homes as one significant factor.
- From July 2015 to June 2016, 4,422 patients had attended CAU. Of those, 2,865 (65%) were treated and discharged and only 1,557 (35%) were admitted as in-patients. The average length of stay on CAU during the same period was just over 14 hours, better than their target of discharging or admitting patients within 16 hours.
- ED receptionists had a list of patients with more minor complaints that they could allocate to the department's team of emergency nurse practitioners (ENPs), together with a list of exclusions. Patients allocated to the ENPs waited in a different area to others and did not have to go through the department's main triage system. This meant patients with minor complaints were seen more quickly, and did not have to be seen by a triage nurse which allowed other patients to be seen more quickly as well.
- ED receptionists had electronic access to appointments to clinics for fractures, transient ischaemic attack ('mini stroke'), ear, nose and throat, eye conditions and nurse practitioners. This meant staff could give patients details of follow-up appointments when they were discharged and patients did not have to wait for a letter about their appointment.
- The trust did not have a medical or surgical admissions unit. This meant patients who had seen their GP and had been referred to the hospital were admitted via ED, and were reviewed by medical or surgical teams in ED cubicles. This caused delays for other patients in ED while non-emergency patients occupied cubicles. One middle grade doctor in ED told us they often found it difficult to review their own patients because ED's cubicles were used for medical patients waiting for beds.
- However, ED staff could arrange admission to a surgical ward for any surgical patients not seen by the surgery team within one hour of arrival. ED staff did this through discussion with the site manager, and did not need agreement from surgeons to do so.
- CAU accepted adult patients from ED, with National Early Warning Score (NEWS) of up to five. However, we were told this was not an absolute cut-off and CAU staff were able to use their clinical judgment about patients whose NEWS was greater than five or who were under 18 years of age if CAU was more appropriate for the patient.
- CAU also accepted ambulatory patients (those able to walk) who had been referred by a GP.
- CAU aimed to treat and discharge most patients within 16 hours of admission. However, if patients' conditions meant a longer stay in CAU would benefit them, staff

made decisions based on clinical needs rather than the time the patient had been there. During June 2016, 68% of CAU's patients were discharged home or admitted to other wards within 16 hours of arrival in the department, and 32% spent longer than 16 hours there.

Learning from complaints and concerns

- Patients we spoke with were aware of the complaints process and knew how to raise concerns.
- Posters and leaflets giving patients, their relatives and carers information on how to make a complaint were prominently displayed throughout ED and CAU.
- From April 2015 to March 2016, the trust received 41 complaints about ED and five about CAU. After investigation, 35 of these were upheld or partially upheld and 11 were not upheld. The majority of complaints related to lack of care (14) or delays in care or treatment (13).
- Staff had feedback on learning from complaints during the department's 'Feedback Friday' sessions, and through 'safety brief' newsletters and emails. Staff we spoke with were all aware of learning from complaints and concerns and could give us examples of recent feedback.

Are urgent and emergency services well-led?

Good

We rated urgent and emergency services as good for being well-led because:

- The trust had systems in place to identify and monitor risks. Performance issues were escalated to relevant senior managers through clear structures and processes.
- Managers were knowledgeable about quality issues and priorities, understood the service's challenges and took action to address them.
- The division had a robust audit calendar, which was used to monitor services and compliance against national and local standards. Leaders at every level prioritised improvements to safe, high quality, compassionate care and promoted equality and diversity. Managers modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- There was a children's and young people's ambassador group that had assisted the redesign of the paediatric ED area.

However:

- There was no divisional strategy in place.
- Despite, mitigating actions being taken, patients were unable to access services in a timely manner for assessment, diagnosis or treatment.

Vision and strategy for this service

- Staff we asked could tell us the trust's vales: compassion, accountability, respect and excellence ('CARE') and said they identified with these values in their work. One member of staff summarised it as "looking after patients like your own family".
- The service reported that at the time of inspection there was no divisional strategy in place. However, staff were aware of the trust strategy and the division were planning to implement a service specific strategy based on the trust objectives and vision.
- The trust had a comprehensive quality improvement plan, which included a number of projects and actions. These were divided into projects such as urgent care, risk management, information governance, reducing harm, estates and clinical effectiveness. Each project was then further divided into themes and action plans. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions. For example, the risk management project included the production of a risk register that reflected the trusts risks accurately, and the completion of patient risk assessments. Both actions were in progress with a new risk register in place, and training plans in place for e learning for staff.

Governance, risk management and quality measurement

- The trust had systems in place to identify and monitor risks, and maintained a risk register, which was reported on at trust level.
- The trust's risk register had seven entries relating to the emergency department (ED). Three of these were graded as very high risk: risks to patient safety during

periods of high demand in the department, risks due to problems with middle grade doctor staffing levels and risks due to the use of the ED back corridor for ambulance patients awaiting cubicle space. The remaining four risks were graded as 'moderate'. These were: the number of consultant vacancies in ED, the number of registered nurse vacancies in ED, risk of harm to patients due to paediatric life support training not being mandatory and risk of harm to patients due to the numbers of ED staff who were not up to date with their mandatory training. Each of these risks had a number of control measures in place to minimise their likelihood or impact, and all had been regularly reviewed.

- We spoke with six senior managers responsible for ED and the clinical assessment unit (CAU). They told us their main areas of risk were recruitment, capacity and management of change.
- Staff actively engaged in the reporting of incidents and openly discussed the learning from these. All staff we spoke with reported a positive culture relating to learning and non-blame.
- Patients were unable to access timely services for assessment, diagnosis or treatment. Action to address this was not always timely or effective. Lack of available capacity caused overcrowding in the emergency department (ED). Despite, mitigating actions being taken, this have not significantly improved.
- Emergency nurse practitioners in ED told us they were supported by a consultant, who conducted case reviews when anything went wrong. They said the case reviews were a positive learning experience.
- The division had a robust audit calendar, which was used to monitor services and compliance against national and local standards. Information was shared to promote improvement and reviewed by the trust board as dashboards.
- The hospital provided capacity information to the regional capacity management team's 'escalation management system' (EMS) several times each day. EMS reports an escalation level for each site, from level 1 (normal pressure) to level 4 (extreme pressure). If the hospital escalated to level 3 out of hours, the trust's on-call manager attended the site to oversee and manage the situation in person.
- Senior nurses, including the practice development nurse, held brief meetings at 2pm each day at the start of the late shift. The meetings allowed staff to have short training sessions, receive feedback and have relevant discussions with supervisors. The nurse facilitating the meeting recorded details of subjects covered or discussed in the department's training diary. We saw entries mentioning discussions or training on safeguarding children, medicine checks, the department's internal escalation plan, pressure damage and infection prevention and control.

Leadership of service

- ED was led by a consultant and a team of senior nurses.
- The trust had implemented a new divisional structure in the weeks preceding inspection.
- Staff in ED told us they felt the trust's chief executive was approachable and visible, and was "pulling the organisation together". Managers in ED told us the chief executive and divisional manager were supportive and provided a good standard of leadership.
- The trust's chief executive carried out team briefing sessions and visited the department at least once per week. Staff told us the divisional nurse director visited the department daily, observed activity and chatted to staff, and helped with patient care if they were under pressure.
- A sister in CAU told us they had good support from ED managers, ED's registered mental health nurse and the trust's senior management team. They told us the senior management team were visible and approachable, and the chief executive could be contacted through an "Ask Richard" email scheme.
- ED and CAU staff we spoke with were all positive about their managers and department heads. They felt well supported and encouraged to develop, and said managers would help out with any jobs that needed doing when staff were under pressure.

Culture within the service

- All staff within the departments told us they felt there was a positive culture and that teamwork and support played a vital role to their day to day practices. A senior specialist nurse in ED told us the team was very supportive and described them as a "second family".
- A member of ED's domestic staff told us they felt part of the team and were treated as such by clinical staff.
- A healthcare assistant told us everyone helped everyone else, staff worked as one team regardless of who a patient was allocated to and senior sisters helped out with healthcare assistant jobs if they needed to.

- Two medical students in ED told us all of the staff in the department were "lovely" and supportive, and morale was good.
- A junior doctor in ED told us they felt well supported, and consultants and middle grade doctors were approachable and open to questions.
- Senior managers in ED told us since the September 2015 inspection there was a wider understanding amongst managers from other wards and departments in the trust about problems faced by ED, and other managers now offered help. When the ED escalated capacity and demand concerns during periods of high activity, the rest of the hospital responded to help ease the ED pressure.

Public engagement

- Each cubicle in ED had 'NHS Friends and Family Test' response cards and a box for feedback from patients, their relatives and carers.
- The hospital made use of social media to advise the public of busy periods in the ED, to give self-care advice on seasonal illnesses and responded to comments put on social media by patients or their relatives.
- There was a children's and young people's ambassador group which consisted of patients who used or had used the service. We spoke with some members of the ambassador group who told us that they were involved in the service redesign when developments took place. For example, the children's ED had recently been refurbished and the ambassadors had been asked to inspect the area and make suggestions for improvement. Their suggestions had been included in the redesign and the ambassadors told us that they were satisfied with the changes made to the interior of ED.

Staff engagement

- The trust gave us information showing staff group coaching sessions took place over a period of three days in July 2015. These allowed staff to share experiences and formulate a shared vision for the department.
- As well as learning from incidents, ED's 'Feedback Friday' sessions and newsletters gave staff updates on key developments in the department and the trust, such as new training, changes to documentation and policies, recruitment and management changes. Staff we spoke with were all aware of 'Feedback Friday' and told us they liked the way it was used to keep them informed.
- Following traumatic incidents, specially trained staff carried out defusing and debriefing sessions for staff that were involved or affected. The trust also provided a confidential counselling service for staff.
- ED managers ran a number of events to engender a team spirit in the department, encourage peer support and assist staff members' wellbeing. Examples included a 'random raffle' run by a senior doctor, 'make overs' provided by a local department store and a massage chair in the staff rest room.

Innovation, improvement and sustainability

- At this inspection there had been the following improvements noted since the September 2015 inspection:
- A rapid assessment area which allowed ambulance crews to be released from the department sooner.
- A change in the focus of bed meetings, providing more support for ED.
- The appointment of a clinical nurse practitioner for ED and CAU.
- The appointment of a registered mental health nurse for ED.
- Increased numbers of registered sick children's nurses and the introduction of paediatric competencies for general nurses in ED.
- Increased numbers of substantive consultants in ED.
- A structured induction process for agency nurses.
- Handwashing facilities in the ambulance corridor.
- There were areas highlighted where improvements were still needed since our September 2015 inspection. These included:
- Access to services in a timely manner for assessment.
- There was not an effective system in place for staff to identify deteriorating patients in the waiting room.
- Systems and processes were not always in place to ensure cleanliness of equipment within the ED.
- Innovations described by the trust included:
- The 'Going the Extra Mile Award' for staff working in the ED in July 2015; describing the excellent patient care received whilst in the department.

Urgent and emergency services

- In September 2015, an in-house trauma intermediate life support course was delivered to trust staff. Another day was planned for May 2016.

Medical care (including older people's care)

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

Information about the service

Wye Valley NHS Trust provided medical services across Herefordshire and mid-Powys, Wales. The trust also had links to hospitals in Gloucestershire, Worcestershire and Birmingham. Hereford Hospital had 124 medical speciality beds split between admission areas, four medical wards, a medical day case unit and discharge lounge.

The trust had recently changed the structure of the organisation and split services into two divisions, medical and surgical. The medical division was further divided into four directorates, emergency care, two clinical speciality directorates, and community care. Emergency care included the clinical assessment unit (CAU), Gilwern assessment unit and stroke services. There were two clinical speciality directorates, one included diabetes, rheumatology and haematology whilst the other included respiratory medicine, gastroenterology and cardiology.

Medical services at Hereford Hospital had 15,633 inpatient episodes from January to December 2015. These were divided into 40% general medicine, 10% clinical haematology, 10% gastroenterology and 40% other specialities.

During our inspection we visited:

- Arrow ward- respiratory and cardiac medicine
- Cardiac catheter laboratory
- Coronary care unit
- Discharge lounge/ medical day case
- Endoscopy services
- Frome ward- acute admissions unit (AAU)
- Gilwern assessment unit- frail elderly
- Leadon ward- female surgical
- Lugg ward- diabetes, endocrinology and gastroenterology
- Neurophysiology department
- Monnow ward- male surgical
- Wye ward- stroke

The emergency department team inspected the CAU during this inspection.

We spoke with 67 members of staff including nurses, doctors, unregistered nurses, pharmacists, allied health professionals and housekeepers. We also spoke with 24 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at 34 care records. We also reviewed other documentation from stakeholders and performance information from the trust.

Medical care (including older people's care)

Summary of findings

We rated medical services (including older people's care) as requires improvement. We found medical services required improvement to be effective and responsive. However, it was good for safe, caring and well led

We found that:

- The new sepsis bundle was not fully implemented or used across the organisation during our announced inspection. This was brought to the trusts attention and during our unannounced inspection the new sepsis methodology had been fully implemented.
- There was no hospital at night service, with separate handovers for medical, nursing and surgical teams. There was no additional nurse support for clinical tasks out of hours.
- There was limited seven-day working across the organisation.
- The trust has an elevated Summary Hospital-level Mortality Indicator (SHMI) rate of 115.
- The trust had an elevated Hospital Standardised Mortality Ratio (HSMR) of 113.
- The service reported variable performance in a number of national audits relating to patient safety and treatment. Including, the national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) were the service was rated in band D; the trust performed worse than the national average in 12 out of 15 domains in the National Diabetes Inpatient Audit (NaDIA) 2014/15; and there were variable results within the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit.
- Patients were not always placed in the most appropriate clinical area, and general medical patients were often moved to facilitate patients admitted with a clinical speciality. An increased number of mixed sex breaches were reported because of speciality bays for clinical conditions, such as stroke and ventilator support.
- There was no formal risk assessment in place for transfers between speciality wards, or outlying patients. The surgical day case unit was used to facilitate additional bed spaces for medical patients pending discharge.
- The medical admissions area was used by all specialities, which increased patient flow through the department and increased patient bed moves.
- Delays in completing discharge letters delayed patients discharge.
- Divisions were not fully established, and as a result, there was limited evidence of division functioning.

However, we also found that:

- There was a positive culture regarding the management and shared learning of complaints and incidents.
- All clinical areas were clean and there were appropriate systems in place for the monitoring and surveillance of hygiene, equipment and staff compliance.
- Medications were stored safely, and the service had systems in place to reduce errors and omissions.
- Patient records were completed with evidence of ongoing monitoring and detailed risk assessments.
- Staff were aware of their responsibilities regarding safeguarding procedures and met targets for adult safeguarding training.
- Despite significant nursing staff vacancies, patients were managed safely with appropriate mitigation implemented to prevent patient harm.
- Medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- There was a proactive attitude towards the use of agency staff that were trained with additional skills to meet the demands of the service, or utilised for their speciality knowledge to assist with staff development.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Staff understood the Mental Capacity Act 2005 and we saw evidence of appropriate mental capacity assessments and Deprivation of Liberty Safeguard assessments and referrals.
- All teams reported effective multidisciplinary team working and delivered coordinated care to patients.
- Patients were treated with dignity, respect and kindness. Patient satisfaction was generally high.

Medical care (including older people's care)

- Patients told us they felt supported and stated staff cared about them.
- Staff were observed encouraging patients living with dementia to participate in activities to occupy their time.
- The service had introduced a system of monitoring patients requiring non-invasive ventilation to promote care in the community and avoid admission to hospital.
- The trust had visions and objectives, which were displayed at ward level.
- All staff spoken with reported that the new division structure was a positive step in moving services forward.
- Staff were dedicated, and proud of the service they provided.
- The service had a robust audit calendar, which was used to benchmark services against other wards and hospitals.

Are medical care services safe?

Good

We rated medical services as good for being safe because:

- Staff were aware of their roles and responsibilities for reporting incidents. We observed multiple examples where incidents were discussed and learning shared amongst the whole team.
- All clinical areas were clean and tidy, and there were processes in place to ensure patients with infections were managed safely.
- Staff used appropriate measures to reduce risks of infection such as hand washing and protective clothing. This was audited regularly to monitor compliance.
- Medications were stored safely, and the service had systems in place to reduce errors and omissions.
- Medication charts showed minimal errors or omissions, and systems were in place to audit compliance with medication regularly.
- The medical team provided a daily briefing to discuss issues, such as staffing and capacity demands.
- Patient risk assessments were generally well completed. However, details of staff interactions were not always recorded.
- Staff were aware of their responsibilities regarding safeguarding procedures and met targets for adult safeguarding training.
- Despite significant nursing staff vacancies, patients were managed safely with appropriate mitigation implemented to prevent patient harm.
- Consultants provided effective cover to manage patient treatments and provided support and training for teams.
- Staff accessed policies and had awareness of major incident planning.

However, we also found:

- The new sepsis bundle was not fully implemented or used across the organisation during our announced inspection. This was brought to the trusts attention and during our unannounced inspection the new sepsis methodology had been fully implemented.

- There was no hospital at night service, with separate handovers for medical, nursing and surgical teams which may impact on individuals' knowledge of activity and pressures within the hospital overnight.
- Mandatory training compliance varied across the medical division, with some areas meeting trust target and others failing to meet trust target.
- Patients' weight were not always recorded on patients' prescription charts, which could potentially lead to the incorrect prescribing of the medicine.
- Patient care plans were not always inclusive of details of actions taken by nursing staff (in preference to checklist records).
- Stroke pathways were not always completed with details of treatments and times of medication administration.
- Not all ward areas had locked medical notes trolleys, which meant that confidential patient information was not always secure.

Incidents

- The trust reported no never events in medical services from January 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff were aware of their roles and responsibilities in the management and escalation of incidents. Staff reported that they were encouraged to report incidents using the trusts electronic system. Staff confirmed they received feedback from investigations and outcomes and we observed the team brief on Lugg ward included feedback on the incidents that occurred that week and feedback on outcomes from previous incidents. We reviewed previous team briefing minutes which confirmed this practice was a standard within the ward.
- Staff used an electronic incident reporting system and the records showed there had been an increase in incident reported by nursing staff from April 2015 to April 2016.
- The trust had reported 40 serious incidents from March 2015 to April 2016, which included category three pressure ulcers (10), slips, trips and falls (10) and infection control incidents (10). Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity from one to four. For example, category one identifies the discolouration of skin, with category four being full thickness skin loss with underlying damage to muscle, bone or tendons. All pressure ulcers reported by the service as a serious incident were category three which denotes damage to full thickness of skin, but not through to underlying tissue.
- The service reported an increase in number of patient falls in April 2016 with Lugg ward (nine); Wye ward (eight), Arrow and Gilwern assessment unit (four) and Frome ward (three). All falls were reported as not causing harm. Nursing staff told us that staff allocation took into account patients at risk of falling and additional training was implemented as required. Staff discussed falls at team meetings to raise awareness. A falls lead nurse had been employed by the trust in January 2016 to monitor falls and provide support to staff within the hospital.
- Frome ward displayed locally the monthly ward newsletter. The July 2016 issue detailed a review of the previous six months incident themes, and actions taken and planned to reduce risks. This included a review of falls documentation in response to an increase in patient falls and focused staff education regarding the risks of pressure tissue damage. The nursing staff had also implemented visual aids on the ward to signify those patients at risk of falls and tissue damage.
- The consultants discussed patients that had died at daily briefings and at mortality meetings. Weekly mortality meetings included case reviews and root case analysis of all deaths. Information gathered from meetings was shared as lessons learnt and distributed in the trust newsletters.
- Morbidity meetings occurred monthly in addition to the mortality meetings. During which patient cases were discussed alongside learning from incidents. Meeting minutes were shared trust wide through board meetings and newsletters and briefings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- Staff were aware of the duty of candour regulation and were able to describe their responsibilities when something went wrong. Staff described incidents when they had used the duty of candour principles and we saw evidence of shared learning.
- We saw evidence of regular duty of candour training, with sessions rostered into medical training timetables. Staff reported a no blame culture and were observed openly discussing incidents amongst the team.

Safety thermometer

- Each ward used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care). Monthly data was collected and displayed locally on pressure ulcers, falls and catheter associated urinary tract infections and blood clots (venous thromboembolism, VTE). Staff we spoke with were aware of the audit and how outcomes were used to track compliance.
- We saw evidence that the service used a VTE and risk of bleeding assessment, which should be completed on admission and repeated after 24 hours. We saw that this did not always follow the National Institute for Health and Care Excellence (NICE) guidelines on Lugg ward and Gilwern assessment unit. For example; initial assessments were completed, however, they were not always repeated within 24 hours of admission.
- NHS Safety Thermometer data showed medicine services reported 29 pressure ulcers (category two to four) from March 2015 to March 2016. The increase had been a result of two spikes in occurrences, with six pressure ulcers identified in May 2015 and four in December 2015. Local ward actions to address the increase in pressure ulcers included raising awareness of staff through teaching and ward meetings and the use of visual reminders of patient's movement regimes.
- We saw that patients' skin integrity was reviewed on admission using a national skin integrity assessment tool. This was completed upon arrival to the admissions ward and assisted staff to identify a baseline condition as well as any pre-existing tissue damage.
- The service used a nationally recognised tool for pressure ulcer prevention. The Surface, Skin inspection, Keep moving, Incontinence and Nutrition (SSKIN) care bundle. The care bundle provided guidance to use five interventions to promote effective skin care. Senior nursing staff reported that each incident was investigated and analysed to identify any learning or changes to practice. For example, nursing staff on Frome ward had implemented a visual aid for staff to use for patients at risk of tissue damage as part of a local trial.
- Wards carried out monthly audits on pressure ulcer prevention. Monthly audits were reviewed by the matron and reported to the trust board as part of the quality performance review of each service. Trends and themes were discussed and action plans devised to address concerns. In February 2016, the trust reported an increased trend in the occurrence of pressure ulcers and planned for a review of training and processes used for pressure area care to be completed by the newly appointed tissue viability lead nurse. In April 2016, the trust board stated that the trust was not an outlier in regards to overall numbers of incidents and the trust wide education programme continued.
- Nine falls with harm were reported across medical services from March 2015 to March 2016. In response, the service had implemented actions to reduce the number of falls across the organisation, which included reviewing patients to ensure they were allocated to the most appropriate bed spaces to allow staff to be able to observe them. The respective ward managers reviewed all the falls and implemented local action plans to address findings. Nursing staff shared learning from incidents at the monthly nursing forum.
- All patients admitted to the service were assessed for falls risks using a national falls risk assessment tool.
- Eleven catheter-associated infections were reported between March 2015 and May 2016, with a spike in occurrence in December 2015 when three episodes occurred. No trends were identified.
- Validated NHS Safety Thermometer data showed that the trust had a harm free rating greater than 95% from January to April 2016, which was in line with trust target and as expected for the organisation.
- All wards also used noticeboards to display recent safety and quality information. These were observed to be up to date and included details of harm free care. For example, Wye ward displayed that they had achieved over six months care without a hospital acquired pressure ulcer and over 19 months since a patient sustained harm from a fall.
- All clinical areas displayed posters giving staff guidance on reporting patient safety concerns and duty of candour.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- All clinical areas were observed to be visibly clean and tidy. Wards displayed current and updated cleaning schedules.
- All staff reported that they were familiar with the hospital infection prevention, control policy, and were able to demonstrate locating it within the hospital intranet site.
- Cleaning cupboards were stocked with appropriate cleaning materials and equipment, such as disinfectants and sanitising solutions. The hospital used a colour coding system to identify correct equipment to be used for tasks and posters were in place to inform all staff of this.
- We saw "I am clean" stickers in use across all clinical areas stating the date and time of last cleaning, showed that equipment was clean and ready for use.
- All staff were observed to be bare below the elbow and using appropriate PPE. Nursing staff were observed washing their hands using identified hand hygiene techniques after patient contact. Posters detailing effective hand-washing techniques were displayed in all clinical areas.
- Infection control audits were completed monthly and the senior nursing team reviewed information to identify trends and learning. The housekeeper on Lugg ward informed us that they were responsible for completing local audits, which included maintenance, hand-washing techniques and mattress quality. All wards scored 100% in hand hygiene audits for April 2015 to March 2016.
- Audits of Infection Prevention Standards were completed in each clinical area quarterly and action plans devised to address identified needs. For example, CCU scored 94% in dirty utility assessment and 97% in bed space assessment in November 2015. Actions identified and completed included the removal of clutter from the dirty utility and replacement of flooring section and paintwork.
- The hospital did not provide an isolation ward, however, side rooms were located in all main ward areas. Lugg ward had 10 side rooms available, which staff used regularly for providing care for patients requiring isolation for either infectious disease or those at higher risk of infections. Nursing staff located patients with infections and those at increased risk at opposite ends of the ward to reduce risks of cross infection. Isolation protocols signage was on display on all side room doors. There were procedures in place to ensure staff could challenge each other as well as visitors regarding the usage of correct protective equipment and we saw this in practice.
- We observed infection control information displayed on patient and staff notice boards in ward areas and this included guidance about correct waste disposal, and hand hygiene techniques.
- All patients were screened for the carriage of MRSA on admission to hospital. We saw evidence of this recorded in nursing records. The service reported no cases of MRSA bacteraemia infections from April 2015 to April 2016.
- The trust reported three hospital attributed Clostridium difficile cases in April 2016. Incidence was in line with the England average and below the trust target of 18. The service investigated these incidents and took a series of actions to minimise the risk of reoccurrence.
- The infection prevention team, consultant microbiologist and senior clinical staff involved with patients care completed a post infection review for all occurrences of reportable infections. The aim of the reviews was to identify any clinical practice which may have contributed to the incident, and identify any learning. Information gathered from reviews was reported through the infection prevention control quarterly report, to the quality committee.
- The endoscopy unit completed monthly water sampling to ensure the water supply was not contaminated. Staff completed regular protein quality checks and random checks of endoscopes to ensure effective decontamination. No anomalies were noted.
- There were processes and procedures in place for tracking each endoscope used. Decontamination records were placed in the relevant patient notes to ensure that use of endoscopy equipment could be traced, this included details of the staff members responsible for operating and decontaminating them.
- We found sharps disposal bins located as appropriate across the service which ensured the safe disposal of sharps, for example needles. Labels were completed to inform staff when the sharps disposal bin had been opened.
- During the ward brief on Lugg ward, staff reported three incidents where sharps had been left in medication trays, and staff were reminded of their responsibilities for the safe management of sharps.

Medical care (including older people's care)

Environment and equipment

- The medical wards varied in size, and design, but were appropriate to the needs of the service.
- The wards and main hospital building had clear signage and visual prompts to assist with patients and visitors attending the hospital.
- Gilwern assessment unit opened in December 2015 and provided a three-day assessment facility for frail elderly patients. The ward design was dementia friendly and included colour coded bays, wide corridors and bathrooms, natural lighting and cushioned flooring to assist with preventing harm when patients fell. Staff swipe cards provided access to clinical rooms and prevented access by unauthorised persons.
- Staff reported that the therapy gym used for patients who had sustained a stroke was not on the ward. Therefore staff had to consider the transfer time and clinical condition of patients before they were able to attend for therapy sessions.
- We inspected the resuscitation trolley on each ward and found them to be visibly clean and safe for use. Daily and weekly checks carried out, demonstrated the equipment was safe and fit for use.
- During inspection, we observed the resuscitation team completing an audit of the emergency equipment trolley within the discharge lounge. Nursing staff reported that this was a regular occurrence. Trust data showed that bi-monthly audits were completed with the audits for May and June 2016 confirming that of 38 trolleys inspected 33 reached the required standard (21 of which were 100% compliant). Reasons for non-compliance included an untidy trolley (Lugg ward), damaged suction catheter packaging (CCU, discharge lounge), and expired stock (endoscopy). The audit data stated that issues identified were discussed with the nurse in charge at the time of audit with further review planned for September 2016.
- Staff reported that equipment was readily available to assist with the care and treatment of patients. This included pressure relieving and alternating air mattresses, bariatric equipment, medication pumps and transfer aids, such as hoists.
- We observed staff reporting faulty equipment to the maintenance department and identifying it as faulty and not to be used.
- Dirty utility rooms (or sluice room) were observed to be clean and tidy with appropriate storage for clinical waste and chemicals. Ward staff reported regular removal of waste from clinical areas.
- Clinical waste bags used, varied across the organisation. Appropriate coloured disposal bags were used for clinical areas. General waste and recycling facilities were available to staff, patients and visitors.
- Sharp boxes for the disposal of needles were found to be appropriate to clinical area and detailed the date, time and person responsible for assembling them. All were assembled correctly.
- Ward firefighting equipment was labelled with dates of last compliance check and the date of expiry/ next review due date. All equipment checked was within date and therefore fit to use.
- The cardiac catheter laboratory was under development at the time of inspection and interim facilities included a mobile catheter laboratory. The developments affected the facilities for the service. Waiting rooms were small and there were no defined area for breaking news. However, staff utilised the facilities well to maintain patient dignity and confidentiality. The new department was due to open within two weeks of the inspection.
- The cardiac catheter laboratory completed a number of audits. This included medical physics, radiation dose and protection audits, lead screen reviews and completes quarterly health and safety inspections. The audits were completed to ensure equipment was fit for purpose, and that radiation dosage was within recommended levels. Results confirmed consistent compliance.
- The endoscopy department had achieved Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in June 2016, which includes the annual review of policy and guidelines and a number of audits in clinical practice. The audits required reviewed consultant specific completion rates, pain scores, timeliness of procedure list and an annual review by clinical commissioning.
- Radiation warning signs and lights were located outside all clinical diagnostic imaging areas, including the endoscopy department where portable c-arm was in use. C-arms are a mobile x-ray device, which is used to produce medical images.
- Endoscopy equipment was stored in locked cupboards in line with best practice.

- Weekly cleaning audits were completed effectively within the endoscopy unit. No anomalies were noted.
- We checked, at random, portable equipment, such as infusions devices to ensure it had been serviced, maintained and electrically tested (portable appliance testing) as appropriate. Regular tests were completed to ensure portable equipment was safe and fit for use.
- Staff told us that specialist equipment was maintained through manufacturer maintenance contracts. Nursing staff reported that they had access to sufficient equipment for the clinical needs of each department. This included the endoscopy unit, catheter laboratory and wards.

Medicines

- Nursing staff were aware of the correct processes and procedures for the administration, recording and safekeeping of medications, and our findings reflected this.
- Appropriate systems and processes were in place for the safe storage, administration and recording of medications used in clinical areas. This included checking of stock levels, nurse checks for controlled medications and ordering of patients own medications. Treatment rooms were keypad access only with locked cupboards for medications and intravenous fluids.
- Ward pharmacists attended clinical areas regularly to complete medication reconciliation and offer advice on medication administration or availability. This helped to identify medicine issues which pharmacists could address immediately. The pharmacist on Lugg ward told us that medicine reconciliation was usually completed within 24 hours of patient admission.
- Medicine incidents were recorded onto a dedicated electronic recording system. We were told about a recent medicine incident when a patient was sent home with another patient's medicines in error. Learning from this incident was undertaken and more checks had been put in place before a patient was sent home. Learning from incidents was cascaded to staff in a monthly MedsTalk newsletter.
- Two patients informed us that they had experienced delays in the administration of analgesia, waiting up to one hour for requested medication. These were historical reports of the patients' current admission. We found that 11 incidents were reported between December 2015 and April 2016 relating to the delay in administration of medication. These referred to delays in requesting and receipt from pharmacy, loss of medication chart and nursing error. Two of the 11 incident forms related to delays in the administration of analgesia, which was a result of medication being unavailable, and an error in the setting of the administration device.
- We reviewed 18 medication charts and found issues with regard to the safe prescribing of the pain killer paracetamol. Paracetamol can be prescribed to be given intravenously (IV) or orally (o). However, we noted that doctors prescribed both 'IV' and 'o' on the same prescription with no clear distinction between the two. There is a difference in the prescribed dose for 'IV' and oral paracetamol based on a patient's weight, which should not be interchangeable. We found that the patients' weight was not always documented on the prescription chart. It was also not always clear from the medicine records whether a patient had been given the paracetamol orally or intravenously.
- The prescribing of a medicine (enoxaparin) to reduce the risk of a VTE did not always follow the NICE guidelines. The medicine should be prescribed following a risk assessment as well as based on patient's weight. We found that patients' weight were not always recorded on patients' prescription charts, which could potentially lead to the incorrect prescribing of the medicine.
- Nursing staff used red tabards during medication rounds indicating that they should not be disturbed.
- We saw nursing staff following national guidance on checking of medication prior to administration. This included medication, expiry date and where appropriate, a confirmatory check by a second nurse.
- Staff were observed checking patients identity prior to administration of medications.
- If patients were allergic to any medicines, this was recorded on their prescription chart.
- Critical medicines were given at the time they were needed. In particular, we were shown how a 'buzzer' was used to remind staff to give Parkinson's disease medicines on time.
- Controlled medications were stored appropriately and there was evidence that two members of nursing staff checked stock levels and administrations. This included storage and administration of medications in cardiac catheter laboratory and the endoscopy unit.

- The discharge lounge was awaiting delivery of a dedicated controlled drug cupboard; however, outpatient facilities were used in the interim.
- Continued delays in waiting for medicines from pharmacy increased the time for discharge. It was recognised that the delays were also due to waiting for doctors to complete the prescription using the electronic discharge system. Nursing and pharmacy staff told us that patients sometimes went home without their medicines, which were later sent to the patient by taxi, or the patient returned later to collect. These incidents had not been reported as a medicine incident and therefore were not identified as an ongoing issue. The provision of and time taken to prepare tablets to take home was a pharmacy key performance indicator and was audited and reported to the trust board. In August 2016, the trust board reported that the target for turnaround times for dispensing of discharge medication was consistently not achieved, due to increased workload, time of arrival within department and pharmacy resources. The actions outlined included ward pharmacists to promote flow into the department and the recruitment of dispensary staff.
- Hospital data showed that 60% of standard track discharge prescriptions were dispensed within two hours of receipt in the pharmacy from April to July 2016. In addition, 64% of fast track medications were dispensed within 60 minutes of pharmacy receipt within the same timeframe.
- Medications stored on the emergency equipment trolley were stored in small cardboard boxes, which were easily accessible. This was escalated to the pharmacy department during inspection and we were informed that this had been risk assessed.
- Patient's own medication was administered from the patient's locker, which had a small locked medication cupboard attached. The nursing staff held the keys, however, there were plans to implement patient self-administration of medications for appropriate patients on Lugg ward.
- Ward managers reviewed and audited patient records monthly and findings were reviewed by the speciality matron and discussed at the trust board. Evidence of this was noted during inspection where medication omissions, clinical area and actions taken were recorded in the trust board minutes.
- We looked at eight drug charts and found evidence of minimal errors or omissions. The pharmacist on Lugg ward informed us that omissions had reduced following a change in process for the request of medication. Previously, medication prescriptions were sent to pharmacy, which meant that medication charts were not always available when medication was due. The pharmacist had however, implemented a process whereby staff would record the medication required and the pharmacist would then complete a full check of medications to ascertain any contraindications for the patient. This process was completed on the ward, and once checks were completed, the pharmacist arranged delivery of the medication. This meant that staff had access to medication charts and were able to administer medications in a timely manner.
- Staff members identified as omitting medications were required to complete a reflective account detailing the incident and personal learning, which were discussed with the ward manager to identify any learning or training needs.
- The trust reported 12 missed medication incidents in April 2016 across the organisation with three occurring within Frome ward. Nursing staff completed reflective accounts as to how these incidents occurred and learning from this.
- Temperatures were monitored on a daily basis in all clinical areas to ensure that temperature sensitive medication was not at risk during storage.
- Medications requiring cool storage were stored in locked medication refrigerators. Nursing staff completed daily temperature checks to monitor temperatures and guidance was available on actions required if the temperatures were exceeded. Staff confirmed the actions required in response to temperature variances.

Records

- The trust had a quality improvement plan (QIP) in place regarding the safe storage of quality information. This included the review of clinical records policy, completion of team briefings and training and completion of record keeping audits. Dates for completion of all tasks varied, with the policy review due for completion in June 2016 and staff training by March 2017. Progress made against the deadlines was reported to the trust board monthly.
- Our September 2015 inspection identified that not all nursing records, including food and fluid charts, observation charts, National Early Warning Scores (NEWS) and drug charts were fully completed and up to

date. During this inspection we looked at the care records of 34 patients across the service. Records were in line with national guidance, trust protocol. They were well organised, information was easy to access and records were complete and up to date, including transfer of care assessments forms, biographical details and next of kin contact details.

- Medical and nursing notes were legible. Most staff identified their role or grade when completing data entries.
- One consultant had implemented a ward round template, which included details of clinical examination, blood results, results of diagnostic tests and a plan of care. The consultant told us the template was used as a prompt for completing assessments of patients and had helped to ensure full reviews.
- NEWS were completed in line with clinical condition or specified timescales, with evidence of patients' risks or clinical deterioration being escalated as necessary.
- Patients' observation and daily monitoring charts were located at the patient's bedside. All patients had appropriate risk assessments in place, which included, skin integrity assessments, risk of falls and risk of malnutrition assessments. Nursing risk assessments were completed on admission to hospital to identify the patient's baseline condition. Changes to the assessments enabled staff to identify progress or deterioration. There was evidence to support that nursing risk assessments were repeated regularly to monitor changes in patient's condition.
- We observed that although patient risk assessments were completed, there was limited written communication detailing interactions and treatments provided within the care plan evaluation sheets. For example, tick charts used to record patient and staff interactions were fully completed, however, charts requiring free text contained limited information.
- The service used intentional rounding charts, for patients at risk of pressure tissue damage or dehydration. The charts were well-completed and included records of patient interactions, such as changing position and offering oral hygiene.
- Patients identified as at risk of tissue damage were placed on reposition regimes and if necessary, provided with pressure relieving equipment. Repositioning charts were completed well, with evidence of patients being assisted to turn or transfer as necessary.
- The service had implemented new fluid management charts, which required nurses to total input and output at 12 hourly intervals. We observed that these were well completed, and total figures were accurately calculated.
- We saw that the stroke pathway documentation was in use across the service and identified that two out of three patients did not have this completed past the first page. This meant that details of investigation and treatment times were not easily identifiable, which could impact patient treatment as full history may not be recorded. In addition, audit completion would be difficult, impacting the service compliance data.
- Notes from endoscopy procedures were recorded in an electronic record system, which could be used to complete audits and collate data.
- The confidentiality and recording of records had been identified on the QIP and we observed that medical records were stored in lockable trolleys at the nurse's station. However, we identified that notes' trolleys were not locked on Lugg and Frome wards at the time of inspection. This meant that notes were not always secure and unauthorised persons could access them.

Safeguarding

- There were clear systems, processes and practises in place to keep patients safe and staff were able to describe previous experiences when they had made referrals to the safeguarding team.
- We found that nursing staff were aware of their responsibilities regarding safeguarding and demonstrated that they were able to access the trust policy on the intranet. Nursing staff were able to give examples of escalating safeguarding concerns. This had improved since our September 2015 inspection, when we identified that not all staff were able to tell us how they reported a concern outside the organisation. Also at that time nursing staff compliance with children's safeguarding training to level two was 30% and safeguarding adults level one training was 55%. This did not meet the trust target of 90%.
- Staff informed us they had completed safeguarding training. Trust records showed that 90% of the medical division, including nursing and medical staff had completed level one adult safeguarding training and 89% had completed level one safeguarding children training. The trust target for training was 90%.

- Staff reported that the trust safeguarding lead was visible and easily accessible. Wards displayed posters containing contact details of clinical leads.
- Nursing staff were able to confirm knowledge of female genital mutilation, however, reported no specific training.

Mandatory training

- The medicine division compliance data from June 2016 showed that mandatory training in health and safety (95%) was in line with trust target of 90%. The remaining mandatory training topics varied in compliance, for example, 78% and 88% for equality and diversity and infection control level 2 training respectively. Trust target was 90% for all training.
- The trust board papers reported plans to link mandatory training to staff pay increments to encourage staff training compliance.
- Mandatory training was logged on the electronic staff record for all nursing staff, which enabled ward managers to identify compliance and plan leave for training.
- We saw that the trust provided additional training for staff following the implementation of a trust wide sepsis bundle.

Assessing and responding to patient risk

- We found that the trust had implemented a new admission clerking form, which included details of patient's past medical history, medications, admitting reason, clinical findings, blood results and details of ward rounds. The new clerking form replaced a similar template, which had been amended to allow the use of separate clinical bundles for appropriate patients identified as having clinical conditions, such as sepsis or acute kidney injury.
- During our announced inspection we found that both old and new clerking forms had been used for recent admissions and five patients admitted with a suspected sepsis, did not have a completed sepsis bundle or template. All five patients were identified as having infections that should have triggered the implementation of sepsis bundle outlined in the old clerking form; however, these had not been completed. These patients were escalated to the trust for clinical review. The service informed us that the old form had been used in error for a number of patients, the new sepsis bundle differed, and the patients did not trigger implementation of the pathway. Consequently, we saw during our unannounced inspections on the 17 and 18 July 2016, the trust had removed all old forms from clinical areas to prevent further confusion. We also saw the new sepsis bundle in use for a patient admitted with sepsis.
- A consultant reviewed all patients within 12 hours of admission. This was completed either within the emergency department, clinical admissions unit or upon arrival to Frome ward. Medical staff reported that consultants completed ward rounds within admission areas a minimum of three times per day, which ensured that all new admissions were reviewed within the 12 hours specified by the London Quality Standard.
- Consultants or the medical registrar reviewed all patients every weekday, including those out lied onto other speciality wards. Patients who were cared for on a different speciality ward, to that of the responsible consultant were classed as an outlier. For example, we saw a patient under the care of a respiratory speciality consultant cared for on a different speciality ward such as a surgical ward.
- Nursing staff reported that medical teams were responsive to calls for assistance.
- There was provision within the service to admit patients who either attended for outpatient procedures, such as endoscopy, and those pending discharge who became unwell. Nursing staff within the discharge lounge reported that they were able to arrange transfer to inpatient services following discussion with the site management team and postpone discharge if a patient deteriorated.
- There was no established hospital at night team and clinical specialities managed their own handovers and activity. We noted that the medicine service had a robust out of hour's medical team, which included one registrar who was responsible for admissions and inpatient areas, plus one foundation level two and a junior doctor. However, they had no support from a senior nurse or assistant practitioner to assist with tasks such as cannulation, blood sampling or catheterisation, reporting that ward staff often performed these tasks where possible. The doctors we spoke with told us that the lack of senior nurse was not problematic and there was adequate medical cover to meet the demands of the service at night.
- We observed the medical handover between day and night shifts and found this was structured and

methodical, working through admissions from that day, any outstanding tasks, patients at risk of deterioration and confirmation of team contact numbers. The team used the electronic patient tracker to assist with this process.

- The surgical handover between day and night shifts was completed at a different time and location, so overall view of the hospitals patients was not possible. The potential risk associated with teams working independently was that patients classed as "at risk" were unknown by all medical staff on night duty and staff were unaware of any support required by the individual clinician. However, medical staff reported that they maintained regular contact within the service and were updated on risks and workload.
- The critical care outreach team were available to support between 8am and 8pm. Medical staff confirmed that they were able to refer patients to the intensive care unit if necessary.
- Nursing staff reported using one to one supervision for all patients who were confused and at risk of harm if left unattended. Where possible on the medical wards, patients were cohorted into small groups to enable activities and supervision. This role was usually completed by an unregistered nurse, and changed regularly to prevent fatigue and maintain patient interest. Nursing staff reported that patients often responded to changes in staff, as different staff would engage in different activities.
- The service had developed a small group of unregistered nurses who had been specifically trained in the one to one supervision of patients with dementia.
- Patients who were identified as at high risk of falls who used a walking aid were identified by applying a red tag to the walking aid. Staff were able to identify which patients required assistance or supervision at a glance and offer assistance if observed mobilising unattended.
- Patients with high risk of falls were also nursed using falls alarms, which would alert staff to occasions when the patient was getting out of their chair/bed. This enabled staff to attend the patient immediately to prevent any harm from falling.
- We saw that the trust used the SSKIN care bundle for minimising the risk of skin damage. This was effectively followed in all the care plans we looked at. Appropriate pressure relieving equipment was in place and we saw that staff could refer patients to a tissue viability nurse when required.
- In accordance with the trust's deteriorating patient policy, staff used the NEWS to record routine physiological observations. Examples included; blood pressure, temperature and heart rate, and the monitoring of a patient's clinical condition. This was used as part of a 'track-and-trigger' system whereby an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations up to urgent review by a senior nurse or a doctor.
- At the September 2015 inspection we identified that there was variance in compliance with completion of NEWS and appropriate escalation. However, during this inspection we identified that NEWS were completed and calculated appropriately on all wards, with evidence of referrals to medical teams within nursing notes regarding changes in clinical condition.
- On Lugg ward, we observed nursing staff escalating a deteriorating patient. The medical team responded quickly to bleeps and calls, offering advice and support. The medical team attended the ward immediately and reviewed the patient.
- In September 2015, we found that the relocation of non-invasive ventilation (NIV) to Arrow ward had resulted in concerns regarding patient safety being escalated to the trust. The concerns had been addressed in terms of provision of competent staff to oversee patients on NIV. During this inspection, we identified that staff had the appropriate training and skills to manage patients receiving NIV, and nursing staff maintained an appropriate nurse to patient ratio of one nurse to two patients in line with British Thoracic Society recommendations.

Nursing staffing

- All wards displayed planned and actual staff numbers and during inspection, all areas were staffed to the correct level. In June 2016 the trust reported the average fill rates for day shifts for registered nurses was between 75% (Wye ward) and 98% (Arrow ward). Night fill rates ranged between 87% (Wye ward) and 104% (Gilwern assessment unit). Unregistered staff fill rates were consistently better than planned rates, with up to two times the planned number of staff on duty. Nursing staff reported that to assist in the safe management of patients, additional unregistered nursing staff were used when the planned number of registered nurses were unavailable.

Medical care (including older people's care)

- We reviewed staffing rotas and staffing reporting tools for the three months prior to inspection and noted that wards had sufficient staff to maintain patient safety.
- The trust reported significant difficulties in the recruitment of registered nursing staff, with 72% of vacancies in June 2016 relating to nursing and midwifery staff. Band 5 registered nurses were the largest portion, with 83% of all nursing and midwifery vacancies.
- Nursing agency spend was consistently worse than the trust target of 8% from April to June 2016, with April recorded at 15%, May 17% and June 19%.
- To promote a stable workforce the service had block booked agency nurses across all clinical areas. The block bookings varied in length from a couple of weeks to several months depending on availability. Agency staff reported that teams were supportive and inclusive.
- To address some issues relating to lack of registered nursing staff the service had introduced a training programme for unregistered nursing staff to become assistant practitioners. The medical division had 24 students in place at the time of inspection. Nursing staff reported good working relationships and experiences with the training programme and the impact on patient care.
- Skill mix was appropriate on all wards with sufficient registered and unregistered staff to maintain patient safety during our inspection. The numbers of staff on each ward varied according to the speciality and ward activity. Staffing establishments had been reviewed in line with ward bed numbers and activity. The medical wards had sufficient staff numbers with the appropriate skill mix to enable effective delivery of care and treatment.
- Ward managers reviewed and reported staffing on a daily basis in line with the trust's safe staffing tool, which took into account nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas of pressure and allocate staffing across the organisation. The sister on call would have an overview of staffing levels across the organisation and would allocate staff to specific areas when activity increased. When staff moves were not possible, additional bank or agency staff were sought to assist with the management of the workload, this was usually unregistered nursing staff due to difficulties in recruiting registered nurses.
- The impact of increased activity and reduced ability to recruit registered nurses meant that ward based senior nursing staff were regularly working clinically. During inspection, we observed all ward sisters working clinically, and all stated that they had minimal non-clinical shifts for ward management duties.
- Nursing sisters reported that they frequently reviewed the staffing levels required for ward activity. Frome ward reported that they had reduced the number of staff working by adjusting the way in which they managed the ward.
- The matrons reported that each wards' staffing levels were reviewed annually as a minimum. This was completed to ensure that the number of staff planned for the wards met the demands of the service.
- During inspection, an additional member of staff working within the cardiac catheter laboratory was responsible for assisting with the transfer of patients between the mobile catheter laboratory and the recovery area. This was a temporary measure whilst refurbishment was completed.
- We observed nursing handovers and found these to be thorough and informative. On Lugg ward, the nursing team split into three teams and each staff member received a printed handover sheet detailing patient clinical history and updated treatment plans. The nurse handing over discussed each patient, how the patient had been and what changes had occurred. We noted that there was an agency nurse handing over to an agency nurse. When we discussed this with the nurse in charge we were informed that the agency nurse was working on the unit as a block booking, which enabled continuity of care. We were informed that where possible a substantive member of staff would care for the patients at least one shift per 24 hour period. However, when this was not possible, the nurse in charge completed regular checks and attended the handover.
- Nursing staff reported that they were eagerly awaiting the commencement of the permanent director of nursing as they felt this would provide further stability and support.

Medical staffing

- Medical cover was appropriate with senior medical staff available 24 hours per day to review admissions, which was in line with the standards set in the Society for Acute Medicine and West Midlands Quality Review

Services publication 2012, Quality Standards in the Acute Medical Units (AMU). Medical staff reported that consultants who lived further than 30 minutes from the hospital would remain on site throughout their on call period to ensure that they were available to support the teams.

- Medical staff spoken with confirmed that they had the appropriate skills to manage patient care and treatment. For example, 83% medical staff had a valid advanced life support (ALS) certificate. The trust target for compliance in ALS training was 90%.
- The trust reported consultant vacancies across most specialities, with proactive recruitment in place by individuals. For example, one consultant had attended a conference and displayed comparisons between the trust and other hospitals in London and Glasgow. This had resulted in the successful recruitment of two consultants.
- Where necessary locum staff were used to fill medical posts (including consultants) to ensure patient safety. This was reported to have been particularly effectual within Wye ward, where the consultant locum had been working for six months. Nursing staff informed us that the consultant was familiar with ward routines and staff, and assisted in providing consistency in patient care. The use of locum staff and high consultant vacancies were recorded on the trust risk register as an operational risk.
- Medical staffing had a slightly higher proportion of consultants (36%) than the England average (34%), with a lower proportion of middle career doctors (3% compared to 6%) and registrars (30% to 39%). There were a higher proportion of junior doctors (31%) in comparison to the England average (22%).
- The trust had recently recruited three acute medicine consultants who worked predominantly within the admissions area and completed on call rotation with the general medical consultants. This included covering admissions at weekend and overnight. During the weekend, the consultants were on site between 8am and 8pm, and were available for busy periods or senior reviews or advice. Medical staff reported that consultants were responsive and would always attend the hospital if they escalated concerns, offering support and appropriate training.
- Consultants conducted daily meetings at 9am to review allocation of patients, any issues identified in the past 24 hours or overnight, on call team, bed capacity, any deaths adverse events or near misses, junior doctor allocation and teaching plans. We observed this meeting, staff discussed staffing variances and the launch of a chest pain pathway. The meeting was well organised, inclusive and well attended by the multidisciplinary team.
- Handover between medical staff occurred at 9am and 9pm daily and followed the recommendations for improved, standardised handover protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011. We observed this and found it to include an overview of daily activity, details of acutely unwell patients, pending admissions and any outstanding jobs. Medical staff confirmed contact details and informed each other of their priorities for the evening.
- Wards named consultants provided a Monday to Friday 8-5 service with care provided by the on call consultant and medical team out of normal working hours and at weekends.
- The endoscopy team had an effective process in place to manage patients requiring an urgent endoscopy with on call provision out of normal working hours.
- Junior doctors reported an excellent environment for training with protected teaching times, and supportive consultants and clinical tutors. During the unannounced inspection, we saw a teaching timetable for medical staff, which included both clinical and non-clinical teaching activities.
- The service had access to visiting neurological speciality consultants from another acute trust. They attended Gilwern assessment unit to review and assist with treatment planning of patients.

Major incident awareness and training

- The bed escalation policy was available on the trust's intranet and were updated in September 2015. This included action cards for all staff and details of grading of escalation required. Nursing staff were able to describe actions taken during periods of increased activity and demonstrate that they were able to access information required.
- The trust had a comprehensive major incident policy and staff were able to tell us where this was located on the trust website. However, it was noted that the trust

wide major incident policy was due for review in 2014 and had not been updated since it was published in 2013. According to the intranet, the trust was currently in the process of updating this policy.
- The trust had appropriate plans in place to respond to emergencies, business continuity (for adverse weather) and major incidents.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire.
- Staff we spoke with were aware of the trust's fire safety policy and their individual responsibilities. Ward sisters told us of fire drill discussions with staff on an ad hoc basis.
- Wards had ward specific based evacuation plans in place in the event of a fire.
- The trust had an escalation policy in place regarding additional bed areas that could be used to cope with increased demand for beds.

Are medical care services effective?

Requires improvement

We rated medical services as requires improvement for being effective because:

- There were reported delays in the effective management of pain.
- The trust has an elevated Summary Hospital-level Mortality Indicator (SHMI) rate of 115.
- The trust had an elevated Hospital Standardised Mortality Ratio (HSMR) of 113.
- The service reported variable performance in a number of national audits relating to patient safety and treatment. Including, the national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) were the service was rated in band D; the trust performed worse than the national average in 12 out of 15 domains in the National Diabetes Inpatient Audit (NaDIA) 2014/15; and there were variable results within the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audit.
- There were delays in completing discharge letters, which affected patient experience and influenced the discharge process.
- Appraisal rates did not meet the trust target.

However, we also found:

- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Staff understood the Mental Capacity Act 2005 (MCA) and we saw evidence of appropriate mental capacity assessments and Deprivation of Liberty Safeguard (DoLS) assessments and referrals.
- Medical and nursing staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.
- Staff were supported to maintain and further develop their professional skills and experience.
- Bank and agency staff were trained in specialist techniques, such as non-invasive ventilator (NIV) support to ensure the safe management of patient undergoing specialist clinical treatments.
- All teams reported effective multidisciplinary team working and delivered coordinated care to patients.
- Staff had access to information necessary to assess, plan and implement patient care.
- Nutritional screening was effective, with at risk patients identified and actions taken to reduce the risks of harm.
- Endoscopy services were Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited in June 2016.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- The service had a series of care bundles in place, based on the appropriate National Institute for Health and Care Excellence (NICE) guidance for the assessment and treatment of a series of medical conditions including; community acquired pneumonia, dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), gastro-intestinal bleeding, sepsis and acute kidney injury. Wards had posters on display to provide staff guidance on these care bundles.
- The hospital followed the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards did

not have "sepsis boxes" available but did have access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.

- The stroke unit, Wye ward, had local policies in place, which followed NICE guidance for adult stroke patients. Staff we spoke with were familiar with the guidance and care pathway outlined in the recommendations. We saw effective treatment planning recorded in both nursing and medical records for the implementation of care and treatments in line with the national guidance. We saw evidence that the ward's standardised therapy assessments tools were based on national guidance, for example, use of the Montreal Cognitive Assessment tool and Barthel Index.
- We observed three patients admitted with a stroke and tracked their treatment. All were admitted to the emergency department, received appropriate scanning, results and treatment within the timelines recommended by national guidelines.
- Endoscopy services were JAG accredited in June 2016. This meant that the service met the accreditation standards framework for aspects such as policies, practices and procedures.
- Medical services followed the trusts audit calendar to capture compliance against policy, procedure and NICE guidance. Data captured was displayed and reviewed by service leads to identify trends and development needs.
- In September 2015, we found that Arrow ward had a draft care plan for care and treatment of NIV patients, based on national guidance, devised by the lead NIV consultant. During this inspection, we found that the care plan had been ratified and the team were developing additional clinical pathways for the use of high flow oxygen. A draft version was in use on the ward, which was being trialled to ensure it was appropriate for use.

Pain relief

- We saw patients' pain assessed regularly and recorded on National Early Warning Score (NEWS) charts. We identified seven patients who had received analgesia and noted their pain score recorded on their NEWS charts. Nursing staff recorded a pain score at each contact for completion of observations and administered analgesia in line with medicine prescriptions.
- During our inspection, two patients told us that they had experienced delays in the administration of analgesia. This included one patient who claimed to have waited two days for an effective analgesia regime to be prescribed. We found two reported incidents between December 2015 and April 2016 relating to the delay in administration of analgesia, which included one delay in obtaining the medication prescribed, as nursing staff were unaware of the formulation of the medication prescribed. The appropriate medication was provided after discussion with pharmacy the same day. The second referred to the incorrect setting of the medical device by nursing staff, resulting in a four hour delay in administration.
- Nursing staff told us that patients could be referred to the pain control specialist nurse if pain management was difficult to control.
- The pain control specialist nurse had developed a pain assessment tool specifically for use by patients with dementia. This was being piloted within the wards.
- Staff in the endoscopy department recorded patient comfort and pain scores. This process was in line with requirements set out by the JAG guidelines.
- We saw nursing staff interacting with patients and relatives, discussing effective pain management, and actions that could be taken to assist with patient comfort. This included referrals to pain specialist nurses and the palliative care team for symptom control.

Nutrition and hydration

- Patients were screened for risk of malnutrition on admission to hospital using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST). Screening was completed on admission and repeated at weekly intervals, unless the patient's clinical condition changed. All nursing records reviewed, detailed regular nutritional assessments and we saw evidence of repeated screening when patients' conditions changed.
- Nursing staff accurately recorded patient's daily oral intake, which enabled a thorough and accurate nutritional assessment, and identification of patient's risk of malnutrition or dehydration.
- Patients identified as at risk of malnutrition were referred to the hospital dietetic service for assessment, with regular monitoring of nutritional condition in place.
- The hospital did not provide food snacks to patients between meals as per British Dietetic Association guidance (The Nutrition and Hydration Digest:

Improving Outcomes through Food and Beverage Services) which states that at least two snacks a day should be provided to meet patient's nutritional needs. Instead, dietitians told us that oral nutritional supplements were used to meet patient's nutritional requirements. Dietitians told us that a business case had been submitted to purchase snacks for patients. Patients could store their own snacks in the fridge but were not permitted to heat food on the ward.

Patient outcomes

- Medical services had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. The trust board used information gathered to benchmark practices against similar organisations.
- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. The trust's HSMR for the 12 month period May 2015 to April 2016 was higher than expected, with a value of 113. This had been reported to the trust board. The trust had implemented a series of actions to address this concern including the introduction of regular mortality review meetings to identify any actions to improve overall patient care and treatment.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In June 2016, the trust reported a 12-month rolling figure of 115, worse than expected (100).
- The trust had implemented a series of actions to address this concern including the introduction of regular mortality review meetings, reviews of each inpatient death, implementation of NEWS and a series of care treatment bundles to identify any actions to improve overall patient care and treatment. Mortality review tracking systems were in place including reviews of nursing and medical notes.
- Hospital mortality was reviewed weekly to identify root causes and any learning shared across all clinical teams. The trust had implemented a series of actions to address this concern including the introduction of regular mortality review meetings, reviews of each inpatient death, implementation of NEWS and a series of care treatment bundles to identify any actions to improve overall patient care and treatment. In addition to letters to consultants regarding case reviews, introduction of mortality review newsletters, and a case not review process-detailing escalation of findings.
- In the March 2016 for the national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) the trust was rated as band D (A being the best and E the worst). The audit looks at several domains, which includes scanning, implementation of treatments, provision of therapy services and discharge planning. The service scored well for the provision of occupational therapy, physiotherapy and discharge planning. However, had lower scores relating to provision of speech and language therapy, implementation of thrombolysis, specialist assessments and multidisciplinary working. Nursing staff reported that recruitment affected the ability to provide effective implementation of treatments and speech and language therapy. Actions taken to address this included nursing staff being trained to complete swallow assessments and a review of stroke specialist nursing numbers, which had been increased.
- Additional complications had occurred because of high numbers of stroke patients were admitted and allocated to other speciality wards after the acute phase of illness. From January to March 2016, the trust had a number of wards closed due to infections and therapists were restricted from accessing patients on the closed wards due to risks of cross infection. These factors increased patient length of admission, which affected audit data.
- Stroke services were included in the trust quality improvement plan, with plans to improve the service through the implementation of a single site stroke service and the introduction of a seven-day transient ischaemic attack (TIA) service. TIA's are a temporary disruption to the blood supply of the brain and are known as "mini- strokes". Progress against the action plan was reported to the trust board. The service currently provided a TIA treatment service during weekdays only with treatments provided within the emergency department out of hours.
- The hospital performed similar to the England average in the latest published National Heart Failure Audit (National Institute for Cardiovascular Outcomes Research (NICOR)/ Health Quality Improvement Partnership HQIP) for 2013/14 for cardiology inpatients, receiving echo, discharge planning and referral to heart failure nurse. However, the trust performed worse than

England average in input from consultant cardiologist, cardiac specific medication provided on discharge, referral to cardiology follow up and referral to heart failure liaison services. The service had an action plan in place; however it was not seen during this inspection.

- The most recent published Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14 reported that the trust performed in line with England average. For the 2013 to 2014 audit, the number of nSTEMI (non-ST-segment-elevation myocardial infarction, a common type of heart attack) patients seen by a cardiologist or a member of team was 97%, which was better than the England average of 94%. The number of nSTEMI patients admitted to cardiac unit or ward was 51%, which was slightly worse than the England average of 56%. The hospital also was in line with the England average for those patients who were referred for or had angiography (with 77% of patients having angiography compared to the national average of 78%).
- National Diabetes Inpatient Audit (NaDIA) 2014/15 audit data showed that the trust was better than England average for five out of 17 applicable domains including the ability to take control of diabetes care, staff knowledge, meal choice and prescription errors. However, scored worse than England average for the remaining domains, which included foot risk assessments, insulin errors, meal timings, and visit by specialist diabetes team. The diabetes nurse specialist reported that the team were struggling due to a high number of vacancies, however, were actively recruiting and implementing training programmes across inpatient areas to assist with educating ward staff on safe management of diabetic patients.
- The service performed as expected in the 2014 National Chronic Obstructive Pulmonary Disease Audit Programme (Royal College of Physicians (RCP) / Health Quality Improvement Partnership (HQIP)). Which collates trust data relating to the number of admissions for patients with the lung disease, treatment provided, patient outcomes, staffing levels and environment. The service action plan included the completion of chest x-ray within four hours of admission, locating patients on the appropriate respiratory ward area, and the implementation of an early discharge team.
- The trust completed the National Lung Cancer Audit 2015 with details of 101 patients from January to December 2014. The trust achieved a better than peer average in the completion of multidisciplinary meeting (95%). The trust performance for pathological diagnosis (65%) and involvement by specialist nurse (74%) was lower than peer average (67% and 84%). The trust had an action plan in place to address this which included the recruitment of a lung specialist nurse, completed by 2016.

Competent staff

- Staff had the appropriate skills; knowledge and experience for their roles and responsibilities, and the trust had processes in place to identify training needs and compliance. The service had completed recent training in sepsis management and policy following the introduction of the sepsis bundle.
- Nursing staff within non-medical wards reported that they had the appropriate skills to care for outlying medical patients. This was due to the patients being out lied were predominantly well and waiting for care packages.
- Nursing staff reported that they felt that there were increased opportunities for professional development over the past year. Staff were able to access courses at local universities to complete training and experience different roles within the organisation. This included assistance for unregistered staff to complete nurse training and assistant practitioner training. This was an improvement from the September 2015 inspection when staff reported limited opportunities for professional development.
- In conjunction with training, staff were supported through non-formal clinical supervision, which included one to one meetings between matrons and ward sisters, ward sisters and junior sisters, and through annual appraisals.
- Nursing revalidation was supported by the trust and nursing staff were given assistance and support to complete the appropriate reflective accounts, and training to complete this.
- The induction programme for new permanent staff and students included mandatory training and competency based ward skills. Nursing staff reported working supernumerary for periods when commencing a new role. This was to ensure competence and offered new staff with the opportunity to learn new skills and methods of working.

- Newly registered nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- Nursing staff reported that external providers often supplied specialist skills training. This was particularly relevant to developing services such as the medical day case, where clinical practice was changing in line with the demands on the service. The ward sister explained that they had used an agency nurse with the relevant qualifications and competence to assist with the training of staff and treatment of patients whilst specific services were introduced. This had enabled patients to receive treatment locally.
- Nursing staff told us that due to staffing vacancies the service had trained agency and bank staff to manage speciality patients. This included the use of NIVs, dementia, and specialist medication infusions. This process enabled patients to receive treatment by appropriately trained and registered staff.
- Agency staff were observed being inducted to the ward area. This included a tour of the ward, introduction to staff and details of the equipment used. A checklist was used for this process. Agency staff confirmed that this always happened, even if they had worked on the wards previously. This was an improvement since the September 2015 inspection.
- Nursing staff on the coronary care unit (CCU) stated that they were supported by the critical care outreach team to manage level 2 patients if their clinical condition was not cardiac in origin. Level 2 refers to patients requiring single organ support (excluding mechanical ventilation).
- Wards reported that staff had link roles with specialist subjects such as infection control, dementia and falls.
- We saw evidence of shared learning on Lugg ward when staff discussed recent training at the team briefing.
- The trust had a medical appraisal and revalidation policy in place ratified in November 2014 (due for review November 2017) and reported that 97% of medical staff had an appraisal in place and completed the revalidation process. Revalidation is the process for doctors to positively affirm the General Medical Council that they are up to date and fit to practice.
- We saw evidence of weekly education meetings for medical staff. Topics were timetabled to enable staff to attend.
- Junior doctors reported that consultants and the clinical educator were proactive in educating and seeking learning opportunities.
- The endoscopy unit completed training lists at registrar level to ensure competence. This was in line with JAG guidance.
- The trust reported 78% compliance in nursing staff appraisal and 98% consultant appraisal rates in June 2016, against the target of 90%. This had improved since September 2015 when 33% of general medical doctors had completed an appraisal.

Multidisciplinary working

- All necessary staff were involved with the assessing, planning and implementation of patient care. Medical records detailed an admission treatment plan and were amended according to clinical findings and patient condition.
- We observed the multidisciplinary team meetings on all wards visited and found they included physiotherapy and occupational therapists, dietitians, speech and language therapists, complex discharge coordinators and hospital at home matrons, in addition to nursing and medical staff. Meeting were well structured and inclusive of all disciplines. All staff were observed contributing to the meetings and the team were open to ideas and suggestions from individuals. Staff reported that the speech and language therapists were not always available to attend the meetings on Wye ward, however, staff reported that the service was represented a minimum of weekly.
- We saw that the multidisciplinary team assessed patients on the first day of their admission. These included reviews by pharmacist, and where appropriate a physiotherapist and occupational therapist.
- Wards reported consultant lead ward rounds were held daily which the wards discharge nurse attended and where possible the named nurse for that day.
- All wards also completed board rounds, which included brief discussions relating to the actions required for treatment or discharge planning.
- Consultants reported excellent working relationships between medical staff, stating that colleagues were supportive and caring.
- In addition to ward and board rounds nursing staff reported regular huddles throughout a clinical shift to ensure all staff were aware of ward activity and plans. This was observed during the inspection.

- Patients were referred to specialist consultants if their condition changed and we saw evidence of effective referrals within medical notes. In addition to the paper written referral, medical staff reported that they would contact the specialist teams directly to request a review.
- Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment.
- Nursing staff told us that relationships with medical staff and other professionals were inclusive, positive and promoted multidisciplinary working. Ward sisters reported that the working relationship with the speciality consultants was particularly strong.

Seven-day services

- The service did not provide a full seven-day service. Dietetics and speech and language therapy provided a Monday to Friday service. There were no plans in place to move to a seven-day service. However, physiotherapy and occupational therapy provided a seven-day service for higher risk patients.
- The endoscopy unit operated a weekday service with two or three sessions per day. In addition to this, there was a gastroenterologist on call to meet any demands for urgent referrals.
- The medical consultants provided seven-day cover between 8am and 8pm, with on call facilities overnight.
- Medical consultants were reported as completing a minimum of three daily ward rounds at weekends, which was in line with London Quality Standards.
- Additional weekend medical cover included three registrars, two foundation level two doctors and one foundation level one doctors 9am to 9pm, and two registrars, one foundation level two doctors and one foundation level one doctor 9pm to 9am. This provision assisted with admissions through the emergency department and inpatients. Medical staff reported that staffing was sufficient to meet the demands of the service.
- All wards reported that at weekends, patients would continue the treatment plans identified by their consultant unless they became acutely unwell. The consultant on call would then review the patients and advise on any changes to clinical treatment.
- Local diagnostics services were available daily with out of hour's facilities for emergency procedures, such as x-ray and pathology. Staff reported no issues with accessing diagnostic testing out of hours.
- The hospital pharmacy provided an emergency cupboard, which was accessible by nursing staff for any medications prescribed that were unavailable on the wards. Nursing staff were observed contacting the site manager to collect medication out of hours.

Access to information

- Medical and nursing staff reported that they had access to all information necessary to ensure safe delivery of effective care and treatment.
- Patient records were kept in similar locations on each ward, with nursing notes such as clinical observations and risk assessments at patient bedsides and medical notes in trolleys by the nurse's station. This meant that staff were able to access information required to assist with clinical decisions, care and treatments.
- The patient tracking system was used during medical handovers. Staff were observed accessing the trust tracking system to discuss each patient, identify action required and allocate tasks. This system was used by the wider hospital to identify vacant beds, allocate wards and identify requirements for discharge.
- Referrals to other specialities were by a paper referral and direct contact with the speciality team. Medical staff reported no problems with this process.
- Access to diagnostic testing was through electronic database, which medical staff reported as slow which hampered result reviews. Nursing staff told us abnormal blood results were reported by telephone directly to the ward, to alert staff of abnormalities as soon as they were available.
- All computers were password protected, and we were informed that each ward had unique access codes. During inspection, all computer screens were locked when not in use and no patient identifiable information was on display.
- Medical staff completed electronic discharge letters, which included details of patient's admission, medication to take home and details of any follow up appointments. Nursing staff reported that there was often a delay in the production of these, as they were often completed after ward rounds. The impact of this was delays in the preparation of patient's medication to take home. The discharge lounge nursing staff reported frequent contact with medical staff to complete discharge letters, and waits for up to six hours for

patients whilst waiting for letters and medication. We saw 13 incidents relating to the delay in receipt of medication for patients to take home, from December 2015 to March 2016.
- GPs received copies of discharge letters to ensure updates of clinical changes to patients care.
- Trust policies and guidance were available on the trust intranet and staff demonstrated how to access them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an understanding of the Mental Capacity Act 2005 (MCA) and we saw evidence of appropriate mental capacity assessments and Deprivation of Liberty Safeguard (DoLS) assessments and referrals. Staff confirmed capacity assessments had taken place and described actions taken by as a result. We saw written evidence in patients' notes which outlined the outcomes of capacity assessments, and details of best interest actions staff should take to maintain the patient's safety.
- Staff completed mental capacity assessments when there were concerns that the patient was unable to make an informed decision. Guidance was available on the process and a trust template accessible for use.
- We saw appropriate best interest decisions in use on Frome ward, and staff caring for the patient were able to detail what this meant for the patient and the staff involved with the care.
- The dementia care leads informed us that the trust had increased MCA and DoLS training, and as a result had empowered staff to perform assessments. Nursing staff reported being supported by the safeguarding team with this process.
- MCA training compliance was recorded as 75% for the medical division for July 2016.
- DoLS training compliance was recorded as 74% for the medical division for July 2016.
- Endoscopy and cardiac catheter laboratory nursing staff reported appropriate use of sedation for procedures, and stated that patients were not permitted to return to ward areas until patients were fully awake.

Are medical care services caring?

Good

We rated medical services as good for being caring because:

- Patients were treated with dignity, respect and kindness during interactions with all staff. Staff completed interventions and discussions in private to maintain confidentiality.
- Nursing staff had access to support networks for patients with emotional or mental health issues.
- Data collected through patient satisfaction audits was generally positive and regularly shared with the team.
- Patients told us they felt supported and stated staff cared about them.
- Most patients and those close to them felt involved with decision making and making choices about their care, and felt supported.
- Staff were observed encouraging patients living with dementia to participate in activities to occupy their time.

Compassionate care

- Staff respected patients, their individual preferences, habits, culture, faith and background.
- Staff were observed being polite and respectful during all contacts with patients and relatives. This included when patients and relatives attended each ward, during telephone calls and in public areas.
- Patients we spoke with told us that staff always asked how they would prefer to be addresses, respected privacy and were courteous.
- We observed nursing staff closing doors and screens when discussing patients or completing tasks to promote privacy and confidentiality.
- Patients told us staff were very good and responsive to their needs, answering call bells promptly. We noted that call bells were within the patients reach.
- Patients told us staff were caring, with compassionate attitudes and they were well looked after.
- NHS Friends and Family Test recommendation results varied across all inpatient areas. CCU, Gilwern assessment unit and Wye wards reported 100% satisfaction, whilst Lugg and Frome wards reported 96% and 94% respectively and Arrow ward 85%. The

response rate for each ward also varied with CCU achieving 10%, Frome ward 90% and the remaining wards from 52% to 75%. Arrow ward had the lowest response rate at 35%.

- Hospital performance in the Care Quality Commission Inpatient Survey, published in June 2016, was about the same as other trusts in all questions. 674 patients completed the survey.
- The trust participated in the National Cancer Patient Experience Survey, which was published in July 2016. Between October 2015 and March 2016, 368 eligible patients from the trust were sent the survey, and 264 questionnaires were returned completed. This represented a response rate of 75% which was better than the national rate of 66%. The trust performance was as expected for 44 of the 50 indicators. This included; length of waiting times for tests, explanations of results, information sharing and financial guidance. The trust scored worse than expected in six indicators, which included; involvement in decision-making, clinical nurse specialist access and participation in research. Overall satisfaction with the service scored 8.7, with zero (very poor) and 10 (very good).

Understanding and involvement of patients and those close to them

- We saw evidence of discussions regarding treatments and plans with patients and family members documented in patient records. This included discussions relating to resuscitation and ceilings of treatment.
- Most patients told us they felt involved in planning their care, in making choices and informed decisions about their care and treatment.
- Staff communicated in a way that patients could understand and was appropriate and respectful. We observed staff involving patients and those close to them in discussions and offering opportunities to discuss treatments and plans. This was observed on Lugg ward when a relative was distressed about a new diagnosis. Nursing staff answered questions and escalated concerns to the consultant and specialist nurse to ensure the patient and family members were fully informed.
- The endoscopy unit held quarterly user group meetings, which were attended by patients and staff members to discuss plans of work, and any issues identified.
- Nursing staff on Lugg and Frome wards were observed treating patients living with dementia with kindness and compassion. Patients were observed walking unattended around the ward, and staff spoke to the patient calmly, offered assistance, accompanied them back to their room, and offered a cup of tea. They provided additional activities for the patient to ensure they were occupied.
- We observed therapists supporting and involving patients appropriately with their therapy assessments on all wards.
- We found medical staff took time to explain to patients and those close to them the effects or progress of their medical condition.
- We saw evidence in care records that communication with the patient and their relatives was consistent throughout the patient's care.

Emotional support

- Most patients reported that staff were attentive and caring. We received two comments from patients who had not received a satisfactory experience due to poor communication. However, one patient told us that they received "exceptional treatment" and many stated they could not "fault it".
- Staff understood and showed how they would support the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- Relatives of distressed or confused patients were able to attend the wards at any time to assist with the care and support of the patient.
- All staff on Wye ward were observed discussing patients pain management and emotional issues in a manner that demonstrated a respectful empathetic approach to patients care. Relative's views were also discussed, for example discharge plans and goals.

Are medical care services responsive?

Requires improvement

We rated medical services as requires improvement for being responsive because:

- Patients were not always placed in the most appropriate clinical area.

Medical care (including older people's care)

- General medical patients were admitted to available beds on speciality wards, and transferred to other wards when patients requiring that speciality were admitted. This increased the number of transfers between wards for general medical patients.
- There was no formal risk assessment in place relating to the movement of patients from one clinical area to another, and transfers occurred frequently and out of normal working hours.
- Non-medical patients were admitted to hospital through the medical admissions unit, which increased ward activity and patient moves.
- The service reported multiple mixed sex breaches in response to shared acute bays for clinical conditions, such as a strokes, cardiac care and non-invasive ventilator support.
- The service used the surgical day case as a ward area for patient planned to be discharged the following day, mixing medical patients with elective surgical cases.
- Staff had access to specialist services, such as diabetic specialist and pain management nurse during weekdays only.

However, we also found that:

- Access to the trust included pathway management from the outset, with patients appropriately referred to speciality areas.
- The service had introduced a system of monitoring patients requiring non-invasive ventilation to promote care in the community and avoid admission to hospital.
- Staff implemented appropriate actions to address situations where mixed sex breaches occurred, which included reporting, additional screens and informing patients.
- The medical day case was providing a number of pathways to assist patients treated locally.
- The virtual ward enabled some patients to receive treatment within their own home.
- All wards showed evidence of sharing complaints and learning.
- Patients were offered opportunities to feedback to staff and processes were in place to manage complaints locally and at trust level.

Service planning and delivery to meet the needs of local people

- The service was working collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners to identify the needs for the local community and planning of clinical pathways to meet demands. This was particularly noticeable within stroke services with the development of the early discharge team and discharge lounge.
- Patients admitted to the trust with suspected acute cardiac conditions were transferred to another acute hospital. This was in line with service level agreements and planning. Cardiac services within the trust completed non-ST elevation myocardial infarction and routine treatments. The cardiac catheter laboratory provided planned procedures.
- Wye ward had six dedicated hyper acute stroke beds, which included two side rooms and one four bedded bay. Patients requiring thrombolysis were managed in the emergency department until treatment had been completed. The ward sister explained that due to staffing vacancies, it was not possible to admit patients to the ward for this treatment; however, the plan was to start accepting patients once therapy had commenced.
- The trust provided specialist stroke nurses who assisted with the management of patients admitted to the hospital with suspected strokes or transient ischaemic attacks (TIA- mini strokes). The team liaised with the regional centre and GPs by assessing patients on admission and offering support throughout the inpatient period. The service was available between 8am to 5pm Monday to Friday.
- The trust had six coronary care beds and a cardiac catheter laboratory. Acute cardiac interventional services for patients experiencing a myocardial infarction with ST elevation were provided at the regional centre.
- The service had cardiac specialist nurses who assisted with the management and planning of patient care and treatment.
- The non-invasive ventilation (NIV) facility was developing plans to include palliative care patients and patients that required high flow oxygen therapy.
- Gilwern assessment unit was developed as a frail elderly unit to assist with the flow of patients through the hospital. As the local demographic included a higher portion of older adults, the service developed the unit with the aim to provide older adults with an appropriate

environment to promote a speedy recovery. This included an appropriate environment, additional therapy support and activities to promote and encourage maintained mobility.

- The inpatient gym was located on the ground floor. Some therapists told us that this posed a problem, because inpatients would need to be transferred from the ward area on the first or second floor, down to the ground floor. For some patients, such as patients who had had a stroke, this was not always feasible and therefore the patients did not always benefit from the gym facilities. Therapy was instead carried out at the bedside, which therapists did not always feel was the most appropriate level of therapy. This had been identified on the risk register.
- The medical day case unit opened in January 2016 and was continuing to develop as a service. The team were reviewing service needs and implementing new clinical pathways to provide outpatient treatments for patients who currently required an inpatient episode to manage the care. The service had been approached by consultants to provide care for a number of their patients, including those that were currently travelling to other providers for treatment due to the unavailability of treatment locally. We spoke with one patient who received specialist treatments that required them to travel twice weekly to another acute trust 150 miles away. The nursing team on the unit had developed the necessary skills to provide the care, whilst the local consultant liaised directly with the specialist clinician. This process enabled the patient to remain at home for longer periods.
- The trust had a quality improvement plan in place concerning the provision of care for vulnerable adults, such as those with dementia. Alongside this, the service had a three-year dementia strategy, which had been agreed by the trust board. This included the setting up of a core working group, the re-launch of trust wide dementia champions, and a review of training needs.
- There were dementia champions working across all clinical areas. The champions wore badges identifying their role. The service held monthly focus group sessions with the dementia champions that were used to train and develop how the service could meet the demands of the patients. The aim was to roll out the champions across the surgical division and other clinical areas.
- The trusts quality improvement plan included service planning for patients with long term conditions, such as diabetes. The service aimed to improve the working relationships with GPs, the introduction of health promotion and wellbeing care plans, and staff training in every contact count. Making every contact count is a system used by the NHS to utilise day-to-day interactions with patients to support them in making positive changes to their physical and mental health and wellbeing.

Access and flow

- The site management team coordinated the flow of patients through the hospital, the allocation of beds and made decisions regarding transfers between wards. The chief operating officer (COO) who had overall responsibility for the hospital capacity and management led this team.
- From October 2015 the site management team consisted of two teams. The first team was responsible for all referrals into the hospital and provided a central review of referrals to the hospital by GPs and other medical practitioners or trusts. Unregistered nursing staff used patient pathways to identify the most appropriate route of actions, and directed the referrer accordingly. This process was monitored and reviewed by a senior nurse to ensure patient safety. The second team worked closely with the referrers to determine activity coming into hospital and managed beds allocation. This role was completed by a senior nurse supported by an unregistered nurse. This part of the team provided support to ward and emergency care staff. Staff rotated through each team to enable understanding of the roles and responsibilities, and ensured all staff were competent with all roles.
- We found the referral centre effectively directed patients to the most appropriate clinical area. For example, patients received treatments for infections as a day case, or were admitted to the assessment unit, bypassing the ED. However, there appeared to be an overlap between this service and the team based on the wards. For example, the referral centre staff were under the impression that ward based site team were assisting with clinical aspects of the role, and providing a senior nurse support. However, the ward based site team members we spoke with commented that their role involved little clinical support and they did not assist with clinical skills out of hours. This was supported by

medical staff, who stated that out of hours, they had no nursing support for tasks, such as cannulation, taking of bloods and catheterisation. Medical staff reported that these skills were usually completed by ward nurses and medical staff were called to assist if the ward nurse was not competent or able to complete the task. The impact of this could be a delay in treatment especially if the doctor was occupied with other medical tasks or an emergency. We did not observe any delays in treatment during our inspection.

- Patients could be admitted to the trust from the clinical assessment unit or the ED. The medical staff reported that the on call medical consultant saw patients within 12 hours of admission. We saw evidence to confirm this within medical records, with consultant ward rounds recorded at regular intervals throughout the day.
- Following clerking, patients were transferred to the most appropriate area, which was usually Frome ward, the acute admissions ward. Patients on admission to Frome ward were reviewed and depending on bed availability, transferred to either another ward or discharged. We noted that Frome ward admitted all speciality patients.
- Nursing staff informed us that due to the trust not having a dedicated surgical admissions ward, some surgical patients admitted from the ED that required review were clerked on Frome ward prior to transfer to a surgical ward. The only exceptions were orthopaedic patients or those requiring direct admission to a speciality unit such as critical care. This meant that Frome ward had an increased number of patients admitted through the ward which increased the activity and frequency of patient transfers between wards.
- Patients admitted to the service were given a date which related to the expected date of discharge. This was based on clinical condition on admission and the type of treatment planned. The predicted date of discharge then acted as an aim for the clinical team.
- The hospital had a "home for lunch" discharge initiative whereby wards focused on arranging appropriate discharges in the mornings, with transfer of appropriate patients to the discharge lounge by 2pm. Nursing staff reported that this was usually achieved. However, there were exceptions to this. There was no evidence to support delays in transfer to discharge lounge, but there were eight incidents reported from December 2015 to March 2016 relating to delays in discharge home from medical wards. These related to changes in patients clinical condition and non-arrival of transport.
- Data reviewed for April 2014 to April 2015 showed that 37% of all patients were not transferred to a ward, being discharged directly from the admission area. 36% of all patients were transferred once, 19% of all patients were transferred twice. The remaining 9% of all patients were transferred three or more times. This was an increase from April 2013 to April 2014 when the trust reported 6% of patients were transferred three or more times.
- Each ward within the service had a speciality and a dedicated medical team. Patients were allocated to a consultant with the relevant specialist knowledge for the admitted clinical condition, for example, patients with a cardiac diagnosis would be transferred to the cardiologist for ongoing care. Once allocation had been agreed, patients were transferred to the speciality ward.
- Patients admitted with a non-speciality condition were allocated to consultants at the daily consultant meeting, and allocated to the next available bed on the ward. During inspection, it was identified that patients with a non-speciality clinical condition were often transferred between wards, because of beds being required for another patient with that speciality condition. This meant that general medical patients were often transferred between wards, whilst patients of that speciality tended to remain on the speciality ward.
- Nursing staff reported no formal checklist in place for transferring patients between wards. However, we did not see any evidence of a negative impact on patients care and treatment as a result.
- Nursing staff told us that the service had a hospital charter, which gave guidelines on movement of patients out of hours. However, the copy received from the trust outlined the ambitions of the trust and how these could be achieved. We did not observe references to the transfer of patients.
- Nursing staff informed us that patients were moved between wards up to midnight, and the decisions to transfer would be based on the clinical needs of the individual concerned. We saw the majority of patients had been transferred between wards from 6pm to 10pm and two patients transferred to a different ward at 2.40am and 5.40am. These two transfers were reported as clinical incidents between December 2015 and April 2016.
- Medical staff reported that the trusts electronic patient tracking system enabled all staff to know where patients were, and decreased time spent searching for patients after an internal transfer.

Medical care (including older people's care)

- During the announced and unannounced inspection, we identified nine outlier patients. An outlier is a patient under the care of a speciality consultant such as respiratory medicine, who is an inpatient on a different speciality ward such as surgical. Of the nine patients, we found that four patients had been transferred twice, three patients had been transferred three times, one patient had been transferred four times and one patient had been transferred five times. We identified two patients who had been transferred between wards twice in one day, which may impact on the continuity of patient care, and their experience.
- Nursing staff on Monnow ward (surgical) told us they had no risk assessment for the admission of medical patients to the ward and the decision for transfer was based on clinical judgement of the medical team. The impact of this was that clinically stable medical patients living with dementia awaiting care packages were often transferred to the ward which often led to the patients becoming confused due to the transfer. Nursing staff struggled to meet the demands of all patients, finding it difficult to balance the monitoring of post-operative surgical patients and ensuring patients with dementia safety. Nursing staff explained that due to the surgical ward having several unlocked exits, they often spent time supervising patients due to the risks associated with patients leaving the ward unattended. These issues were not reported as incidents and the impact on surgical patients' care was not recorded. We did not see patients with dementia being supervised on surgical wards during inspection.
- There were five allocated medical beds within Leadon ward (surgical ward), which were increased or decreased depending on pressures within the medical division. The ward sister explained that the number of medical patients flexed from one to 10 at any point. Nursing staff reported similar difficulties in the management of medical patients on the ward, and were in the process of devising admission criteria.
- Both Monnow and Leadon ward nursing staff told us that they felt that medical patients experienced a longer inpatient period because of being cared for in surgical beds, increased patient confusion and prolonged waits for care packages. However, we saw no evidence to support this.
- Medical teams responsible for patients on non-medical wards reviewed them every weekday. Nursing staff reported that the allocation of medical staff to outlying wards had recently changed. Previously a specific doctor was identified as the contact. However, the system had changed to include the wider medical team. This had resulted in difficulty in contacting the most appropriate doctor for the task required, although staff reported that this did not affect patient care, as when urgent assistance was required any member of the medical team would attend.
- Nursing staff informed that patients appropriate for high dependency beds were often nursed in the cardiac care unit (CCU) instead of the intensive care unit, despite the CCU not being commissioned for level two beds. Nursing staff were appropriately trained to manage these patients and reported that they called for support when necessary to maintain patient safety. This was observed during inspection, when a confused and agitated medical patient was admitted from the ED. The patient required monitoring due to the clinical condition, and became aggressive towards staff on duty. The situation was escalated to the matron and appropriate actions were taken to ensure that all patients were safe within the unit, including a medication review and what staffing provision was required.
- CCU nursing staff also reported that they often cared for high dependency level 2 patients, even when the intensive care unit had vacant beds. Level 2 refers to patients requiring single organ support (excluding mechanical ventilation). Nursing staff reported that they completed the trust incident-reporting tool when these occurred and we saw four incident reports relating to the placement of patients within CCU from December 2015 to March 2016.
- During the unannounced inspection, we were informed that the critical care staff had approached them that morning to take a high dependency unit (HDU) patient, however they had declined the patient due to capacity. The impact being, the HDU patient would remain within the intensive care unit, which would not be the most appropriate clinical area to complete their care, and reduce the availability of an intensive care bed.
- Stroke patients were assessed in the ED where they received diagnostic scans and where necessary intravenous medication commenced before being transferred to Wye ward. During inspection, two patients with stroke symptoms were admitted within two hours of each other to the ED. Both required transfer to the stroke unit, however, the second transfer was delayed

whilst the first patient was settled on the ward. We were informed that the ward had admission criteria in place, which meant that patients were not to be admitted to the ward within one hour of a stroke admission. This process was implemented following discussion with clinical leads to ensure patient safety on the wards due to staffing numbers and availability of stroke nurse specialists. Ward staff confirmed that it was common for multiple stroke patients to be admitted at any one time, and therefore to ensure patients received safe care the transfer from admissions areas were controlled.

- Wye ward tracked all patients admitted with a stroke if transferred to other clinical areas. They placed details of outlying patients on the ward board, so all staff were aware of where the patients were. During inspection, two stroke patients were on other wards; this included one medical and one surgical ward. Wye ward had a protocol for the safe management of stroke patients on other speciality wards. This was developed after a challenging period in January 2016 when a large number of stroke patients were admitted to hospital.
- Therapy staff described difficulties in managing stroke patients' therapy when they were transferred to other wards. They said this reduced the time available for treatments. The increased number of patients also affected staff availability to complete necessary treatments. Therapy staff described a period recently when there had been a large number of strokes admissions, and there was a high number of patients on other wards. Attendance for therapy sessions was further impacted by the occurrence of infections on the wards, which meant that the areas were closed. This data was captured within the SSNAP audit and affected overall scoring. Actions taken to address this included cohorting staff to specific clinical areas to prevent loss of treatment time.
- The trust had opened Gilwern assessment unit, a 16-bedded frail elderly unit originally outlined as a winter pressures plan in September 2015. The ward had admission criteria, which excluded patients who had sustained a stroke, or admitted with cardiac symptoms or abdominal pain. Admissions were taken directly from GPs, ED, and clinical assessment unit.
- The speciality aim was to promote early discharge for patients through increased support. The strict admission criteria enabled patients to receive appropriate therapy and treatment to meet the demands of their admitting illness, and promote early independence and safe discharge. The aim was to promote discharges within 72 hours of admission. Patient awaiting discharges were transferred to another medical ward, however, we identified that some patients remained on the ward after the 72-hour period. This was largely due to lack of bed capacity in the remainder of the hospital.
- We identified that one patient on Arrow ward had been admitted via the ED at 6.30am with poor respiratory function. The patient was known to the respiratory team and was noted as requiring NIV. The critical care outreach team reviewed the patient at 9.30am, however, a referral to the respiratory ward was not completed until mid-morning, and the patient was transferred to the NIV area at midday. Although there was a delay in transferring the patient to the appropriate ward, we found that the patients care was not compromised.
- We identified that the surgical day case unit was used for the management and care of patients overnight. Nursing staff told us that there was usually a mix of patients on the unit including, medical and surgical patients waiting discharge the following day and post-operative patients attending the surgical day case unit. We saw three completed incident forms relating to medical patients being placed within the surgical day case unit, which stated that the placement was inappropriate.
- Nursing staff within the surgical day case unit reported that beds were placed within the endoscopy department to assist in the management of patients during periods of high activity. This was implemented in line with an operational policy and staffed appropriately with registered and unregistered nursing staff. We were informed that the senior manager on call approved any additional capacity prior to implementation.
- The service reported some difficulties in obtaining social care packages largely due to the rural nature of the county. Patients living in remote areas or across the county border could experience a longer hospital inpatient period.
- Some stroke patients were referred to the community stroke team/early supported discharge team. This group of therapists continued patient's treatments in their own home. A member of the team would attend the unit weekly to discuss possible discharges and review capacity for services.
- The trust reported delays in discharges resulting in the loss of over 700 bed days in January 2016, over 500 bed

days in February 2016 and 499 bed days in March 2016. Although the figures refer to trust wide loss of beds, medical patients were the largest portion of patients and staff reported delays in social care packages and discharges to community hospitals. The trust reported in June 2016 that they had jointly sponsored a project with the local commissioning group and council to improve the discharge pathway.

- The trust reported 94% bed occupancy in June 2016 with a year to date average of 92% against a trust target of 90%.
- The service had an established virtual ward or hospital at home team who assisted with care for patients within the community, whilst remaining under the care of a consultant. Patients identified appropriate for the service were required to be clinically stable and treatments were planned for short periods, for example intravenous courses of antibiotics. Patients requiring ongoing care were referred to the medical day case unit, GP or care services depending on needs. The matron for the virtual ward attended bed capacity meetings and wards to identify patients who may be appropriate for the service. Nursing staff told us that up to 20 patients could be facilitated by the service depending on their location and requirements. This process enabled patients to receive treatment at home, which would normally be administered within the hospital setting, reducing demand on inpatient beds and decreasing patient length of stay. The service completed an audit following implementation of the service from October 2013 to July 2014 and identified that 349 patients received care at home, 622 were signposted to other services, and 187 patients were discharged from hospital before their predicted date of discharge.
- Between January 2015 and January 2016 the average length of stay for elective medical patients was slightly lower than the national average (2.4 in comparison to 3.9), with the exception of Cardiology (2.3 in comparison to 1.9). For non-elective medical admissions, the service length of stay slightly higher than the national average with 6.8 in comparison to 6.7. The exceptions to this was gastroenterology with an average length of stay of 6.7 in comparison to 7.4 and respiratory medicine with 6.8 in comparison to 7.1.
- The trust was better than the England average for non-elective readmission risks at 80 for general medicine, gastroenterology and 75 for respiratory medicine and 82 for non-elective compared to the England ratio of 100 patients. Elective readmission rates were in line with England average at 100, with the exception of gastroenterology with 150 in comparison to 100. This meant that patients were at a lower risk of readmission than other hospitals in England.
- There were 29 same sex accommodation breaches reported trust wide from April to June 2016, with 10 occurring in June 2016. Nursing staff reported that mix sex breaches were common due to ward layouts. The trust reported 23 mix sex breaches within medical ward from December 2015 to March 2016. We observed the stroke hyper acute bay, the NIV bay and CCU had limited facilities to meet the demands of both sexes, and often reported mixed sex breaches. During inspection we observed that one male patient was located in the same bay as three females on the stoke unit. Staff reported that they always discussed this issue with patients prior to placing them in a bay and reported that they had not experienced any patients who requested this not to happen. We observed that interventions such as additional screens were used to maintain privacy.

Meeting people's individual needs

- Arrow ward had four dedicated NIV beds, used for patients requiring ventilation. Patients were admitted into one of the four dedicated beds which facilitated close monitoring. However, this increased the occurrence of mixed sex breaches. NIV is the provision of ventilator support through the patients' upper airway using a mask or similar devise.
- Stroke services included specialist stroke nurses who were available 8.30am to 6.30pm on weekdays via a bleep. Their role included attending the ED and assisting with the care and treatment of patients admitted with a suspected stroke. The team followed patients through the service and provided on ward specialist advice and support. The specialist nurses upon their return to work reviewed patients admitted out of hours.
- Stroke services reported limited speech and language therapy (SLT) support for patients experiencing, for example, difficulties with either speech and/or swallowing after a stroke. The therapy team suggested that SLT would contribute to the morning handovers; however, this did not always possible due to staff vacancies. The hospital had increased the number of

staff trained to complete swallow assessments in response to the shortage within SLT. This was recorded as an action for the quality improvement plan and was reported on the risk register.
- The cardiac specialist, cardiac rehabilitation and acute chest pain nurses attended the CCU on weekdays. These provided additional support to patients and staff and assisted with various aspects of patient care pathways including outpatient programmes.
- The dementia lead reported that the trust had trained 30 individuals as dementia champions at the time of inspection, and were planning to increase numbers of dementia-trained staff across all areas as staffing levels permitted.
- Patients with a history of dementia were identified on the ward and patient name boards by the use of a forget-me-not flower symbol. Permission was sought from relatives prior to completing this. The use of the symbol-enabled staff to identify patients who had a dementia diagnosis and ensured additional care and support were available.
- We were informed that a member of administration staff played music on the trust radio station between 10am and midday. The session was called "pure gold" and music from the 1950's, 60's and 70's was played to entertain patients.
- The dementia team had a dedicated email address, which was available on the intranet, which enabled staff to access them directly and seek support or advice regarding patients.
- Gilwern assessment unit was not identified as a dementia ward, however, this had been taken into consideration when planning the environment. The unit had been decorated with photographs of "old Hereford" which were used to help with patients reminiscing. Additional facilities included flooring that was sprung to reduced sound and risk of harm if patients fell, colour coded bays and wide corridors to allow assisted mobility. Memory boxes were available for relatives to place personal items and memory aids for patients with a history of dementia, and twiddle mittens provided as patient activities.
- Gilwern assessment unit provided regular activities for patients, which included monthly tea parties and games.
- The service had been successful in obtaining funding for the purchase of two overnight chairs, which could be used by relatives of patients who were distressed.
- We saw that carers for patient with a learning disability were encouraged to continue to assist with care and wards provided facilities to enable carers to stay with patients as necessary. We also saw that key patient information was held within nursing records to identify individual's likes, dislikes and any communication advice or needs.
- Translation services and hearing loop facilities were available throughout the hospital.
- The trust risk register detailed risks associated with the lack of psychiatric support for patients with mental health and physical health needs. However, nursing staff we spoke with reported that liaison services were accessible and responsive to needs, attending admission areas when necessary to assist with assessments and treatment plans.
- The red equipment system for identifying patients who required additional support with oral fluids and nutrition was in use across all inpatient areas. The red equipment system is used to identify patients who require additional attention when eating or drinking.
- The nursing staff on Gilwern assessment unit told us that they were in the process setting up a service so finger foods would be available for patients with a history of dementia to promote self-feeding and improve nutrition. This work was being completed in conjunction with the dementia team, which consisted of clinical staff and patient representatives to identify actions that could be taken to assist with the management and care of patients living with dementia.
- Patients had access to a chapel and multi faith room on site.

Learning from complaints and concerns

- Patients we spoke with were aware of the complaints process and knew how to raise concerns.
- Wards were observed requesting feedback from patients. Leaflets and questionnaires were readily available across all clinical areas.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method, such as by telephone or email. Patients were informed about the right to complain further and staff encouraged patients to use the patient advice and liaison service.
- The service discussed complaints openly and all staff were aware of complaints made and actions taken to address issues raised.

Medical care (including older people's care)

- The medical services received 76 complaints from April 2015 to March 2016 with two peaks in number of complaints received in October 2015 (10) and March 2016 (11). There was no specific topic raised in complaints with 9% relating to clinical treatments, 7% quality and safety of care, 5% communication, 5% admission and discharges, 5% patient care and 4% staff behaviour. Twenty six percent of complaints referred to general medical patients, 14% cardiology, and 10% respiratory care. The remaining 60% referred to other clinical specialities including 5% oncology, 4% endoscopy and 3% rheumatology.
- There were 10 open complaints within medical services at the time of inspection and a further 24, which were delayed.
- We saw evidence of lessons learned from concerns and complaints, for example Frome ward displayed their newsletter, which outlined achievements and learning from April 2015 to March 2016. This included details of complaints and the actions taken by the team to address the issues raised and prevent further occurrence.
- We saw many compliment letters and thank you cards displayed in ward areas.

Are medical care services well-led?

Good

We rated medical services as good for being well-led because:

- The trust had visions and objectives, which were displayed at ward level.
- The trust had systems in place to monitor and assess risk. However, the effective management within divisions was not established because of recent structure changes.
- All staff reported that the new division structure was a positive step in moving services forward.
- Risk registers were reviewed and updated regularly with actions taken recorded against the risks identified. Staff were aware of risks.
- Staff engaged in the reporting of incidents and openly discussed the learning from these.
- Staff were dedicated, and proud of the service they provided.
- Patient's views were often used to assist with changes to pathways or services.
- Senior nursing teams regularly reviewed wards and action plans to ensure improvements were identified and completed.
- The service had a robust audit calendar, which was used to benchmark services against other wards and hospitals.

However, we also found:

- There was limited evidence to support the governance processes within the division as a result of recent structure changes. However, we saw evidence relating to planned meetings and processes.

Vision and strategy for this service

- The trust had implemented a vision in autumn 2015, which had been compiled following staff engagement events. The vision was not embedded, however, staff identified that it had been implemented and shared the values outlined within the statement. The vision was displayed on wards and reported as being discussed at trust lead events and meetings. The mission, vision, values included;?Vision "To improve the health and well-being of the people we serve in Herefordshire and the surrounding areas".
- Mission "To provide a quality of care we would want for ourselves, our families and friends". Which means: "Right care, right place, right time…every time".
- Values · Compassion · Accountability · Respect · Excellence
- The service reported that at the time of inspection there was no divisional strategy in place. However, staff were aware of the trust strategy and the division were planning to implement a service specific strategy based on the trust objectives and vision.
- The trust had a comprehensive quality improvement plan, which included a number of projects and actions. These were divided into projects such as risk management, information governance, reducing harm, estates, stroke services and clinical effectiveness. Each project was then further divided into themes and action plans. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions. For example, the risk management project included the production of a risk

register that reflected the trusts risks accurately, and the completion of patient risk assessments. Both actions were in progress with a new risk register in place, and training plans in place for e learning for staff.

- The stroke pathway quality improvement plan included the development of a single site stroke unit, recruitment of clinical staff including an early supported discharge team and consultant, plus plans to engage with partner organisations to develop a seven day transient ischaemic attack (TIA) service. TIA's are caused by a temporary disruption to the blood supply of the brain and are also known as "mini- strokes". The stroke pathway quality improvement plan reported progress within its service which included a second computed tomography (CT) scanner and the implementation of an early supported discharge team, who were responsible for assisting patients with treatments at home, to promote increased flow through the hospital.
- The dementia strategy was developed in conjunction with the carers association and clinical commissioning group to ensure the development of partnership working. The project was working to time scale specified within the action plan and included actions based on the national dementia strategy with priorities to improve the quality of care. We saw that progress made was reviewed at regular intervals and reported to the trust board.
- The trust reported the estates department liaised with the dementia team to ensure they conformed with the dementia strategy. For example, they considered the colours used, when redecorating patient areas to assist with easy identification for patients.

Governance, risk management and quality measurement

- The trust had systems in place to identify and monitor risks, and maintained a risk register, which was reported on at trust level. The medical division risk register was not in place at the time of inspection as the division had been newly formalised. However, a risk register for the previous divisional structure was in place, as well as ward risk registers. We were informed that the new senior clinical leads were planning to review and update the risk registers as part of the governance meetings.
- The trust had a comprehensive risk register which reflected risks across all services. This included inadequate staffing (medical and nursing), inadequate stroke service provision, delays in completion of medical discharge summaries, lack of rehabilitation resources, and lack of psychiatric liaison support. Each risk was grade according to the severity and impact and mitigating actions identified to reduce risk. For example, to address the risks associated with lack of psychiatric support, the service had implemented a lead nurse, and used high dependency nurses to manage patients whilst waiting full assessment.
- During our September 2015 inspection, we identified that ward staff had previously not held local risk registers, however, during this inspection we found that there was an increased knowledge and understanding of risk and local registers were in place. Risks were numerically graded according to the likelihood and impact. A score from one to 25 was possible with higher numbers demonstrating higher risk. Risks 15 or above were included on the trust risk register and were escalated through regular quality and clinical risk committee meetings. Staff were aware of risks locally, and were able to inform us which they felt most affected patient safety. The majority of staff stated that recruitment and the financial strain of locum and agency staff caused the highest risks within the organisation.
- We saw that risk registers were reviewed and updated regularly with actions taken recorded against the risks identified.
- Staff actively engaged in the reporting of incidents and openly discussed the learning from these. All staff we spoke with reported a positive culture relating to learning and non-blame. This had improved since September 2015, when we found there was a lack of understanding in relation to how learning from incidents was implemented and cascaded to staff.
- Nursing staff reported that the director of nursing, infection control team and an external staff member, completed safety and quality visits regularly. Local action plans were devised to address issues identified. For example, replacement of equipment, estates management (such as cracked flooring, scuffed paintwork) and de-cluttering of clinical areas.
- We saw that external agencies such as mental health specialists, GPs and the local university were involved with the planning of care and treatment. For example, the university was used to assist with specialist skills training for nurses.
- Medical services division had not attended clinical governance meetings since the restructure in June 2016.

However, evidence provided showed that staff previously attended the trust governance committee meetings. Plans were in place to introduce divisional meetings, which would include attendance by the clinical director, business manager and the senior nurse. A series of meetings would include review of performance, patient pathways, health and safety, audit results, incidents and complaints. Information from the divisional meeting was planned to be shared with the trust board.

- The division had a robust audit calendar, which was used to monitor services and compliance against national and local standards. Information was shared to promote improvement and reviewed by the trust board as dashboards. Details of audit results were displayed on ward boards for viewing by staff, patients and visitors.
- Ward sister meetings were held monthly and discussions included a review of complaints and compliments, details of incidents including falls and mediation omissions, NHS Safety Thermometer, clinical effectiveness audit results, details of activity and pressure on capacity, staffing and recruitment, training, finance overviews and risks.
- The service completed regular audits, such as National Early Warning Score (NEWS) compliance and sepsis audits. The results were shared with the trust board as clinical audit project reports and included action plans to address findings. An example of this was that finding from the October 2015 NEWS audit which stated that 77% of NEWS scores that triggered a medical review occurred out of hours, and that the SBAR tool was not widely used for communication between teams. SBAR is a tool used to communicate situations clearly and widely used within ward settings (Situation, Background, Assessment, Recommendations).
- In addition to the clinical audits, the service had implementation plans for changes to service, such as the sepsis bundle. Project leads were identified, and details of actions required, the responsible person for completion and timescale were outlined. We saw minutes from the NEWS and sepsis implementation meeting in April 2016 included details of medical briefings, preparation of training equipment and preparation for a trust talk.
- Medical services completed weekly reviews of any patient who had died by their admitting consultant in addition to monthly mortality meetings. Teams shared meeting details with the board, such as mortality rates in comparison to peers and the need for correct clinical coding.
- Ward teams were observed discussing national alerts and incidents within the trust to ensure staff were aware of learning and changes to practice.
- The endoscopy unit had a robust governance and quality management structure in place. We saw minutes of the alternating monthly meetings which included an operational meeting, user group meeting and global rating score specific meeting.
- Discharge lounge nursing staff told us that service development plan included reviews of best practice and national guidance, prior to the completion of treatment plans and clinical pathways. This also ensured that staff had the appropriate training and competencies to complete tasks in line with current guidance. We saw this in place, when nursing staff were receiving training for specialist medication infusions prior to accepting the patient for care.

Leadership of service

- The medical division was managed by an associate medical director, divisional nurse and divisional operational director who were responsible for the acute and emergency medicine, ambulatory medicine, medicine and community care directorates. Each directorate had a clinical director, matron and general manager. At the time of inspection, not all posts were fully recruited due to the restructure of the division in June 2016.
- The trust had implemented a new divisional structure in the weeks preceding inspection. All staff reported that the new structure was an improvement on the previous with clear definition between services. At the time of inspection, not all clinical lead posts were recruited; however, teams did not feel that this affected the service, and patient care.
- Staff told us that the chief executive was visible across the hospital and easily accessible to all staff. Consultants reported an open door policy, and stated that they could go directly to the chief executive to discuss any concerns they had, and did not have to make appointments to do so.
- There was an interim director of nursing in post during inspection, with a substantive director of nursing

appointed and awaiting commencement of post. Nursing staff reported that they were looking forward to having a substantive director of nursing, as this would provide additional clinical support and stability.
- Each ward area had a band 7 nurse who acted as ward sister. The role was partially clinical 60% and non-clinical 40%. Ward sisters informed us that they had increased clinical hours to assist with the functioning of the wards. This was in direct response to the high vacancies on the wards. The impact of this was that staff were often stretched to meet demands of management and worked additional hours to ensure tasks were completed.
- Staff told us they enjoyed working at the hospital and felt part of a team, felt respected and valued.

Culture within the service

- All staff reported that they were committed to providing a high standard of safe care, and spoke positively about the services that they provided. This was particularly noticeable when speaking to senior nursing staff who praised the dedication and commitment of consultants who managed to provide care to all speciality patients despite a high number of vacancies.
- Nursing and medical staff reported an open and honest culture within the service. Staff felt able to escalate concerns and admit to errors without feeling judged.
- Multidisciplinary meetings demonstrated an open, transparent culture where all staff members' views were respected. Staff were observed to be attentive to each other.
- Staff told us that they felt listened to and involved with changes within the trust. Staff were noticeably engaged with improving services and offering ideas on how things could be improved.
- Senior managers said they felt well supported and there was effective communication with the executive team.
- Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.

Public engagement

- The dementia team reported that they were in the process of obtaining a patient representative to attend the dementia group. There was no defined timescale for this within the action plan.
- The trust and staff recognised the importance of gathering the views of patients and the public. The trust used surveys, comment cards and questionnaires to gather information from patients and the public to enable service improvement.
- Patient experience was reported and discussed at the trust board alongside other performance data. This information was used to make informed decisions about the service.
- The endoscopy unit conducted user group meetings to gain information on how the service could be improved.

Staff engagement

- All staff felt involved with service planning and delivery. This was reported to be due to staff promotions resulting in an enthusiasm to develop by new leaders. This had improved since September 2015, when we round that some staff did not feel actively involved in making decisions about the service.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.
- All wards held regular team meetings. The ward managers shared information via email and newsletters to keep staff informed of changes or plans, which would affect them.
- All staff reported being happy at work and enjoyed working with the team. Nursing staff reported that they frequently celebrated team member's birthdays and had regular team building activities, such as meals.
- One agency nurse who was working away from home informed us that staff had been very welcoming and kind, offering personal phone numbers and somewhere to stay, so they did not feel isolated whilst away from home. The agency nurse informed us that the attitude of staff had been the reason for agreement to extend the block booking. All staff were observed working collaboratively.

Innovation, improvement and sustainability

The respiratory consultant lead for NIV had developed a pathway bundle, which was used for all patients requiring ventilator support. The pathway development was based on a five-year audit of all patients using the service and the identification that increased hospital admissions increased patient mortality. The information gathered directed the service to provide an increased level of care within the patient's own home. Patients were provided with pre-set ventilators and were monitored remotely.

Medical care (including older people's care)

Information was downloaded daily and information and advice feedback to patients by the medical team. This allowed treatments to be altered according to clinical needs. The development had achieved first prize in the trust quality improvement project 2016.

At this inspection there had been the following improvements noted since the September 2015 inspection:

- Evidence of learning from incidents.
- Introduction of the Gilwern assessment unit for frail patients.
- Implementation of NIV competencies for clinical staff working within Arrow ward, improving patient safety.
- Completion of NEWS and the appropriate escalation of concerns relating to findings.
- Staff awareness and knowledge of their responsibilities to escalate safeguarding concerns.
- Increased training and appraisal compliance.
- Staff engagement and professional development opportunities.
- There were areas highlighted where improvements were still needed since our September 2015 inspection. These included:
- The Summary Hospital-level Mortality Indicator (SHMI) score remained worse than expected.
- The number of mix sex breaches had worsened.
- Increased trend in complaints.

Surgery

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

Information about the service

Wye Valley NHS Trust provides surgical services to the population of Herefordshire and mid-Powys in Wales. The surgical service provision covers specialisms including orthopaedics, trauma care, ear, nose and throat (ENT), dermatology, gynaecology and ophthalmology.

There are seven operating theatres as well as a pre-assessment and day case surgery area. The trust also has a fully equipped temporary theatre at Hereford Hospital provided by Vanguard Healthcare and staffed by the trust. This is commissioned until May 2017.

The hospital performance summaries between January and December 2015 showed there were 15,534 elective spells (continuous stays of patients using hospital beds) at Hereford Hospital. Of these approximately 58% were day case procedures, 12% elective cases and 30% emergency cases.

During announced and unannounced inspections, we visited all surgical services and spoke with 39 staff, which included health care assistants, doctors, consultants, allied health professionals and ward managers. We observed care and treatment and reviewed 18 patient records. We also spoke with 14 patients and acknowledged the views expressed by patients on Care Quality Commission (CQC) comment cards, those expressed at the CQC stand and comments made at focus groups attended by staff. We also reviewed documentation from stakeholders and performance information from the trust.

Summary of findings

We rated surgery services as requires improvement overall. We rated the service requires improvement for effective and well-led; inadequate for responsive; and good for safe and caring because:

- Between March 2015 and February 2016, the overall referral to treatment (RTT) within 18 was significantly worse than the England average.
- There was an electronic system to monitor and record waiting times for treatment. It was unclear what measures the trust were taking to reduce waiting times. We asked the trust to provide evidence of measures taken but this was not provided.
- Capacity was an issue at the hospital.
- Most staff we spoke with were unaware of the trust's vision and mission.
- There was a strategy for delivering care to patients. The strategy mirrored national performance targets. However, the trust acknowledged within the strategy that demand was outweighing capacity and there were insufficient clinicians to meet this demand.
- There was a new governance structure. However, staff were unaware of the structure and who their line managers were.

However, we found that:

- We saw that all policies were current and followed the appropriate guidelines, such as National Institute for Health and Care Excellence (NICE).

Surgery

- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes identified shared learning from incidents.
- The environment was visibly clean and staff followed infection control policies.
- Patient notes had documented risk assessments undertaken.
- The surgical team used the Five Steps to Safer Surgery checklist. The hospital audited and monitored the checklist to ensure any harm caused to patients was avoidable.
- The service assessed the nursing staffing numbers using the national safer nursing tool in order to identify the planned staffing levels.
- There were competency frameworks for staff in all surgical areas.
- Patients told us staff requested their consent to procedures and records seen demonstrated clear evidence of informed consent.
- Staff were clear about their roles and responsibilities around the Mental Capacity Act 2005 and had an awareness of the Deprivation of Liberty Safeguards.
- Staff were caring and compassionate to patients needs and treated patients with dignity and respect.
- The hospital had a nurse led pre-assessment clinic, which provided choice to patients regarding their appointments.
- Length of stay was better than the national average for elective and non-elective general surgery, urology, non-elective upper gastrointestinal surgery, and trauma and orthopaedics. However, elective trauma and orthopaedic length of stay was worse than the England average.
- There was a sense of pride amongst staff working in the hospital.
- The hospital recognised the views of patients and carers.
- Staff working within the service felt supported.
- Ward sisters had access to leadership programmes.

Are surgery services safe?

Good

We rated surgical services as good for being safe because:

- There was access to appropriate equipment to provide safe care and treatment.
- Staff were encouraged to report any incidents. Team meetings, staff information leaflets, and bulletins provided staff with the opportunity to discuss and learn from incidents.
- We observed processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist.
- The service had procedures for reporting all new pressure ulcers, and slips, trips and falls.
- Nursing handovers were well structured and comprehensive.
- The service managed and stored medicines appropriately.
- The environment was visibly clean and staff followed the trust policy on infection control.
- We saw that training levels met the recommended target set by the trust.
- Medical staffing was appropriate and there was good emergency cover. Medical handovers were well structured within the surgical wards visited.
- Consultants worked throughout the week within the surgical services with support by specialist registrars during the weekend.
- Patient information and records were stored securely in lockable trolleys.
- Patient records identified risk assessments undertaken.
- Staff were aware of their responsibilities regarding safeguarding procedures to protect the safety of vulnerable adults and children.
- Pre-operative assessments were carried out in line with National Institute for Health and Care Excellence (NICE) guidelines.

However, we also found that:

- We found that some patient records had loose sheets within them.

Incidents

- Staff understood their responsibility to raise concerns, to record safety incidents and near misses and to report them internally and externally.
- The surgical team had identified systems, processes, and practices that were essential to services to keep patients safe from avoidable harm.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents; both junior and senior staff confirmed this. Staff told us that if they had reported an incident they received feedback via the email system.
- There were three serious incidents reported within surgical services between March 2015 and February 2016. One of these incidents was a ward closure, another was a diagnostic incident, and the third incident was due to a pressure ulcer. All lessons learnt from serious incidents were analysed by senior staff and cascaded to the team. Staff told us they were informed about any incidents and lessons learnt via team meetings. The trust also produced staff information sheets to share learning. For example,' safety bites' and 'learning from incidents'. We saw copies of ward meeting minutes and information sheets on staff notice boards, which highlighted the learning from incidents.
- Staff within the pre-assessment clinic provided an example of a recent incident regarding a patient who had suffered from myasthenia gravis (a neuromuscular disease that leads to fluctuating muscle weakness and fatigue). A teaching session for staff resulted in the pre-assessment documentation being redesigned to include a prompt to ask patients if they had ever suffered from this condition.
- There had been no 'never events' in the trust between March 2015 and February 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff were aware of the duty of candour regulation (to be honest and open) ensuring patients received a timely apology when there had been a defined notifiable safety incident. We saw evidence that the duty of candour had been applied in trust incident reports.
- There were weekly mortality meetings included case reviews and root cause analysis of all deaths. Information gathered from meetings was shared as lessons learnt and distributed in the trust newsletters.

Safety thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harm and 'harm free care'. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter associated urinary tract infections and falls.
- NHS Safety Thermometer information was displayed at the entrance to each ward to provide staff, patients and visitors information on the service's performance.
- For surgical services overall, between March 2015 and March 2016 there were four catheter associated urinary tract infections, six pressure ulcers and four falls with harm reported. Reported trust wide venous thromboembolism (VTE) rates were 1.18%.

Cleanliness, infection control and hygiene

- The surgical areas visited were visibly clean, with the appropriate green 'I am clean' stickers on clean equipment.
- Personal protective equipment, such as gloves and aprons, were used appropriately and were available in sufficient quantities.
- Hand hygiene gel was available outside the wards, in bays and side rooms. Hand-wash basins were also available in bays and side rooms. We observed staff washing their hands as necessary during our inspection.
- The hospital conducted hand hygiene audits. For all surgical areas between April 2015 and March 2016, results showed 80% to 100% compliance with hand hygiene techniques. Redbrook ward had 80% compliance in April and May of 2015 but this had improved to 100%.
- We observed staff complying with 'bare below the elbow' policy across all the areas visited.
- Instructions and advice on infection control displayed in the ward entrances for patients and visitors provided information on how to prevent and reduce infection.

- In each ward area visited, staff had audited their performance to infection prevention and control measures, for example, audits of the decontamination of equipment and general cleaning audits. All surgical areas visited scored between 90% and 100% in cleaning audits between April 2015 and March 2016. Staff shared reports at meetings and on noticeboards.
- There were no cases of MRSA recorded between April 2015 and March 2016. All patients attending the pre-assessment clinic were swabbed for MRSA and treatment was provided if results were positive. All patients having joint surgery were swabbed for Methicillin Sensitive Staphylococcus Aureus and appropriate treatment provided if results were positive.
- There had been six cases of Clostridium difficile in surgical services between April 2015 and March 2016. Clostridium difficile is a potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patients who have been exposed to antibiotic therapy. NHS England issues upper limits for trusts. According to the trust's quality accounts 2015/16, the trust upper limit was 18 cases for the year and there were 20 cases trust wide.
- All surgical wards had isolation rooms where patients with infections could be barrier nursed to prevent the spread of infection.
- Between April 2015 and April 2016 there were eight surgical site infections reported. All cases were patients that had breast surgery. Surgeons discussed the cases, which resulted in guidance for the prophylactic use of antibiotics. We saw surgical site infections were a standard agenda item in the infection and prevention committee meetings.
- The hospital had a lead nurse for infection control and prevention. The infection control committee met monthly and monitored the trust's performance. We saw minutes of the February 2016 committee meeting, which included infection control policy reviews, and the new NICE infection control and prevention quality standards. The trust also had an annual infection prevention plan for 2016/17.

Environment and equipment

- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, were regularly checked, and documented as complete and ready for use.
- The paediatric resuscitation trolley for use in the recovery department was stored in critical care, which was in close proximately. Recovery room staff kept emergency airway management equipment nearby thus ensuring the safety of paediatric patient's during the retrieval of the resuscitation trolley.
- Some of the surgical wards visited were within an older building within the hospital. They were clean, however, the lack of storage made the areas look cluttered.
- There was sufficient equipment to maintain safe and effective care. Staff told us they could access bariatric equipment when required.
- Equipment had safety test stickers with appropriate dates. This meant that there were procedures in place to ensure the maintenance and use of equipment to kept patients safe from avoidable harm.
- Dirty utility rooms (or sluice room) were observed to be clean and tidy with appropriate storage for clinical waste and chemicals.
- Clinical waste bags used, varied across the organisation. Appropriate coloured disposal bags were used for clinical areas. General waste and recycling facilities were available to staff, patients and visitors.
- Sharp boxes for the disposal of needles were found to be appropriate to clinical area and detailed the date, time, and person responsible for assembling them. All were assembled correctly.
- We observed that blood samples were stored in a designated container on the nursing station of wards visited. All samples were labelled and packaged correctly. Nursing staff alerted porters that the samples were ready for collection and the porters then took them to the pathology laboratory.
- In theatres, the hospital had plans to introduce a new computerised inventory system. Staff in theatre explained that this new system would have many advantages. For example, it would mean less waste and more control over stocks of equipment, would save space and would mean the avoidance of cancelled procedures due to not having the required equipment.

Medicines

- The service had processes and procedures to complete weekly checks and reconciliation of medicines as well as monthly audit to check stock and utilisation.
- Pharmacy staff allocated to wards checked medicine charts daily through weekdays, and provided advice on, for example, doses and contraindications.

- Some surgical areas had a check and top up service provided by the pharmacy department. This service was financed out of the individual surgical area budget and meant that staff did not have to order medicines as the pharmacy technician did this for them. This ensured medicines used regularly were readily available to treat patients.
- Some prescription medicines are controlled under the Misuse of Drugs Act legislation. These medicines are called controlled drugs (CDs). We examined the CD registers and found these to be appropriately completed and checked. These were audited every three months we asked the trust for evidence of the audit results but this was not provided.
- Medicines within the wards and theatres were stored correctly, including in locked cupboards or fridges when necessary.
- To ensure the safety and usage of stored medicines the service conducted daily recordings of medicine storage rooms and fridge temperatures. All temperatures were within the required ranges. We saw guidance for staff within the treatment rooms should temperatures fall outside of these ranges.
- Medicine trolleys were stored securely. During our inspection, we observed a medicine round. The nurse administering medicines wore a plastic tabard, which said 'medication round in progress do not disturb'. This meant that staff and patients knew that the nurse was engaged in a medicine round and therefore limited distractions to ensure they could concentrate on the safe administration of medicines.
- We found no issues or concerns with the administration of medicines. Pharmacy and nursing staff audited drug charts and we found no omissions in those medicine administration records (MAR). For example, we found allergies clearly documented in the prescribing document used.
- The MAR records showed antibiotics prescribed in accordance with local antibiotic formularies. This complied with NICE (QS61) guidance.
- Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff in a monthly MedsTalk newsletter.
- Nursing staff were aware and were able to seek guidance from the hospitals medicine policy and British National Formulary (BNF), which was the latest up to date version. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- There was no policy to support patients in the self-administering of their medicines. This process had been suspended and the policy was being updated. However, the trust recognised that it may be appropriate for some patients to administer certain of their own medicines under supervision of a trained nurse. There was a list of medicine that this was appropriate for, such as inhalers and ointment or creams.

Records

- In surgical wards and theatres, we examined 18 patient notes, which included assessments for patients treated in operating theatres. Within the patient's notes, there were detailed and comprehensive pre-assessment records documented within a pre-assessment pathway booklet for patients prior to admission. 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.
- Care bundles were used for patients when appropriate. Care bundles are a set of evidence based interventions that when used together significantly improve patient outcomes. Examples included sepsis and acute kidney injury care bundles.
- In ward areas, nursing and medical staff used the shared assessment record to ensure risk assessments were completed. For example, falls and nutritional risks assessments.
- National Early Warning Score (NEWS) were completed in line with clinical condition or specified timescales, with evidence of patients' risks or clinical deterioration being escalated as necessary.
- We found some of the records we reviewed had loose sheets. This meant that some of the notes were prone to falling out with the risk of being lost or misplaced. This had been identified as an issue on our September 2015 inspection.
- The confidentiality and recording of records had been identified on the trust quality improvement plan. We observed on this inspection that medical records were stored in lockable trolleys on all wards.

Safeguarding

- There were clear systems, processes and practises in place to keep patients safe. The hospital had safeguarding policies and procedures available to staff on the intranet.
- Staff received training through electronic learning and had a good understanding of their responsibilities in relation to safeguarding adults and children in vulnerable circumstances.
- The surgical teams were able to explain safeguarding arrangements. Staff knew when to report issues to protect the safety of patients.
- The training records showed that 89% of staff had received their safeguarding adults training level 1, 71% of staff had received level 2 safeguarding children training and 92% of staff had received level 3 safeguarding children training. The trust had a training target of 90% and the trajectory was to achieve this by the end of 2016.
- Staff reported that the trust safeguarding lead was accessible. We saw posters on the walls by the nursing station providing contact details for any safeguarding concern.

Mandatory training

- All staff within the surgical service attended mandatory training in issues, such as moving and handling, and safeguarding.
- The records showed that 84% of staff had completed mandatory training at the time of our inspection, which was an improvement from our last inspection in September 2015 where there was a 78% compliance rate. This did not meet the target set by the trust of 90%. However, we saw senior staff kept good records of staff training needs and staff were sent reminders via e-mail of any outstanding training. Staff told us that there were procedures in place to release them from clinical duties in order to attend training or complete on line modules as required.
- Staff chose how they completed their annual mandatory training, whether by e learning, face-to-face or ad-hoc sessions for practical work.
- The trust had an electronic E-learning service and all staff had a card access to this system.
- We saw that training had been completed for nursing staff following the implementation of a trust wide sepsis bundle.

Assessing and responding to patient risk

- Preoperative assessment is a clinical risk based assessment where the health of a patient is appraised to ensure that they are fit to undergo anaesthetic and therefore the planned surgical operation. It also ensures patients are fully informed about the surgical procedure and post-operative period and can arrange for admission, discharge and post-operative care at home. The preoperative assessment clinic was nurse led and all patients undergoing a surgical procedure attended.
- Any pre-operative investigations, for example blood tests were carried out during clinic. Preoperative assessments were carried out in line with NICE guidelines.
- The pre-operative assessment unit had the presence of a consultant anaesthetist for five sessions a week who reviewed the records to assess the need for further investigations or face-to-face consultations with patients.
- Two of the surgical wards had patients with non-surgical conditions. Staff felt they were able to raise concerns with the ward sisters and/or clinical site manager if they felt inappropriate patients were allocated to surgical wards. Staff were not completing incident forms when this occurred. The hospital had a critical care outreach team between 8am and 8pm each day. They provided clinical support to staff in caring for deteriorating patients and staff could raise concerns about patients with the critical care outreach team.
- Risk assessments were undertaken in areas, such as VTE, falls, malnutrition, pressure sores, and falls. Actions to mitigate risks were identified and documented in patient records.
- In operating theatres, the staff had implemented robust measures to reduce the likelihood of patients developing pressure ulcers during operations. There were completed risk assessments and subsequent actions taken, with appropriate devices used, such as heel pads and arm supports, to reduce the risk of pressure damage.
- Staff were able to assess and respond to a deteriorating patient in line with the trust policy and guidelines. The surgical wards used the NEWS to identify if a patient was deteriorating. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these.

- Staff we spoke with in the anaesthetic and recovery areas were competent in recognising deteriorating patients. In addition to the NEWS, a range of observation charts and procedures, pathways and protocols for different conditions or operations were used.
- We found that the trust had implemented a new admission clerking form, which was in general use. The form included details required to complete a patient assessment on admission and included past medical history, medications, admitting reason, clinical findings, blood results, and details of ward rounds. However, during inspection we found that the old clerking form was still in use, which included a sepsis-screening template. The service had removed the template from the new admission form in preference to a separate sepsis bundle template, which was also in use. We found that one surgical patient had been admitted with a suspected infection and should have triggered the implementation of sepsis bundle outlined in the old clerking form; however, this had not been completed. The patient was escalated to the trust for clinical review. The service informed us that the old form had been used in error for a number of patients, the new sepsis bundle differed, and the patient did not trigger implementation of the pathway. The trust consequently removed all old forms from clinical areas to prevent further confusion. This was confirmed during our unannounced inspections on the 17 and 18 July 2016, when admission clerking forms were noted as not including the sepsis bundle previously identified. We also saw that the new sepsis bundle was used for one patient admitted with sepsis.
- All theatre teams used the Five Steps to Safer Surgery checklist to prevent avoidable mistakes; this was an established process within the teams. We looked at 15 completed checklists. We found that all checklists were fully completed with patient information clearly documented including, the patient's identity and whether they had any known allergies. This was an improvement from the September 2015 inspection, when we observed checklists were not always completed correctly. The quality improvement plan outlined actions the trust had taken to improve checklist compliance, such as staff education and monthly audits. The theatre staff information board identified there had been 100% completion of checklists for 281days.
- Theatre staff had safety huddles before the morning and afternoon procedures commenced. During these huddles, staff discussed elective cases and order of patients along with flow and any necessary escalations. There was a standard operating procedure to support this process and ensure continuity.
- The National Safety Standards for Invasive Surgery (NatSSIPs) were introduced in September 2015. NatSSIPs are a high-level framework of national standards of operating department practice. The hospital had to produce a statement of purpose by September 2016 informing of their progress with the implementation of NatSSIPs. Within the theatre department was a band 6 service improvement nurse who conducted a teaching session for staff to raise their awareness of NatSSIPs. They had also conducted an initial gap analysis between the hospitals local policies and NatSSIPs, and were working to produce a site marking policy and reviewing the Five Steps to Safer Surgery checklists.
- Since our previous inspection, the trust provided evidence that they had reviewed the records of patients who had waited over 18 weeks for treatment. The reviews were overseen by the medical director and service unit director. Patients who were found to be at risk of harm whilst waiting were identified and appropriate action taken. The trust had contacted relevant GPs to inform them of waiting times and ensure that they had oversight of patient care whilst on the waiting list. This ensured patient safety.

Nursing staffing

- Senior staff used the national safer nursing tool to assess and identify planned staffing levels. The wards visited displayed the required and actual staffing numbers. During our inspection, the records showed no issues or concerns with the planned numbers of staffing. The trust aimed to have a nursing fill rate of at least 90%. Trust board papers indicated that for April and May 2016 this was not achieved for registered nurses on Redbrook ward and additional health care assistant's had been used to support the nursing workload. For June 2016, the average registered nurses fill rate on Redbrook ward was 82% in the day and 106% at night. For health care assistant's it was 121% and 156%, respectively. For June 2016 Monnow, Teme and Leadon wards all reached at least 100% registered nurses fill rates.

- Skill mix was appropriate on all wards with sufficient registered and unregistered staff to enable delivery of patient care and treatment. Staffing establishments had been reviewed in line with ward bed numbers and activity.
- Recruitment of staff remained a challenge for the hospital and stayed on the risk register. Vacancies existed within the surgical service despite a recent recruitment drive. Bank and agency staff filled identified vacancies. The ward sisters told us that some staff picked up additional shifts to support the wards. The sisters told us they requested the same agency staff to ensure continuity within the wards.
- We saw completed induction booklets in place for bank and agency staff within the surgical wards and units.
- Nursing handovers occurred at the change of shift. We observed handovers provided concise information on each patient. For example, on Redbrook ward handovers occurred outside of the bays to maintain confidentiality. However, on Leadon ward we saw the handover was at the patient bedside. Other patients and relatives could overhear the patient information being discussed which meant that a patient's privacy, dignity and confidentiality could not be maintained. The corporate risk register identified the risk of negative patient experience due to the inadequate environment condition of Leadon and Monnow wards, including privacy and dignity breaches due to the nightingale ward layout. However, there were no mitigating actions denoted to specifically reduce the risk of breaches in patient confidentiality.
- During the night, there were two clinical site managers on duty, one of which worked in the integrated flow and management centre managing patient pathways into the hospital, the other managed allocation of beds. Neither of them seemed to support the ward nurses clinically, this meant that nurses had no senior nurse to contact for advise if they needed it.

Surgical staffing

- Leadon and Monnow wards had dedicated ward doctors based on the wards. The other surgical wards had daily visits by the on-call teams and could bleep doctors when required.
- During our unannounced visit, we saw that there were no surgical foundation year two junior doctors on duty covering the surgical wards at night. Although there was a registrar and foundation year one junior doctor on duty, the foundation year one junior doctor also covered trauma and orthopaedics between 1am and 8am. This meant that if the registrar was called to theatre with a patient, a junior doctor was covering the care of both general and specialised surgical patients without any direct support. The doctors told us that registrars on duty for the emergency department had provided support with orthopaedic patients on occasions, and that orthopaedic registrars were on call as required.
- There was a separate night medical team of doctors who provided care to medical patients, there appeared to be no cross covering between surgical and medical doctors at night. There was also no senior nurse with oversite coordinating the care of all patients.
- Consultants worked throughout the week within the surgical services. Specialist registrars supported the consultants during the weekends.
- There were surgical handovers from day to night doctors that took place. Doctors we spoke with told us that during these handovers patients that there were concerns with would be fully discussed and new patients that had been admitted
- Ward rounds took place twice daily, once in the morning and again in the afternoon.
- Every Friday afternoon a surgical ward round took place where all consultants and junior doctors attended. Every surgical patient was reviewed and the plan of care over the weekend discussed so that doctors on duty over the weekend had clear treatment plans for all patients.
- Doctors had completed mandatory training, which included Mental Capacity Act 2005, Deprivation of Liberty Safeguards and breaking bad news training.
- The business plan for the service identified that there was increased demand in inpatient activity requiring further medical recruitment within some specialities. There were recruitment and retention challenges within the trust; however, there was action plans to increase consultant numbers and locum usage where necessary.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents. Staff we spoke with told us that there had not been any recent practice scenarios.
- A new emergency planning officer had commenced recently at the trust and had sent out an emergency planning leaflet to all staff in May 2016. This detailed the

definition of a major incident and gave practical reminders what staff should do if an incident occurred. The emergency planner details were contained within the leaflet and staff confirmed their awareness of both the leaflet and the planner within the trust.
- There was a bed management system in place which was aimed at ensuring patients' needs were met when there were increased demands on beds. However, during our inspection some medical patients were cared for on the surgical wards.

Are surgery services effective?

Requires improvement

We rated the service as requires improvement for being effective because:

- There was no hip fracture pathway within the hospital although we were told that this was being drafted.
- Appraisal rates for staff did not meet the trust target.
- There were mixed patient outcomes and not always an action plan to ensure improvements. For example, the National Emergency Laparotomy Audit had mixed results but we were not made aware of any further action plan that addressed issues from the audit.
- There was no lead for learning disabilities within the trust.

However, we also found that:

- All policies were current and reflected evidence-based guidelines. There were systems in place to provide care in line with best practice guidelines.
- Staff were clear about their roles and responsibilities around the Mental Capacity Act 2005 (MCA) and had an awareness of the MCA and Deprivation of Liberty Safeguards (DoLS).
- Patient's pain was assessed and treated and was discussed at handovers.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patient risk of malnutrition. Staff used a fluid pathway to assess a patient's fluid status.
- There were competency frameworks for staff in all surgical areas.
- We observed a good working relationship between, nurses, doctors, and physiotherapists. We found effective multidisciplinary team working that delivered coordinated care to patients. Staff had access to patient related information when required.
- Patients told us that doctors discussed consent prior to any procedures and the records demonstrated clear evidence of informed consent.

Evidence-based care and treatment

- Staff provided care to patients based on national guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. Staff were aware of recent changes in guidance and we saw evidence of discussion based on these guidelines in patient's health care records.
- Polices were current and we saw that the hospital had systems in place to provide care in line with best practice guidelines. For example, the service used an early warning score to alert staff should a patient's condition deteriorate (in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital).
- The surgical services adhered to the NICE guidelines for the treatment of patients. The surgical governance process assessed compliance with the NICE guidance.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with national guidelines. Staff accessed these policies on the trust's intranet.
- Local audits monitored adherence to policies and procedures such as, National Early Warning Score (NEWS) and the Five Steps to Safer Surgery.
- Venous thromboembolism (VTE) assessments recorded were clear and evidence based, ensuring best practice in assessment and prevention.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death recommendations and national guidelines. Including Royal College of Surgeons, standards for emergency surgery.
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.
- There was no hip fracture pathway within the hospital although we were told that this was being drafted. Patients who suffer a fractured hip have a high mortality

and morbidity rate and often need long term care post fracture. A hip fracture pathway ensures that care is coordinated and is evidence based to reduce length of stay and mortality and morbidity.

Pain relief

- Patients received information on pain relief during their pre-operative assessment.
- The records showed that patient's pain relief had been risk assessed using consistent and validated tools, such as the pain scale found within the NEWS; results were recorded alongside other vital signs. Handovers discussed patient's pain when appropriate.
- When required, patients could access pain relief in accordance with the trust policy.
- The acute pain clinical nurse specialist (CNS) provided ongoing pain management to patients. When the CNS was unavailable the anaesthetist covered pain management. Pain management was included in the Acute Illness Management (AIM) course, which was provided for registered nurses working in the acute hospital setting.
- The CNS had developed a pain assessment tool specifically to assess patients living with dementia. The surgical wards were piloting this tool.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. Patients identified as at risk of malnutrition were referred to the hospital dietetic service for assessment, with regular monitoring of nutritional condition in place.
- Patient's nutrition and hydration intake was recorded when applicable.
- We observed staff used fluid balance charts to monitor patients' fluid intake. We saw that patients had jugs of water on their bedside tables within reach to promote hydration.
- The dietetic department had conducted a hospital wide audit of MUST assessments in September 2015. This showed an improvement in the completion of assessments, which was 95%, compared to 68% in 2014.
- An audit was undertaken in December 2015 into the hospital compliance with NICE clinical guidelines 174-Intravenous fluids (IV) in adults in hospital. Fifty patient's notes were reviewed, which included both medical and surgical patients who had received IV fluid as part of their treatment. The results showed poor compliance resulting in the introduction of an IV fluid care pathway for the assessment of a patient's fluid intake. We saw evidence of this in use during our inspection. Staff said they would make a referral to the dietitian as required. Patients had access to drinks by their bedside. Care support staff checked and monitored that patients took regular drinks.
- There were processes in place to ensure that patients that needed assistance with eating and drinking were identified and supported.
- All patients who presented with nausea and/or vomiting post-surgery were, where applicable, given suitable analgesic and antiemetic (a drug effective against vomiting and nausea). We saw these medicines identified in the patient's records.

Patient outcomes

- The service continuously reviewed and improved patient outcomes through participation in national audits.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry, and the National Emergency Laparotomy Audit.
- PROM audit measures health gain in patients undergoing hip and knee replacement varicose vein and groin surgery in England. The patient related outcome measures for the hospital were in line with national results.
- The National Emergency Laparotomy Audit looks at the structure, process and risk adjusted outcome measures for the quality of care received by patients undergoing emergency laparotomy. The audit rates performance on a red, amber, green scale where green is best and red is the worst. The hospital had three greens for final case mix ascertainment, arrival in theatre in the timescale appropriate to urgency and consultant surgeon presence in theatre. The hospital had red results for consultant review within 12 hours of admission, preoperative review by consultant, direct postoperative admission to critical care and assessment by medical crises in older people specialist in patients aged 70 plus. The hospital scored ambers for the remaining four measures. We were not made aware of any further action plan that addressed issues from the audit.
- The data from the National Bowel Cancer Audit (2014/15) showed that a CNS saw 95% of patients and had

their case discussed at a multidisciplinary meeting, which was better than the England average of 93%. However, 76% of patients had a length of stay longer than five days, which was worse than the England average of 69%.

- The National Hip Fracture Database (NHFD) is part of the national falls and fragility fracture audit programme. A review of the 2014 report (published 2015) indicated a mixed performance areas of good performance and areas for improvement. The main areas for improvement were identified were: 25% of patients had not received a medical review pre-operatively within 72 hours of admission and 20% of patients had received a geriatrician review. In response to the audit, the trust told us they had been actively recruiting for a consultant orth-geriatrician to support the service but the post had not yet been filled.
- The surgical team monitored and reported information through the governance structure to ensure early intervention. Hospital mortality was reviewed weekly to identify root causes and any learning shared across all clinical teams. The trust had implemented a series of actions to address this concern including the introduction of regular mortality review meetings, reviews of each inpatient death, implementation of NEWS and a series of care treatment bundles to identify any actions to improve overall patient care and treatment.

Competent staff

- All staff told us that they had received their annual appraisal. Information provided by the hospital confirmed between 80% and 100% of staff in surgical services had received their appraisals against a trust target of 90%. This meant that the trust target of 90% was not met in all surgical areas.
- There was an induction programme for all new staff. This included mandatory training and competency based ward skills. All staff that we spoke with confirmed they had attended an induction.
- Nursing staff reported working supernumerary when commencing a new role. This was to ensure competence and offered new staff the opportunity to learn new skills and methods of working. The sisters in charge said that all new staff were allocated a “buddy” to work alongside them.
- Newly qualified nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- There was a surgical academy programme for newly qualified staff nurses. This involved a rotation in surgical areas and attending study days provided by education and development facilitators.
- Agency staff were inducted to the ward area. This included a tour of the ward, introduction to staff and details of the equipment used. We saw completed templates used for this process. Agency staff confirmed that this always happened, even if they had worked on the wards previously.
- All staff spoken with said that they were able to access study days relevant to their area of work, both internally and externally.
- We saw that there were competency frameworks for staff in all surgical areas and that these were completed and up to date.
- Junior doctors had specific training and development plans and had scheduled training sessions. They had both educational and clinical supervisors. They also attended monthly audit days where training sessions were provided on certain subjects and updates on audit results and action plans were given. However, one junior doctor was concerned that they had limited training sessions with two hours a week for formal training, and that opportunities for bedside teaching were limited.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered coordinated care to patients.
- Surgical wards undertook daily ward rounds seven days a week. This involved medical and nursing staff together with physiotherapists and/or occupational therapists as required.
- We observed a good working relationship between ward staff, doctors and physiotherapists.
- Staff said that they could access medical staff when needed, to support patients’ medical needs.
- Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment.
- The hospital had a critical care outreach team seven days a week between the hours of 8am and 8pm who worked closely with nursing and medical staff.

- There was dedicated pharmacy support on all the wards we visited, which helped to speed up patient discharges with "to take out" medicines.
- The hospital no longer had a lead nurse for learning disabilities. However, staff in the pre-assessment clinic told us that they contacted the community nurse for learning disabilities for advice and support and were able to give a recent example of when this had been necessary to support a patient coming into hospital for surgery

Seven-day services

- The pharmacy was available on weekdays as well as Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medicines.
- The trust provided a seven-day diagnostic service there was access to all key diagnostic services 24 hours a day, for example, endoscopy. This supported clinical decision-making.
- Consultants conducted ward rounds every day and participated in on call systems.
- The service did not provide a full seven-day service. Dietetics and speech and language therapy provided a Monday to Friday service. There were no plans in place to move to a seven-day service. However, physiotherapy and occupational therapy provided a seven-day service for higher risk patients.

Access to information

- Staff, including agency and locum staff, had good access to patient-related information and records when required. This included care and risk assessments, care plans, case notes, and test results to enable them to care for patients appropriately.
- Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Nursing staff told us that when patients transferred between wards and/or teams they conducted a comprehensive handover. This ensured that staff were aware of the patient's condition, relevant medical and social history and on-going care needs and plan of treatment.
- Patients experienced co-ordinated care with clear and accurate information exchanged between relevant health and social care professionals.
- Medical staff completed electronic discharge letters, which included details of patient's admission, medication to take home and details of any follow up appointments.
- GPs received copies of discharge letters to ensure continuity of care within the community. The summary had the consultant surgeons contact details this meant that the GP had a point of reference if further information was needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up to date policy on consent for surgical treatment.
- Staff understood consent, decision-making requirements, and guidance. The hospital had five nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were unable to give consent for their operation or procedure and another for procedures not under general anaesthetic.
- 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.
- Ward staff were clear about their roles and responsibilities regarding the MCA.
- Staff had received training about the MCA to ensure they were competent to meet patients' needs and protect their rights where required. This also included training regarding DoLS. Staff we spoke with had a good understanding of DoLS, there were no patient's subject to restrictions during our inspection.
- The dementia care leads informed us that the trust had increased MCA and DoLS training to empower staff to perform assessments. Nursing staff reported being supported in this process by the safeguarding team.
- Pre-operative assessment unit staff communicated to surgeons and anaesthetists if they had concerns around a patient's mental capacity. Questions around learning disabilities and dementia were included in the pre-assessment and this prompted staff to ensure that where required patients had a hospital passport. The hospital passport detailed patient needs and accompanied them during their admission.

Surgery

- Edmonton frailty assessments were completed, when required. The Edmonton scale looked at the patient's cognition, general health status and functional independence and performance.

Are surgery services caring?

Good

We rated surgery services as good for caring because:

- Staff were caring and compassionate going the extra mile to ensure that patient's needs were met.
- Patients told us that the care they received was better than good. Patients felt involved and informed about their treatment.
- The NHS Friends and Family Test results for May 2016 showed that between 96% and 100% of patients would recommend the surgical services to their family and friends.
- We saw staff respected patient's privacy and dignity during personal care.
- Patients were encouraged to be as independent and mobile as possible following their surgery.

However, we also found :

- On Leadon ward, nursing handover took place at the end of each patient's bed, which made it difficult to respect privacy and confidentiality.

Compassionate care

- We saw staff respected patient's privacy and dignity during personal care, for example, staff pulled curtains around the bed space. However, on Leadon ward nursing handover was conducted at the end of each patient's bed, this meant other patients could hear what was being handed over.
- Patients felt that staff treated them with respect.
- The NHS Friends and Family Test results for May 2016 showed that between 96% and 100% of patients would recommend the surgical services to their family and friends.
- A relative we spoke with told us that they had witnessed not just the compassionate care of their loved one but towards other patients on the ward.
- Patients were encouraged to be as independent and mobile as possible following their surgery. For example, we saw physiotherapists mobilising patients out of bed and around the ward area.
- One patient described the care they received as 'tender' in a letter of thanks they wrote to ward staff.
- Other comments on care received from patients include 'outstanding' and 'better than excellent', 'fantastic care' and 'the best care I have ever had'.
- A patient visiting the CQC engagement stand told us that they felt staff on surgical wards maintained their confidentiality at all times. Another patient said that staff on surgical wards were polite and very helpful.
- Staff told us that if patients did not have any visitors they went to great lengths to ensure patients had things that they liked. For example, staff provided patients with snacks, such as fruit and cordial.
- Redbrook ward and the recovery area had both recently won the trust's 'going the extra mile award' to acknowledge and celebrate their dedication and achievement to patient care.
- Staff in the day case unit arranged for a patient with diabetes who was attending for a procedure, to have a hospital meal before going home. Relatives felt their loved one was in 'safe caring hands'.
- Patients told us that they generally had managed to rest and sleep.
- A staff member on one of the wards we visited had organised a care toiletry box to ensure staff always had access to toiletries to help make patients feel more comfortable.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt informed about their care and treatment and were all aware of their estimated discharge date.
- Patients were involved in making choices around their care within their care pathway. For example, a patient told us that staff talked to them about the treatment options available and supported them in their decision. Another patient told us that they had felt very anxious about their procedure and, as they were due to go to theatre, they were not sure if they wanted to proceed. Staff took time to have a further discussion with them going over the options for treatment ensuring they fully understood what was involved in each treatment option.

Surgery

- Consultants visited their patient's daily and were available to answer any questions they might have and informed patients of what to expect and their plan of treatment.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- Relatives we spoke with told us that staff were supportive and that they ensured that they had something to eat and drink especially if they had been on the ward a long time with their loved ones who were very ill.
- A patient whose first language was not English told us that staff used the resources available to ensure that they were well informed and understood what was happening.
- A patient told us that they felt staff promoted them as being partners in their own care.

Emotional support

- There was information available to staff on how to contact members of the clergy to meet patient's individual spiritual needs.
- Patients had access to clinical nurse specialist, for example, breast care nurses and stoma care nurses. This meant that patients received specialist support when coming to terms with any adaptions in their everyday lives.
- On one ward, we visited early in the morning patients told us that they had been woken up in the early hours of the morning by a fellow patient who was very confused and was shouting at staff. They told us that staff reassured the patient and managed to settle them down but also they spoke to all the patient's on the ward as many were scared by the shouting. A healthcare assistant made all the patients who had been woken a hot drink and patients told us they felt reassured and safe.

Are surgery services responsive?

Inadequate

We rated surgery services as inadequate for being responsive because:

- Between June 2015 and May 2016, the overall referral to treatment (RTT) indicators within 18 weeks was worse than the England average. For example 33% of ophthalmology patients were being treated within 18 weeks compared to a England average of 83%; and for ENT, 47% of patients were treated within 18 weeks compared to an England average of 76%.The RTT times were significantly worse than the England average and had not significantly improved in the last 12 months.
- Although an electronic system had been implemented to monitor and record wait times, there was no evidence of measures taken to actively reduce the waiting times.
- The percentage of patients that had cancelled operations was worse than the England average of 5%, at 28%.

However, we also found :

- The hospital had a nurse led pre-assessment clinic, which provided pre-booked and drop in appointments. This offered flexibility to patients.
- A discharge lounge was available throughout the week between 9am and 8pm.
- Length of stay was better than the national average for elective and non-elective general surgery, urology, non-elective upper gastrointestinal surgery, and trauma and orthopaedics. However, elective trauma and orthopaedic length of stay was worse than the England average.
- There were translation services available to support patients and ensured that patients had the relevant information about their care.
- There was a 'care passport' scheme to support patients with dementia and/or a learning disability.
- Reported complaints were handled in line with the trust's policy.
- There was a trust stakeholder group.
- The hospital conducted regular bed capacity meetings, which were attended by representatives from the service.

Service planning and delivery to meet the needs of local people

- There was a trust stakeholder group, which met bi-monthly and provided feedback on trust business plans and patient care improvement plans. The group had representation from patients, carers, staff and commissioners.
- The surgical management team acknowledged that bed capacity had not always been effectively managing

leading to cancelled patient operations. Recently forward planning was introduced to ensure that elective cases were accommodated. A bed booking system for elective patients had been introduced to identify potential bed capacity issues and prevent last minute cancellations.

- The facilities and premises were appropriate for the services. During our September 2015 inspection, the trust's strategic objective had identified that the hutted wards were past their intended useable life span and were no longer adequate. The estates strategy for the trust identified and planned for the relocation of these areas.

Access and flow

- Between June 2015 and May 2016, the overall RTT indicators within 18 weeks for admitted patients was worse than the England average (80%), with 61% of referred patients treated within 18 weeks. For general surgery, 49% (373) of patients were not treated within 18 weeks; in ENT, 53% (332) of patients were not treated within 18 weeks. Of the patients requiring ophthalmology surgery, 72% (1353) of patients were not treated within 18 weeks. For trauma and orthopaedic surgery, 50% (1030) of patients were not treated within 18 weeks.
- The hospital had implemented a 'live' electronic system for recording and monitoring waiting times of patient's on the admitted pathway. Within the system, medical and nursing staff could see which patients had dates for procedures and the wait times per speciality. This system was progressing to include patients on the non-admitted pathway. This meant that there was a clearer understanding of what RTT times were across all pathways. However, the hospital were not scheduling theatre initiative lists in order to reduce their wait times and it was unclear if surgical procedures were being outsourced to private healthcare providers.
- Emergency surgery was facilitated by an on call theatre team. Consultants in each speciality were on call at night and weekends and therefore could facilitate emergency procedures if necessary.
- Staff we spoke with told us that management of beds within the hospital was an issue. The DCU remained open regularly overnight and at weekends to facilitate patient stays due to lack of bed capacity within the rest of the hospital. This was staffed mainly by bank and/or agency staff, alongside one substantive staff member on duty. Medical cover was provided by the ward surgical and medical teams.
- The percentage of patients that had cancelled operations was worse than the England average of 5%, at 28%. On average 20% of patients' cancelled operations were not then treated within 28 days as per NHS England standard.
- The trust advised us that for the 12 month period ending March 2016, there were 22 patient operations cancelled on the day, due to lack of bed availability on the intensive care unit. This was for patients who needed level two or three care post operatively. This was significantly worse than the previous year, when six patients had their surgery cancelled on the day. The surgical division were aware of this and were trying to forward plan operation better to prevent on the day cancellations.
- There were five allocated medical beds within Leadon ward. The ward sister explained that the number of medical patients flexed from one to 10 at any point, depending on pressures within the medical division. Nursing staff reported difficulties in the management of medical patients on the ward, and were in the process of devising admission criteria.
- Nursing staff on Monnow ward (surgical) told us they had no risk assessment for the admission of medical patients to the ward and the decision for transfer was based on clinical judgement of the medical team.
- Recovery room staff we spoke with told us that on occasions where there was a shortage of critical care beds, patients would be cared for by critical care nurses in the recovery room area. There had been four occasions in February 2016 whereby patients were cared for in recovery whilst awaiting a critical care beds a standard operating procedure had been implemented in May 2016 providing guidance for staff in this situation to ensure the safety of patients.
- The booking system within the pre-assessment clinic offered some flexibility to patients allowing them where possible to select an appointment date around family and work commitments. There was capacity for 'drop in' appointments for patients coming directly from clinics.
- Patients who attended the pre-operative assessment clinic had access to information leaflets such as; you and your anaesthetic, preventing thrombosis, a day case pack and ward specific information.

- The discharge lounge was available from Monday to Friday from 9am to 8pm.
- There was an electronic system for managing blood test requests and results. Staff told us they were able to access the system and it worked well.
- The Hospital Episode Statistics for 2015 showed that the length of stay was better than the national average for elective general surgery and urology. Length of stay in non-elective upper gastrointestinal surgery was 3.2 days better than the England average of 4.6 days. Length of stay in non-elective trauma and orthopaedics was 8 days, also better than the England average of 8.7 days. Length of stay in non-elective general surgery length of stay was 3.8 days, again better than the England average of 4.1 days. However, elective trauma and orthopaedic length of stay was 4.2 days worse than the England average of 3.4 days.
- We saw that theatre utilisation between January and April 2016 ranged from 79% to 96% However, the records showed that theatre 3 (trauma/emergency theatres, was used more than 100% for this period.
- On arrival to the DCU, patients saw the nurse who assessed their wellbeing and processed them for surgery and the post-operative ward.
- On the day of surgery, patients with elective (planned) surgery were admitted to the surgical admissions unit.

Meeting people's individual needs

- During our visit to the recovery unit, we observed that children used the same recovery area as adults. There were two bays specifically allocated for children and we saw there were always two members of staff with a child. Therefore, the hospital were recovering children separately to adults as far as the physical environment would allow. Staff said parents and carers were encouraged to come into the recovery area.
- We saw that the surgical services planned and coordinated patients individual needs from the surgical assessment unit through to the anaesthetic room and again in recovery when needed. Information from pre-assessment was clearly recorded and relevant information about individual needs was documented on the electronic theatre scheduling system. For example, the needs of a patient living with dementia were communicated on the system and staff along the patient's journey were aware that they needed the support of their carer
- The trust did not have a named lead for learning disabilities. Staff told us that they could seek advice from the community nurses for learning disabilities.
- Staff demonstrated an awareness of the learning disability and dementia, 'care passport' scheme. Staff documented patients' care needs in the care passport, including patient preferences and other useful information, which enabled staff to support them.
- There was a dementia care lead nurse within the hospital who offered advice and support in the care of people suffering with dementia.
- The 'forget me not flower' was used at bed spaces and outside individual rooms to discreetly identify patients living with dementia. Permission for this was sought from relatives prior to completing this. The use of the symbol-enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- Staff in pre-assessment gave an example of meeting a patients' needs by arranging for the patient to have their pre-assessment at home over the telephoned supported by a family member and a community nurse for learning disabilities.
- Staff in pre-assessment clinic referred patients directly to a dietitian where appropriate and leaflets were available advising patients on healthy weight loss where required. Within the leaflet, information was given on supportive organisations.
- Because of patient comments about lengthy waits to go to theatre, daily papers were provided and the ward had purchased radios and reclining chairs to help patients feel more comfortable whilst waiting.
- Translation services were available within the hospital.
- The ward had protected visiting times during mealtimes. There was 'red equipment' to identify patients who needed help with eating and drinking.
- We saw that during mealtimes patients sat out of bed in order to eat and staff were giving assistance to patients when needed.
- Patients had access to a chapel and multi faith room on site.

Learning from complaints and concerns

- Staff reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service if they were unable to deal with their concerns directly.

- The ward/unit sisters received all the complaints relevant to their service and gave feedback to staff regarding complaints in which they were involved. Lessons from complaints were shared within the department during team meetings.
- We saw evidence of actions put into place because of concerns raised by relatives. For example, a relative felt the communication with patients living with dementia could be improved. As a result, dementia champions were identified throughout the hospital who had an interest in improving the service. They acted as a point of resource and advice for staff when caring for patients living with dementia.
- Literature and posters displayed within the wards advised patients and their relatives how they could raise a concern or complaint, either formally or informally.

Are surgery services well-led?

Requires improvement

We rated surgery services as requiring improvement for being well-led because:

- Staff were unaware of the trust mission, vision, and strategic objectives.
- The strategy for the service acknowledged that demand did not meet capacity. There were not enough clinicians, available beds and theatre capacity to meet patient demand that was contributing to increased referral to treatment times (RTT) waits and cancelled operations.
- There was no clear position on RTT and it was unclear what steps the trust were taking to reduce these timeframes.
- Staff were unclear about the new governance structure and said they were unsure who their managers were.

However, we also found:

- The trust had systems in place to identify and monitor risks.
- Each ward had a lead nurse who provided day-to-day leadership to staff.
- The service had directorate meetings and there was divisional quality and safety meeting to discuss issues, such as complaints and audits.
- Staff we spoke with were clear about their roles and responsibilities.
- There was a sense of pride amongst staff.
- Staff described a supportive working environment.
- The hospital recognised the views of patients and the public.
- The service had clinical governance and elective care performance meetings.

Vision and strategy for this service

- The trust had implemented a new mission, vision and values.
- Most staff we spoke with were unaware of the trust vision and mission. However, staff were aware of the trust values.
- There was a strategy for delivering care to surgical patients. The strategy mirrored national performance targets. However, the trust acknowledged within the strategy that demand was outweighing capacity and there were insufficient clinicians to meet this demand.
- The trust had a comprehensive quality improvement plan, which included a number of projects and actions. These were divided into projects such as risk management, information governance, reducing harm including the Five Steps to Safer Surgery checklist, estates, and clinical effectiveness. Each project was then further divided into themes and action plans. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions. For example, the risk management project included the production of a risk register that reflected the trusts risks accurately, and the completion of patient risk assessments. Both actions were in progress with a new risk register in place, and training plans in place for e learning for staff.

Governance, risk management and quality measurement

- The service held monthly clinical governance meetings where quality issues were discussed. For example, incidents and audit results. Information was then cascaded to staff through directorate and team meetings and safety bite bulletins.
- The service also held elective care performance meetings monthly. Quality and performance indicators were discussed, for example, RTT times, medical outliers, actual and planned admissions, and service risks.
- The trust had systems in place to identify and monitor risks. The surgical division held its own risk register and

clinical leads we spoke with were able to identify the top three risks. Risks were reviewed at monthly quality and safety meetings and fed back to staff through team meetings.

- Staff were aware of risks locally, and were able to inform us of those which they felt most affected patient safety. The majority of staff stated that recruitment and the financial strain of locum and agency staff caused the highest risks within the organisation. The leads for the service also identified staffing as being in the top three risks for the service.
- Clinical leads we spoke with told us that there was now focus on elective patients and forward planning in capacity.
- The service held directorate meetings and attended the divisional quality and safety meetings to discuss, issues such as complaints, incidents, and audits. Feedback from these meetings was cascaded to staff through team meetings and the minutes and actions plans sent to all staff via e-mail.
- Staff we spoke with were clear about their roles and understood what they were accountable for.
- Senior managers had ensured that there was a clear plan in place for the development of NatSSIPs and there was a project underway to assess the need for each standard against invasive procedures carried out within the service.

Leadership of service

- In June 2016, the trust introduced a new divisional structure. The surgical division was split into four directorates with each directorate led by a clinical director, general manager, and matron.
- Some staff we spoke to were unaware of the structure and told us that they were unsure who their managers now were. They felt the communication around the change was poor. They felt that they wanted some stability, as there has been a lot of change.
- Most staff said they had awareness of the chief executive officer (CEO) and the director of nursing (DON) and saw them around the hospital. They told us that the executives would visit the area on occasions. Staff told us they saw the matron and medical director for their area regularly.
- The CEO had an open door policy that staff could access when required.
- Each ward or area had an executive link with who staff could contact directly with any concerns or issues. We saw the link for areas displayed on the notice board.
- Staff within the surgical services said they felt supported by their managers who looked after their welfare. They felt able to raise concerns and that their concerns would be acknowledged.
- Each ward had a lead nurse who provided day-to-day leadership to members of staff on the ward.
- Ward sisters said they had access to leadership development programmes.

Culture within the service

- Leadership within the surgical services reflected the vision and values of the hospital and promoted good quality care.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.
- Staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged.
- There was evidence of collaborative working throughout the service and a shared responsibility to deliver good patient centred care.
- Each clinical area displayed thank you cards from patients and relatives.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. Using surveys, comment cards, and questionnaires to gather information to enable service improvement. We saw comments and suggestions boxes were stationed in all areas of the hospital, including on entering surgical wards.
- Information on patient experience was reported alongside other performance data. This information was used to informed decisions about the service.
- There was trust stakeholder group that provided feedback on trust business plans and patient care improvement plans. The group had representation from patients, carers, staff and commissioners.

Staff engagement

- All staff we spoke with were focused on and committed to providing a high standard of safe care and were proud of the services that they provided.

Surgery

- Staff in all surgical areas visited were focused continually improving the quality of care for patients. They told us that their areas had entered the trust wide poster competition and had produced posters on innovative practice. These posters were displayed in the education centre.
- Staff felt that their efforts to improve the quality of care for patients were recognised through the trust poster competition and the trust 'going the extra mile awards' which many areas had been awarded. These acknowledged good practice and team contributions to quality of care.
- Senior managers we spoke with said they felt well supported and there was effective communication with the executive team.

Innovation, improvement and sustainability

- A pain assessment tool for patients living with dementia was being piloted in the surgical wards with a view to implementing hospital wide to improve pain assessment and management for patients.
- Staff were focused on continually improving the quality of care and were engaged in the trust 'going the extra mile award' scheme that recognised good and innovative practice.
- At this inspection there had been the following improvements noted since the September 2015 inspection:
  - Learning and feedback from incident reporting was shared with staff.
  - Staff continued to have access to mandatory training and were now able to be released to attend training. Mandatory training compliance rates were near to the trust target and action plans to ensure staff compliance were in place.
  - Appraisal rates amongst staff had improved.
  - Staff felt more supported and felt able to raise concerns with their managers.
  - The Five Step to Safer Surgery checklist was completed.
  - Challenges that remained since the September 2015 inspection:
    - Staff vacancies remained a risk within the trust. However, there was continuity of use of agency and bank staff and all staff received an induction.
    - Some patient's records we reviewed had loose sheets. This meant that some of the notes were prone to falling out with the risk of being lost or misplaced.
    - RTT waits remained a challenge, although there was greater awareness of the position and steps had been taken to ensure patients facing long waits for surgery were safe whilst waiting.
    - Bed capacity, medical outliers and theatre capacity, and mortality rates remain an issue although there was action planning within the business plan to address and manage these.

Critical care

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

Information about the service

Critical care includes areas where patients receive more intensive monitoring and treatment for life threatening conditions. Critical care provided for adults requiring advanced respiratory support (ventilation) and other complex therapies is known as level three care and patients who require high dependency care receive level two care.

Critical care services are located at Hereford Hospital on the six-bedded intensive care unit (ICU). The ICU had 375 patients admitted in the 12 months ending March 2016. In this year, the ICU provided 659 days of level three care and 1139 days of level two care. There were 41 patients cared for on the unit following elective (planned) surgical procedures and received 334 emergency admissions.

A critical care outreach team was also available 12 hours a day to assist staff with the assessment and management of deteriorating patients throughout the hospital. The outreach service includes the provision of clinical expertise, leadership and education.

During this inspection, which took place between 5 and 8 July 2016, the inspection team spoke with 22 members of staff including medical staff, trainee doctors, different grades of nurses, allied health professionals, healthcare assistants and support staff. We also spoke with patients and their visiting relatives and friends. We checked the clinical environment, observed ward rounds, nursing and medical staff handovers and assessed patients' healthcare records. We reviewed the trust's performance data.

Summary of findings

We rated critical care services as good overall. We rated critical care services good for safety, effective, caring and well-led and requires improvement for responsive.

We found:

- We found an active patient safety incident reporting culture and evidence of learning from incidents.
- There were low infection rates and good adherence to infection prevention and control policies and use of handwashing and personal protective equipment.
- Patients' pain was regularly assessed and pain relief was provided.
- Staff acted in accordance with the Mental Capacity Act 2005 when treating patients on the ICU and requested Deprivation of Liberty Safeguards authorisations when necessary.
- Patients were treated with dignity, respect and kindness during interactions with staff.
- Staff responded compassionately when patients needed support and helped them to meet their personal needs.
- During the inspection, patient's privacy and confidentiality was respected at all times.
- The unit worked hard to meet individual patients' needs and accommodate preferences.
- The staff accessed use of translation services appropriately during our inspection.
- The service had a low formal complaint rate.
- Members of the multidisciplinary team worked well together on the unit.

Critical care

- The overall mandatory training compliance met the trust target (90%).
- 60% of trained nursing staff on the intensive care unit (ICU) held a post registration award in critical care nursing, which met Guidelines for the Provision of Intensive Care Services (GPICS) 2015.
- The ICU was performing as, or better than expected (compared to other similar services) in seven out of eight indicators used in the Intensive Care National Audit and Research Centre (ICNARC) 2015/16 report.
- There was an improvement in the minutes of mortality and morbidity meetings, with ongoing actions to improve care.
- We found evidence that staff regularly discussed new guidance and presented patients clinical cases in meetings, which resulted in recommendations and changes in practice.
- The unit engaged in the hospital bed capacity meetings.
- Leadership of the unit was in line with GPICS 2015.
- The unit had a risk register which contained relevant risks. There was evidence of frequent discussions and reviews of the risks and leaders were all aware of them.
- There were regular meetings including at unit and clinical leader level. The minutes of these demonstrated that quality, risks, incidents, mortality and morbidity were discussed and ongoing actions were monitored.
- The ICU team had been nominated by theatre staff to receive the trust's 'going the extra mile' award for their dedication and hard work.

However, we also found:

- The ICNARC 2015/16 report showed that the unit was performing worse than expected for transferring patients out of hours to a ward and this had increased from the previous year.
- There was no follow-up clinic for ICU patients following discharge home from hospital, which was recommended in National Institute for Health and Care Excellence (NICE) guidance and GPICS 2015.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches each month. There were 27 instances of mixed sex occupancy reported from January to June 2016.
- There had been 22 cancellations of on the day of surgery due to lack of ICU beds in 2015/16, which was significantly worse than the previous year.
- In the six months ending April 2016, there were 14 critical care patients who were ventilated outside the unit and eight patients transferred to another hospital for non-clinical reasons (in the three months ending April 2016) due to bed pressures.
- NHS Safety Thermometer data was not on display and staff were unaware of the results.
- Antibiotic stewardship audits showed that improvements were required in documenting when an antibiotic prescription required review.
- We found there were many local policies and guidance that were beyond review date.
- There was not always a consultant anaesthetist that specialised in intensive care covering the ICU because the on call rota was shared between critical care and anaesthetics.
- The ICU nursing staff appraisal rate was 76% and did not meet the trust target of 90%. However, this was an improvement from the September 2015 inspection when 50% of staff had an annual review.
- There was unclear understanding of a vision and strategy for critical care services.

Critical care

Are critical care services safe?

Good

We rated critical care services good for being safe because:

- We found an active patient safety incident reporting culture and evidence of learning from incidents.
- There were low infection rates and good adherence to infection prevention and control policies and use of handwashing and personal protective equipment.
- The overall mandatory training compliance met the trust target (90%).
- There was an improvement in the minutes of mortality and morbidity meetings, with ongoing actions to improve care.

However, we also found:

- NHS Safety Thermometer data was not on display and staff were unaware of the results.
- There was not always a consultant anaesthetist that specialised in intensive care covering the intensive care unit (ICU) because the on call rota was split between critical care and anaesthetics. However, there was an improvement in the level of resident medical cover for the ICU. The resident was allocated to cover critical care and did not have to cover maternity and theatres departments.
- Antibiotic stewardship audits showed that improvements were required in documenting when an antibiotic prescription required review.

Incidents

- During the September 2015 inspection, we were not assured that all incidents were reported because the nurse in charge of the unit usually reported them and not all staff had reported an incident. ICU had reported 61 incidents in the four month period ending June 2015. During this inspection, we found that there had been an increase in the number of incidents reported by ICU, with 92 incidents reported in the same length of time (December 2015 to March 2016). Staff told us that there had been a change in culture since the September 2015 inspection, with more junior staff encouraged to report incidents and concerns. This meant that safety concerns were more consistently reported.
- Of the 92 incidents reported by ICU staff from December 2015 to March 2016, 75 of these were classed as causing no harm, 10 minimal or low harm and seven moderate or short-term harm. Six of the moderate harm incidents were about lack of available ICU beds resulting in patients being transferred to other hospitals to access level three care. The remaining moderate harm incident, related to acquired pressure damage.
- During the September 2015 inspection, we found there had been 10 reports of acquired pressure damage of varying severity to patients' skin in the three months ending in June 2015. We found during this inspection, that the incidence of acquired pressure damage had reduced, with three incidents reported in four months ending March 2016. We observed that patients' pressure ulcer prevention was discussed during handovers, including between the nurses in charge and there was generally an increased awareness. When patients had been transferred to ICU with already established pressure damage, staff had reported this and plans of care developed accordingly.
- The trust used an electronic incident reporting system to record incidents. Staff told us that anyone could report incidents. Staff were able to discuss incidents that they had reported and gave examples of how they had received feedback. Staff were also able to describe actions taken to learn from incidents. For example, an invasive line had been found to be cracked. Staff reported the defect as a clinical incident and all the unit stock was checked, then the supply company was contacted to inform them of this occurrence.
- A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. There had been no never events reported for this service. From May 2015 to May 2016 there had been one serious incident reported which related to delays encountered when a patient required transfer to another provider for specialised care. An investigation into the incident was ongoing during the inspection.
- Most staff felt they received feedback from incidents. In the minutes of ICU meetings, we saw they included discussions about incidents that had happened. There was also an information board on the staff corridor displaying the previous month's incidents, which had been reported by the ICU staff.

- The trust were using a new system to inform staff throughout the hospital, about key safety actions taken following serious incidents. We saw that a document called 'safety bites' was shared with the ICU team during the inspection. This had been issued for immediate actions to be taken within two days of a serious incident being reported.
- The unit held regular meetings to review mortality and morbidity. We reviewed the minutes of the quality improvement meetings held in January and February 2016. There was a noticeable improvement in the quality of the minutes recorded for these meeting since the September 2015 inspection, which included updates from previous meetings and evidence of following up outstanding actions to improve care. Information was shared across directorates, as the meetings included joint mortality and morbidity sessions with the surgical and orthopaedic teams.
- Duty of candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we spoke with were generally aware of the regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them.
- During the inspection, the clinical lead for critical care had a conversation with relatives to begin the duty of candour process. They explained that the patient or relatives would be offered a copy of the completed investigation report and would receive a letter explaining the findings. The trust told us that written explanation to meet the duty of candour requirement was sent following a moderate incident reported by ICU in February 2016. However, evidence of this was requested, but not provided by the trust.

Safety thermometer

- The NHS Safety Thermometer was a tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas for example, new pressure ulcers, catheter related urinary tract infections, and patient falls.
- The ICU had two pressure ulcers and a catheter related urinary tract infection reported to the NHS Safety Thermometer from October 2015 to March 2016. However, staff were unable to describe the results of the safety thermometer and they were not seen on display on the ICU.

Cleanliness, infection control and hygiene

- The environment and the majority of equipment in the ICU was visibly clean and tidy. We found that a machine used to analyse blood samples on the unit was contaminated at the point where the sample was introduced. This was raised with staff in the unit and the microbiology department was contacted. Later that day a member of the team from microbiology attended the unit to demonstrate to staff how to clean the equipment in the future.
- We found that items had been labelled to indicate when they were last cleaned. There was a central cleaning and checking log for ICU that was used by housekeeping staff, healthcare support workers and other members of the nursing team, to sign when items were cleaned and checked. This was consistently completed.
- Hand washing facilities and alcohol based hand rubs were readily available for patients, staff and visitors in all areas of the unit and were used consistently. This met the requirements of the World Health Organisation (WHO) guidelines for hand washing, Health Building Note 00-09 Infection control in the built environment, and the Department of Health code of practice on the prevention and control of infections (the Code).
- We saw staff complied with the WHO Five Moments of Hand Hygiene and the trust's infection prevention and control policies. This included being 'bare below the elbow', hand washing before and after every episode of direct contact or care, and correct use of protective personal equipment such as disposable gloves and aprons. We saw that nurses wore eye protection masks when undertaking certain procedures at the patient's bedside.
- ICU local audit results showed 100% compliance with hand hygiene standards from April 2015 to February 2016.
- The unit took part in ongoing 'saving lives' audits including infection prevention and control related to insertion and ongoing care of vascular devices (lines inserted peripherally or centrally to enable administration of intravenous medicines and fluids),

decontamination of equipment, and the care of the ventilated patient. The results showed that the unit complied with best practice (April 2015 to February 2016).

- We saw that toileting aids and the commode had been checked monthly for cleanliness and had 100% compliance with this (April 2015 to February 2016).
- Disposable equipment was in sealed bags and placed in drawers or cupboards possible to prevent damage to packaging. Equipment in store cupboards was on racks to enable the floor area beneath to be cleaned.
- During our September 2015 inspection, we had found the positioning of certain items of equipment was inappropriate. We found that oxygen cylinders for emergency patient evacuation remained stored in the dirty utility room during this inspection. The lead nurse for critical care explained that the infection control and prevention team had provided advice and plans were made to move the cylinders to the clean utility area. However, there had been problems encountered with available space so this had not been possible.
- The unit used disposable curtains between patient's bed spaces for privacy and dignity. They were all dated to indicate when they needed changing. Staff told us that this was every three months unless contaminated in the meantime.
- There were two single rooms available on the unit with special airflow to enable isolation for infection prevention and control or for the protection of immune-suppressed patients.
- Infection control training was part of the trust's mandatory training for staff. ICU had achieved 100% compliance with level one training and 89% with level two training at June 2016.
- The Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients) showed that critical care services had a low rate of patients with unit-acquired infections in their blood and this performance was in line with similar services.

Environment and equipment

- The unit was accessed via locked doors. There was a keypad and swipe access for staff to enter the doors. Visitors to the unit used a buzzer and telecom system and the staff could open the doors remotely. However, CCTV was not installed at the entrance. This meant there was a risk that staff would not know who was accessing the unit. During the inspection, we observed that staff were careful to meet visitors in the lobby of the unit prior to them accessing the patient area.
- We found that most of the equipment appeared to be well maintained and portable appliance tested. However, two items of equipment in the storeroom were beyond their service dates. This was brought to the attention of the lead nurse for critical care who ensured that the items were sent for checking. They explained that they had a system to highlight those items that needed checking and there had been many items that required checking all at the same time. Following the inspection the trust provided details of all the units' equipment, which showed that items were correctly maintained. Storage areas were tidy and kept free of clutter.
- The ICU had appropriate equipment for use in an emergency. There were resuscitation drugs and equipment including a defibrillator and a difficult airway trolley. Resuscitation equipment was checked daily with completed records in place. A new checking form had been used which showed when items had been replaced. The resuscitation trolley containing the emergency equipment had closed drawers but it was not secured to prevent theft or indicate tampering with the contained drugs or other equipment between checks.
- Documented evidence of a local Cleanliness, Environment, Maintenance Assurance Tool (CEMAT) used monthly was seen. The results for March and April 2016 were 98% (met pass rate). However, May 2016 the score was 95%. Staff were able to describe actions required following an audit failure and how progress was monitored.
- The main theatre complex was located close to ICU for accessing emergency support. The emergency department was also located nearby, as recommended in Department of Health 2013 guidelines for critical care facilities (Health Building Note 04-02).
- The bed spaces were of a suitable size for giving up to five staff enough space to work safely with a patient in an emergency. The equipment around the bed space was located on ceiling-mounted pendants for optimal safety. There were sufficient oxygen, four-bar air, and vacuum outlets (as recommended in Department of Health 2013 guidelines for critical care facilities, Health Building Note 04-02).

- There was adequate mobile equipment available including haemofiltration machines, an electrocardiography machine, defibrillator, non-invasive respiratory equipment and portable ventilators. There were two side rooms available with adjustable air pressures that could be used to isolate patients for infection control and prevention reasons.
- There had been investment in equipment replacement since the September 2015 inspection, including bedside patient monitors and ventilators.
- We found a hand-washing sink had a seal that had failed and needed attention. This was discussed with critical care staff who showed us that this had been recognised and reported the week before the inspection, to the estates and facilities department. The housekeeper then followed the request up.

Medicines

- Medicines were stored in locked cupboards in an unlocked clinical area adjacent to the main four-bedded area of the unit, which was continually staffed. Some intravenous fluids were also stored in this area on open shelving. This has been the subject of a standard operating procedure, which was kept in the clinical room for reference. This meant there remained a small risk that intravenous fluids could be tampered with.
- We checked the medicines fridge temperature checklists, which were signed to show the temperature had been checked each day as required. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported.
- The medicines fridge was unlocked in an unlocked clinical area adjacent to the main four-bedded area of the unit. There was a risk assessment for reference confirming that the medicines fridge was to remain unlocked to enable immediate access to emergency drugs. However, this meant that there was a risk of theft and tampering with medicines in the fridge.
- We saw controlled drugs (CDs) were managed in line with legislation and NHS regulations. The CDs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. Stocks were accurate against the records in all those we checked at random. However, we found items that were not CDs stored in the cupboard. This increased the risk of unnecessary access to the CD cupboard. We brought this to the attention of staff during the inspection who removed the items.
- Local audits showed that documenting aspects of CD handling required improvement. For example, when a page in the CD register was complete, the transfer of the CDs to a new page had not been documented. We saw evidence in minutes of unit meetings that reminders had been shared with staff. We checked the CD register during the inspection and it had been completed correctly.
- There was an assessment completed exploring the risks of all the medicines cupboard keys being held together, including the CD keys. A copy of the assessment was available in the clinical area for reference.
- There was not a dedicated senior critical care pharmacist for ICU, which did not meet the GPICS 2015. This had been recognised and was captured on the units risk register. A senior job role had been created and the trust had attempted to recruit to the post but with no success so far. In the meantime, cover was provided by a senior pharmacist and pharmacy assistant topped up the medicines Monday to Friday.
- Medicine incidents were reported on the trust's electronic recording system. Staff were able to discuss medicine incidents and learning was shared with trust staff in a monthly newsletter.
- The ICU had a specific prescription chart for patients receiving critical care. However, we found that this was not used for all of the patients present on the unit during the inspection. The nurse in charge explained the only difference between the charts was an area to prescribe the infusions that critically ill patients often required. Therefore, if a patient required these infusions, a critical care prescription chart would be used instead.
- We reviewed all five patient's prescription charts. We found that all the charts included the patient's allergy status, were written legibly and all medicines that were not administered had a documented reason. We also found that all of the prescriptions were signed. However, two items were not dated.
- We observed the nurse check a patient's wristband against details on the prescription chart, to ensure the medicine was administered to the correct patient.
- The trust provided local audit scores indicating the unit's compliance with the antibiotic policy. Two audits took place twice in the six months ending March 2016

and showed poor compliance (41% and 61%). The latest audit result for June 2016 showed an overall improvement with 70% compliance. There were aspects of the audit that the unit had 100% compliance with for example, allergy recording and following guidelines or microbiologist advice. The main area for improvement (20%) was documenting the duration that the antibiotic should be given for and including a review date. Staff told us there was no action plan in place following the audit.

Records

- The patient's healthcare records were stored securely in paper-based files in drawers at the bedside, which helped with maintaining confidentiality. The documentation was noted to be contemporaneous, maintained logically and filed appropriately. Entries were signed and dated, however the time was not always included. We looked at healthcare records and found that out of 15 entries made by medical staff they were all dated, 14 entries were signed and 12 included the time of the documentation. The author did not always print their name as stated in generic medical record keeping standards (2015). This meant it might have been difficult to identify the clinician who had reviewed the patient.
- The ICU observation charts included the patient's vital signs, incorporated fluid balance and fluid prescription charts, position changes for patient, notes for goals and records of specimens sent. All five ICU charts we reviewed were completed as required and timed, dated, legible and clear. The ICU charts also incorporated a checklist to be signed each shift to indicate for example, that the emergency equipment was present in the bed space.
- Overall, the nursing documents were well completed. We saw completed entries for example, malnutrition screening, falls risk, stool assessment and patient manual handling assessments. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided. However, we found that there was some duplication related to risk assessments and patients' individual care plans. This may have caused some confusion for clinicians.
- We found that there was documentation in the patient record of the time and decision to admit to intensive care. This was supported by referral to ICU audit forms, which we saw completed during the inspection. This met National Institute for Health and Care Excellence (NICE) guidance CG50: acutely ill adults in hospital: recognition and response to acute illness in adults in hospital.

Safeguarding

- We spoke with a range of doctors and nurses about safeguarding. We found staff varied in their ability to describe their responsibilities to report abuse and how to make a safeguarding referral. However, we found lots of evidence in patients' healthcare records that timely and appropriate referrals had been made to the adult safeguarding team.
- Safeguarding training was mandatory and covered vulnerable adults and children. Mandatory training figures supplied by the trust for June 2016 showed 96% compliance with adult safeguarding training level one (trust target met). However, ICU staff had not met the trusts target for safeguarding children training with 67% compliance with level one training and 85% compliance with level two training. This meant that not all staff had completed the relevant training for safeguarding children.
- We observed that adult safeguarding issues and referrals were discussed in the handover to the oncoming nursing team and during separate medical staff handovers.

Mandatory training

- There were arrangements in place for staff to complete mandatory training. We saw that mandatory training covered a range of topics and was provided either face to face or through on-line learning. These included; dementia awareness, fire safety, health and safety, infection control and moving and handling.
- Unit staff had met the trust target in the following training:
  - Dementia awareness (91%)
  - Fire safety (91%)
  - Infection control level one (100%)
  - Moving and handling (not people) (100%)
  - Safeguarding adults level one (100%).
- However, the target had not been achieved for the following:
  - Equality, diversity and human rights (87%)
  - Infection control level two (89%)
  - Information governance (87%)
  - Moving and handling (people) (89%)

  - Safeguarding children level one (67%)
  - Safeguarding children level two (85%).
- The average mandatory completion rate was 90% (June 2016). This had improved since the September 2015 inspection, when the overall mandatory compliance rate was 78%.

Assessing and responding to patient risk

- There was a standardised approach for detection of the deteriorating patient. The National Early Warning Score (NEWS), a tool designed to standardise the assessment of acute-illness severity in the NHS was used. If a ward-based patient triggered a high risk score from one of a combination of indicators, a review of the patient by the critical care outreach team (CCOT) would be required. This team had been established to support all aspects of the adult critically ill patient, including early identification of patient deterioration. The CCOT and the patient's medical team were able to refer the patient directly to the ICU consultants for support, advice and review.
- The CCOT consisted of one fulltime experienced critical care nurse and other senior nurses that rotated out from the ICU to work shifts in outreach. They provided cover for the hospital 12 hours a day, seven days a week. However, the CCOT did not provide 24-hour cover for the hospital as recommended in the GPICS 2015. This could increase the risk of staff caring for deteriorating patients not receiving timely access to critical care support and advice overnight. This was not documented on the unit's risk register. However, the ICU planned to have two senior (band six) nurses on duty each night to enable support to be provided to the wards in the absence of a 24 hour CCOT service. Evidence was provided showing that for the three month period ending June 2016, this was achieved on 79% of the night shifts.
- CCOT had undertaken a survey to evaluate the service they provided to the hospital. There were many positive comments about the support the CCOT staff gave to ward staff when caring for critically ill patients. Ward staff also commended the teaching that the CCOT provided regarding key aspects of acute care. However, ward staff stated in the response to the survey, that they wished CCOT was available 24 hours a day.
- CCOT supported patients that had non-invasive ventilation, tracheostomies and central venous access devices, throughout the hospital.
- The CCOT undertook regular audits to assess the compliance with use of the NEWS chart and the escalation when patients triggered. The report for October 2015 showed an increase in nursing documentation of escalation to medical teams in response to an amber NEWS trigger from 30% to 45% and in response to a red NEWS trigger had fell marginally from 68% to 63%. This meant that there was a risk that not all patients that were deteriorating received the supportive care they required. The audit results were shared at the director of nursing forum, the physicians meeting, general surgery and trauma and orthopaedic meetings. We saw that in the minutes of the NEWS and sepsis implementation group meeting in April 2016 that the trust's communication team and staff briefing were used to raise awareness regarding NEWS and improve compliance. There were no incidents reported by ICU related to delays in referring deteriorating patients for advice or admission (December 2015 to March 2016).
- The CCOT and lead senior nurse from ICU delivered a monthly study day called 'acute illness management' (AIM). This internally delivered training for trust staff aimed to ensure that ward staff could assess the risk of patients deteriorating. It incorporated competencies, which were assessed during the day. NEWS escalation and audit results were also shared during AIM study days.
- The ICU provided critical care for adult patients. However, children were admitted in emergency situations. The unit admitted three children patients in the 12 months ending March 2016. They were stabilised and retrieved by a specialist paediatric team and transferred to specialist paediatric care. 10 senior nursing staff had completed the paediatric immediate life support (PILS) training and the remaining six staff were booked to complete the courses in July and October 2016. There were no paediatric trained nurses based on ICU but they could access advice from children's ward nurses on site. The clinical lead consultant explained that in these rare occasions the paediatric consultants would remain directly involved and responsible for the patients care.
- The ICU was performing as expected (compared to other similar services) regarding high risk sepsis admissions in

the ICNARC report (2015/16). This included patients admitted from a ward, intermediate care or obstetric area of the same hospital with sepsis during the first 24 hours following admission to ICU.

Nursing staffing

- The GPICS 2015 were used to establish staffing requirements and staff ratios. A nurse to patient ratio of one to one was provided for a level three patient and a ratio of one nurse to two patients requiring level two care.
- We observed that actual staffing levels consistently met planned staffing levels. Throughout the inspection, the actual nursing staffing also met the levels of care required for the patients being cared for on the unit.
- We checked nursing staffing rotas for previous months at random and compared this to the level of care required by patients that were present on the unit at the time. All shifts had the appropriate levels of staff. Information about how actual nursing staffing levels met planned levels was provided and this showed from December 2015 to March 2016, the average fill rates for trained nurses were 93% to 104%.
- We observed that the ICU used a flexible approach to staffing and adjusted nursing staffing on a shift by shift basis to meet patient acuity.
- An experienced supernumerary nurse (who was not allocated a patient to care for) was allocated as the nurse in charge of each shift, which met Core Standards for Intensive Care Units (2015). The nurse in charge handed over to the oncoming nurse in charge and this included checking staffing levels for coming shifts. They also wore a 'nurse in charge' badge to enable easy identification for visitors to the unit.
- The nursing whole time equivalent (WTE) establishment was 41.2 with 39.3 WTE actually in post (March 2016). The staffing vacancy was 5%, which was the same as the September 2015 inspection and in line with the trust target.
- We checked a folder containing details of temporary staffing (agency and bank) used by the unit. During the six week period ending 3 July 2016, seven temporary staff had been used. Five of these staff had been new to the unit and required an orientation induction to familiarise them with working on the unit. All five temporary staff had forms completed to evidence that orientation was provided. The trusts orientation checklist included, emergency procedures, the NEWS system and how to escalate, infection control procedures, assessments for patient's skin and falls risk.
- There was a set escalation process for staff to follow if they were short staffed. This included checking rotas for shift swaps and when all other avenues had been explored, specialised agency staff for critical care staff could be requested (following authorisation by a divisional level nurse manager).
- The ICU also employed a housekeeper and health care assistants each shift to support the unit.
- There was good handover among nurses. The nurse in charge handed the patients over to the oncoming team and this was structured to include updates regarding communication, hygiene, malnutrition, fluid balance, pain, elimination, sleep or ability to rest, and potential risk of harm to individual patients. It was followed by brief key messages to the team. The handover was attended by all the oncoming nursing team including the band eight nurse for the ICU and the CCOT nurse. Then nurses had a more detailed handover at the bedside for the patient they had been allocated to care for. This was structured by use of the ICU observation chart and the patient's healthcare file.

Medical staffing

- The level of cover provided by medical staffing on the ICU did not meet all recommendations in GPICS 2015. Areas in which this was met were:
  - There was a good consultant to patient ratio because there was one consultant on duty or on call for a maximum of six beds. This was significantly better than the GPICS recommended ratio of one consultant for a maximum of 15 beds.
  - Consultants provided a good level of continuity. A consultant would usually cover the unit for a week at a time (Monday to Friday).
  - There was a designated clinical lead consultant for ICU.
  - On weekdays, there was a specialist registrar doctor on duty. This met the recommendations of GPICS for there to be a trainee doctor for no more than eight patients.
  - There was a resident senior trainee doctor immediately available 24 hours a day, seven days a week (with advanced airway skills) for ICU. This resident was responsible for critical care cover with

no other areas of responsibility. This was an improvement from the September 2015 inspection, when they also provided cover for maternity, the emergency department and sometimes assisted to cover theatres.
    - The use of temporary staff was low. The trust provided locum temporary medical staffing figures for anaesthetics (which included ICU), which showed that for the three months ending June 2016 there were on average three WTE locums per month.
- Areas which did not meet professional GPICS 2015 were:
    - There was not always a consultant anaesthetist that specialised in intensive care covering the ICU. This was because the on call rota was split between critical care and anaesthetics. Four out of 13 consultants on the on call rota were registered with the faculty of intensive care. The faculty of intensive care medicine was the professional body responsible for the training, assessment, practice and continuing professional development of intensive care medicine consultants in the UK. The trust told us Monday to Friday, 8am to 6pm there was an intensive care medicine consultant immediately available for the ICU. 45% of the on call consultant cover had intensive care medicine intermediate level and above competencies and had regular ICU sessions in their job plan. A new intensive care medicine consultant had been recruited into the current vacancy for the unit. Medical staffing issues for anaesthetics and critical care were documented on the directorates risk register.
    - Staff told us and we saw evidence in patients' health records that ward rounds took place twice daily in the morning and evening each day including at the weekend. However, the evening review was carried out by a senior doctor covering ICU. This did not meet GPICS, which stated that consultants must undertake at least twice daily ward rounds including weekends and bank holidays.
    - When consultant intensivists were on call, this was for critical care, obstetrics and general cover for the hospital. The GPICS stated that a consultant in intensive care medicine must be immediately available 24 hours a day, seven days a week for ICU. Staff from a variety of disciplines told us the consultant was easily contacted.

Major incident awareness and training

- The trust had a major incident plan (overdue for review in October 2014) that covered critical care. The plan carried action cards that gave written instructions for key staff who would be involved in the organisation and management of a major incident. This included action plans for preparing extra ICU beds and informing the consultant anaesthetists. A business continuity plan was not available as this was being developed by the trust. As plans were mostly requiring updates or in development they may not adequately support or inform staff in the event of a major incident. This had not been addressed since the September 2015 inspection.
- The trust provided fire safety as part of mandatory training. The staff on the unit were 91% compliant with attending this training at June 2016. This was an improvement from the September 2015 inspection when compliance did not meet the trust target.
- The trust's orientation checklist for temporary staff included the fire procedure and exits and how to make emergency calls.

Are critical care services effective?

Good

We rated critical care services good for effective because:

- The ICU was performing as, or better than expected (compared to other similar services) in seven out of eight indicators used in the ICNARC report (2015/16).
- Patients' pain was regularly assessed and pain relief was provided.
- Members of the multidisciplinary team worked well together on the unit.
- 60% of trained nursing staff on the ICU held a post registration award in critical care nursing, which met Guidelines for the Provision of Intensive Care Services (GPICS) 2015.
- We found evidence that staff regularly discussed new guidance and presented patients clinical cases in meetings, which resulted in recommendations and changes in practice.
- Staff acted in accordance with the Mental Capacity Act 2005 when treating patients on the ICU and requested Deprivation of Liberty Safeguards authorisations when necessary.

However, we also found:

- The ICU nursing staff appraisal rate was 76% and did not meet the trust target of 90%. However, this was an improvement from the September 2015 inspection when 50% of staff had an annual review.
- We found there were local policies and guidance that were beyond review date.

Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered mostly along national and best-practice guidelines. For example, National Institute for Health and Care Excellence (NICE) 83: Rehabilitation after a critical illness, and NICE 50: Acutely ill patients in hospital. Most elements of NICE 50 and 83 were met.
- There was an element, however, of NICE 83 that was not met in relation to rehabilitation post discharge from the unit or hospital. This was in the area of providing patients with a structured and supported self-directed rehabilitation manual for use for at least six weeks after discharge from critical care (recommendation 1.1.18). There was no follow-up clinic for patients to determine if they needed further input after two to three months (recommendation 1.1.25). These had not been escalated to the risk register. However, we found evidence of daily physiotherapy assessments with rehabilitation plans and goals set. The Chelsea critical care physical assessment tool was also used on the unit to evaluate a patient's progress. Patients who required level two or three care for greater than 48 hours had an intensive care long stay multidisciplinary rehabilitation assessment and plan commenced. This also incorporated treatment plans that continued following discharge from the unit. No audits had been undertaken within the last 12 months to check compliance with NICE guidelines.
- A tool was used daily to support consultant-led ward rounds. This was called FASTHUGFIDDLE with each letter prompting a review of a certain aspect of care to be checked for completion. For example, the first F stood for 'feeding'; the A for 'analgesia'; the U for 'ulcer prophylaxis'; D for 'drug review'; and the L for 'line review'. We saw evidence that these were completed each day and documented in the healthcare records.
- The ICU followed NHS guidance when monitoring sedated patients, by using the Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of the patient for different responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). Any scores below the baseline of zero (or below the score desired by the prescribing doctor) would indicate the need for a discontinuation of the sedation infusion (termed a 'sedation hold') to monitor the patient's response.
- Patients were assessed for risks of venous thromboembolism (VTE). Four out of the five patients present on the unit at the time of our inspection had a documented VTE risk assessment in their healthcare records. The patient without a VTE assessment was highlighted to senior ICU staff. Appropriate clinical care was in place with the patient receiving continuous anticoagulant infusions, which were adjusted according to frequent blood test results. However, following our inspection the trust provided a copy of the patient's VTE form, which had been completed on admission to hospital, prior to transfer to the ICU. They also provided a copy of the current reassessed VTE risk assessment.
- Patients were provided with preventative VTE care including compression stockings and sequential compressions devices in line with NICE 83 statement 5.
- The ICU met best practice guidance by promoting and participating in a programme of organ donation, led nationally by another NHS provider. As is best practice, the ICU led on organ-donation work for the trust. There was a specialist nurse for organ donation who was employed by another NHS provider and was based at the hospital, to directly support the organ donation programme and work alongside the clinical lead. The specialist nurse also supported a regional and community programme for promoting organ donation, which was supported by the trust organ donation committee. The specialist nurse submitted data to the national audit regarding potential organ donors.
- The ICU team were meeting GPICS 2015, relating to engaging, and participating in a critical care operational delivery network. They belonged to the Birmingham and Black Country network and we saw minutes from a tri network clinical forum meeting (February 2016), which two senior nurses attended.
- Many of the local polices for the unit were beyond their review dates. This included management of pain, agitation and delirium, haemodialysis and ten separate guides for medicines used in critical care. This was discussed with senior ICU staff during the inspection.

They explained, with the recent change in clinical lead there was a backlog of guidance and policies that required review. However, this meant that in the meantime there was a risk that staff were not following the most up to date practice.

- We checked minutes of meetings held by unit staff in the month's prior to the inspection and found discussions of new guidance, patient case presentations that resulted in changes in practice and recommendations. For example, the ventilation strategy per weight.
- The May 2016 quality improvement unit meeting minutes, showed that new Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Adult Critically Ill Patient (2016) were discussed.
- The trust provided a list of active local and national audits for critical care. This included;
  - Potential organ donor audit.
  - Intensive Care National Audit and Research Centre (ICNARC).
  - Intravenous fluid therapy in adults in hospital.
  - Sedation scoring in ICU.
  - This was an improvement from the September 2015 inspection when there were no local audits taking place.

Pain relief

- Patients' pain was regularly assessed, and appropriate pain relief was prescribed and administered.
- A sedation level audit carried out in 2015/16 by a medical trainee also checked the frequency of patients' pain assessment. They found that out of 10 level three patients, seven were found to have had pain assessments documented each day. This was noted for an area for improvement and staff told us that another audit was due to take place.
- The ICU had access to the trusts acute pain management specialists if required for patients with complex issues.

Nutrition and hydration

- Fluid intake and output was measured hourly and fluid balance was calculated and recorded on the ICU observation chart. The method of nutritional intake was also recorded and evaluated each day.
- We saw in healthcare records that the Malnutrition Universal Screening Tool (MUST) was used to assess a patient's risk of malnutrition.
- A dietitian attended the ICU every weekday to support ICU patients with individualised nutrition plans. There were approved protocols for nursing staff to commence enteral feeding on ICU. The unit could also access advice and support from speech and language therapists as required, Monday to Friday.
- Food to meet specialist dietary requirements were available on request including gluten free, low allergen and altered textured meals.

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participated in ICNARC, the national clinical audit for adult critical care. Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. Mortality indicators were integral to the ICNARC audit.
- The ICU was performing as expected (compared to other similar services) in most indicators used in the ICNARC report (2015/16) and these areas were:
  - High risk sepsis admissions (to ICU with sepsis during the first 24 hours following admission from a ward, intermediate care or obstetric area in the same hospital).
  - Bed days of care post eight hour delay.
  - Unit acquired infection in the blood.
  - Non clinical transfers (out).
  - Unplanned readmissions within 48 hours.
  - Risk adjusted acute hospital mortality.
  - Risk adjusted acute hospital mortality with predicted risk <20%.
- However, the ICU was performing worse than expected (compared to other similar services) for the indicator about patients' out of hours discharges to ward (not delayed). This issue was documented on the unit's risk register.
- There was an audit clerk who input data for ICNARC as part of their role. ICNARC reports were discussed at mortality and morbidity meetings and ICU staff meetings.

Competent staff

- Staff were required to be assessed each year for their competency, skills and development. Nursing staff told us that they had an appraisal and could describe key objectives for development that had been set. Senior nurses told us during the inspection that 83% of the

nursing staff had been given an annual review of their competence and performance. However, the figures that were provided by the trust for June 2016 showed 76% completion rate. This did not meet the trusts target rate of 90%. However, this was an improvement since our September 2015 inspection when we found that 50% of staff had completed an appraisal.

- Medical appraisal rates were 100% and revalidations were completed with no non-engagement notifications.
- One of the senior critical care nurses role focused on professional development and staff competencies on the unit. This met GPICS 2015, which stated that each unit should have a dedicated clinical nurse educator responsible for coordinating the education, training framework for nursing staff and pre-registration student allocation.
- Two trained nursing staff each year, could access a post registration award course in critical care, provided by University of Wolverhampton. Post registration award should be held by at least 50% of trained staff on a critical care unit according to GPICS 2015. There were 60% (29 out of 48 staff) of trained nursing staff on the ICU with a post registration award in critical care nursing, which met this standard.
- The national competency framework for adult intensive care nurses, were used for trained nursing staff on the unit. The framework comprised three levels to build skills, knowledge and confidence, in becoming competent critical care nurses and had been developed for use alongside academic programmes of study. Completed competency files were seen during the inspection.
- The senior nurses (band six) working with critical care outreach team (CCOT) had completed competency booklets regarding outreach skills.
- New nursing staff joining the ICU team, had a period of time where they were supernumerary (extra to the clinical numbers) in line with GPICS 2015. Generally, it was between two and six weeks, although the length of time varied dependent on the individual's needs. We saw clear induction processes were described and supported by documentation and competencies, including a checklist that was completed in this period. There were also staff that were working on the unit from other areas in the hospital on secondments. During the inspection, we observed that a member of staff on secondment was supernumerary and well supported and supervised by an experience nurse. They also had a competency booklet to work through.
- A student nurse working on the unit explained how they had visited prior to starting the placement and had met one of their allocated mentors at this time. They had also been provided with an orientation booklet, with useful information about how the unit worked prior to starting their placement. They had felt well supported by all the staff on the unit.
- Nursing staff we spoke with said there was a positive attitude on the unit regarding training and development. They were encouraged to complete competencies in intensive care and there was often a lot of interest in completing the post registration award course in critical care. Regular in house teaching sessions were also available and well received.
- We saw that staff were provided with training to ensure they were familiar with the use of equipment.
- At the time of inspection, there was no senior pharmacist dedicated to the ICU. This had been identified and documented on the risk register. The trust was in the process of recruiting a full time ICU pharmacist.

Multidisciplinary working

- The ICU had input into patient care and treatment from the physiotherapists, dietitians, microbiologist (a consultant concerned with the detection, isolation and identification of microorganisms that cause infections) and other specialist consultants and doctors as required. Staff from a variety of disciplines felt that the unit had a good ethos of multidisciplinary team (MDT) working. However, not all of the members of the MDT attended the ward rounds on the unit. The nurse in charge would share plans and input from other disciplines.
- A physiotherapist was available on the unit twice daily (Monday to Friday). At weekends there was a physiotherapist covering ICU and wards via an on-call service out of hours. The physiotherapy team included a senior lead physiotherapist who specialised in critical care.

- We saw evidence that physiotherapists performed a short clinical assessment to determine the patient's risk of developing physical and non-physical morbidity following admission to ICU, in line with NICE guidance CG83: rehabilitation after critical illness.
- There was an operational policy, which outlined patients who would and would not benefit from admission to the ICU. This was available on the trusts intranet and could be accessed by other teams.
- We observed the nurse in charge of the unit handing over to two physiotherapists on the unit. The discussion about patients who required treatment was noted to be collaborative. We also saw physiotherapists working well with the MDT on the ICU.
- The unit could access advice and support from occupational therapists and speech and language therapists as required.
- We found evidence of frequent dietitian reviews in all patients' healthcare records on ICU.
- We saw in the patients' healthcare records that on admission to ICU, patients had a treatment plan, which was discussed with the consultant. However, this may not have been a consultant in intensive care medicine out of hours, as the on call cover rota was shared with the anaesthetics team.
- The CCOT reviewed patients who were discharged from ICU. The CCOT would liaise between critical care and other members of the MDT.
- Patients discharged from ICU, had a discharge summary completed by the medical staff and the nursing staff. The patients were also seen by a physiotherapist following discharge.
- The CCOT reviewed patients who were discharged from ICU within 24 hours. The CCOT would liaise between critical care and other members of the MDT.

Seven-day services

- Physiotherapists were available for ICU patients including at the weekends and overnight, via an on call system. Frequent physiotherapy reviews were seen documented in health care records; including reviews of patients at the weekend.
- A pharmacist was available Monday to Friday. This was not a not a dedicated service for ICU, and recruitment of a senior pharmacist was taking place at the time of inspection.
- The dietitian provision was again not a dedicated service for ICU, but available Monday to Friday.
- Speech and language therapists and occupational therapists were available on request Monday to Friday.
- Critical care services met most of NHS England's seven day services priority standards including;
  - We saw that patients present during the inspection, who had been emergency admissions to the unit, had been reviewed by a consultant within 14 hours.
  - Critical care had seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI) and reporting was available seven days a week.
- NHS England's seven day services priority clinical standards eight stated all patients on ICU must be seen and reviewed by a consultant twice daily. The consultant reviewed patients each day but a senior doctor covering ICU usually carried out the evening review. We saw evidence of consultant led ward rounds documented in patient healthcare records once a day. This also did not meet the GPICS 2015, which stated this should be a minimum of twice a day, 365 days a year. Medical and nursing staff maintained that consultants were available out of hours and were easy to reach and would come in if required. However, consultants did maximise continuity of care by working multiple day blocks.

Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their ICU stay. Healthcare records were paper based and available at the patient's bedside. Some information including results from patient tests and guidance was available via the trusts intranet.
- There was no electronic database for critical care. Paper based admission sheets were kept in a folder and required completion with key information, especially regarding admission and discharge.
- The trust intranet was open and available to all substantive staff. The staff had good levels of access to information. Critical care has its own generic email address for all ICU staff so that they can access emails, and had a trust email address.
- All patients discharged from ICU had discharge summaries completed by medical and nursing staff, to ensure information is available to ward teams.

Consent and Mental Capacity Act

Critical care

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the Mental Capacity Act 2005 (MCA) when treating an unconscious patient, or in an emergency. A review of consent forms in patient notes showed an appropriate member of the medical team had correctly completed them. When appropriate, a consent form had been completed, specifically for adults who were unable to consent to treatment, noting lack of capacity and best interest decision making.
- We found evidence of mental capacity assessments being carried out; appropriate paperwork had been completed and documented in healthcare records. Deprivation of Liberty Safeguards (DoLS) authorisation forms had been received back from local authorities and there was ongoing liaison documented between them and the trust's safeguarding lead.
- During the inspection, bedside nursing staff varied in their ability to describe the mental capacity assessment process. However, we observed appropriate decision-making had taken place and discussion of MCA and DoLS was included in the handover to the oncoming nursing staff.

Are critical care services caring?

Good

We rated critical care services good for caring because:

- Patients were treated with dignity, respect and kindness during interactions with staff.
- Staff responded compassionately when patients needed support and helped them to meet their personal needs.
- During the inspection, patient's privacy and confidentiality was respected at all times.

Compassionate care

- During our inspection, we were able to speak with a patient about the care they had received while on the unit. They described being treated as if they were a member of the family. They said that staff had been polite, caring and stated that the service provided was 'brilliant'.
- Relatives we spoke with during the inspection were happy with the care that was provided to their loved one.
- We observed nursing handover during the inspection and staff seemed genuinely proud and involved in the patients' progression and clinical improvement.
- There was a letter of compliment on display. This had been sent by a relative of a patient who had been cared for on the unit and was extremely complimentary of the care given by the doctors and nurses and thanked them for their kindness, which they said they would never forget.
- We observed patients being treated with dignity, kindness, compassion and respect. Bedside nursing staff would always introduce themselves and use appropriate tone of voice and explanation to reassure patients.
- The unit had a system to collect feedback from relatives and patients. There was a short survey that could be completed anonymously and placed in a collection box in the relative's waiting room. Patients that were able to complete forms were offered the opportunity to take part just prior to transfer from the unit. The box was checked each month and results were collated and shared with the team. There were six forms completed for June 2016. We checked these during the inspection. There were many positive comments including 'I don't think the care could be improved, it was first class' and 'the doctors and nurses were really nice and caring… (they) told me everything… I have been well cared for, thank you'.

Understanding and involvement of patients and those close to them

- Relatives we spoke with told us they had been involved in discussions about the patients care and treatment on the unit. They also said that they had been kept informed appropriately and that staff did not get annoyed when they asked questions about treatment and equipment being used at the patient's bedside.
- A patient that we spoke with told us that staff had explained everything to them in a way that they could understand.

Emotional support

- We saw that patients were assessed for anxiety and depression as part of the sedation, pain and agitation scoring and was documented on the intensive care unit (ICU) observation chart.

Critical care

- There was no onsite counselling or psychology service at the hospital. However, the trust informed us that they could refer patients to a clinical psychologist if needed.
- We observed a patient receiving a visit from a ward sister. The sister introduced themselves to the patient and explained they had come to say hello, in preparation prior to the transfer to the ward.
- Nurses, doctors, and a range of allied health professionals were actively involved in supporting peoples' emotional needs during the patient's stay.
- Emotional support was also provided by the critical care outreach team. They visited were able to reassure and support patients on the ward following discharge.
- Staff were aware of relevant support groups and services, such as the multi-faith chaplaincy service and follow up support for patients. The hospitals chaplaincy service was available to support the staff, patients and visitors on the ICU.

Are critical care services responsive?

Requires improvement

We rated critical care services as requires improvement for responsive because:

- The Intensive Care National Audit and Research Centre (ICNARC) 2015/16 report showed that the unit was performing worse than expected for transferring patients out of hours to a ward and this had increased from the previous year.
- There was no follow-up clinic for intensive care unit (ICU) patients following discharge home from hospital, which was recommended in National Institute for Health and Care Excellence (NICE) guidance and Guidelines for the Provision of Intensive Care Services (GPICS) 2015.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches each month. There were 27 instances of mixed sex occupancy reported from January to June 2016.
- There had been 22 cancellations of on the day of surgery due to lack of intensive care unit (ICU) beds in 2015/16, which was significantly worse than the previous year.
- In the six months ending April 2016, there were 14 critical care patients who were ventilated outside the unit and eight patients transferred to another hospital for non-clinical reasons (in the three months ending April 2016) due to bed pressures.

However, we also found:

- The unit engaged in the hospital bed capacity meetings.
- The unit worked hard to meet individual patients' needs and accommodate preferences.
- The staff accessed use of translation services appropriately during our inspection.
- The service had a low formal complaint rate.

Service planning and delivery to meet the needs of local people

- In the event of patients experiencing long term and complex weaning problems from ventilation or patients with long-term rehabilitation needs, the trust had identified other specialist providers to which referrals for transfer would be made.
- There were no patient facilities to shower or bath on the unit, and there were no patient toilet facilities. Patients awaiting a ward bed used commodes. Patients could be taken to a ward to access these facilities. However, this was not ideal especially in terms of privacy and dignity.
- Visiting times could be flexible to meet the needs of the patient and their loved ones. They were described as 'open'. From 2pm to 3pm, the patients had a rest period when visiting was not encouraged. The policy allowed up to two visitors per bed space.
- There was no follow-up clinic for patients that had been discharged home from after an ICU admission, which was recommended in NICE guidance. The lack of the clinic was not entered on the risk register.
- Relatives and visitors of patients being cared for on the ICU had access to two waiting rooms that had recently been decorated with comfortable large chairs. There were also facilities to make hot drinks available. We were told that there were up to four rooms available for relatives to stay overnight if required.
- We found that a shower that was in the relative's toilet facilities had been removed and the drain covered. This work had been identified as required at our September 2015 inspection and the work had since been completed.

Meeting people's individual needs

Critical care

- Every day a core care plan for patients was completed by nursing staff. These were individualised meet patient's needs.
- Patients on ICU who were able to eat and drink, were given choices every day regarding what they would like for their meals and assistance provided as necessary, to enable the food to be eaten.
- Meals were available to meet patient's cultural and religious needs.
- Specific requests related to patients wishes and individual needs were seen to be respected. For example, a patient had requested not to be cared for by members of the opposite sex. In addition, patient's preferences regarding who was allowed to visit were complied with.
- Each patient's bed space had a notice board that included orientating details including the date and the names of the nurse and consultant caring for them.
- For patients that were living with a learning disability, usual carers were actively encouraged to attend and take part in care to provide support and reassurance for the patient. This also ensured that they could work in partnership with the ICU staff as someone who was familiar with the individual's needs and routines. Staff were unable to tell us if there was any specialist nurse support available at the trust.
- Information leaflets about what to expect on intensive care for patients and relatives were available on the unit printed in English.
- Translation services were actively used by ICU staff as required. Staff were aware how to access this service and told us that there some translators available at the hospital.
- There was an electronic device available, which could be used to aid patients communication. There were also non-verbal cards and letter boards that could be used.
- We observed a patient having a 'dry shampoo' being carried out by one of the senior nursing staff. The patient seemed appreciative of this.
- Each bed space had a television mounted for patients to use. However, we were told that there was a problem with them currently and patients were unable to use them. This had been reported to estates.
- There was a link nurse on the unit for patients living with dementia who could provide advice and support. The nurse wore a dementia and dignity champion badge.

Access and flow

- The ICU had six beds, all of which were funded to provide level three or two care. The ICU had an operational policy that detailed admission criteria and access. The policy had recently been reviewed and updated. However, the policy still mentioned level two patients being cared for in a combined cardiac care/ interim high dependency unit, which we were informed, closed prior to our previous inspection in 2015.
- The ICU had 375 admissions in the 12 months ending March 2016. In that year, the ICU provided 659 days of level three care and 1139 days of level two care. 41 patients were cared for on the unit following elective (planned) surgical procedures and 334 emergency admissions. The critical care bed occupancy rates for the unit were mostly in line with the England average for the period March 2015 to February 2016.
- The unit did not always have enough capacity to admit those patients that required critical care services. This was highlighted by data showing that in the six months ending April 2016, there were 14 patients ventilated outside the unit (in areas including operating theatre recovery). This was an increase over the winter months, as in the six months ending October 2015 there were no patients ventilated outside of the unit. This meant that critically ill patients were not always able to access critical care beds in a timely manner. This was documented on the service's risk register.
- Senior ICU staff told us that during the recent ICU bed capacity issues, ICU staff had cared for patients in the recovery area in the theatre department. A policy had been developed to guide staff if this happened again. We saw a copy of the standard operating policy (SOP) was available on the unit. This was marked draft awaiting corporate approval. The SOP detailed how to arrange the use of theatre recovery for the temporary accommodation of patients requiring critical care. It included safety considerations, reporting requirements and infection control precautions. Critical care outreach team (CCOT) nurses were to be the first line staff to assist and care for the patient whilst in recovery until other staffing cover was arranged. This meant that the wards would be unable to access CCOT during this time for advice and support with the deteriorating patient.
- Five patients' healthcare records were checked and all had been admitted within four hours of the decision to admit time and had been reviewed by a consultant within 12 hours of that admission.

- The trust advised us that for the 12 month period ending March 2016, there were 22 occasions when patients had their surgery cancelled on the day, due to lack of bed availability on ICU. This was for patients who needed level two or three care post operatively. This was significantly more than the previous year, when six patients had their surgery cancelled on the day. The staff told us that the unit's practice was to limit elective booking for post-operative patients to one each day to try to minimise the number of cancellations. This risk was documented on the units risk register.
- The service had to transfer eight patients out of the unit to another hospital for non-clinical reasons in the three months ending April 2016. This was due to lack of available ICU beds for the number of critically ill patients. This was a worse performance from the previous inspection, when there had been no clinical transfers (April to September 2015). However, despite the increase, the ICNARC quality report 2015/16 showed that the unit performed as expected compared to similar units. This issue was documented on the units risk register.
- The ICNARC quarterly quality report for the year 2015/16 showed the percentage of bed days of care provided on the unit, for patients delayed more than eight hours after the reported time they were fully ready for discharge was 5.4%. This was better than similar units (7.3%) and in line with the average of all units (5.3%). The unit monitored the situation regarding delayed patient discharges. In the ICU business meeting in June 2016, staff looked at the data for May 2016 and calculated that out of 24 discharges from the unit, 21 patients experienced delays of more than four hours (86%). This issue was documented on the unit's risk register.
- There were patients that were transferred out overnight from the ICU and these occurrences were reported locally as incidents and to ICNARC. The GPICS 2015, stated that discharges should occur between 7am and 10pm. The ICNARC quarterly quality report 2015/16 indicator for out of hours discharges to ward (not delayed), showed that the unit was performing worse than expected and that there had been a noticeable increase from 2014/15. 8.2% of eligible admissions were transferred overnight compared to 2.6% of similar units. This was documented on the unit's risk register.
- A senior nurse told us, after a patient has been deemed ready for step down transfer to a ward yet remained on the unit for more than 24 hours, a mixed sex occupancy breach would be declared and reported electronically as an incident. This was supported by an information flowchart on display at the nurses' station on the unit. There were 27 instances of mixed sex occupancy reported by ICU from January to June 2016. This was due to delays in accessing ward beds within the hospital in a timely manner. The clinical site manager would be informed when a patient was ready to step down to ward care. This was documented on the unit's risk register.
- Despite issues experienced with the units bed capacity, the ICNARC report (2015/16) showed that the ICU was performing as better than expected (compared to other similar services) regarding unplanned readmissions within 48 hours. This suggested that patients were not discharged from ICU before they were clinically stable to transfer.
- Each morning the nurse in charge of the unit attended a 'huddle' meeting attended by the clinical site manage and members of the senior theatre and surgery teams. This meeting was to discuss capacity to admit patients for their elective surgery and facility step down transfer from ICU when patients were ready for ward based care. The nurse in charge would highlight patients that were ready for discharge out of ICU. However, beds within the rest of the hospital were not always available to facilitate the discharge.
- There was also a trust wide capacity bed meeting, which was attended by the lead nurse for critical care. A general manager led this meeting. The meeting was held to look at bed capacity and flow of patients through and out of the hospital. Each area brought an update to share at the meeting. On the day we attended, there were no ICU patients waiting to be transferred to wards and there was a critical care bed available.

Learning from complaints and concerns

- The critical care service continued to have a low formal complaint rate. Since the previous inspection, the unit had not received any formal complaints.
- Staff told us that relatives often complained informally or commented on feedback forms about the cost of car parking at the hospital site. Concessions for visitors to the ICU against the cost of car parking were available.
- Issues that had been raised by visitors in feedback forms included sometimes there seemed to be a delay in staff

communicating with relatives in the waiting room. In response to this, signs had been put in the waiting room giving permission for visitors to come to the unit doors and use a buzzer if they wished to check on patient progress after waiting 15 minutes.
- There were 'comment, compliments and complaints' leaflets available in the visitors waiting room for information, printed in English.

Are critical care services well-led?

Good

We rated critical care services as good for well-led because:

- Leadership of the unit was in line with Guidelines for the Provision of Intensive Care Services (GPICS) 2015.
- The unit had a risk register which contained relevant risks. There was evidence of frequent discussions and reviews of the risks and leaders were all aware of them.
- There were regular meetings including at unit and clinical leader level. The minutes of these demonstrated that quality, risks, incidents, mortality and morbidity were discussed and ongoing actions were monitored.
- The intensive care unit (ICU) team had been nominated by theatre staff to receive the trust's 'going the extra mile' award for their dedication and hard work.
- There had been improvements since our September 2015 inspection, including increasing medical staff cover out of hours, flexible nursing staffing, nurse leadership (two band seven nurses now on permanent basis) and Intensive Care National Audit and Research Centre (ICNARC) improved performance in all but one of the eight indicators.

However, we also found:

- There were areas where there had not been any improvement since our September 2015 inspection. These included a lack of ICU follow-up service, there was not always an intensive care medicine consultant on call and no evidence of twice daily documented ward rounds by a consultant.
- Areas in which performance had deteriorated since the September 2015 inspection were related to hospital bed capacity. There was an increase in surgery cancellations due to lack of ICU bed availability and an increase in overnight transfers of patients to a ward.
- There was unclear understanding of a vision and strategy for critical care services.

Vision and strategy for this service

- Staff we spoke with on ICU did not describe the same vision for the service. Some talked about providing care that you would wish your family to receive.
- Senior staff on ICU told us that there seemed to be improvements with channels of communication throughout the wards and departments within the hospital, since our previous inspection. They said that this had been assisted by ICU staff attending capacity meetings. They also felt the board was generally better informed and that the board agreed that there was a need for more critical care beds in future models. Leaders in the critical care service had been invited to take part in the plans and design of a new critical care unit. This was envisaged to include a larger ICU with 10 critical care beds, increase critical care outreach team (CCOT) cover to 24 hours a day and increase the number of consultant anaesthetist posts. However, this was still in planning stages and not expected be built for the next two years.

Governance, risk management and quality measurement

- There had been a recent trust wide restructure, from a directorate model to two main divisions, surgery and medicine with directorates and specialist areas. Critical care services were a specialist area within the theatre and anaesthetics directorate, which in turn came under the surgical division. With this restructure came new arrangements for governance and pathways for meetings. This took place in the weeks prior to the inspection and it was therefore difficult to evaluate the impact. Leaders of critical care felt that it would improve the flow of information and they would have a shorter, clearer path for escalation within the new structure. This had caused delays in governance procedure though. For example, the SOP for the temporary use of theatre recovery for a critical care patient was awaiting ratification by meetings in the new structure.
- ICU had a risk register, which contained three open risks. The first related to the high level of delayed discharges, out of hours discharges to the wards and mixed sex occupancy breaches. This risk was rated red indicating it was categorised as high risk. The second entry related to the risk posed by a lack of level two beds to meet

elective surgical requirements. This was also a red rated risk. It had been updated with data illustrating the issue, for example in February 2016 there had been seven patient transfers to external ICUs due to lack of beds (non-clinical transfers) and three patient operations were cancelled. The third risk was rated amber and logged the risk of harm from medicine errors due to lack of clinical pharmacist support to ICU and theatres. A role had been created and was being actively recruited to. All risks showed evidence of regular review and updates. The SOP for caring for patient temporarily in recovery was linked to the open associated risk register entry.

- Leaders of the critical care service were aware of the risks on the register for the unit.
- The unit had meetings to monitor governance issues including ICU quality improvement meetings. The minutes for the meeting in May 2016, showed that items that were discussed included:
  - The unit's mortality report.
  - A case presentation.
  - Updates about ongoing audit projects.
  - Out of hours discharges.
  - A national guideline review.
  - A plan to develop local safety standards for invasive procedures using the National Safety Standards for Invasive Procedures.
- However, there were many local critical care polices and guidelines that were beyond review dates. Staff explained this had been impacted on by the recent change of clinical lead consultant, as many were related to medicines for use in critical care. This had not been identified on the risk register.
- An ICU business meeting in June 2016, reported on critical care activity, including an update against risks on the register regarding transfers for non-clinical reasons and the use of theatre recovery for critically ill patients. The minutes showed that incidents and quality issues were also on the agenda as regular items.

Leadership of service

- The unit was led by a clinical lead consultant and a lead senior nurse who were experienced, visible and approachable. The leads were knowledgeable and the lead nurse had worked at the trust for a significant period. Two senior critical care nurses, one whose role was professional development, while the other focused on quality and finance, also supported the unit. They had supernumerary time to enable them to carry out their roles.
- The leadership demonstrated that they were engaging with other directorates. For example, through assistance with the surgical academy by facilitating critical care secondments and training.
- The leadership of the service met the GPICS 2015, including:
  - There was a designated clinical lead consultant for the unit.
  - There was an identified lead formally recognised with overall responsibility for the nursing elements of the service.
  - There was a supernumerary senior nurse in charge on duty every clinical shift.

Culture within the service

- Staff told us that they felt really proud of the care and service that they provided on ICU. They strived to provide a safe and caring service. They told us that they enjoyed working on the unit and felt supported.
- Staff said that they felt invested in and they described the care on the unit as 'very good' and 'really safe'.
- During an extremely busy period in the spring 2016, the ICU team had supported the care of patients in theatre recovery because there were no beds available on the unit. The theatre staff had recognised that the ICU staff had worked hard and decided to nominate them for a trust award for 'going the extra mile'. A copy of the letter was requested from the trust but not provided.

Public engagement

- Feedback from users of the critical care services was obtained via simple survey forms available in the relative's room or offered to patients when they were ready to leave the unit. The lead nurse felt that this was an area that was being worked on to ensure that people's views were acted on to shape and improve the services.

Staff engagement

- Staff told us that there was good team working on the unit and that they were communicated with via unit meetings, emails, and feedback at handovers. Communication generally seemed to have improved since our September 2015 inspection.

Critical care

- A new way to encourage critical care staff to put forward ideas had recently started. There was a folder on the unit where staff could complete forms to highlight a good idea and suggest how to implement them. For example, a new form for checking the resuscitation trolley had been put forward. The new form was to allow staff to include when items had been replaced. This had been accepted as a good idea and the new resuscitation checking form was seen in use during the inspection.
- There were ICU team meetings and band six meetings within the unit. They seemed well attended. We saw that the minutes included feedback about incidents and were kept in the staff coffee room.

Innovation, improvement and sustainability

- At this inspection, there had been the following improvements noted since our September 2015 inspection:
  - Increasing medical staff cover out of hours.
  - Flexible nursing staffing.
  - Nurse leadership (two band seven nurses now on permanent basis).
  - CCOT competencies completion.
  - Reduction in unit acquired pressure ulcer incidence.
  - Cross directorate working.
  - ICNARC performance improved performance in all but one of the eight indicators.
  - Local audits to evaluate care and treatment.
  - Quality of mortality and morbidity review meetings.
- Areas in which performance had deteriorated since our September 2015 inspection, were related to hospital bed capacity. There was an increase in surgery cancellations due to lack of ICU bed availability and an increase in overnight transfers of patients to a ward.
- There were areas highlighted where there had not been any changes since our September 2015 inspection. These included:
  - Lack of ICU follow-up service.
  - Not always an intensive care medicine consultant on call.
  - No evidence of twice daily documented ward rounds by a consultant.
- We requested details of any innovative initiatives that critical care services would like to highlight. However, none were provided.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services at Wye Valley NHS Trust are part of surgical division and provide women's health and paediatric services in the hospital and child health, sexual health and school nursing in the community. The trust's maternity services are available across hospital and community settings.

The maternity service at Wye Valley NHS Trust is the smallest in the West Midlands region. The birth rate is falling at the trust and between April 2015 and March 2016, 1,762 babies were born at Hereford Hospital.

The maternity service at Hereford Hospital offers: a consultant-led delivery suite with a virtual midwifery-led room for low-risk women; an outpatient antenatal clinic; a day assessment unit (DAU); a triage unit; and antenatal and postnatal inpatient wards. Women can also choose to have a home birth supported by community midwives. Five teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes.

The gynaecology services at Hereford Hospital offer inpatient care, outpatient care and emergency assessment facilities. The gynaecology ward has eight beds which consist of a four-bedded bay and four side rooms. One side room is kept for patients undergoing termination of pregnancy. Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists receives support from specialist gynaecology nurses, general nurses and healthcare assistants.

We visited all wards and departments relevant to maternity services. For the maternity services we spoke with four patients and 17 midwives and support workers. For the gynaecology services we spoke with five patients and two nurses. We also spoke with four medical staff who worked across the maternity and gynaecology services. We checked the clinical environment, observed ward rounds and assessed patients' healthcare records. We reviewed the trust's performance data.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as requires improvement overall. We rated maternity and gynaecology services as requires improvement for safe, effective, responsive and well-led. We rated the service as good for caring.

We found:

- Systems and processes in maternity were not always reliable or appropriate to keep patients safe. The anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby, and injury to staff from moving and handling within a small space. The trust had implemented mitigating actions to reduced the risk. However, the environment did not meet patient demand and could impact on patient care.
- The caesarean section rate for 2015/16 was 30.3% which was worse than the national average of 26.5%. The caesarean section rate had risen to 42.9% in April 2016. This was worse than the caesarean section rate in the two previous years. The deteriorating caesarean section rate was not recorded on the risk register.
- The midwife-to-birth ratio was 1:30 (one midwife to 30 births).
- 95% of women received one to one care in labour.
- Root cause analysis demonstrated detailed investigations of incidents. Recommendations and lessons learnt were recorded within the documentation. However, we did not see evidence of these always being followed up.
- There were gynaecology patients on surgical wards due to lack of gynaecology beds. This meant that gynaecology patients were not always cared for on the most appropriate ward.
- 39 operations were cancelled on the day of surgery between March 2015 and April 2016, 18 of those were due to lack of beds.
- Lack of medical staffing resources to deliver the gynaecology cancer pathway meant there was a number of women breaching referral to treatment times.
- There was no dedicated bereavement room.
- Compliance with mandatory training did not meet the trust target.
- Two documents were used to monitor outcomes: the quality report obtained from the maternity information system and the dashboard. This meant there was no clear oversight of outcomes and activity.
- Although staff we spoke with understand their role and responsibilities regarding the Mental Capacity Act 2005. The trust did not provide data to demonstrate that staff had the appropriate skills to care for patients under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

However, we also found:

- Patients, partners and relatives felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- Women's privacy and dignity were protected.
- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- Staff were aware of their responsibilities regarding the duty of candour and we saw those involved in incidents were offered an apology.
- Staff we spoke with demonstrated an understanding of the arrangements in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- The gynaecology ward displayed quality data that demonstrated the ward had been free for pressure ulcers, falls and MRSA bacterium for over 1000 days.
- The planned and actual staffing levels were displayed and met on the gynaecology ward.
- All areas of the service were visibly clean and well maintained with display boards detailing cleanliness and safety information.
- Equipment was maintained and was safe for use.
- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- Women we spoke with felt that their pain and analgesia administration had been well managed.
- Staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.

Maternity and gynaecology

- Appraisal rates met the trust target.
- There was a statement of vision and strategy.
- There was an active women's forum that met regularly and provided input into projects in the maternity services.

Are maternity and gynaecology services safe?

Requires improvement

We rated maternity and gynaecology services as requires improvement for being safe because:

- Systems and processes in maternity were not always reliable or appropriate to keep patients safe. The anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby, and injury to staff from moving and handling within a small space. The trust had implemented mitigating actions to reduce the risk. However, the environment did not meet patient demand and could impact on patient care.
- The midwife-to-birth ratio was 1:30 (one midwife to 30 births).
- Compliance with mandatory training in February 2016 was 76.5%, which did not meet the trust target compliance of 90%.
- Root cause analysis demonstrated detailed investigations of incidents. Recommendations and lessons learnt were recorded within the documentation, however, we did not see evidence of these always being followed up.
- Whilst the trust was using a safety thermometer, it did not report on maternity specific harm. The thermometer reported some outcomes but not others, which meant that the proportion of patients that were kept 'harm free' from was not recorded.

However:

- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- Staff were aware of their responsivities regarding the duty of candour and we saw those involved in incidents were offered an apology.
- Staff we spoke with demonstrated an understanding of the arrangements in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- The gynaecology ward displayed quality data that demonstrated the ward had been free for pressure ulcers, falls and MRSA bacterium for over 1000 days.

- The planned and actual staffing levels were displayed and met on the gynaecology ward.
- The named midwife model was in place and women told us they had a named midwife. Staff told us that they offered all women one to one care in labour; data demonstrated 95% of women received this.
- All areas of the maternity and gynaecology service we visited were visibly clean and well maintained with display boards detailing cleanliness and safety information.
- Equipment was maintained and was safe for use.

Incidents

- Staff were aware of their roles and responsibilities in the management and escalation of incidents. Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- Escalation of risk was identified through a computer based incident reporting system. We saw that a trigger list based on the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations was used to guide incident reporting in maternity. For gynaecology, the women's health ward incident reporting trigger list was used. We saw that the trigger lists contained incidents that needed to be considered as serious incidents. Such incidents had to be escalated to the trust quality and safety unit within 24 hours.
- We saw that 282 maternity and 58 gynaecology incidents were reported between December 2015 and March 2016. In maternity two incidents were classified as causing severe harm, 14 moderate harm, 34 low harm and 232 no harm. For gynaecology, one incident was classified as causing severe harm, four moderate harm, 10 low harm and 43 no harm.
- We saw that learning from nine obstetrics and gynaecology reports between April 2015 and March 2016 was published for staff to read. A brief case history, adverse outcomes and important learning highlighted by each route cause analysis were contained within the report.
- All incidents were reviewed at the obstetrics and gynaecology weekly risk review meeting attended by the senior management team. Discussions at the meetings were minuted. Lessons learned were fed back to staff via a safety brief at handover, 'Close Encounters' a monthly clinical risk newsletter, a 'Hot Topic' board in ward areas and shared learning files located in all ward areas.
- The trust were using a new system to inform staff throughout the hospital, about key safety actions taken following serious incidents. We saw that a document called 'safety bites' was available for staff to read.
- It was the responsibility of the band 7 manager reviewing incidents to allocate the level of harm in line with National Patient Safety Agency and the National Reporting and Learning System definitions of harm. We saw that there was a variation in the assessment of harm. For example, the log of maternity incidents for April 2015 to March 2016 contained 11 incidents relating to third or fourth degree tears. Two of these were classified as causing no harm, six were classified as causing low harm and three were classified as causing moderate harm. Staff explained that harm was not an outcome measure and they were looking for sub-optimal care when allocating the level of harm. An audit in February 2016 had been completed to evaluate the management and care given to women who had third or fourth degree perineal tear, against the set standard in Green Top RCOG guideline on management of third and fourth degree perineal tear. The audit concluded that there was a 3.1% incident rate for patients. An action plan was devised, and we saw improved patient documentation and guidelines on the management of obstetrics anal sphincter tear in place as a result.
- The trust had changed its approach to incident management since our September 2015 inspection. We saw that following a review by the senior team, potential serious incidents were discussed by the executive team. If a root cause analysis (RCA) was required, it was delegated to a lead investigator. We looked at a sample of RCAs and found that one had been investigated by a reviewer who was not an expert in obstetrics. There was a risk that investigators did not always have midwifery and obstetric experience to identify any clinical issues.
- We saw documentary evidence of 11 serious incidents across the women's and children's service between March 2015 and April 2016. Two maternity investigations were ongoing in March 2016, one of which was late with an agreed extension.
- Seven serious incidents were reported to the Strategic Executive Information System (STEIS) by maternity services between March 2015 and April 2016. There were two incidents concerning both the mother and the baby; one incident concerning the mother only; one unexpected admissions to the special care baby unit

(SCBU); one relating to a confidential information breach; one relating to failure to act on test results; and one surgical procedure that met serious incident criteria.

- RCA's demonstrated detailed investigations of incidents, including pre and post-investigation risk assessments and a concise timeline review of events. Recommendations and lessons learnt were recorded within the RCA documentation. However, we did not see evidence of these always being followed up. For example, one recommendation from a RCA completed 6 June 2016 was for the obstetrics and gynaecology governance group to review and consider introduction of presentation scans being undertaken in triage when labour was suspected. However, in the governance meeting on 17 June 2016, this was not minuted as being discussed.
- The trust had reported four maternity incidents between April 2015 and March 2016 which met the threshold for a serious incident to the clinical commissioning group (CCG). To date three investigations had been completed and closed, one was outstanding. A lack of timely escalation and a lack of a formalised process for individual emergency situations were the main themes arising from the serious incidents.
- There had been no never events reported for this service from March 2015 to February 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- We were told by managers that when necessary women and those close to them were involved in reviews they ensured that requirements under the duty of candour were met. We saw a duty of candour letter sent to parents which offered them an apology and assured them they would be kept informed with the action plan. We saw within RCAs that duty of candour was considered.

Safety Thermometer - Maternity

- 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 score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a newborn infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- Whilst the trust was using a safety thermometer, it did not report on maternity specific harm. We saw no evidence during inspection that the trust was using the Maternity Safety Thermometer. After the inspection the trust told us that the Maternity Safety Thermometer had been piloted since June 2016, however, no evidence was provided to support this claim at any time. Outcomes for many of the factors of the maternity thermometer were recorded on the monthly quality report. These included: perineal and/or abdominal trauma (caesarean section) partum haemorrhage, infection and babies admitted to SCBU. Other outcomes were not recorded in this way and meant that the measurement of the proportion of patients that were kept 'harm free' from, separation from baby, psychological safety, and babies with an Apgar score of less than seven at five minutes, were not recorded.

Safety Thermometer - Gynaecology

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm

and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- We saw that on the whole 'harm free' care was provided in the gynaecology service. The ward displayed quality data that demonstrated the ward had been free from pressure ulcers, falls and MRSA bacterium for over 1000 days. This information had not changed since our September 2015 inspection.
- There had not been a case of Clostridium difficile since 23 November 2014.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. An external company was responsible for cleaning and we saw cleaning schedules on all wards.
- The environmental audit showed that maternity ward achieved 98% compliance in March 2016. Data was unavailable for the delivery suite. The gynaecology ward scored 100% compliance in October 2015, however, data after this date was not provided by the trust.
- A safety and quality monthly matrix was used on the maternity ward to ensure that equipment was checked and that the ward was clean and tidy.
- We saw that equipment was labelled with tags to indicate when it had been cleaned.
- Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae.
- We observed compliance with the trust infection prevention and control policy. We saw staff used hand gel, protective clothing and adhered to the bare below the elbow policy.
- Hand sanitising gel dispensers were available in corridors and wards. We saw posters in corridors advising patients and visitors to use hand gel dispensers.
- We saw that patients scheduled for surgery were screened for MRSA, with appropriate action taken if results were positive.
- The infection prevention team, consultant microbiologist and senior clinical staff involved with patients care completed a post infection review for all occurrences of reportable infections. The aim of the reviews was to identify any clinical practice which may have contributed to the incident, and identify any learning. Information gathered from reviews was reported through the infection prevention control quarterly report, to the quality committee.

Environment and equipment

- There was only one obstetric theatre; the anaesthetic room was used as the second theatre if there was an emergency when the theatre was in use. There was a risk the lack of a second theatre could prevent timely emergency intervention. We saw the potential for this to happen during inspection, when the elective caesarean section list was delayed due to an emergency, a second emergency was waiting to go to theatre and a woman who was in premature labour was admitted to triage. This demonstrated that the capacity of the environment may not meet the demands of patients.
- The lack of a second obstetric theatre was on the risk register and was recorded as a priority of works on the estates plan. We saw that project team had been established and membership agreed. The project would also include the development of a midwifery led unit (MLU) and bereavement suite.
- The trust recognised that the environment in the anaesthetic room needed to be improved because of inadequate lighting, ventilation (negative pressure room (dirty air)) and poor room configuration. This could lead to increased risk of infection for mother and baby, injury to staff from moving and handling within a small space and possibly fail to meet the Health Technical Memorandum (HTM) and Mechanical and Electrical compliant standards. The trust had implemented mitigating actions to reduce risk including monthly skills drills, floor plans indicating where equipment was stored and a standard operating procedure. The trust were planning to reconfiguration of the obstetric intervention area in 2016.
- Women with complex needs were cared for in room 5, which was adjacent to the anaesthetic room. This was the largest clinical room and enabled more staff to be present if required to treat the patient. There was an interconnecting door which meant that there was a risk that privacy and dignity may not always be protected. However, we saw no evidence of this during inspection.
- The recovery area was in a curtained bay, off the corridor adjacent to the theatre. This did not have an emergency call bell which meant that help could not be summoned in an emergency. Furthermore, the location

of the bay did not afford adequate privacy and dignity for women that had recently delivered. The need to reconfigure the obstetric intervention area was on the departmental risk register. However, the risk of the bay not having a call bell was not identified.

- An intercom and buzzer system was used to identify visitors and staff wanting entry into the delivery suite and the maternity ward. This helped to ensure women and their babies were kept safe. However, there was a risk of security breaches due to the security system not being robust, as there was the risk of human error when entering the lock code or unauthorised individuals gaining access to wards if the doors are unknowingly left open. There was also a risk that in an emergency, staff required to attend from other hospital areas, such as the delivery suite, would be unable to gain access to the ward as the access code would be unknown to them. This was rated high on the risk register and mitigation included plans to install video entry systems on maternity, delivery suite, SCBU and the children's ward. The target date for this was March 2017.
- We found equipment was clean and fit for purpose. Portable appliance testing or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- A telemetry (remote) cardiotocography (CTG) machine was used for women whose babies needed monitoring in labour, but did not want to be restricted to the bed. This helped promote normality. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour. This involves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. Telemetry CTG machines are operated by Wi-Fi and enable women to be mobile.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures. We observed the emptying and cleaning of the inflatable pool. A booklet on the delivery suite contained photographs demonstrating evacuation of the pool.
- During our September 2015 inspection, we found that the antenatal clinic was also used as a gynaecological clinic. We were told that clinics were scheduled so that gynaecology and obstetrics patients were not in the waiting room at the same time. However, we observed both maternity and gynaecology clinics running concurrently.
- We saw that there was a small waiting area in the corridor outside the scan rooms and a curtained off area used for gynaecological treatments. This was crowded at the time of our inspection with people accompanying patients standing in the corridor.

Medicines

- Nurses and midwives were aware of the correct processes and procedures for the administration and recording of medications.
- Emergency medicines were stored on emergency trolleys in sealed cardboard boxes which were not secured to the trolley. This meant they could be removed and therefore be unavailable in an emergency. This was escalated to the pharmacy department during inspection and we were informed that this had been risk assessed.
- All other medicines including controlled drugs were safely and securely stored. Controlled drugs are medicines which require additional security. Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- We saw that the nurse or midwife administering medicines was identified by wearing a red tabard. This indicated that they were not to be disturbed during the medicine round to allow them to concentrate on the administration of medicines.
- Temperatures of refrigerators used to store medicines were monitored and documented daily. This ensured that medicines were maintained at the recommended temperature.
- Midwives may supply and administer medicines under a system known as midwives' exemptions. We were told that sealed medicine packs were dispensed by the pharmacy for community midwives to supply and administer. This was best practice and ensured the medicines had been checked for safe administration.
- Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff in a monthly MedsTalk newsletter.

Records

- The maternity service had moved to a paper-light record management system. Women no longer carried handheld notes and instead accessed their records using a secure password via a smartphone App or a

computer with internet access. We reviewed records on the maternity information system to gain understanding of the system. Hard copies were unavailable for us to review.

- We saw a thorough audit of obstetric records carried out by the supervisors of midwives which explored midwives' adaptation to the paperless system. The audit recommended 'staff training was required to address the evolving system, quality issues and continued liaison with a medical software company to modify the system to deliver the development of data pathways/standard operating procedures/strategies in line with local and national service delivery'. We were told by staff this training was planned for by the end of 2016.
- The trust had stopped the monthly audit of 40 case notes on the maternity management system because the IT lead was reassigned to clinical duties. The lack if IT support was on the risk register.
- Community midwives carried touch screen tablets which contained patient records. These were protected by three separate log-in sessions. Midwives reported lost or stolen devices to security so they could be disabled. This meant that patient's information was protected.
- On the maternity unit we saw individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.
- The trust had a quality improvement plan in place regarding the safe storage of quality information. This included the review of clinical records policy, completion of team briefings and training and completion of record keeping audits. Progress made against the deadlines were reported to the trust board monthly.
- We saw that patient records on the gynaecology were stored in the main corridor of the ward in a trolley with key pad access. This meant that patient records were stored securely. The key pad on the notes trolley on the postnatal ward was broken and this had been reported.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). A safeguarding case supervision policy was in date and community midwives undertook safeguarding supervision in line with trust policy.
- Safeguarding adult level three training compliance for maternity and gynaecology staff was 88.7%, this did not meet the trust target of 90%.
- Evidence demonstrated 100% of maternity and gynaecology staff had been trained in safeguarding patients at risk of, and to treat, those affected by female genital mutilation.
- A flag showed on the maternity information system for any woman who had a safeguarding concern to help alert staff to the concern. Any safeguarding plans were uploaded to the information system.
- If a woman presented herself for treatment who was unknown to the service, staff informed the multi-agency safeguarding hub who then made enquiries with the social services department in the woman's home locality.
- The trust recognised that the number of child safeguarding cases had increased within maternity services over the last five years. There was a risk this could lead to a robust management plan not being in place at the time of birth, which would impact on the decisions staff make for the mother and baby. This was on the risk register and actions were due for completion by April 2016. We did not see evidence to confirm that all had actions been completed.
- The safeguarding team had been expanded so that midwives could get timely support with safeguarding concerns. Staff reported that the trust safeguarding lead was accessible. Wards displayed posters containing contact details of clinical leads.
- A standard operating procedure for identifying social factors for vulnerable women accessing antenatal care was used by the community midwives at booking. A 'midwife assessment framework form' identified women with additional needs. Women then had a further risk assessment with a detailed family history completed and were referred for consultant care.

- There was a child and baby abduction policy in place to ensure the safety of children and babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- Staff knew how to make referrals to other agencies in cases of domestic abuse disclosure. An audit of 40 records in June 2016 demonstrated that 75% women were asked about domestic abuse in line with the National Institute for Health and Care Excellence (NICE) guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. This meant not all women were screened for domestic abuse. We were told an action plan would be developed as a result.

Mandatory training

- Trust mandatory training covered subjects including information governance, conflict resolution, equality and diversity, learning disability awareness, positive mental health, fire prevention, infection control, load handling, medicines management and safeguarding.
- The overall compliance with mandatory training for maternity and gynaecology staff in February 2016 was 76.5%, which did not meet the trust target compliance of 90%.
- Maternity specific mandatory training and other learning and development was managed by the practice development midwife, who was also responsible for infant feeding.
- Professional midwifery mandatory training covered subjects including: antenatal screening, Gestation Related Optimal Weight (GROW) training, promoting normality in high risk women, infant feeding update and revalidation. We saw that 87% of midwifery staff had completed this training in February 2016.
- Multidisciplinary intrapartum training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breach presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse. The training also covered updates from national studies such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), human factors in communication, care of the seriously ill woman and neonatal resuscitation. We saw that 70% of midwives and 90% of obstetricians had attended this training by February 2016.
- The CTG machine was used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. The trust had introduced the RCOG/ Royal College of Midwives fetal monitoring on line learning package in 2016. The trust did not provide data for compliance with CTG training.

Assessing and responding to patient risk

- For women using the maternity services, the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. We saw that in January 2016 95%, in February 2016 98% and in March 2016 97% of women had an antenatal risk assessment completed at booking compared to the trust target of 98%. On-going risk assessments were carried out at subsequent antenatal visits and women were referred to the obstetric team if risk factors were detected.
- A screening midwife was responsible for antenatal and newborn screening. The regional quality assurance screening team for the West Midlands and NHS England collected data on nine key performance indicators (KPIs) for screening including the number of women tested for human immunodeficiency virus; the number of women referred for hepatitis B virus specialist assessment; the number of completed laboratory request forms for Down's syndrome screening; the number of women tested for sickle cell and thalassaemia; the number of women tested by 10 weeks gestation; the number of laboratory requests with completed family origin questionnaire; the number of avoidable repeats for new born blood spot test; and the number of babies having Newborn and Infant Physical Examination (NIPE).
- Data demonstrated compliance with all KPIs except the number of completed laboratory request forms for Down's syndrome screening and the number of babies having NIPE. The reasons for this were documented. For example: 'There are 32 babies that we are unable to account for due to the NIPE not being documented in the correct field, or not documented at all, on the

maternity information system. The NIPE SMART system was implemented on 15 June 2016 and this will allow us the ability to accurately collect this data for the next quarter.'

- Women that had problems in pregnancy were reviewed on the day assessment unit (DAU). From DAU they could be admitted to the ward for short periods of time to be reviewed by the obstetric staff.
- NHS England's 'Saving Babies' Lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy. However, the charts were not part of the paperless records. Women had to carry these around with them which could prohibit full assessment of fetal wellbeing should they be lost. Managers explained that this was because of the licensing issues with GROW software and they were in discussions with the Perinatal Institute who administer the programme regarding this.
- There was only one consultant trained to perform middle cerebral arterial Doppler assessments. Middle cerebral arterial assessment is recommended in the RCOG Green top guideline no 31: Small for Gestation Age Fetus Investigation and Management and is used in several obstetric situations including Intrauterine Growth Restriction (IUGR) after 32 weeks gestation until timed delivery, to screen for fetal anaemia following parvovirus infection and in cases of haemolytic disease of the newborn. This had led to women either not being scanned or being referred to a specialist centre for the test to take place. This had the potential to result in a missed or delayed diagnosis, which increased the potential risk of fetal death or fetal morbidity. This was on the risk register and there were two actions due for completion later in 2016, the training of obstetricians to increase test availability and a quality impact assessment.
- An audit of 40 records in June 2016 demonstrated that 57.5% of midwives discussed vaccinations against influenza and whooping cough with women. This meant that women and babies were not routinely protected from these infections. We did not see an action plan following this audit.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman. We saw evidence of a guideline for management of sepsis in the obstetric patient maternity which helped staff identify women at risk of sepsis and initiate required treatment.
- We were told that the critical care outreach team supported midwives with the care and management of critically ill women. Any woman who needed additional support and care, such as central venous lines, was transferred to the intensive care unit.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery guidelines. We observed 99.5% compliance between December 2015 and February 2016 and that all the stages were completed correctly; checklists showed that this was usual practice. This was an improvement from the September 2015 inspection, when we observed checklists were not always completed correctly. The quality improvement plan outlined actions the trust had taken to improve checklist compliance, such as staff education and monthly audits.
- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. In March 2016, compliance with swab counting was 79% after delivery of the baby and 62% after a woman had perineal sutures. This meant that women were potentially at risk from a retained swab, which is a never event.
- The senior midwives on duty provided CTG review known as 'fresh eyes'. This was in accordance with 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. Data entered onto the maternity information system showed that in between January and June 2016, compliance with both hourly and 'fresh eyes' review was 90%.
- Multidisciplinary CTG case reviews were held three times a week to facilitate discussion and learning. CTG machines using a computerised system to standardise analysis of fetal heart rate traces were in use by the trust. Computer based analysis reduces subjectivity and helps in making decisions about ongoing care.

- We saw that venous thromboembolism (VTE) scores were monitored and recorded in women records on the maternity and gynaecology wards. VTE is the term given to blood clots. In July 2016 the VTE score for delivery suite was 90%, the maternity ward was also 90% compared to the trust target of 95%. The gynaecology ward scored 83% in February 2016. Treatment to prevent blood clots was prescribed and administered in accordance with the trust policy.
- Midwifery handover took place at the change of each shift. Handover included a review of all women on the wards and allocation of workloads. Formal multi-disciplinary handovers were carried out four times during each day on the delivery suite attended by medical staff and the labour ward coordinator. We observed the 8.30am handover which was structured following SBAR (Situation, Background, Action, and Recommendation) and included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor. SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- The trust did not use Birthrate Plus®. The Centre for Workforce Intelligence tool had been used to analyse their maternity workforce aligned with their service's individual care pathways.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The delivery suite required five midwives and two maternity support workers (MSW) on each shift. We saw that required and actual staffing was met during our inspection.
- Staffing requirements for the maternity ward was two midwives and two MSWs on the day shift and two midwives and two MSWs on the night shift. We saw that required and actual staffing were met on this ward during the week of inspection, with the exception of the night shift on 7 July 2016 when there was only one MSW on duty.
- The average staffing fill rate for day and night shifts was 100% for nurses and midwives on the maternity ward between January and March 2016. The average staffing fill rate ranged between 93% and 100% for MSWs on the maternity ward between January and March 2016.
- Recruitment remained an ongoing concern for the trust and had worsened since our September 2015 inspection. The budgeted establishment for the midwifery workforce was 67.7 whole time equivalents (WTE). Staffing was on the risk register and the trust recognised that the deficit of 16 WTE midwives across the acute and community midwifery workforce would leave a significant gap in the midwife to birth ratio and would result in a reduction in safe staffing levels within the local maternity service delivery plan.
- There was an absence factor of 9.1 WTE (8.1 WTE on the September 2015 inspection). The vacancy rate was 3.2 WTE (1.8 WTE on the September 2015 inspection); the sickness rate was 3.26 WTE (2.7 WTE on the September 2015 inspection) and maternity leave 6.47 WTE (3 WTE on the September 2015 inspection). In addition, three WTE midwives currently were working in non-clinical roles, pending investigations.
- To mitigate this risk, a rolling recruitment programme had been in place since January 2016. In March and April 2016, eight WTE newly qualified midwives had been recruited. The maternity unit did not use an external agency and had its own bank of temporary staff, called Apple. In the month preceding our visit, the staff usage through Apple was 5.8 WTE. Despite this, managers told us they were still two WTE short. In order to further increase midwifery staffing, the trust employed staff from a neighbouring trust on the bank and until the newly recruited midwives were embedded, managers would need to be involved in front line work.
- Midwives worked a mixture of eight hour and 12 hour shifts. We saw that the band 7 delivery suite coordinator was supernumerary and coordinated the activity on the ward. They required constant oversight of the ward so that decisions could be made regarding care and treatment. We were told that in times of increased

activity, they may have to care for women in labour. This could impact on the safety of women in labour as the co-ordinator needed to have an overview of activity at all times in order to manage the ward safely.

- The numbers of midwives rotating between the hospital and community had been also reduced to ensure continuity of care for women and for the midwives providing care in the antenatal and postnatal periods. However, in times of high activity specialist community midwives were relocated to the hospital to work on the wards.
- We saw that the midwife-to-birth ratio was 1:30 (one midwife to 30 births). This was worse than our September 2015 inspection when the ratio was 1:27 and was a consequence of an increase of staff maternity leave.
- An acuity tool to assess workload and capacity in the maternity unit was used by the labour ward coordinator. Capacity was assessed four hourly and entered onto the maternity information system. Midwives were able to provide one to one care in labour to 95% of women. The escalation policy was used when one to one care in labour was unachievable. The CCG had built performance data regarding individualised care into Wye Valley NHS Trust's 2016/17 contract. Therefore, performance information would be available to demonstrate compliance with continuity of care.
- Each full time community midwife had a caseload of 100 patients which was worse than a ratio of 1:96 recommended by Birthrate Plus®.
- On our September 2015 inspection we found a disparity between grades and caseloads, which were allocated according to the hours a midwife worked rather than on the experience required for specific caseloads. The manager had strengthened the teams by placing experienced midwives with junior midwives to support their development.
- MSW's with additional training, known as 'Pink Ladies' due to the colour of their uniforms, supported the midwives on the postnatal wards and in the community. They carried out feeding support, weighed babies and took blood samples for the newborn blood spot test (tests offered to babies to look for conditions including cystic fibrosis). Patients told us they appreciated the breastfeeding support given to them by the 'Pink Ladies'.
- Obstetric support workers supported the obstetrician in theatre and provided support to the delivery suite when not working in theatre.

Nursing staffing

- We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift on the gynaecology ward: one registered nurse (RN) was required on the early, late and night shift, a second RN worked from 10am until 6pm. One health care assistant (HCAs) supported the RNs on the early and late shift and two HCAs worked on the night shift.
- This staffing plan was put into effect after our September 2015 inspection when the lack of a second RN breached the trust's recommended two RN requirement.
- The average staffing fill rate ranged between 81% and 110% for RNs on the gynaecology ward between January and March 2016. The average staffing fill rate ranged between 93% and 100% for HCAs on the gynaecology ward between January and March 2016.
- Nurses rotated to the gynaecology outpatient clinic to maintain their skills and were supported by HCAs.
- Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank or agency staff. New staff were inducted locally using a checklist and would be allocated to work with a 'buddy' to support them.

Medical staffing

- The trust employed 17 WTE medical staff across maternity and gynaecology services. The level of consultant cover was 36% which was similar to the national average of 35%. The percentage of registrars 24% which was fewer than the national average of 50%. The percentage of middle grade doctors was 34% which was greater than the national average of 8%. There were 6% junior grade doctors which was similar to the national average of 7%.
- Consultant obstetric cover on the delivery suite was on average 66 resident hours per week. At the time of the inspection consultants stayed on the delivery suite from 8.30am until 8.45pm, Monday to Friday; and from 8.30am until 11.30am on Saturdays, Sundays and bank holidays. Out of hours cover was provided by the 'hot week' consultant on call from 8.30pm on Friday until 8.30am on Monday. Consultants were required to be within 20 minutes of the hospital if required.

Maternity and gynaecology

- Delay in consultant presence due to not being on site remained on the risk register since our September 2015 inspection. There was an action plan in place with responsible persons nominated and deadlines set.
- There were eight speciality middle grade doctors who covered the maternity and labour ward from 8.30am until 8.45am Monday to Sunday, including bank holidays. Difficulties in recruiting middle grade staff in maternity was on the corporate risk register.
- Four junior grade doctors covered the gynaecology ward 8.30am until 8.30pm Monday to Thursday; and 8.30am until 5.30pm on, Friday, Saturday, Sunday and bank holidays. The absence of junior doctor cover after 8.30pm most weekdays and 5.30pm at weekends meant that the registrars covered this work out of hours. This resulted in consultants being called in if there was high patient activity.
- The gynaecology service was covered by a junior trainee and a registrar from 8.30am to 5pm and by a junior trainee with support from the obstetric on call registrar out of hours. Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.
- There was 24-hour senior anaesthetic cover for labour ward. A consultant anaesthetist was available twice a week for the caesarean section lists.
- 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 observed one medical handover where patient care was discussed and discharges planned.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.
- The trust had a major incident plan dated October 2013 (overdue for review in October 2014) that covered maternity and gynaecology services. The plan carried action cards that gave written instructions for key staff who would be involved in the organisation and management of a major incident.
- There were arrangements in place should maternity services be suspended. These were outlined in the escalation policy.

Are maternity and gynaecology services effective?

Requires improvement

We rated maternity and gynaecology services as requires improvement for being effective because:

- The caesarean section rate for 2015/16 was 30.3% which was worse than the national average of 26.5%. The caesarean section rate had risen to 42.9% in April 2016. This was worse than the caesarean section rate in the two previous years. The deteriorating caesarean section rate was not recorded on the risk register.
- Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care. However, the results of monitoring were not always used effectively to improve quality. Action plans were drawn up but deadlines were not always adhered to.
- The trust were using quality data obtained from the maternity management system rather than the maternity dashboard. This meant that all data necessary to confirm effective treatment was not contained in one document. The maternity unit no longer had information technology support for issues with the maternity management system, or for collating reports and audits using the system and staff we asked to show us the system struggled to obtain data.
- Although staff we spoke with understand their role and responsibilities regarding the Mental Capacity Act 2005. The trust did not provide data to demonstrate that staff had the appropriate skills to care for patients under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

However:

- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.
- Staff worked collaboratively to serve the interests of women across hospital.
- Staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff.

- Appraisal rates for staff demonstrated that 95% of midwives and 90% of doctors had been appraised meeting the trust target of 90%.
- The trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- We saw that the procedure of consent was reviewed prior to surgical procedures which was good practice.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- To ensure compliance with NICE guidance, the trust regularly benchmarked their guidelines against those of NICE. For example, we saw a baseline assessment tool for preterm labour and birth (NICE clinical guideline NG25) that demonstrated the trust policy was 77% compliant with NICE recommendations. An action plan was in place to improve compliance, with leads identified and deadlines set.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- We found from discussions with staff and our observations that care was provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found some evidence to demonstrate that women were cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included 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 100 women had experienced a water birth between April 2015 and March 2016. A water birth resource file was available for midwives, however, this contained information dated 1997. This meant there was a risk out of date information would be used to care for patients.
- 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 mostly managed in accordance with NICE Quality Standard 132.
- The caesarean section rate was 42.9% in April 2016 in comparison with the national average of 26.5%. This was worse than the caesarean section rate in previous years. Between April 2015 and March 2016 the caesarean section rate was 30.3%; and between April 2014 and March 2015 the caesarean section rate was 28.4%. The deteriorating caesarean section rate was not recorded on the risk register.
- The trust had adopted the Robson classification system for recording caesarean sections which has 10 categories that support the analysis of the caesarean section rate.
- National statistics from the RCOG demonstrated a 72% to 76% success rate for women who opted to have a vaginal birth after caesarean section (VBAC) following previous lower segment caesarean section. The results of the Robson audit for July 2016 showed that although the rate for first time mothers had reduced, overall women having a repeat caesarean section was 52% which was similar to the results we found in August 2015.
- Managers had analysed this trend and found that women changed their minds at 41 weeks of pregnancy after consultation with an obstetrician. Of 60 women who chose the VBAC pathway at initial counselling, 13 changed their minds later. A total of 40 women attempted a trial of labour; 31 women went into spontaneous labour and 19 had successful VBAC. Nine women underwent Induction of labour and two of those had a successful VBAC. This meant that 52% (21/40) of women had a successful a VBAC.
- On our September 2015 inspection the trust told us that steps were put in place to reduce the repeat caesarean section rate. These included improved counselling around the risks and benefits of caesarean birth; reviewing all emergency caesarean sections from the previous 24 hours; and a staff multi-disciplinary study day on normality was held. We found that these steps had been completed yet the caesarean section rate continued to rise.

- We discussed plans to reduce the caesarean section rate with managers who told us that the VBAC pathway would be reviewed to remove the 41 week consultation with the consultant and replace it with attendance at the VBAC clinic. A VBAC clinic was held by the supervisors of midwives aimed at reducing the caesarean section rate.
- We did not see evidence that the trust had a standard operating procedure for women requesting caesarean section in the absence of clinical indication. However, the trust had 'guidelines for individualised care planning for women that choose care options outside of local/ national policies'. The guidance aimed to support practitioners to deliver individualised care to women who requested care outside of usual pathway guidance.
- There was evidence to indicate that NICE Quality Standard 37 guidance was 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. For example, on the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was provided in line with the NICE 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.

Evidence-based care and treatment: Gynaecology

- Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Following consultation in a designated termination of pregnancy clinic, women could choose to have early medical abortion (EMA), late medical abortion up to 18 weeks of pregnancy or surgical treatment up to 10 weeks of pregnancy under general anaesthetic. Women requesting surgical treatment after 10 weeks were referred to a private termination of pregnancy service.
- Women needing termination of pregnancy for fetal abnormality could be cared for in labour by either the nurse from gynaecology or by a bereavement midwife. This offered continuity of carer for the women if she wanted it.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STIs) should be made available. All women were tested for chlamydia infection prior to any treatment (chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STIs and treatment.
- Blood was tested at the initial assessment to determine Rhesus factor and anit-D immunoglobulin administered to women who were found to be rhesus negative.
- Contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after the abortion. These included long acting reversible contraception (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with the Department of Health's RSOP 3: Post Procedure.

Audit

- The trust provided us with the clinical audit plan for 2015/16 which showed 16 obstetric audits and eight gynaecology audits listed. Examples of audits included caesarean section, multiple pregnancies, complex needs in pregnancy and pregnant women with red cell antibodies. We saw recommendations and action plans as a result of audits. However, the action plans did not consistently demonstrate that actions had been achieved.
- An audit and education afternoon was held monthly to which all staff were invited to share learning.
- The trust actively participated in national audits including the National Screening Committee: antenatal and new born screening audit, National Neonatal Audit Programme (NNAP) and the National Diabetes in Pregnancy Audit.
- The NNAP 2014 results showed that the trust did not meet three of the five national standards. An action plan had been developed which indicated low achievement had been due to data collection and actions focused on addressing this.Three of the five standards the trust did not meet included:

  - 100% of eligible babies should receive retinopathy of prematurity (ROP) screening within the time windows for first screening.
  - 85% of mothers who deliver babies between 24 and 34 weeks gestation inclusive should receive a dose of antenatal steroids.
  - For all neonatal unit admissions there should be a documented consultation with parents.
- In February 2016, an internal audit of third and fourth degree tears demonstrated good practice in the repair of tears. Recommendations included use of a standard proforma for documentation, standardising the types and administration of antibiotic and laxative, updating the guideline on management of obstetric anal sphincter injuries (OASIS) and giving the RCOG OASIS leaflet to patients who experienced third and fourth degree tears.
- In February 2016, the 26 recommendation of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), a national report on perinatal deaths for births from January to December 2014, were reviewed by a multidisciplinary team of obstetricians, paediatricians and midwives at the trust to establish compliance with recommendations. The trust was fully compliant with 16 recommendations, partially compliant with seven recommendations and non-compliant with three recommendations. A review date of 30 June 2016 was set on the action plan; however, such updates were not evident. For example, there was no confirmation that actions were completed for recommendations with partial compliance that concerned updating of guidelines. The three areas of non-compliance were protection of funding for bereavement care to ensure the quality of support provided was not compromised for this vulnerable group of women and their families and was part of the trusts five year plan; undertaking a standardised multidisciplinary review of all stillbirths with a deadline of 31 August 2016; and symphysis fundal height to be measure from 24 weeks gestation which was implemented immediately.
- The government National Maternity Review report, Better Births, published in February 2016 made recommendations based on seven themes: personalised care, continuity of carer, safer care, better postnatal and perinatal mental health care, multi-professional working, working across boundaries and a fairer payment system. The supervisors of midwives team had benchmarked the service against the recommendations. There was non-compliance with the recommendation for a fairer payment system; compliance with four of the recommendations: personalised care, safer care, multi-professional working; action plans were in place to address continuity of carer and working across boundaries.
- Arden, Herefordshire and Worcestershire Clinical Commissioning Group (CCG) had also assessed the maternity service against the recommendations. The CCG suggested that additional classes and support should be offered to assist women to make informed choices. It also recognised that perinatal mental health care at the trust needed improvements. Herefordshire CCG was facilitating Wye Valley NHS Trust and a local mental health trust to develop a pathway, to comply with NICE and MBRACE.

Pain relief

- Women we spoke with in maternity felt that their pain and administration of pain relieving medicines had been well managed.
- We saw staff interacting with patients, discussing effective pain management, and actions that could be taken to assist with patient comfort.
- On the maternity ward we saw a variety of pain relief methods available including TENS (transcutaneous electrical nerve stimulation) machines and Entonox, a ready to use medical gas mixture of 50% **nitrous oxide** and 50% oxygen that provides short term pain relief. Epidurals were available 24 hours a day.
- A birth pool was available on the delivery suite so women could use water immersion for pain relief in labour.

Nutrition and hydration

- The practice development midwife was also responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust 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 to feed their baby.
- The trust had been awarded and maintained The United Nations Children's Emergency Fund Baby Friendly Initiative stage one accreditation and was working towards assessment for stage two accreditation in

October 2016. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.

- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 84% between January and March 2016 which was better than the national average of 75% and 54% of women were breastfeeding on discharge from maternity care (January and February 2016 only).

Patient outcomes: Maternity

- March 2015 to April 2016 quality data demonstrated that:
  - The normal delivery rate was 57%, which was worse than the RCOG recommendation of 60%.
  - The homebirth rate was 2.5% which was similar to the national average of 2.3%.
  - The caesarean section rate was 30.3% worse than the national average of 26.5%.
  - Of these 15.3% were elective, which was worse than the national average of 10.7% and 15% were emergency which was similar to the national average of 14.7%. However, at times the caesarean section deteriorated, for example 42.5% in April 2016 and 39.2% in May 2016.
  - The induction of labour rate was 18%, which was better than the national average of 22%.
  - The Ventouse delivery and forceps rate was 13% which fell in line with the trust target of 10 to 15%.
  - There were 49 third or fourth degree tears recorded which equated to 2.2% of patients.
  - There were six stillbirths, but these were not recorded on the dashboard.
  - 72 term babies were admitted to special care baby unit (SCBU) within a day of birth.
- Clinical data normally recorded on a maternity dashboard, for example, postpartum haemorrhage, admission to the intensive care unit following complications after the birth and unexpected term admissions to SCBU were not recorded on the quality data but were available from the maternity management system.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in gynaecology outpatients during the week. A team of staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.
- Activity data for April 2015 to March 2016 that demonstrated the following:
  - 4,152 referrals to the gynaecology service
  - 10,023 outpatient appointments
  - 451 elective split-spell discharges
  - 885 day case split spell discharges
  - 378 non elective split spell discharges
- Patients were offered a choice of medical or surgical treatment for termination of pregnancy. There were four theatre slots per week available for surgical termination of pregnancy. There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4.
- We saw that consent forms were completed appropriately. The patient's GP usually signed Part 1 of the HSA1 form (a HSA1 form must be completed, signed and dated by two registered medical practitioners before an abortion is performed under Section 1 (1) of the Abortion Act 1967). Alternative systems were in place for obtaining a second signature if the GP had not completed the form.

Competent staff

- We were told that in response to an incident where a second theatre was unavailable, staff had regular training in the procedure of setting up a second theatre. We saw a photographic manual of this on the delivery suite that had been produced to support staff.
- Five midwives had been trained in Newborn and Infant Physical Examination (NIPE). Succession planning was in place and two more midwives were booked to undertake the course in October 2016.
- The 'Academy' had been established to provide induction and training for band 5 and newly appointed band 6 midwives. Midwives spent two to three weeks in the class room followed by five weeks supernumerary clinical orientation.
- All newly qualified midwives undertook an 18 month preceptorship period prior to obtaining a band 6 position. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.

Maternity and gynaecology

- Midwives on the preceptorship programme project managed initiatives as part of their training. We saw evidence of the projects; a midwife had developed flashcards for community midwives to use when communicating with emergency services from a woman's home. Other projects included breastfeeding initiatives.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is 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 for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:16 (LSA Report 2014) which meant that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice. One midwife was on the preparation for supervisors programme.
- 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.
- The induction programme for new permanent staff and students included mandatory training and competency based ward skills. New staff were inducted to the clinical area.
- Student midwives spoke highly of their mentors and felt well supported.
- Newly registered nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- Nursing revalidation was supported by the trust and nursing staff were given assistance and support to complete the appropriate reflective accounts, and training to complete this.
- From November 2015 a Paediatric Deanery directive prohibited paediatric junior doctors to undertake the NIPE out of hours and at weekends. This was on the risk register.
- Appraisal rates for staff demonstrated that 95% of midwives and 90% of doctors had been appraised meeting the trust target of 90%.

Multidisciplinary working

- A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients. We observed one medical handover where patient care was discussed and discharges planned. The labour ward coordinator attended this meeting. We noted that an anaesthetist was not in attendance.
- Communication with community maternity teams was efficient. The teams worked closely together and the community team provided cover for the hospital during peaks in activity.
- The women's health ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- Patients were referred to specialist consultants internally and externally if their condition changed.
- Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment.

Seven-day services

- Access to medical support was available seven days a week.
- Community midwives were on call over a 24 hour period to facilitate home births.
- Women could attend the day assessment unit for glucose tolerance tests on Saturday mornings. This was helpful for women who worked or had family responsibilities in the week as this test requires them to be on the hospital premises for up to two hours.
- Postnatal clinics were available every day which meant babies received their first examination before 72 hours of age.
- The maternity triage unit was available for women to telephone over a 24 hour period. Staff told us that they often received calls from mothers that required support and advice during the night.
- Local diagnostics services were available daily with out of hour's facilities for emergency procedures, such as x-ray and pathology.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role.

Maternity and gynaecology

- Staff had access to a maternity specific system. The system was real-time and allowed staff to securely share and access maternity patients' information, for example birthing plans.
- The IT lead post had been assimilated into the midwifery workforce to provide clinical care. This meant that the maternity unit did not have IT support for issues with the maternity management system, or for collating reports and audits using the system. This was on the risk register. Staff we asked to show us the system struggled to obtain data.
- One root cause analysis completed in June 2016 had identified issues with accessing information and recommended that a meeting was arranged between IT and maternity staff to discuss how to resolve these issues and consider making abnormal results more prominent on the system.
- Patient discharge summaries were sent electronically to the patients GP at the time of discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the procedure of consent was reviewed prior to surgical procedures which was good practice.
- Staff we spoke with had an understanding of the Mental Capacity Act 2005 and were able to explain their role and responsibilities should they need to assess a patients capacity.
- We asked the trust for data regarding the staff training compliance with three yearly Mental Capacity Act 2005 training and with three yearly Deprivation of Liberty Safeguards training. 90% of midwives had received Deprivation of Liberty Safeguards training and 87% of midwives had received Mental Capacity Act 2005 training.
- We saw evidence that two doctors had authorised terminations of pregnancies in line with the Abortion Act 1967.

Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services as good for being caring because:

- The majority of women and those close to them were positive about the care and treatment they had received.
- The NHS Friends and Family Test (FFT) showed that the maternity service generally performed in line with the England average.
- In the CQCs Maternity Survey of Women's Experience of Maternity Services 2015, the service performed the same as other trusts in the three main areas; labour and birth; staff during labour; and care in hospital after birth.
- Staff were kind and caring towards patients.
- Patients, partners and relatives felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- Women's privacy and dignity were protected.

However:

- The FFT for the gynaecology ward, showed 51.8% of patients would recommend the service to friends and family, which was significantly worse than the national average of 95%.

Compassionate care

- Women and their relatives we spoke with were positive about the care they had received on the delivery, maternity and gynaecology wards.
- We observed caring, compassionate and informative interactions between staff and patients.
- We observed staff protecting women's privacy and dignity by knocking on doors and waiting to be invited in on the gynaecology ward and the delivery ward. We also observed staff waiting outside of curtains and asking permission to enter. One woman said "the people (staff) here are respectful towards us (patients) and they are always on hand to close my curtains when I am nauseous which makes me feel comfortable".
- Privacy and dignity was also enabled by the use of privacy screens around beds and on the entrance to rooms on delivery suite.
- Women we spoke with felt that there were enough staff to meet their individual needs.
- The NHS Friends and Family Test (FFT) results between March 2015 and February 2016 were similar to the England average for the antenatal and postnatal wards. The percentage of people recommending the birth and postnatal community provision were also similar to the England average.

Maternity and gynaecology

- Between March and May 2016, the percent of patients that would recommend the service varied from 96% to 99%. However, the response rate varied between from 28% to 43%.
- For the gynaecology ward between March and May 2016, 51.8% of patients would recommend the service to friends and family if they needed similar care or treatment. This was significantly worse than the national average of 95%.
- The results for the CQCs Maternity Survey of Women's Experience of Maternity Services 2015 were about the same as other trusts for most areas of questioning. The trust performed better than other trusts for questions pertaining to being left alone by midwives and doctors at worrying times and being helped within a reasonable time when needing attention.
- The women's forum reported that feedback from the postnatal group was positive about the care they had received.

Understanding and involvement of patients and those close to them

- Women told us that they felt well-informed and able to ask staff questions if they were unsure of anything. One woman said "I feel able to ask for help at any time of the day and night because staff are very kind and approachable".
- Women and their partners we spoke with on the maternity ward told us they felt involved and reported that communications with staff were good throughout their stay.
- A carer of a patient on the gynaecology ward told us that consultant staff always greeted the patient's carer upon arrival and introduced themselves.
- We observed staff informing and updating patients of delays to clinics both in person and by writing it on the boards in waiting areas.
- Women who had received minor gynaecological surgery a day case basis, told us they had received good care and they had been informed about their discharge home. This met patient expectation, as discussed with staff pre-operatively, that they would be discharged home on the day of the procedure.

Emotional support

- Women were able to telephone the maternity triage unit 24 hours a day and speak with a midwife for support. Midwives told us this was regularly utilised by mothers that required breastfeeding support and advice throughout the night.
- Midwives observed women for anxiety and depression levels.
- There was not a dedicated bereavement midwife as the unit size was small. However, midwives with a special interest led on bereavement services for women who had experienced pregnancy loss.
- Counselling for termination of pregnancy was not provided at the trust. Staff referred women to their GP's if they requested support.
- The trust had a chaplaincy team who were available to provide pastoral and religious support to patients and their families.
- We saw within root cause analysis documentation that support for patients and relatives involved in an incident was offered.

Are maternity and gynaecology services responsive?

Requires improvement

We rated maternity and gynaecology services as requires improvement for being responsive because:

- Gynaecology services were not always responsive to patient's needs. There were gynaecology patients on surgical wards due to lack of gynaecology beds. This meant that gynaecology patients were not always cared for on the most appropriate ward.
- Lack of medical staffing resources to deliver the gynaecology cancer pathway meant there was a number of women breaching referral to treatment times. The two week wait for cancer patients had been managed by adding extra lists and working with a neighbouring trust.
- 39 operations were cancelled on the day of surgery between March 2015 and April 2016, 18 of those were due to lack of beds.
- The trust had recognised a gap in gynaecology cancer provision on the risk register and long term mitigating actions were planned to be completed by the end of 2016.

- There was no dedicated bereavement room which meant women were cared for on labour ward.
- Complaints about maternity and gynaecology services were managed in line with trust policy. However, we could not establish if learning had been identified form complaints as the trust did not provide this information.

However:

- Maternity services were responsive to patient's needs. The service was flexible and provided choice and continuity of care.
- Patients' individual needs and preferences were considered when providing care and treatment.
- Women were supported to make a choice about the place to give birth.
- Midwives with special interest provided care and support to women. For example, women who suffered pregnancy loss and women with gestational diabetes.
- There were facilities for people who did not speak or read English and who required hearing loops.

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.
- 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.
- We were told of plans to open a nurse led outpatient termination of pregnancy service which would relieve flow through the gynaecology ward.
- There was a Z-bed available should a partner wish to use it. There was also a relative's room on the ground floor that could be used.
- We saw a variety of patient information leaflets available. We saw that since our September 2015 inspection, the women's forum had reviewed the updated information leaflets for induction of labour. For women suffering pregnancy loss, leaflets were available outlining the choice of expectant (awaiting events) or surgical management.

Access and flow: Maternity

- The maternity unit had not closed between April 2015 and March 2016. Staff told us that flow was not a problem in the maternity unit because the duty manager had a 'helicopter view' of the service which meant the service could be managed the effectively.
- We saw that in January 2016, 85% of women, in February 2016 92% of women, and in March 2016 97% of women were seen by a midwife by 12 weeks and six days of pregnancy against the trust target of 98%. National Institute for Health and Care Excellence (NICE) guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Downs's syndrome, which must be completed by the 13 weeks and six days of pregnancy, can be arranged in a timely manner.
- The trust had investigated the reason for late initial assessments and found that the main reasons for women not attending by 12 weeks and six days of pregnancy were late presentation due to moving into the area, women with safeguarding issues and those who did not speak English as a first language. To address the issue of non-English speaking women, the trust planned to engage with the Eastern European community and had draft leaflets in Lithuanian and Bulgarian for women.
- We saw documentation which confirmed women were supported to make a choice about the place to give birth. Women discussed their choice regarding place of birth and birth plans with their midwife at the 36 week antenatal appointment. We saw that specific risk factors were taken into account which needed to be considered and would lead midwives to advise a hospital rather than a home birth. The birth plan was then entered onto the maternity management system so that midwives caring for the woman in labour knew their wishes. We saw that this happened.
- Elective caesarean section lists ran twice a week with three operations on each list. We saw that one woman had to wait for her caesarean birth due to an emergency that required treatment in theatre.
- The day assessment unit (DAU) provided an assessment service to women between 8.30am and 6pm, Monday to Friday on an appointment basis. Women could be referred to the DAU by community midwives, GPs or self-referral. Day care was available for women with

concerns, such as reduced fetal movement. The DAU was run by one midwife and a support worker. Medical cover was provided by obstetricians from the on call team. Women were seen on the triage unit out of hours.

- There was a designated triage area open 24 hours each day where women with urgent complaints could be reviewed and assessed. All women who were in labour were assessed on triage. Women were provided with the telephone number for the unit and could access it directly if they had any concerns. Staff kept a log of phone calls that demonstrated they spoke with an average of 25 women per day. Appointments were offered to women and we saw that 10 to 12 women each day were reviewed on triage.
- The trust had introduced daily Newborn and Infant Physical Examination (NIPE) clinics on the postnatal ward. Women who had gone home before 72 hours could have their babies examined at home.
- At the weekends, a postnatal clinic was run in the outpatient department. This meant women had a choice of set appointments rather than waiting at home for a midwife.
- Between September and December 2015, bed occupancy for maternity was 76% which was worse than the England average of 60%.

Access and flow: Gynaecology

- A midwifery-led early pregnancy assessment unit (EPAU) offered appointments between 8am and 4pm each weekday. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and emergency department. There was access to scans each morning and medical opinion was accessible from the on call registrar.
- There were no outliers on the gynaecology ward at the time of our inspection. However, there were gynaecology patients on surgical wards due to lack of gynaecology beds. One patient was also waiting for review in the emergency department. This meant that gynaecology patients were not always cared for on the most appropriate ward, where staff have specialised skills and knowledge.
- Lack of medical staffing resources to deliver the gynaecology cancer pathway meant there was a number of women breaching the recommended review within two weeks, and then subsequently treated within 62 days. Increased GP referrals had contributed towards the risk. This was on the risk register. The two week wait for cancer patients had been managed by adding extra lists and working with a neighbouring trust.
- We saw that the waiting time for gynaecological outpatient appointments was 12 to 13 weeks which was within the RTT of 18 weeks. There had been one 52 week breach.
- There were 5.5 theatre lists per week for gynaecology operations. The trust provided us with information that showed 39 operations were cancelled on the day of surgery between March 2015 and April 2016, 18 of those were due to lack of beds. Theatre lists were cancelled due to lack of beds. For example, the RTT for admitted patients was 91% in December 2015 but this fell to 69% in January 2016 and 66% in February 2016. One formal complaint was received in March 2016 received following cancelled surgery. The trust had recognised a gap in gynaecology cancer provision on the risk register and long term mitigating actions were planned to be completed by the end of 2016.
- Colposcopy and hysteroscopy was offered on an outpatient basis. There were plans to move this to a nurse-led service on our September 2015 inspection. Two specialist gynaecological nurses had been employed but the nurse led service had not started at the time of this inspection.
- A side room was used on the gynaecology specifically for women undergoing termination of pregnancy.

Meeting people's individual needs

- Women with complex requests or needs, for example requesting home birth when risk factors were present, held discussions with the supervisor of midwives to establish a safe birthing plan.
- We saw that there were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Downs's syndrome, were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.
- In the CQC In-patient Survey 2015, the trust scored 9.3 for responsiveness of staff during labour, better than the England average of 7.3.
- One of the rooms on delivery suite was used as a low risk room. This room offered specialist equipment, such as beans bags and birthing balls to promote the comfort of women in labour. A birth pool was located in this

room for women who wished to use water immersion for pain relief in labour. In addition to the birth pool, there was also a portable 'birth pool in a box' (inflatable birth pool) available which meant that two women were able to have a water birth at the same time.
- Midwives led 'active birth classes' for women to help them prepare for labour. This was part of the midwifery initiative to promote normal birth.
- There was no dedicated bereavement room. Women who had experienced a stillbirth were cared for on the delivery suite. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss. The trust had established a project group for the redesign of the maternity unit. Plans included a dedicated bereavement suite.
- Midwives with special interest provided care and support to women who suffered pregnancy loss from 16 weeks of pregnancy. Lead nurses told us that a previous business case for a band 7 bereavement lead had not been approved. The head of midwifery (HOM) told us that a business case would be submitted for a dedicated bereavement team.
- The trust ran a diabetes clinic to support women with gestational diabetes throughout pregnancy.
- Specialist midwives for screening and safeguarding who had successfully completed additional training, gave advice and support to women and midwives. Midwives with special interests led on maternity projects as part of their substantive role, such as bereavement support, and care of women with diabetes.
- There was no designated mental health midwife. However, a clinical practice nurse in mental health had capacity to see four women in antenatal clinic per month. A designated consultant was responsible for perinatal health and triaged women who required a referral to the mental health services.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was an on-site special care baby unit.
- Supervisors of midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They ensured that the care received met women's needs.
- Partners could visit between 9am and 9pm, visiting times for grandparents was 2pm until 4pm and other people could visit between 6.30pm and 8pm. At the time of our inspection, visiting times were under review. A survey of over 100 people had been carried out and staff had sought the views of the women's forum to establish how visiting times could improve.
- For gynaecology, visiting hours was 3pm until 5pm and 7pm until 8.30pm.
- The trust had a varied menu and catered to a wide range of nutritional and cultural needs. However, a woman we spoke with told us that they had not received an alternative menu despite telling staff that they had intolerance to certain foods. We raised this with the ward manager who resolved the issue immediately.
- Food was available outside of set meal times for women if they did not feel like eating at set meal times.
- Staff told us information leaflets could be requested in different languages via the patient advice and liaison service.
- We saw that there was an interpreter service available face to face or by telephone. We observed interpreters presence on the maternity ward during our inspection.
- Patients had access to a chapel and multi faith room on site.
- Hearing loop facilities were available throughout the hospital.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the patient experience team if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Once a complaint was made, it was sent to the division's inbox and distributed to responsible officers for investigation and responded to within 25 days.
- Information from the trust indicated that there had been 16 formal complaints between November 2015 and March 2016. However, these were for all of women's and children's services. There were three maternity or gynaecology complaints received in March 2016.

Maternity and gynaecology

- Seven informal complaints had been made regarding the gynaecology service. Outcomes were recorded and none of these had progressed to formal complaints.
- We asked the trust for information regarding the formal complaints but this was not provided.

Are maternity and gynaecology services well-led?

Requires improvement

We rated maternity and gynaecology services as requires improvement for being well-led because:

- Not all risks were identified on the risk register and mitigated. For example, the worsening caesarean section rate had not been identified as a risk and we saw no plan to address the risk.
- Two documents were used to monitor outcomes: the quality report obtained from the maternity information system and the dashboard. This meant there was no clear oversight of outcomes and activity.
- There was a risk that patient care was compromised. For example, the midwifery led unit (MLU) and second theatre had not yet been built.

However:

- There was a statement of vision and strategy.
- There were improvements to the leadership structure since our September 2015 inspection. A new governance structure was in place. However, it was too early to assess its impact.
- The team of managers were enthusiastic and were making sustainable changes in maternity.
- Leaders were described as visible and approachable.
- There was an active women's forum that met regularly and provided input into projects in the maternity services.
- The culture within the service encouraged candour, openness and honesty.

Vision and strategy for this service

- We saw the 'Integrated Family Health Service Strategy on a Page' document containing the mission statement and values. These were underpinned by six strategies: improving quality of care, improving responsiveness of the service, development of a highly skilled workforce, development of first calls facilities, transformation of health and wellbeing through partnership working, and having a role as an asset to the people of Hereford and the surrounding areas.
- Staff told us the vision was having the right care in the right place at the right time.
- Senior managers cited the redevelopment of the maternity unit to include a second obstetric theatre, midwifery led unit and bereavement suite, and development of the mental health pathway as the main priorities for the maternity service.
- At our September 2015 inspection, a maternity patient care improvement plan (PCIP) was in place. There were 63 items on the PCIP. This was replaced by gynaecology and obstetrics improvement plan. There were four items regarding gynaecology and 11 regarding maternity on the action plan. We found that one action was completed, nine were in progress, four were overdue, and one action had not yet started. We saw that responsibilities had been allocated, deadlines set and progress towards completion was noted.

Governance and risk management

- The governance structure was less fragmented following the June 2016 restructure, this was new and staff were still adapting to it. Obstetrics and gynaecology was part of the surgical division. It was led by a triumvirate of the matron, business manager and clinical director who reported to the divisional operating manager, divisional clinical director and divisional director of nursing.
- The maternity service was led by a matron who was professionally accountable to the director of nursing and responsible to the divisional director of nursing. It was unclear whether the matron reported to the head of midwifery (HOM), who had a strategic role and in turn, reported to the director of nursing and quality.
- The RCOG Good Practice No.7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- At our September 2015 inspection, the trust was not using the RCOG maternity dashboard. This has since

been put in place but was not fully populated. For example, we could not see an intrapartum stillbirth that occurred in January 2016 entered on the dashboard. The trust also continued to use quality data obtained from the information management system, so in effect, had two documents. Staff said the quality data document was the working document and not the RCOG dashboard. This meant that although data could be obtained from the management system to combine the two documents, delivery outcomes were not matched against other factors, such as staffing number of incidents and complaints.

- We saw documentary evidence that the clinical commissioning group (CCG) had reviewed the Wye Valley NHS Trust acute contract to enable the development and monitoring of a maternity dashboard which would enable the CCG to formulate robust challenges regarding maternity care.
- The risk coordinator managed obstetrics and gynaecology risk, audit and complaint activities.
- Managers met at the weekly risk review group to review incidents and reported to the monthly obstetrics and gynaecology governance group which in turn reported to the monthly divisional governance group who reported to the board. As the structure was new, we were unable to view meeting notes.
- We saw the action logs from obstetrics and gynaecology governance group for 2016 which contained actions, agreed responsibility and a column for timelines. However, this was not consistently completed. For example, one recommendation from a root cause analysis completed 6 June 2016 was for the obstetrics and gynaecology governance group to review and consider introduction of presentation scans being undertaken in triage when labour was suspected. However, in the governance meeting on 17 June 2016, this was not minuted as being discussed.
- The maternity and gynaecology risk register for July 2016 contained thirteen risks. Eleven related to maternity, one risk related to gynaecology and one risk related to both areas.
- Not all risks were identified on the risk register. For example, the increasing caesarean section rate had not been identified as a risk and we saw no plan to address the risk.
- A quarterly perinatal mortality and morbidity meeting reviewed adverse events in order to identify the causes and identify steps could be taken to prevent recurrence.
- A labour ward forum met quarterly to identify areas of good practice and new evidence based guidelines and fed into the clinical excellence group. We were told that a labour ward innovations group had been established and met fortnightly.
- We were told that following review at the weekly meeting, significant incidents, such as intrapartum stillbirth, were subject to a multidisciplinary rapid review within 24 hours. The risk coordinator coordinated reports which were reviewed by the executive team who decided whether the threshold for reporting to Strategic Executive Information System and commissioners was met and allocated the case to a lead investigator. We saw one root cause analysis could be led by an investigator who was not an expert in obstetrics.
- Since our September 2015, guideline management had been changed and this had resulted in more efficient approval of guidelines. A named lead was responsible for overseeing all guidelines. Monthly meetings were held and there were clear timelines for review. However, we found out of date guidelines in a folder on delivery suite which could cause confusion for staff. We discussed this with senior staff who told us the latest versions of guidelines were on the intranet. Guideline management was identified on the risk register.
- Staff told us that they recieved feedback in various ways. Performance issues were taken up with the individual staff member. A quality and risk newsletter was available electornically and in hardcopy.

Leadership of service

- Gynaecology and maternity services was led by the clinical director for obstetrics and gynaecology following a governance restructure in June 2016.
- We observed an enthusiastic and motivated team of managers who were making sustainable operational changes to the maternity service.
- Senior staff told us the trust business manager was supportive, that they listened and facilitated change. They told us that the executive team 'get it' and they felt a 'sea of change'.
- Six ward managers had undertaken a band 7 development programme. This was not mandatory and we were told staff who were interested could be nominated to attend the programme. Those who had undertaken the programme spoke highly about how it

had helped them develop managerial and project management skills. We observed excellent examples of facilitative leadership at ward level, particularly in the community service.
- Midwifery staff spoke positively about matrons at departmental level and their support in general. Staff said that senior managers were visible and that an 'open door' policy was in operation.
- We were told that the senior midwifery management had direct access to the trust board. This meant midwifery issues were taken to the board by staff with oversight and understanding of maternity service issues.
- Members of the trust board were visible. There was a nominated non-executive director with the responsibility for maternity services.

Culture within the service

- Midwifery staff were flexible and told us they worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.
- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of patients. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.
- From our observations and discussion with staff we saw a continued resilience and a determination to do the best they could under the constant pressure they were facing.
- The culture within the service encouraged candour, openness and honesty.

Public engagement

- An active women's forum was in place. We saw minutes of meetings held in December 2015, February 2016 and March 2016. A standing agenda was followed and members had the opportunity to provide input and ask questions on a variety of issues including the development of the **MLU.**
- We met with two members of the women's forum who said that the forum gave them to opportunity to influence maternity care provision. They attended trust meetings to give input into issues, such as visiting hours, grandparent sessions, breastfeeding support and service developments, for example the plans for the MLU.
- Members expressed concern that the trust women were travelling to other maternity units in the region because of the lack of a birth centre. They were frustrated to see that the frailty unit was built very quickly but the plans for the MLU had been cancelled. The trust explained that this was because the cost of the build exceeded the available budget. However, a MLU was part of the plan to redesign the maternity unit to accommodate a second obstetric theatre.

Staff engagement

- There was a 'Going the extra mile' recognition scheme in place for staff.
- Staff we spoke with said they felt listened to and were able to make suggestions.
- We saw within root cause analysis documentation that support for staff involved was offered where appropriate.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.

Innovation, improvement and sustainability

- We found that staff were focussed on continuously improving the quality of care for patients.
- There was evidence of sustained and continual improvement across the maternity service. For example, band 7 managers had led a staffing review and midwives were moved to reduce the pressure on the community midwives to attend labour ward in times of escalation.
- A more robust and less fragmented leadership structure had been developed in June 2015 however, it was not yet fully embedded.
- Following the September 2015 inspection, the trust developed a quality improvement plan to capture improvements. However, maternity did not directly feature in this plan. We did see a local gynaecology and obstetrics improvement plan. Responsibilities had been allocated, deadlines set and progress towards completion was noted.
- At this inspection there had been the following improvements noted since the September 2015 inspection:

- Flexible staffing arrangements.
- Local leadership.
- Band 7 managers were cohesive and enthusiastic.
- An improved governance structure had been developed.
- Development of a maternity dashboard.

Maternity and gynaecology

- Improved practice of fresh eyes reviews and local audit.
- Implementation of appropriate learning from incidents.
- Areas in which performance had deteriorated since the September 2015 inspection were:
- Caesarean section rates had worsened which had not been identified on the risk register and therefore, we saw not mitigating actions in place.
- Gynaecology patients cared for on non-gynaecology wards.
- Referral to treatment times that did not meet targets.
- Cancelled gynaecology operations on the day of surgery.
- The ratio of midwives to births had worsened.
- We requested details of any innovative initiatives that maternity and gynaecology services would like to highlight. However, none were provided. We did not see any evidence of innovation during our inspection.

Services for children and young people

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

Information about the service

Services for children's and young people at Hereford Hospital consisted of a paediatric outpatient department, special care baby unit (SCBU) and a paediatric ward which included an assessment unit, on the second floor of the hospital.

The SCBU had 12 cots. One cot was for babies that needed intensive care and two were for babies with high dependency needs; the remaining nine cots were for babies who required special care. The unit did not routinely care for babies born at 30 weeks or under, and where this did happen it was for periods of less than 24 hours. Babies who required intensive care which was expected to be for more than 24 hours were transferred to other hospitals in the West Midlands.

The paediatric ward had 16 beds, four of which were in the paediatric assessment unit on the ward. The assessment unit was open from 8am to 8pm Monday to Friday. There was one bed for children who required closer observation and four cubicles which could be used for isolation. The beds were in bays of four or in single cubicles. There were play areas and facilities for teenagers on the paediatric ward. There were facilities for parents and carers on the paediatric ward and SCBU.

Services for children and young people had a dedicated outpatients' area for patients attending appointments.

During the inspection we visited the SCBU, paediatric ward, outpatients' area and theatres. We spoke with a number of staff including nurses, doctors, support assistants as well as patients and their relatives. We observed interactions between staff, patients and parents. We read patient care records, policies and procedures and other documentation as necessary. We reviewed data provided by the hospital.

Services for children and young people

Summary of findings

We rated services for children and young people as requires improvement. We rated the service requires improvement for effective and well-led. We rated the service as good for being safe, caring and responsive.

We rated the service as requires improvement because:

- There was not always effective and timely incident reporting and management.
- Lessons learned from incidents were not always shared and understood by staff.
- Not all risks were identified on the risk register, such as ligature risk. However, mitigating actions had been taken.
- The trust's mandatory training target of 90% had not been achieved although there had been some improvement since the September 2015 inspection.
- The trust did not use an acuity tool to assess whether additional staff were required depending on the acuity and age of patients present on the ward. However, we saw staffing levels met patient need.
- Procedures and guidance available to staff were not always up-to date. This had been identified in September 2015 but action had not been taken.
- Audits were undertaken to monitor compliance. Audit aims and objectives were clearly defined. However, audit plans did not define clear timescales, were not always assigned to a lead, actions and recommendations were not always documented and there was no evidence of discussion around the audit findings.
- Intended Patient outcomes were either in line with the national average or worse than the national average. The trust had developed action plans to make improvements.
- The transition arrangements for conditions, with the exception of diabetes, were not clearly defined.
- The service did not have a clear vision.
- Objectives in the business plan had been set but were not supported by actions, timescales or accountability.
- Some risks we identified during our inspection had not been included on the risk register, we also highlighted this in the September 2015 inspection.
- Risks were overdue their review date.
- Governance processes were not in place to assess and review policies and care pathways.

However, we also found:

- Patients and stakeholders were involved in service development, including a children's and young people's ambassador group.
- Play workers arranged activities for patients, to provide patients with the opportunity to meet peers who had similar patient experiences.
- Patients and / or their relatives were informed when things went wrong.
- Good standards of cleanliness and hygiene were maintained on the paediatric ward and special care baby unit (SCBU) which was an improvement since September 2015.
- There was adequate equipment to meet the needs of patients.
- There were suitable arrangements in place for management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Patient's individual medical records were written and managed in a way that kept patients safe.
- Staff were clear about their roles and responsibilities around the safeguarding children.
- Patient risks were managed appropriately and their risks were assessed on admission; observations were made in line with their risk assessment.
- Medical staffing levels and skill mix were planned so that patients received safe care and treatment.
- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.
- Most staff had the right qualifications and experience to carry out their role.
- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner patients could understand.
- There were facilities to engage and occupy young children and teenagers admitted to the ward.
- There were overnight facilities for parents to stay on both the paediatric ward and SCBU.

Services for children and young people

- Leaders were visible and approachable; ward managers understood the challenges at a local level.
- Staff felt well supported and listened to, there was a strong culture of putting the patient first.

Are services for children and young people safe?

Good

We rated services for children and young people as good for being safe because:

- Good standards of cleanliness and hygiene were maintained on the paediatric ward and special care baby unit (SCBU) which was an improvement since September 2015.
- The paediatric department including SCBU had adequate equipment to meet the needs of patients.
- There were suitable arrangements in place for management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Patient's individual medical records were written and managed in a way that kept patients safe.
- Patients and/or their relatives were informed when things went wrong.
- Staff were clear about their roles and responsibilities around the safeguarding children.
- Patient risks were managed appropriately and their risks were assessed on admission; observations were made in line with their risk assessment.
- Medical staffing levels and skill mix were planned so that patients received safe care and treatment.

However, we also found:

- There was not always effective and timely incident reporting and management.
- Lessons learned from incidents were not always shared and understood by staff.
- We were not provided with a records audit for SCBU patients.
- Not all risks were identified on the risk register, such as ligature risk. However, mitigating actions had been taken.
- The trust did not use an acuity tool to assess whether additional staff were required depending on the acuity and age of patients present on the ward. However, we saw staffing levels met patient need.

Incidents

- Staff understood their responsibilities to report incidents, incidents were investigated and patients and / or their relatives were informed when things went wrong.
- There were a total of 167 incidents reported within the children and young people's acute services from February to June 2016.
- The trust had reported no never events within between March 2015 and February 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The trust used an electronic incident reporting tool to report incidents. The staff we spoke with were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so.
- From our analysis, we found that the majority of incidents were reported and investigated on a timely basis. However, we found that nine (5%) incidents took between five and 25 days to be reported with no reason stated for the delay. These incidents related to unexpected admissions to SCBU or the paediatric ward, as well as patients absconding. All incidents should have been reported in line with the trust's incident reporting policy which stated that incidents should be reported in a timely and appropriate manner.
- Most incidents had been investigated on a timely basis; 87 (52%) within 10 days and 68 (41%) within 40 days; two incidents (1%) had taken between 80 and 90 days to be investigated. We noted that one moderate incident had been recorded as investigation completed on the electronic system but the narrative stated the investigation was ongoing. The incident reporting policy did not stipulate timescales for investigations to be completed for incidents classified as moderate.
- The trust target was to complete a root cause analysis for a serious incident within 60 working days. However, there was no guidance within the policy on the length of time to complete an incident reported that was not serious. There were 10 (6%) incidents awaiting final investigation at the time of our inspection, two of which dated back to April and May 2016.
- There had been one serious incident reported which related to SCBU in 2015/16, in August 2015. The investigation root cause analysis report included a summary of the incident, as well as a clear timeline of events, subsequently, the incident was downgraded to moderate. Immediate actions taken were reported and lessons learned were supported by a completed action plan. The investigation report stated that the incident details had been shared with the patients parents and carers involved.
- Another incident with slightly different learning points occurred in SCBU in March 2016. This was graded as moderate following a root cause analysis. An action plan had been developed and actions were due for completion at the end of August 2016. SCBU staff were aware of the incident but staff who worked within paediatrics (ward and outpatients) were unaware.
- We were told by managers that shared learning took place at team meetings and at daily handovers. We spoke with staff about learning lessons from incidents. Staff told us that they received feedback relating to incidents they had reported themselves. However, most staff who worked within paediatrics were unsure whether shared learning took place and were unable to recall recent incidents which had occurred within the previous 12 months either on their unit or from other wards and departments within the hospital.
- Staff who worked on SCBU commented that shared learning took place as part of the handover and were able to recall some incidents that had been reported within their unit. However, they were unaware of incidents reported by other departments in the trust but were aware that there was a trust wide bulletin that shared this information.
- There was a trust wide newsletter, 'safety bites' which reported on safety issues, including incidents.
- The trust held internal perinatal mortality and morbidity meetings on a quarterly basis which were attended by those presenting a case investigation. Discussions were held around each case presented and learning points recorded which were referenced to individualised action plans.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- Staff understood the duty of candour regulation and told us that they would share information with patients and their parents or carers as soon as practicable following an incident.
- We were told that paediatric deaths were discussed at the monthly Hereford and West Midlands children and young people death review. There had been no inpatient deaths in Hereford Hospital between July 2015 and June 2016.

Cleanliness, infection control and hygiene

- Good standards of cleanliness and hygiene were maintained on the paediatric ward, paediatric outpatient department and SCBU. We saw areas were visibly clean,
- All staff were required to compete infection control training. Level 2 infection control training had been completed by 91% of paediatric medical and nursing staff, and 85% of nursing staff within SCBU. This did not meet the 90%.
- We reviewed a sample of cleaning logs and found these to have been completed on most days on each of the areas within paediatrics and SCBU. This was an improvement from the September 2015 inspection, when we found that cleaning logs had not always been completed and staff told us that cleaning had not taken place on SCBU when the unit had become too busy.
- We saw "I am clean" stickers in use across all clinical areas stating the date and time of last cleaning. This showed that equipment was clean and ready for use.
- We observed staff complying with infection control guidance. For example, staff were bare below the elbows and wore personal protective equipment as required. Personal protective equipment and hand gel was available throughout the ward areas.
- Isolation facilities were available on both the paediatric ward and SCBU to prevent spread of infection. Signs to inform staff of the need for isolation procedures were visible.
- The outside play area on the paediatric ward had a drainage ditch around it that contained stagnant water. This had been closed off until repairs had taken place.
- We saw that toys were cleaned as required and they did not use soft toys in children's play areas.
- Monthly infection control and hand hygiene audits were undertaken. We requested details of these for the first six months of 2016 but these were not provided. The trust submitted evidence of annual audits undertaken by the infection prevention and control team in 2015. SCBU and children's outpatients had both achieved the 90% or above compliance and the paediatric ward was slightly under at 87%. There were action plans in place for each area and these were recorded as completed.
- There had been no reported cases of MRSA or Clostridium difficile between July 2015 and June 2016.

Environment and equipment

- The paediatric department including SCBU had adequate equipment to meet the needs of children and young people. Equipment was maintained and portable appliances had been subject to relevant safety tests.
- Clinical waste was appropriately stored and disposed of.
- During the September 2015 inspection we found that the blind cords in the children's outpatients department were too long and presented a ligature risk. A ligature audit had been undertaken in 2016 by the 2gether trust across the paediatric ward and each risk had been scored. We saw that some action had been taken for identified risks. For example, plastic rods had been placed over pull cords in bathrooms and the blinds had been changed and no longer presented a ligature risk.
- Risks, such as, shower hoses in the bathrooms as opposed to fixed shower heads, had been identified via the audit. An action plan had been developed which included practical solutions to mitigate risks, but most actions were, to improve staff awareness. Although we saw no evidence to demonstrate staff awareness was adequate to mitigate the risk, staff we spoke with were aware that there were ligature risks and all patients admitted to the ward with mental health needs were allocated a registered mental health nurse who provided one to one care. The ligature risks had not been included on the risk register.
- The resuscitation equipment in the paediatric department, including SCBU, contained varied sizes of apparatus to cater for the potential range in ages and sizes of the children. Daily checks were performed to ensure required equipment was available and that emergency medicines on the resuscitation trolley remained in date.
- There was a dedicated area within the post-operative recovery room to care for paediatric patients.
- Treatment rooms were appropriately secure and locked by use of a keypad. This had improved since the

September 2015 inspection, when we identified that these areas were unlocked and contained items which children or teenagers could cause harm to themselves or others.

- During the September 2015 inspection we found that there was only one piped air point for high flow oxygen on the paediatric ward which meant that if more than one child on the ward required piped air, they would need to be transferred to another hospital immediately. In the July 2016 inspection we found that additional points had recently been installed.
- The wards were not adequately secure to ensure intruders did not enter the ward.
- There was a buzzer entry system for both the neonatal ward and paediatric ward and we observed staff asking visitors who they were visiting before entering the ward. However, there was an incident when an intruder had entered the ward by tailgating a visitor leaving. A root cause analysis had been undertaken and an action plan developed. The actions had been partially completed and as a temporary measure patients and relatives were asked to request a member of staff to escort them to exit the ward. However the risk remained as patients may not remember to ask staff to do this in practice; the paediatric ward were awaiting funding to improve the physical security arrangements and this had been placed on the risk register.
- The paediatric department did not have access to security guards. In the event of an incident we were told that staff would request a porter to attend the ward or that the police would be called. Porters had been offered training on clinical holding but this had not been taken up.

Medicines

- There were suitable arrangements in place for management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines. However, we did note that one patient did not have a name band on and had received treatment. We raised this with the nurse in charge who addressed this immediately. Action was subsequently taken to remind all staff to ensure that patient name bands were placed on the wrist and ankle of all patients.
- We saw that room and fridge temperatures were checked daily and that these had all been within the required range.
- We found that medicines were securely stored in both the paediatric ward and SCBU. Controlled drugs were stored in accordance with required legislation.
- A controlled drug register was used to record details of controlled drugs received into the cupboard, administered to individual patients as well as controlled drugs which had been disposed of. We reviewed a sample of controlled drugs and found that accurate records had been maintained.
- Medication records were completed for patients. A medicine administration record specific for children was used to record medication prescribed and administered and we saw that these had been completed appropriately for patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly.
- If patients were allergic to any medicines this was recorded on their prescription chart.
- The paediatric ward and SCBU had a dedicated pharmacist who came to the ward Monday to Friday. Checks were made on stock levels as well as audits of the controlled drugs registers; pharmacists also undertook checks on patient medication records.
- A separate neonatal prescription chart was used for the specific prescribing of the antibiotic gentamicin. This antibiotic requires monitoring to ensure a safe dose is administered. We were told that the specific chart helped to ensure that the correct dose was prescribed and highlighted what monitoring was required.
- There was a trial being undertaken for the self-administration of medicines. This was specifically for children or their parents to administer medicines whilst the child was in hospital. We were told that parents were shown how to give their children specific medicines in order for them to care for their children at home. A standard operating procedure for patients to self-administer their medication had been drafted and approved in December 2015. This was an improvement from the September 2015 inspection as trialling had already begun but there were no documented procedures.
- Eight medication incidents had been reported between February and June 2016 immediate action taken had been recorded with details of further action required for the closed incidents.

Records

- Patient's individual care records were mostly written and managed in a way that kept patients safe. An audit on paediatric records had taken place in August 2015 and actions taken as a result. We requested findings for a recent SCBU patient records audit, however, this was not provided.
- We found patient records were locked securely in trolleys located at the nurse's stations. This had improved since the September 2015 inspection, when records were not securely stored.
- Records we reviewed were mainly legible and up to date and contained an appropriate level of information.
- There were flags on the system to identify venerable patients. For example, children subject of a child protection plan.
- A records audit on acute admissions had been undertaken and reported on in July 2015. This identified a need to update the paediatric integrated health record and this had been achieved.

Safeguarding

- There were systems in place to ensure safeguarding concerns were identified and reported, although tick box checklists on patient files were not always completed consistently.
- The trust had a quality improvement plan in place, with an action plan to improve safeguarding younger people. This included completion of audits, learning from audits and appointing a paediatric safeguarding lead. Progress made against the actions were reported to the trust board monthly.
- A new safeguarding lead had been appointed to directly support paediatrics and had been in post for approximately six months at the time of the July 2016 inspection. The lead worked 15 hours per week in this role and supported staff in identifying concerns and taking appropriate action.
- Staff we spoke with had an understanding of the types of concerns that would prompt them to make a safeguarding referral including; neglect, physical, emotional, sexual abuse, female genital mutilation and sexual exploitation; although most of the staff told us they would seek advice from the new safeguarding lead.
- Staff understood the safeguarding referral process and how to make a referral.
- We reviewed of a sample of patient files and found that safeguarding referrals had been made appropriately and in accordance with trust policy. The staff we spoke with told us that their confidence had increased since the new safeguarding lead had been in post and that if they needed assurance they would speak with the lead. This had improved since the September 2015 inspection, when we identified that safeguarding referrals were not made consistently and in accordance with trust policy.
- There were arrangements for safeguarding supervision and the staff we spoke with told us they found this helpful.
- There was an alert field in patient notes to alert staff if there may be safeguarding concerns relating to a patient.
- We reviewed a sample of three safeguarding records and found that some elements of records had not always been completed. For example, tick box prompts to determine whether a patient was depressed or if there was a possibility an injury could have been non accidental had not been completed for two of the three sets of records we reviewed.
- There are four levels of safeguarding training, levels 1, 2, 3 and 4. The Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff 2014 states that, 'all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns must be trained to level 3'. Named professionals must be trained to level 4.
- Review of staff training data confirmed that 100% of nursing staff on the paediatric ward, 87% of support staff and 97% of registered nurses on SCBU had completed level 3 training.
- Two named medical professionals had completed level 4 training. 83% of all eligible medical staff (excluding named professionals) had completed level 3 training against a trust target of 90%.
- Overall 90% of paediatric staff had completed adult safeguarding training. Only 82% of medical staff had completed the required training. The trust target was 90%.
- In addition to mandatory training staff of all disciplines could access the quarterly safeguarding forum, where individual cases and scenarios were discussed as well as themed sessions including child sexual exploitation and serious case reviews.

- The trust had a chaperone policy which made specific reference to chaperone arrangements for children under the age of 16.

Mandatory training

- There was a structured induction programme, the trust's mandatory training target of 90% had not been achieved although there had been some improvement in the completion rate since the September 2015 inspection.
- There were 14 mandatory training modules which each member of staff was required to complete in line with agreed frequency, this included; equality and diversity, health and safety, information governance, fire safety, moving and handling, safeguarding adults, safeguarding children level 2, resuscitation, dementia awareness, infection control, female genital mutilation awareness, Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and safe use of insulin.
- The staff we spoke with told us that they had completed their mandatory training, staff were allocated dedicated time to complete 'face to face' mandatory training, such as basic life support. Some of the mandatory training was completed on line and it was expected that staff complete this whilst working on the ward during quieter periods. The staff we spoke with told us that this did not pose any difficulties and that they found training provided by the trust helpful.
- The trust had a target of 90% compliance. Overall compliance for nursing and support staff in paediatrics was 87%, SCBU nursing staff 86% and medical staff (excluding safeguarding) had achieved 87% compliance.

Assessing and responding to patient risk

- Patient risks were managed appropriately and their risks were assessed on admission. Observations were made in line with patient risk assessments. However, the trust did not have an acuity tool and although a 'higher dependency' bed was on the paediatric ward, there was no clear admission criteria.
- Children who were admitted to the ward with mental health needs were admitted to a side room and provided with a minimum of one to one care from a registered mental health nurse. This had improved since the September 2015 inspection we found that patients who were admitted to the ward with mental health needs did not always receive immediate one to one care from a nurse specialist in mental health and that they received care from their parent or carer until one to one care was provided.
- The service was not commissioned to provide high dependency level 2 care, however, the paediatric ward had one bed which they used to care for patients who had 'higher dependency needs'. We noted there was no set criteria for which patients should be admitted to the higher dependency room. There was no policy on care management patients within this room.
- We were informed by the trust that they were monitoring the number of patients and their clinical conditions treated in the higher dependency bed, to establish whether funding should be applied for to expand the service to provide level 2 care. We were provided with a list of patients treated within the higher dependency room and their clinical conditions. The information provided did not state the patient's acuity and therefore, it was not possible to establish what level of care was required.
- Services for children and young people did not have an intensive care unit (ICU) bed, patients who required ICU level care were stabilised in the adult ICU and transferred to a suitable tertiary centre. There were no paediatric patients admitted to an ICU bed during our inspection. However, we were told that if a patient was admitted a children's nurse would be requested from the paediatric ward. A transfer policy was in place.
- Theatres had the capacity to run three emergency situations and would stop routine surgery to divert resources as required.
- SCBU had one intensive care cot and two HDU cots and set criteria for which babies should be admitted to each cot.
- A paediatric early warning score (PEWS) tool was used to monitor and manage deteriorating patients on the paediatric ward. A separate tool was used according to the child's age and we saw examples of these having been completed. Each patient's PEWS score was calculated on admission and subsequently at the agreed frequency in accordance with their latest score. We reviewed a sample of patient records and found that the PEWS tool had been completed appropriately in all cases and action taken as required.
- An audit on the use of PEWS had been undertaken in August 2015 which identified some weaknesses and

recommendations were made, although deadlines had not been set and progress with recommendations had not been documented. This was due to be re-audited as part of the 2016/17 audit plan.
- SCBU used a Newborn Early Warning Trigger and Track (NEWTT) tool to monitor and manage deteriorating patients. We found that these had been completed in all patient records reviewed and in accordance with requirements. Appropriate action had been taken if the newborn showed deterioration.
- We reviewed a sample of PEWS and NEWTT records. There were none which required the sepsis pathway to be followed.

Nursing staffing

- Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift. However, the trust did not use an acuity tool to assess whether additional staff were required depending on the acuity and age of patients present on the ward. We were told that an acuity tool had been developed and it was awaiting formal ratification before it could be used to define staffing numbers. It was anticipated this would be in use by the end of 2016.
- There were an agreed number of registered nurses working each shift (three during the day and two at night on the paediatric ward, this increased to four registered nurses during the day and three at night during the winter);the number of staff increased to cope with increased demand during the winter period, particularly due to respiratory related illnesses. There was one unregistered nurse on each shift which meant that at night during the summer months there was a ratio of 70:30 registered to unregistered staff. This meant that the recommended Royal College of Nursing ratio was not met, however, we saw no evidence of impact of this within patient care.
- We reviewed 24 shifts at random between January and July 2016 on the paediatric nursing rota. We found that most shifts had the minimum number of staff required based on the age of the child, in accordance with Royal College of Nursing safer staffing guidance. We found that there was insufficient data for three shifts reviewed to make a judgement of staffing levels. Four shifts did not have enough registered nurses duty but this was 0.8 whole time equivalents or less. However, the acuity of patients had not been considered.
- All nurses who worked on the paediatric ward were paediatric trained and each shift had a minimum of one nurse trained in advanced paediatric life support.
- The SCBU was staffed by three nurses during the day and at night. We reviewed a sample of eight whole shifts and found that 98% of shifts had been staffed to the required level. One shift was short 0.5 whole time equivalents. The SCBU worked to national requirements to provide one to one care for intensive care cots; one to two for HDU cots; and one to four for SCBU. SCBU did not use healthcare assistants on the unit.
- Three incidents related to staffing shortages on the paediatric ward had been reported from February to June 2016. No reported incidents impacted directly on patient care.
- Most of the paediatric nursing staff we spoke with told us that staffing arrangements worked well but that on occasions the ward could become busy. Particularly when patients with complex needs were admitted. Staff told us that sometimes this meant they did not get time for a break but that patients were cared for safely. Efforts were made to uplift staffing levels but this was not always possible.
- There were no nurse vacancies on the paediatric ward. There was a 9% registered nurse vacancy on SCBU. SCBU used their own nurses to work on the bank to cover shifts and promote continuity of care, no agency staff were used
- We observed nursing handovers on SCBU and the paediatric ward. They were detailed and effective, with each patient on the unit/ward discussed by the nurse in charge and allocated to a nurse for the shift.

Medical staffing

- Staffing levels and skill mix were planned so that patients received safe care and treatment.
- A review of a sample of rotas confirmed that actual medical cover agreed to planned staffing arrangements. Locums were used as required to ensure gaps in the rota were filled, for example to cover sickness or annual leave. A standard checklist was used to induct locums into the service. Locums who worked for the service long term accessed the trust induction, as well as mandatory training.
- There were no vacancies for paediatric medical staff.
- There was 24-hour consultant paediatrician cover for the SCBU and the paediatric ward.

Services for children and young people

- There were 10 consultants employed for children and young people services, working hours to ensure adequate cover to keep patients safe.
- Each consultant had a 'hot-week' when they were responsible for the paediatric ward and SCBU and they were the named 'Consultant of the Week' (COW), with a colleague taking over from them at 5pm. The COW provided cover to ensure consistency of care and support Monday to Sunday, 8.30am to 6pm.
- The middle grade doctors did not undertake night shifts. There were three middle grade doctors who covered hours between 8:30am and 9:30pm seven days per week.
- Eight junior doctors worked across paediatrics and SCBU, with a minimum of three working during the day covering paediatrics and labour ward. There was one junior doctor at night supporting the consultant. The junior doctors' rota provided consistency as one doctor was responsible for an area such as the SCBU for three or four days consecutively.
- Handovers took place twice each day and were led by a consultant paediatrician. We observed a handover and found it to be adequate.
- The unit had contact telephone numbers and access to advice from specialist paediatricians at all times.
- We saw from review of patient records that all children admitted with an acute medical problem were seen by a middle grade doctor within four hours of admission and within 14 hours seen by a consultant. All children with an acute medical problem had been assessed by a consultant prior to discharge.

Major incident awareness and training

- The trust had a major incident plan reviewed in October 2013 which was due for review in October 2014. The policy had been approved by the trust's quality and performance board. The plan carried action cards which gave written instructions for key staff who would be involved in the organisation and management of a major incident. We identified this was out of date as part of the September 2015 inspection and no action had been taken.
- We were told by management that there was no business continuity plan in place to deal with adverse weather for example.
- There was a winter management plan and an escalation policy which addressed staffing issues.
- The trust had developed and approved an abduction policy in June 2015. The policy included action cards for staff to follow in the event of an abduction although this did not cover attempted abduction. We asked staff what they would do in the event of an abduction. All staff we spoke with who worked on SCBU were familiar with the protocol and what to do and most of the staff on the paediatric ward were familiar with this.

Are services for children and young people effective?

Requires improvement

We rated services for children and young people as requires improvement for being effective because:

- Procedures and guidance available to staff were not always up-to-date. This had been identified in September 2015 but action had not been taken.
- Audits were undertaken to monitor compliance. Audit aims and objectives were clearly defined. However, audit plans did not define clear timescales, were not always assigned to a lead, actions and recommendations were not always documented and there was no evidence of discussion around the audit findings.
- Outcomes from patient's care and treatment was collected and monitored in line with national audit requirements. Intended patient outcomes were either in line with the national average or worse than the national average. The trust had developed action plans to make improvements.
- The transition arrangements for conditions, with the exception of diabetes, were not clearly defined.
- Not all staff had received training in restraint.

However, we also found:

- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.
- Patients care was planned and delivered in line with evidence based guidance.
- Assessments were made of patient's pain levels and arrangements made to ensure their pain was managed effectively.

- Most staff had the right qualifications and experience to carry out their role.
- Most nursing staff who worked on SCBU and most medical staff had received an appraisal.
- All necessary staff were involved in assessing, planning and delivering patients care and treatment.
- Patients had access to most services seven days per week. Some services had a reduced level of service provided out of hours but arrangements were in place to keep patients safe.

Evidence-based care and treatment

- Patient's care was mostly planned and delivered in line with evidence based guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. However, procedures and guidance available to staff were not always up-to-date.
- There were a range of trust wide policies as well as those specific to neonates and paediatrics. We reviewed a sample of policies including, head injury, the critically ill child, management of asthma, management of diabetes, epilepsy as well as neonatal jaundice. Policies and guidelines were available on the trust intranet along with regional and national guidance. We found that local and regional guidelines and policies did not always provide consistent information and that this may be confusing for staff when searching for the most up to date guidance. For example, the local guidelines for head injury reflected the most up to date National Institute for Health and Care Excellence (NICE) guidance from 2014 whilst regional guidelines made reference to NICE guidance from 2007; these were both available on the trust intranet which meant that staff may refer to out of date guidance.
- During the September 2015 inspection, we found that a number of policies and care pathway protocols were either out of date or not dated, and there was a risk that policies may not be updated or reviewed based on the latest national guidance. We reviewed policies and guidelines as part of the July 2016 inspection and found that they had not been updated. The care pathways for anaphylaxis, paediatric sedation guidance, cystic fibrosis admission proforma and tricyclic antidepressant poisoning, did not reference the current evidence base, and there were no appropriate references recorded. The paediatric sedation guidance and cystic fibrosis admission proforma did not have any information on who wrote them, when they were written and/or when they needed to be reviewed.
- The guidelines and policies, which were part of the paediatric and neonatal network (including the management of sick neonates and children by their respective retrieval services) and had thus been ratified across the region were well referenced and written.
- Staff on special care baby unit (SCBU) were part of the southern and West Midlands newborn network. The group agreed guidelines for shared working and developed audit tools to assist consistency of approach, and to provide continual improvement of services. This demonstrated service participated in local groups and sharing of knowledge and learning.
- Audits were undertaken to monitor compliance with best practice and an annual clinical audit plan was in place. We were provided with copies of the children's health services clinical audit plans for 2015/16 and 2016/17. The audit plans were devised based on audits required nationally, as well as to assess compliance with NICE guidance and local priorities; identified through complaints and incidents.
- The audit plan for 2015/16 listed 21 audits planned for the year, of which 11 had been completed; the remaining 10 were either no longer relevant or were data collection rather than clinical audits. The audit plans were devised based on audits required nationally, as well as to assess local compliance with NICE guidance and local priorities, identified through complaints and incidents.
- The 2016/17 plan listed 28 audits. The plan did not record proposed start and completion dates or an identified lead. If leads are not identified and proposed start and end dates specified there could be an increased risk that planned audits may not take place.
- We requested four recent clinical audit reports; two for neonates and two for paediatrics, accompanied by the action plans and evidence of presentation at committee. We were provided with three of the audits requested; Asthma and viral induced wheeze, sepsis screen and National Patient Safety Agency alerts, the latter did not form part of the clinical audit plan for 2015/16 or 2016/17 which meant that audits undertaken during the year had not formed part of the plan.
- The audits provided demonstrated that aims and objectives had been defined and results analysed.

However, two of the three audits were not supported by clear recommendations and action plans. One audit was accompanied by a documented action plan, however, the plan lacked detail and did not specify deadlines or ownership for the actions. Agendas were provided as evidence of presentation of the audits to share learning. However, meeting minutes were not, therefore, it was unclear whether audits had been challenged and findings approved.

- National tools were used to monitor and manage deteriorating patients, such as the paediatric early warning score and the Newborn Early Warning Trigger and Track (NEWTT).

Pain relief

- Assessments were made of patient's pain levels and arrangements made to ensure pain was managed effectively.
- There was a pain protocol for babies which outlined how to identify, assess and manage pain experienced by babies and a nationally recognised tool for scoring pain in children and we saw these in use.
- Pain assessment charts were used by staff to help determine pain scores for babies and young children. Through review of patient notes we saw that pain assessments had been completed. Pain relief was prescribed and administered as appropriate when pain assessments had been completed.
- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.

Nutrition and hydration

- Patient's nutritional and hydration needs were met during their stay in hospital.
- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs to ensure well balanced meals were provided.
- Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- There was a hot meal served twice-a-day, the choices included healthy options, as well as more traditional children's foods. The meals were designed to cater for a variety of ages. Meals were prepared by catering staff who worked on the ward.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided. However, we spoke with some patient ambassadors who told us that the portion sizes of meals were the same for young children and teenagers, which meant that older children were left wanting more food. They also told us that they wanted a broader choice of meals. The ambassadors had plans to address this with the ward
- Snacks were available on the paediatric ward 24–hours-a-day. These included fruit, sandwiches, crisps and cereals. This meant that patients could have food at any time outside of meal times.
- Food to meet specialist dietary requirements were available on request including gluten free and low allergen. Meals were also available to meet patient's cultural and religious needs. Staff said they could order specific foods if required and there were no problems obtaining them. This showed a variety of nutritional needs were catered for adequately.
- Staff who worked on SCBU promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- On both units patients were weighed on admission and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support.
- Parents and carers could also make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- Outcomes from patient's care and treatment was collected and monitored in line with national audit requirements. Intended outcomes for some patients were worse than the national average and the trust had developed action plans to make improvements.
- The trust took part in the National Paediatric Diabetes Audit (NPDA), April 2013 to March 2014 which showed that the percentage of patients with controlled diabetes was slightly worse than other trusts. The trust had developed an action plan in response to the audit which included actions to target specific groups, better appointment availability during school holidays, to provide education sessions, as well as ensuring the annual psychological assessment was documented for all patients. We saw most actions had been implemented.
- According to data sourced from Hospital Episode Statistics, the multiple emergency admission rates for December 2014 to November 2015 for children with

asthma and epilepsy being readmitted within 12 months, was worse than the national average. The asthma multiple admission rate was 17.6%, compared to a national average of 16.5%. The epilepsy multiple admission rate was 32%, compared to a national average of 28.6%.

- An action plan had been devised to address the weaknesses identified in the audit on asthma; however, not all weaknesses had been addressed. For example, the audit identified that the child's 'device technique' had not been assessed in 83% of cases but an action had not been included. We requested the audit findings and action plans for patients readmitted with epilepsy but this was not provided by the trust.
- The trust participated in the National Neonatal Audit Programme 2015. The most recent data collection in 2014 was reported on in 2015 and found that 85% of babies eligible for retinopathy screening (retinopathy is a disease of the retina which results in impairment or loss of vision) were screened against a target of 100%. The audit findings also reported 81% of babies admitted to SCBU had a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission against a target of 100%. An action plan had been developed which indicated low achievement had been due to data collection and actions focused on addressing this.
- Emergency readmission rates within two days of discharge was worse than the national average for children within the age group one to 17 years for both elective and non-elective care. For elective care, readmission rates were 1.3, compared to the national average of 1. For non-elective care, the readmission rate for under one year was 3.6 and for between one and 17 years was 3.7, compared to national averages of 3.3 and 2.7, respectively.
- Children's Survey 2014 the trust scored similar to other trusts for all eight measures for the effective domain.

Competent staff

- Most staff had the right qualifications and experience to carry out their role. Competency assessments were being developed for nursing staff and due to be rolled out to staff who worked on the paediatric ward as well as SCBU. Training sessions had recently started to improve staff knowledge on how to support patients admitted to the paediatric ward with mental health needs; training focused on communication skills and nurses lacked knowledge of medication which may be required. Anaesthetists were not all trained in paediatric life support.
- We were told that there was a training programme for all staff who worked on the paediatric ward to attend sessions on supporting patients with mental health issues; this commenced in June 2016. Three sessions had taken place which included a general understanding of patients with mental health needs, self-harm and eating disorders. In July 2016, 70% and 57% of registered staff on the paediatric ward were complaint with Deprivation of Liberty Safeguards and Mental Capacity Act 2005 training, respectively. This did not meet the trust target of 90%.
- There was a practice development nurse who had been in post for since August 2015. The practice development nurse had developed competency sheets for all nursing and support staff groups within children and young people. Checklists had been developed which covered a range of competencies including use of equipment and providing certain treatments and procedures to patients. The competency records were due to be rolled out for staff to complete these and signed off by their supervisor.
- Staff completed an annual appraisal as part of their personal development review. Staff told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Appraisal data confirmed that 89% of staff had received an appraisal, which was just under the trust target of 90%.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked. We confirmed through review that all staff listed as employed and registered had a valid registration.
- Each shift on SCBU had at least one nurse of who had a post registration qualification in speciality neonatal care. 66% of SCBU nurses had completed their post registration qualification and one nurse was in the process of completing their training. Once completed, in August 2016, this would bring the total with a qualification in speciality neonatal care to 71% achieving the neonatal toolkit recommendation of 70%.
- The Royal College of Nursing safer staffing guidance recommends that each ward / department has at least one qualified member of staff working each shift who

has undertaken European Paediatric Life Support (EPLS) training. We reviewed a sample of rotas and confirmed this recommendation had been met for each of the shifts reviewed. This had improved since the September 2015 inspection.

- There was not a commissioned high dependency unit bed, however, the paediatric ward had one bed which was used for 'higher dependency' patients. The trust had recently started collecting data on the types of patients admitted to the bed to establish if a business case was required for level 2 care funding. Only one nurse (who was non-practicing) had received training in caring for level 2 care patients. This meant if the bed was commissioned as a level 2 care bed, staff would require further training to meet patient need.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients care and treatment.
- The staff we spoke with told us that there was good support for patients from other services, including physiotherapy, dietetics and speech and language therapy.
- Nurse specialists in oncology and respiratory medicine, diabetes and epilepsy were employed to provide expert support to patients and parents in the wards.
- We saw multidisciplinary team involvement in care was documented in children's notes.
- Play therapists were available on the ward, Monday to Friday and every other Saturday. Play therapists provided communication between medical and nursing staff, and patients and their parents to ensure the child's needs were catered for during procedures. Play therapists also provided additional support in distraction for younger children whilst undergoing procedures.
- A dedicated pharmacist came to each ward to check supplies and review drug charts for patients on the ward.
- Access to psychiatric services was available Monday to Friday from the Child and Adolescent Mental Health Service (CAMHS). A service was unavailable at weekends. Therefore if a child with mental health needs presented over the weekend, they were admitted and waited until Monday morning for a comprehensive assessment. The trust were working closely with the CAMHS to improve provisions and provide a weekend service for patients admitted to the ward. Agency nurses were employed to care for patients with mental health needs as required; patients were not admitted to the ward from the emergency department until one to one care was in place.
- The department did not hold psychosocial meetings to discuss children who had attended the ward for mental health needs.
- The department did not have support from a psychologist except for patients diagnosed with diabetes. This meant that holistic care and review of patients with mental health needs did not take place.

Seven-day services

- Patients had access to most services seven days per week. Some services had a reduced level of service provided out of hours but arrangements were in place to keep patients safe.
- The consultants provided seven days per week, 24 hours per day cover. This meant there was a specialist consultant available at all time.
- The unit had access to advice from specialist tertiary centres as required.
- Pharmacy support was available on the ward each day. Out of hours arrangements were in place.
- Radiology services were provided on an on-call basis out of hours.
- Pathology services were provided seven days per week, 24 hours per day.
- Physiotherapy was available on weekdays and out of hours as required. However, we were told that the on-call physiotherapist had not completed training in children's care. This meant that if a patient needed specialist physiotherapy support out–of-hours to relieve a condition, pneumonia or other causes of pulmonary congestion, the on-call physiotherapist did not have the skills to provide this treatment.
- Endoscopy services were provided by tertiary centres.

Access to information

- Patients care and treatment was planned and shared with other services as necessary.
- Risk assessments were completed for all patients on admission to the wards. We reviewed a sample of patient records and found these to be completed. Patient records were requested as needed on admission or in advance for outpatient appointments. We were not

informed of any issues with access to records. Test results were obtained promptly from the relevant departments to ensure clinical decisions could be made based on supporting pathology or radiology results.
- Transition arrangements were in place for patients with diabetes approaching adulthood, which was supported by a policy and self-management plan for patients. The self-management plan included a competency checklist for the child making transition to adult services.
- The transition arrangements for other conditions were not clearly defined. There was a risk that children may lack the support and skills required to take control over the management of their continuing care.
- A copy of the patient's discharge summary was given to the patient as well as sent to the patient's GP.

Consent

- Staff we spoke with had a good understanding of gaining consent from children and the guidance around this with regard to a child's capacity to consent, including Gillick and Fraser competency. (The Gillick competency and Fraser guidelines helps to balance children's rights and wishes with the trust's responsibility to keep children safe from harm). Staff understood the Mental Capacity Act 2005 and explained how they would assess a child's mental capacity and a decision would be made in their best interest and recorded in their notes.
- Patients and their parents were supported by staff to make decisions. Staff and patients we spoke with told us how the procedures and treatment were explained to them and that they were told about different options available.
- Written consent could be obtained by the child and / or their parents for certain medical and surgical procedures and we saw examples of these.
- The trust had a 'Policy on the Use of Physical Intervention' including methods of restraint of children. However, staff we spoke with were unaware of the policy. Two members of paediatric physiotherapy staff had received training in restraint but this had not been extended to other staff. Some staff had received 'break away' training (break away training is used for managing challenging behaviour in care environments). However, the trusts did not provide data to indicate the percentage of staff trained. Staff told us they would try to talk to a patient to calm them down and call the police if necessary. However, there was a risk that a situation may arise which would require a patient to be restrained and staff would not be appropriately trained. For example, an incident occurred in July 2016, prior to the inspection where it may have been appropriate to restrain the patient. The area was closed down and other patients moved and the situation was managed until the police arrived, however, one member of staff was treated for injuries.

Are services for children and young people caring?

Good

We rated services for children and young people as good for caring because:

- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner patients could understand.
- Patients and parents said they could be involved in care and treatment.
- Responses to the Care Quality Commission's 2014 children's and young people's survey were largely similar to other hospitals.
- Most parents or carers would recommend the service to their friends and family.
- There was a play specialist who provided additional support for children on the paediatric ward during admission.

However, we also found:

- There was limited psychology services available to patients and their families or carers.

Compassionate care

- Staff who worked on the paediatric ward and special care baby unit (SCBU) took the time to interact with patients and their parents in a manner which was respectful and supportive.
- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after. Patients and parents told us that communication had been good. One parent told us that

there were clear plans in place for their child and that referrals had been made to other services which were appropriate for their child's care. Another child told us that their doctor was excellent and really kind.

- We observed staff supporting and treating patients in a kind and caring manner. We saw an example of one child who was frightened of having a cannula inserted. The play therapist worked closely with this child and encouraged the child to use a camera to take photos of the play therapist having this done to reduce the level of fear. This allowed the child to take ownership of the process and feel more in control of having the procedure.
- Patients had the opportunity to provide feedback via the NHS Friends and Family Test. The NHS 'Friends and Family' Test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across all NHS trusts.
- In May 2016 100% of parents or carers for babies admitted to SCBU and 96% of parents and/ or carers of patients in paediatrics would recommend the service to their family and friends.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts with privacy and dignity reported as better than other trusts and communication about care and treatment reported as worse than other trusts.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with patients in a way that patients understood their care and treatment and condition. Although the Care Quality Commission (CQC) children and young people's survey 2014 reported that the ward had performed worse than other trusts for communication. Staff recognised when patients needed additional support and did their best to provide this.
- All of the patients and relatives we spoke with on the ward and in the outpatients department told us that staff had communicated well with them and that they were satisfied with explanations provided about the treatment and care whilst in hospital. Although the inpatient survey had found this trust as performing worse at communicating with patients and their families. We requested a copy of the action plan for the inpatient survey but this was not provided.
- In the children's outpatients department we observed a young teenager being consulted with and enabled to see the paediatrician in private, prior to a shared consultation with their accompanying parent.
- Patients and parents said they could be involved in their own care and treatment if they wished and there were arrangements in place to support parents administering certain medications to their child.
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child. The play therapist also supported young children with this and there were electric cars which children could use to drive themselves to the theatre.
- Patients who spoke other languages were supported by using a translation service by telephone or in person. During the day, a member of the patient liaison service who spoke an Eastern European language was available to attend the ward and speak with patients if necessary. We were told that Polish was the top second language locally but that translation services were not required frequently. A small number of nurses and support staff had also learned some basic sign language (Makaton) to enable them to communicate with patients with a learning disability who used this language. A small number of signs had been learned and there were plans to continue to learn one new sign each week.

Emotional support

- Staff understood the impact that a patients care, treatment and condition had on them and those close to them. Emotional support was provided whilst caring for patients; however there was minimal formal support available although there was a professional psychologist available to provide counselling to patients with diabetes.
- There was a psychologist available to support patients who had been diagnosed with diabetes and this was funded by the commissioners. There was no psychological support for patients with other conditions who may also benefit from specialist support.
- For other patients and families, who may be distressed, support was provided by the medical and nursing team, not specially-trained professionals.
- There was a bereavement folder which included contact details for the hospital chaplaincy and provided details of religious preferences for a range of religions.

Services for children and young people

Are services for children and young people responsive?

Good

We rated services for children and young people as good for being responsive because:

- Patients and stakeholders were involved in service development.
- There was a children's and young people's ambassador group which was involved in the service redesign when developments took place.
- Play workers arranged activities for patients, to provide patients with the opportunity to meet peers who had similar patient experiences.
- The length of stay was in line with the national average.
- There were arrangements in place to support patients with learning or physical disabilities.
- Translation services were provided to patients who were unable to speak English.
- There were facilities to engage and occupy young children and teenagers admitted to the ward.
- There were overnight facilities for parents to stay on both the paediatric ward and special care baby unit (SCBU).
- Patients and their parents were supported to make complaints.

However, we also found:

- The business plan lacked detail around population growth and how to meet the needs of the changing demographics.
- The patient passport for patients with a learning disability was not user friendly.

Service planning and delivery to meet the needs of local people

- Patients and stakeholders were involved in service development, with targets set by the commissioners considered. The business plans for paediatrics and SCBU formed part of the wider division business plan for integrated family health services (IFHS). Each service area had developed a plan which included figures for planned activity against capacity. However, information about the needs of the local population was not used to inform the annual business plan. For example, the business plan noted an increase in patient demand due to an increase in population but did not include estimated growth figures or consider the increase in population from Eastern European countries.
- Planned activity for paediatric outpatients exceeded capacity and there were objectives to meet the anticipated level of demand according to the business plan. Including reducing the did not attend rate, assessment of follow-up rates, consideration to seven day working and an additional specialist nurse.
- SCBU had undertaken an analysis of capacity and demand in 2015 and SCBU nursing staff was budgeted for an average of 70% patient occupancy (this meant the unit was staffed to care for the average number of babies admitted to the unit). The escalation policy was followed according to the acuity of babies and staff ratio. The plan predicted a growth of 3% in activity for 2015/16 but did not estimate growth for the year ahead.
- There was a children's and young people's ambassador group which consisted of patients who used or had used the service. We spoke with some members of the ambassador group who told us that they were involved in the service redesign when developments took place. For example, the children's emergency department (ED) had recently been refurbished and the ambassadors had been asked to inspect the area and make suggestions for improvement. Their suggestions had been included in the redesign and the ambassadors told us that they were satisfied with the changes made to the interior of ED. Ambassadors were also involved in the development of the paediatric ward and had input into the improvement of services. For example, they had made suggestions as to how the Saturday club was run; the Saturday club operated every other week and provided a pre-operative assessment clinic for children and young people. The ambassadors had made recommendations how the club could be improved to better engage teenagers; they had been listened to and changes had been made as a result.

Access and flow

- During the September 2015 inspection, nursing staff who worked on the paediatric ward expressed concern over the number of patients admitted overnight or at weekends due to self-harm, attempted suicide or suicidal intent. The Child and Adolescent Mental Health Service (CAMHS) did not provide a service out of hours which meant patients had to be admitted until a formal

mental health assessment had been completed. This continued to be a problem; however, improvements had been made as patients were not admitted to the ward until one to one mental health nursing was in place which had reduced pressure on ward nursing staff.

- The paediatric ward had 16 inpatient beds, with four in the paediatric assessment units. Paediatric patients were admitted to the ward either via a planned admission process or through an emergency admission from a direct referral via their GP or through ED.
- The overall average length of stay for the paediatric ward for April and May 2016 combined was 3.6 days, which was better than the 4.5 days average length of stay for the same period in 2015/16. The average length of stay for the full year, 2015/16 was 2.7 days.
- According to Hospital Episode Statistics (December 2014 to November 2015) the average length of stay for non-elective patients of all age groups was in line with the national average at one day.
- We were told that although the department could become busy at times, staff worked together to ensure patients' journey through the department worked well. Some patients with mental health needs could remain in the department longer than planned if they were waiting for a bed in a mental health unit but most patients were discharged back to the community team and all patients with mental health needs received one to one care whilst on the ward. During the period January to April 2016 there had been 58 patients under CAMHS admitted to the paediatric ward which averaged 14.7 per month; this compared to an average of 9.1 patients under CAMHS per month during the last nine months of 2015. There were plans in place for weekend CAMHS cover later in the year, with the team working on site, which aimed to reduce the length of stay for patients under CAMHS.
- From review of a sample of patient records, every child admitted to the paediatric department with an acute medical problem was seen by a doctor of the appropriate grade within four hours of admission in accordance with the Royal College of Paediatrics and Child Health, Facing the Future: Standards for acute general paediatric services.
- There was a consultant available 24 hours per day which meant that the paediatric assessment unit could access advice from a consultant at all times.
- The SCBU had 12 cots, including one intensive care bed and two high dependency beds. Neonates were admitted via maternity as a planned or emergency admission. Babies could be transferred from other hospitals if required, although staff told us this did not happen very often.
- The average length of stay for neonates for April and May 2016 combined was eight days, slightly better than the 8.25 days average length of stay for the same period in 2015/16. The average length of stay for 2015/16 was 7.7 days.

Meeting people's individual needs

- Services were planned which took into account the needs of different patients. Consideration had been given to the patients' age and gender as well as any disabilities.
- Services for children and young people were supported by two play workers (one was on maternity leave at the time of inspection). The play workers regularly made arrangements for long term patients to have days out to different places, including soft play areas or bowling. An activity was arranged most months and the play workers sourced the activities from local businesses who donated their good and/ or services. This meant that patients with long term conditions could meet peers who also regularly visited the hospital. Patients found this valuable and liked the opportunity to meet patients who had shared experiences.
- During the September 2015 inspection, we identified that there were no communication tools in place for patients who were unable to communicate verbally and that 'all about me' documents were not completed for patients who were on the ward for a longer period of time. Improvements had been made and the all about me documents were being completed and a communication tool had been developed, although this would have benefited from additional picture prompts.
- The paediatric ward had a mobile sensory unit for patients with visual impairment, as well as other patients who may benefit from this.
- The trust used a document, 'all about me' to complete for patients who were in the department for any length of time which provided details of their personal care needs and social history which may be pertinent in providing care for them. We reviewed a sample of files where it would have been appropriate for these documents to have been completed and found that these had been completed.

Services for children and young people

- A 'patient passport' was completed for patients with a learning disability to explain their likes and dislikes and how they could be supported and cared for. Review of the passport confirmed that it was not 'user friendly'; the passport did not include pictures or simple diagrams to enable or assist with communication between patients and staff.
- Communication aids had been developed to support patients who may be unable to verbalise their needs. We were told this was work in progress as additional pictures were needed, for example, body parts and food items so patients could point to where they had pain or show which food they would like to eat. We were told that some staff had recently learned some basic Makaton signs. Makaton is a simple technique designed to support spoken language. There were plans for staff to learn a new sign each week.
- Translation services were available, although we were told that these were rarely needed. One member of staff who worked for the PALS team spoke Polish and was used as required to provide translation services to patients. If this member of staff was not available or another language required interpretation, Language Line was used and worked sufficiently well although this was not the preferred option.
- Leaflets were not readily available in other languages. We were told that the PALS team could produce leaflets in other languages if requested; however, they were not frequently needed.
- There was a playroom for young children which contained toys and books and a separate room for adolescents with DVDs and books, a computer gaming system and pool table.
- The paediatric ward had four bedded bays which were separated by gender but there was insufficient space to separate patients by age. If patients were unhappy with the arrangements they could ask for a side room if one was available.
- Parents had the option to stay overnight with their child and 'put you up' beds were available. There was also a parents' room on paediatric ward and SCBU to accommodate parents in a more comfortable setting if required.
- There were suitable bathroom facilities for patients with a physical disability and adequate space on the ward to accommodate patients who used wheelchairs.
- Patients had access to a chapel and multi faith room on site.

Learning from complaints and concerns

- There was a process in place for responding to complaints and information was available to make patients aware of how to make a complaint.
- Leaflets informing patients how to make a complaint or contact the patient liaison service were available in the paediatric ward and SCBU.
- We were told that most complaints were resolved and responded to immediately and that these were mostly due to communication issues from nursing and medical staff. Formal complaints were rarely received.
- During the period July 2015 to June 2016 one complaint had been received about the paediatric department and there were no complaints about SCBU. The paediatric complaint related to a delay in surgery, the information provided about the complaint lacked detail and dates recorded for received and response due were incorrect. Therefore, it was not possible to determine whether the complaint had been handled appropriately or whether there were learning points from the complaint.
- Although complaints were received infrequently we were told that they were discussed at staff handovers as and when they occurred and that the outcome of complaints would be reported on in the monthly newsletters.

Are services for children and young people well-led?

Requires improvement

We rated services for children and young people as requires improvement for being well-led because:

- The service did not have a clear vision.
- Objectives in the business plan had been set but were not supported by actions, timescales or accountability.
- The governance framework had recently been restructured. However, service committee meeting minutes lacked detail and did not include discussion around some pertinent issues. For example, performance or finance and some information was not carried forward to future meetings.
- Some risks we identified during our inspection had not been included on the risk register, we also highlighted this in the September 2015 inspection.
- Risks were overdue their review date.

- Governance processes were not in place to assess and review policies and care pathways.
- The staff survey action plans were not specific to paediatrics and SCBU.
- Sickness levels for paediatric nursing staff were worse than the trust target of 5%.

However, we also found:

- Leaders were visible and approachable; ward managers understood the challenges at a local level.
- The views and experiences of patients and those close to them were gathered and acted on to shape and improve the service.
- The service was supportive of staff and care provided was patient focussed.
- Staff felt well supported and listened to, there was a strong culture of putting the patient first.

Vision and strategy for this service

- The service did not have a clear vision; objectives had been set but were not supported by actions or timescales and had not been assigned to a lead.
- During the September 2015 inspection we identified that most staff were unaware of the vision and values for the service and these were not defined in the services business plan. During this inspection we found that staff were aware of the trust's values but not the vision and values of their service. Objectives within the business plan were more specific but were not supported by actions, timescales had not been set and objectives were not owned by any individual.
- The business plan for paediatrics did not set out a clear vision but had improved on the clarity of objectives since the September 2015 inspection. Paediatric services had 10 objectives and the neonatal service six; objectives related to the development and improvement of elements of the service.
- The objectives from 2015/16 plan had been listed in each plan. However, it was unclear whether these objectives had been met or not and if they had not been met they were not carried forward to the 2016/17 plan, as there was not end of year report. The objectives for 2016/17 were not supported by actions and there were no timescales for implementation and ownership of the objectives had not been assigned.
- The trust had developed a quality improvement plan, which detailed the transformation programme the trust had undertaken to address areas for improvement raised by the Care Quality Commission (CQC) in the September 2015 inspection. The quality improvement plan encompassed strategies that influenced services for children and young people. These detailed specific objectives required to meet in order to improve elements such as governance, staff training and safeguarding. These objectives had been devised in accordance with actions the CQC had reported that the trust must and should do, following our September 2015 inspection. Progress against the objectives was monitored by the trust board.

Governance, risk management and quality measurement

- The governance framework had recently been restructured. However, the committee meeting minutes lacked detail and did not include discussion around some pertinent issues. For example, performance or finance information was not carried forward to future meetings. The risk register had not been used to record risks faced by the department which could have been identified through the incident reporting process for example. Similar issues had been identified in the September 2015 inspection.
- In June 2016 the trust moved to a new divisional structure to manage the delivery of clinical services. Prior to June 2016 ward meetings were held within paediatrics and special care baby unit (SCBU) which fed into the paediatric business meeting which in turn reported to the integrated family health service governance meetings (IFHSGM). Ward meetings remained in place in the new structure and the paediatric business meeting was replaced by the performance and governance meeting, reporting to the directorate board meeting who reported to the divisional board. The divisional board reported to the trust board. Each directorate and divisional board were tasked with five key areas; safety, effectiveness, caring, responsiveness and leadership. Meetings under the new structure had not been minuted at the time of inspection and therefore, minutes under the previous structure were obtained and reviewed.
- The IFHSGM attendees were responsible for reviewing and managing risk, quality, performance, human resources, finance and service improvement. The committee met monthly.
- Review of minutes for April, May and June 2016 confirmed that minutes were taken and the level of

detail had improved since the September 2015 inspection. There were standing agenda items which were not always discussed as required. For example, the May 2016 minutes stated that, the quality improvement plan for safeguarding was monitored quarterly and was due the following week this was not included for discussion on the June 2016 agenda. The committee had not discussed finance at its meetings in accordance with its terms of reference. Performance on the dashboard was discussed but it still lacked detail and there was no discussion around improvement of performance. The dashboard focussed on governance and safety aspects of patient care and did not include data on performance such as referral to treatment or re-admission targets; data was not presented or discussed at the meetings.

- Review of the April and May 2016 paediatric business meeting minutes (June minutes were requested but not provided) confirmed they still lacked detail and monthly agenda items were not always discussed. For example, quality measures, activity and finance had not been discussed in April. The April minutes recorded that 'ad-hoc clinics had increased' for outpatients, there was no further information regarding why the clinics had increased or whether this had achieved a desired outcome. May meeting minutes included discussion around finance, particularly agency spend, activity reported on the increase in outpatient attendances and decrease in inpatient activity, but there was no discussion regarding the timeliness of outpatient appointments for example, or other activity, such as readmissions.
- The risk register for integrated family health, 23 June 2016 included three risks which related to paediatrics and / or SCBU. Two related to staffing shortages and the third, security arrangements. All risks were overdue their review date.
- There were an additional three risks where it was unclear whether they related to paediatrics or only to maternity and gynaecology. For example, IT issues and out of date guidelines. From review we noted that the risk register failed to fully assess the risks and gaps and there were a number of risks identified during our inspection which had not been recorded on the register. For example, ligature risks. There had been no improvement in the use of the risk register since the September 2015 inspection.
- Governance processes were not in place to assess and review policies and care pathways. We found policies and care pathways were either out of date or not dated, and there was a risk that policies may not be updated or reviewed based on the latest national guidance. These had not been updated since our September 2015 inspection.
- An annual clinical audit plan was in place. Progress of the plan was reported on through the monthly dashboard presented to IFHSGM. We were provided with the May 2016 dashboard, a colour code was used to monitor progress, green to indicate not due to start yet or started and progressing; amber to indicate either not due to start yet, on hold or to be established; red indicated the audit had started but was not progressing, had not started on time or had been abandoned. The dashboard was not broken down by service area and therefore, reported on all audits included within integrated family health service (IFHS). In May 2016 it was reported that 100% of audits were green or amber but due to the lack of clarity in colour coding it was unclear whether any of these audits had commenced. The dashboard was not transparent and easy to read and it was not possible to monitor progress for service areas in the format the data was presented. Individual audits had not been discussed at the IFHSGM or paediatric business meetings.

Leadership of service

- In June 2016, the trust introduced a new divisional structure. Children's and young people's services featured within the surgical division. This division was split into directorates with each directorate led by a clinical director, general manager and matron.
- The department had a documented accountability structure. Ward managers and specialist nurses reported to the lead nurse, although this post had recently been recruited to with the new lead nurse starting post in September 2016; interim arrangements were in place to report to the head of midwifery.
- Medical staff reported to the clinical director, there had been some recent changes and the clinical director was new into post, although had worked for the trust for some time. The clinical director was an obstetrician and was supported by consultant paediatricians whilst developing the clinical directors understanding and knowledge of services for children and young people.

- There were consultant leads for specific services within paediatrics and neonates. For example, there were leads for oncology, diabetes respiratory, endocrinology, epilepsy management.
- The clinical leadership for children and young people were largely new into post, although most individuals had worked for the trust in other roles.
- We observed the wards and departments were well managed on a day to day basis with good leadership at a local level. However, we observed that staff within SCBU were not diverted to support the paediatric ward at times of peak flow when SCBU was under occupied and the ward had a surge of admissions.
- Job plans were in place for all consultants, with one consultant whose job plan had not been completed between the period June 2015 and July 2016. We were informed this was in progress.
- There were also specialist nurses for diabetes, epilepsy, respiratory, safeguarding, dermatology allergies and oncology.
- Leaders were visible and approachable; ward managers understood the challenges at a local level.
- The staff we spoke with told us that they had good working relationships with their managers and felt able to raise concerns if they needed to and that on the wards they regularly saw their local managers.

Culture within the service

- The service was supportive of staff and care provided was patient focussed.
- Staff told us there were good working relationships amongst their peers as well as other disciplines and that Hereford Hospital was a pleasant place to work. Staff at all levels told us how there was excellent teamwork throughout and that medical staff always took time to listen to concerns of nurses or support staff.
- Staff told us that they were encouraged to report incidents and that they felt confident in doing so and the importance of sharing information with patients and families when an incident occurred which involved them.
- Paediatric nursing staff sickness rates for 2015/16 were 9% on the paediatric ward, 12% in paediatric outpatients and 2% on SCBU. This was worse than the trust target of 5%.
- Sickness rates for consultants was less than 1% for 2015/16.

Public engagement

- The views and experiences of patients and those close to them were gathered and acted on to shape and improve the service.
- The trust had established a young people's ambassador group. This was run by a group of patients who had used the service or continued to use the service. The group met regularly and were consulted on changes on changes and developments, for example they had been instrumental in the development of the 'Saturday club' which was well established and had been running for over one year. The Saturday club had been set up to provide a comprehensive pre-assessment service for children and young people being admitted for surgery. The ambassadors also told us about their involvement in improving the paediatric ED environment and their plans to improve other aspects of care and support on the paediatric ward. The ambassadors felt listened to by hospital staff and were pleased with action taken in response to the issues raised. The ambassadors had an agenda and list of issues they planned to raise with the trust; next on the list was improving food for patients. The ambassadors were currently involved with making a film about transition which would be used nationally across the NHS and this was taking priority; the ambassadors told us they would soon be working their way through agenda items to further improve the service.
- All of the staff we spoke with were familiar with the work the ambassadors had undertaken, they listened to and respected their opinions in making changes to improve the service. They valued their work and it allowed them to see the service provided through the eyes of children and young people.
- Patients were given the opportunity to provide feedback as part of the Children and Young People's Survey 2014. Five areas were identified as performing worse than other NHS trusts. An action plan had been developed to address the concerns raised, deadlines had been agreed for November and December 2015 and were all recorded as achieved.
- Patients also had the opportunity to provide feedback via the NHS Friends and Family Test data collection had previously proved difficult on the paediatric ward and newly introduced to SCBU. The paediatric ward had taken action to improve on completion rate by allocating a healthcare assistant specifically to

encourage patients and their families to complete the feedback. Results had improved in May 2016 for paediatrics to a response rate of 46% which exceeded the 40% target and was an improvement on previous months which had been below target. SCBU had achieved a response rate of 67% in May 2016; the first month this had been completed. 100% of parents of patients and/or carers in SCBU and 96% of parents and/or carers of patients in Paediatrics would recommend the service to family and friends.

- Child friendly comment cards were also handed out to children to gauge their perception of the care and treatment they had received. Most comments were positive with some suggestions made.

Staff engagement

- Staff felt well supported and listened to, there was a strong culture of putting the patient first.
- An annual staff survey took place each year to gauge staff perception on a range of matters. We requested a copy of the action plan for paediatrics and SCBU. Results from the 2015 survey had not been analysed at departmental / directorate level and therefore, it was unclear what issues had been raised by staff who worked within children and young people's services.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with managers and that they felt listened to and supported.
- Staff we spoke with told us that they were encouraged to provide patient centred care and inform patients and parents immediately if something went wrong.

Innovation, improvement and sustainability

- The service strived to make improvements for patients and staff by continuously improving care.
- During the September 2015 inspection we identified concerns about care provided for patients with mental health needs as well as the impact this had on staff working on the paediatric ward as well as other patients. The trust had made significant changes to the admission process for patients with mental health needs and this had hugely improved the service provided to all patients as well as staff morale. A safeguarding lead had been appointed who was instrumental in the changes made to how patients with mental health needs were cared for. Previously patients were admitted to the ward from ED and one to one care from a mental health nurse was arranged following admission to the ward; staff placed responsibility on parents and carers to look after their child until one to one care arrived. This had process had been discontinued and patients with mental health needs were only admitted to the ward from ED once one to one care was in place. The staff we spoke with told us this had made a huge difference and they felt more confident in their approach because of support provided by the safeguarding lead.
- The trust have developed innovative ways of working to mitigate recruitment problems to paediatric posts at training grades by providing a resident consultant at night to support the junior doctor.

End of life care

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

Information about the service

Wye Valley NHS Trust provides end of life care to patients with progressive life-limiting conditions including cancer, advanced organ failure, such as heart and renal failure, and neurological conditions.

The trust provides community services and hospital care to a population of slightly more than 180,000 people in Herefordshire and mid-Powys in Wales. There are 236 beds at Hereford Hospital. The hospital reported there had been 791 in-hospital deaths between 1 January and 31 December 2015 at Hereford Hospital.

There are no dedicated wards for the provision of end of life care at the Hereford Hospital. This is delivered on most wards in the trust.

The hospital reported that between 1 January and 31 December 2015, its specialist palliative care team (SPCT) saw 566 patients. The majority of all patients the team saw in 2014/15 had cancer (80%).

The SPCT supports patients, giving advice on symptoms such as pain control, sickness, and poor appetite. The team also offers emotional and psychological support, and helps families and carers in all settings. A palliative care consultant, who is hospital based 2.5 days a week, leads the team. The team also has support from a specialty doctor one day each week. There are 2.3 whole time equivalent (WTE) clinical nurse specialists in palliative care, based at the hospital.

The trust employs a chaplain 15 hours a week who, with the support of volunteers, covers all Christian denominations. The chaplaincy team has access to contacts in the community for support for other religions. In addition to the chaplaincy team, the bereavement office provides support to relatives after a loved one's death.

There are two full-time mortuary staff, one mortuary manager and one mortuary technician. The two full-time staff worked Monday to Friday, from 8am to 4.30pm. They provide a 24-hour on-call rota.

During our inspection, we spoke with a patient and two relatives. We also spoke with 20 members of staff, including the palliative care team, mortuary staff, chaplaincy, nursing, medical staff, a bereavement officer, a non-executive director with an interest in end of life care, a porter and an operations manager. We observed care and treatment, and looked at care records and 33 do not attempt cardio-pulmonary resuscitation (DNACPR) forms. We visited wards across the hospital, the mortuary, the chapel and the multi-faith room. We received comments from people who use the service and we reviewed the trust's performance data.

End of life care

Summary of findings

We rated end of life care services as good. The service was safe, effective, caring, responsive and well led because:

- Care records were maintained in line with trust policy.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of their life.
- The trust had a replacement for the Liverpool Care Pathway (LCP) called the multidisciplinary care record for adults for the last days of life (MCR). The use of this document was embedded in practice on all of the wards. The MCR was also used in community based care homes in the area.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed had been signed and dated by appropriate senior medical staff. There was a clear documented reason for the decision recorded. This included relevant clinical information.
- Policies and procedures were accessible and based on national guidance. We saw improvements since the September 2015 inspection, with regard to only one DNACPR policy being accessible to staff on the intranet.
- We found the trust had addressed maintenance issues affecting the mortuary body storage units (fridges), that we had identified on the September 2015 inspection. We also saw a new governance structure in place. The mortuary staff had a clear reporting structure.
- Patients were happy with the care they had received. Relatives were happy with the care their relatives had received.
- Patients were involved in making decisions about their care. Staff carried out care in a respectful and careful manner.
- Care and treatment was coordinated with other services and other providers. The specialist palliative care team (SPCT) had good working relationships with their community colleagues, which ensured when patients were discharged, their care was coordinated.
- 100% of patients were seen by the SPCT within 24 hours of referral.
- The trust had an executive and a non-executive director on the trust board with a responsibility for end of life care.
- The risks regarding the mortuary were identified on the support services risk register.
- Risk associated with SPCT were on the divisional risk register. The staff had taken action to mitigate against risks.

However:

- The SPCT were not collecting information on percentage of patients that had been discharged to their preferred place of death within 24 hours. Without this information, the service was unable to monitor if they were able to honour patients' wishes and assess if they needed to improve on this. This had not improved since the inspection in 2015.
- We did not see evidence of a hand hygiene audit being completed in the mortuary.
- The mortuary team did not have oversight of the service arrangements for mortuary equipment so were unable to assure us that this was completed in a timely manner.
- The facilities management company provided staff training, while it did not specifically include safeguarding training. However, it identified the need to raise any concerns about the treatment or condition of deceased patients to the mortuary staff and their line manager.
- The service did not provide face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday. This did not meet the recommendation from the National Institute for Health and Care Excellence (NICE) guidelines for 'End of life care for adults'.
- Medical staffing did not meet the NICE guidance for end of life care staffing, that recommends there is one whole time equivalent consultant/associate specialist in palliative medicine per 250 hospital beds. However, in addition to the hospital based medical cover, an out of hours consultant led palliative care advice service was available through the local hospice 24 hours a day, seven days per week.

End of life care

Are end of life care services safe?

Good

We rated end of life care services as good for safety because:

- The staff within the end of life care service understood their responsibilities for ensuring patients were protected from the risk of harm. The service had systems in place to recognise and minimise patient risk. We saw evidence that learning from incidents had been implemented within the service.
- The chaplaincy team, the specialist palliative care team (SPCT) and the mortuary team were 100% compliant with child safeguarding level two training and adult safeguarding level one training.
- Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients who were at the end of their life.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records had been signed and dated by appropriate senior medical staff and there was a clear documented reason for the decision recorded, this included relevant clinical information.
- Care records we reviewed were maintained in line with trust policy.
- Most wards had a palliative care link nurse who acted as the connection to the SPCT. They had bi-monthly training sessions that helped them stay up-to-date and competent. The trust expected them to share relevant knowledge, processes and skills with their ward teams.
- Equipment, for example syringe drivers, were visibly clean and fit for purpose.
- We found the trust had addressed maintenance issues affecting the mortuary body storage units (fridges), that we had identified on the September 2015 inspection. We also saw a new governance structure in place. The mortuary staff had a clear reporting structure.

However:

- Medical staffing did not meet the National Institute for Health and Care Excellence (NICE) guidance for end of life care staffing, that recommends there is one whole time equivalent consultant/associate specialist in palliative medicine per 250 hospital beds. However, in addition to the hospital based medical cover, an out of hours consultant led palliative care advice service was available through the local hospice 24 hours a day, seven days per week.
- We did not see evidence of a hand hygiene audit being completed in the mortuary.
- Equipment in the mortuary was maintained through the service level agreement (SLA) with the facilities management company. The mortuary team did not hold information about the service arrangements so were unable to assure us that this was completed in a timely manner.

Incidents

- Staff we spoke with understood their responsibilities to raise and record safety incidents, concerns and near misses using the trust's electronic reporting system (the system to collect and report incidents).
- The SPCT were informed of incidents that had happened across the trust via a trust briefing 'safety bites'. We saw evidence these incidents were discussed at SPCT meetings in the meeting minutes, this ensured lessons were shared beyond the affected team or service.
- There were no never events or serious incidents reported by the SPCT, between March 2015 and February 2016. "Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented."
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Whilst the SPCT, chaplaincy team and mortuary team had not recorded any incidents, staff we spoke with were aware of their responsibilities and principles with regard to duty of candour regulation. They were aware they would be required to inform the patient or their relatives of the incident, make an apology and explained how the trust should respond to any incidents.

End of life care

Cleanliness, infection control and hygiene

- Relatives and patients we spoke with told us "the wards seem clean, we see cleaners about the place regularly." "Staff are always washing their hands."
- Standards of cleanliness and hygiene were maintained in the mortuary and viewing areas. We saw these areas were visibly clean and well ventilated. The mortuary staff informed us a designated member of staff cleaned all areas. We saw completed cleaning schedules for each area. We saw that these were completed routinely and in a timely manner, which provided assurance that the areas were cleaned regularly and within a specified time scale.
- The mortuary had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage.
- Porters we spoke with said that they were aware of the personal protection equipment (PPE) protocol for the mortuary and said they were able to access the necessary equipment. SPCT wore clean uniforms with arms 'bare below the elbow' to enable good handwashing and reduce the risk of infection. We saw staff in the mortuary area wearing the correct PPE, such as gloves, aprons and over shoe protectors as per trust protocol. We observed PPE to be accessible throughout the department.
- There were some safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were available in the mortuary. There was a standard of practice document for the receipt of bodies (suspected infection) on the intranet. On the September 2015 inspection, we found that staff were unable to direct us to a specific document relating to handling bodies with infectious diseases. On this inspection, we found staff were able to direct us to policies necessary for their practice. Mortuary staff and porters told us about the procedures they followed and equipment they used, which assured us they were able recognise, assess and manage risks. Ward staff we spoke with were aware of the procedures to be taken when performing last offices, in order to minimise infection risks.
- A trust led audit of infection prevention standards had been carried out in the mortuary 22 January 2016 by the trust wide infection control and prevention team. This audit found there to be no evidence of local (mortuary led) infection prevention auditing within the mortuary. Equipment had not been labelled when cleaning had taken place. The audit had identified the mortuary fridge trays and fridge doors were heavily damaged, and required replacement to enable adequate cleaning. The infection control team action plan stated a cleaning record was to be completed, and the team were to carry out regular hand hygiene audits. We saw evidence of daily cleaning records, and that equipment was labelled after cleaning. The damaged doors and trays had been replaced to aid cleaning but we did not see evidence of a hand hygiene audit being completed. However, we saw staff following effective hand hygiene routines.

Environment and equipment

- Staff told us that syringe pumps used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner. The trust told us that only one type of syringe pump was used at the hospital since March 2015, following recommendation from the National Patient Safety Agency. The SPCT had provided a comprehensive education programme for all nursing staff about how to use the syringe pump. All new nursing staff received training on this equipment as part of their induction. On-going training was provided to maintain competence and confidence in using the equipment. Nurses we spoke with who used the equipment regularly told us they felt confident and competent in using this equipment. Nursing staff we spoke with, who did not routinely use this equipment, knew where to gain advice and support to enable them to use the equipment confidently. We saw evidence the syringe pumps were maintained and used in accordance with professional recommendation.
- The mortuary was equipped to store 40 deceased patients, 36 in fridges and four in long-term storage. Staff told us these facilities were usually sufficient to meet the needs of the hospital and local population. Additional storage was available on site using a temporary portable method. The trust used this during time of high demand, for example, during bank holidays. The temperature of the mortuary fridges was recorded on a daily basis and were within acceptable limits.
- There were four spaces for bariatric patients; there were specific storage trolleys and large fridges to accommodate them.

End of life care

- During our last inspection in September 2015, we found there to be maintenance issues with the mortuary fridges resulting in one bank of fridges not staying at the required temperature of 4-8°C. The staff in the department had not escalated this risk or made alternative storage arrangements. Safety concerns were not consistently identified or addressed quickly enough and monitoring of safety systems were not robust. On the July 2016 inspection, we saw the fridge had been repaired and the fridges were maintaining temperatures within recommended guidelines. The mortuary department had a 24-hour seven-day, SLA should urgent repair be required.
- The Human Tissue Authority (HTA) had licenced the mortuary to carry out post mortem examinations and storage of bodies. The licence was renewed annually, following a self-assessment audit; the trust had successfully renewed their licence. The next site inspection by HTA was due in 2019. Post mortems were carried out on the premises five days per week in the morning.
- On the September 2015 inspection, some staff we spoke with thought that the trolley used for transporting bodies to the mortuary was in a poor condition and was due for replacement. We found the trolley to be in a poor state of repair. On this inspection, we saw the service had purchased a new trolley suitable for transporting patients up to 190kg. Staff told us they were confident in using the new trolley and we saw evidence of staff training on use of the new trolley.
- On the September 2015 inspection, we saw equipment in the mortuary was maintained through the SLA with the facilities management company. We could not see test stickers on equipment and so were unable to establish if the equipment maintenance schedule was timely. The mortuary team did not hold information about the service arrangements so were unable to assure us that this was completed in a timely manner. On the current inspection, we saw this was still the case. The mortuary team still did not have oversight of the service arrangements, so were unable to assure us that this was completed in a timely manner.
- The risks regarding the mortuary were identified on the support services risk register. There was one risk identified, regarding security and access to the mortuary. The mortuary team had identified they required swipe card entry to the area, to prevent unauthorised people gaining access. Work was planned to address this in this financial year.

Medicines

- We saw that the specialist palliative care nurses worked closely with ward based medical and nursing staff and pharmacy staff to support the prescription of anticipatory medicines.
- The service had arrangements in place for managing medicines. There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice.
- Anticipatory end of life care medication required for discharge, such as symptom control medication, was identified and written up as part of the discharge process. Medication could be provided by district nurses on discharge. We saw a prescription chart for the syringe pump, in use, which had been designed for continued use once the patient went home.

Records

- Medical records were stored in lockable cabinets. The cabinets were locked when we visited the wards, which reduced the risk of people who did not have appropriate authority accessing the notes.
- The care records and care plans we looked at were written in line with trust policy. In medical notes for patients approaching the end of their lives, we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment, whilst still supporting the patient and their families.
- The DNACPR forms were stored at the front of the patients' notes. This meant the forms were easy to find.
- We reviewed 33 DNACPR forms across all ward areas and the emergency department. We saw two types of forms in the notes. We saw forms that were white with a red border, these were the forms initiated by the hospital. We saw forms that were completely red, these were the forms that had been initiated in the community. Both forms met Resuscitation Council guidelines and demonstrated forms were transferred with the patient during transfer between home and hospital. All the forms we reviewed were signed, dated

and where appropriate were countersigned, according to trust protocol. All forms reviewed included a summary of why cardiopulmonary resuscitation was not in the patient's best interests.

- The trust carried out routine DNACPR audits. They provided us with data from a DNACPR audit carried out in May 2016. 24 sets of notes were audited. The audit found 73% of forms had the summary of communication with patient competed. 91% of forms had the communication with patient's relatives or friends section completed. 79% of forms were countersigned by a consultant. Although most patients were deemed to have capacity, there was no formal assessment as to how this decision was made. Of the patients documented to lack capacity; for 82% the reason for their decision had been stated and 18% had no clear documentation related to how they had come to their decision. In no cases had formal assessment been undertaken. The resuscitation team had developed an action plan from the audit results and fed this back to the specialty leads. The trust had carried out extensive mental capacity assessment training with medical staff and the DNACPR policy had been updated. On the inspection in July 2016, we looked at 33 completed DNACPR forms across all ward areas, all were completed accurately, in line with trust policy and the MCA.

Safeguarding

- There had been no reported safeguarding concerns relating to patients receiving end of life care between March 2015 and February 2016.
- On the September 2015 inspection, we found 82% SPCT and 50% of the mortuary staff were up to date with their safeguarding training. This did not meet the trust target of 90%. Following the most recent inspection in July 2016, we saw the chaplaincy team, the SPCT and the mortuary team were 100% compliant with child safeguarding level two training and adult safeguarding level one training.
- Arrangements were in place to safeguard adults and children from abuse. Staff we spoke with told us they understood their responsibilities and adhered to safeguarding policies and procedures. Staff were able to tell the inspection team what signs of abuse were, and how to locate the trust policy. In addition, staff were able to identify their responsibilities with regard to reporting safeguarding concerns.
- At the September 2015 inspection, we found the portering staff were provided via a SLA with a facilities management company. The SLA did not ensure that there was an expectation that the porters received safeguarding training. However, on this inspection we found porters had attended a competency based training module specific for the staff attending the mortuary. The facilities management company provided the training; while it was not specifically safeguarding training, it identified the need to raise any concerns about the treatment or condition of deceased patients to the mortuary staff and their line manager. However, without safeguarding specific this training, there was a risk that portering staff did not understand their responsibilities in identifying safeguarding concerns. This was not identified on the support services risk register.
- We saw the facilities management company manager had a direct reporting structure through the support service manager at the trust. Whilst there were no formal meetings arranged to discuss issues, regular informal contact enabled any concerns to be raised with the trust.

Mandatory training

- On the September 2015 inspection, we saw none of the mortuary staff had completed their mandatory training or had a date booked to complete their mandatory training. On this inspection, we saw an improvement in training compliance in equality and diversity, health and safety, fire safety, moving and handling, dementia training, all were above the trust target of 90%. This meant the service could be assured the staff had the necessary knowledge in these areas. However, information governance training compliance was 50%, which was worse than the trust target of 90%.
- The chaplaincy team and all of the SPCT were 100% compliant with their mandatory training.
- The SPCT provided an awareness training session on the care of dying patients for all staff as part of their induction training.

Assessing and responding to patient risk

- We saw evidence of a triage system for SPCT referrals. The SPCT clinical nurse specialists held daily review meetings to discuss new referrals, review their workload and discuss patients seen and allocate new referrals. The team also held weekly multidisciplinary meetings.

They used this meeting to discuss diagnostic challenges, management options and any other pertinent issues relating to their current patients. Caseload would be reviewed and allocated appropriately between all available team members. The trust reported that 100% of patients referred to the palliative care team were seen within 24 hours between June 2015 and June 2016.

- We saw that the trust used the National Early Warning Score (NEWS) assessment tool for ensuring that deteriorating patients were identified and treated appropriately. The assessment tool scored each patient according to their blood pressure, pulse, respirations and conscious status. It prompted staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patients' risk of clinically deteriorating, including those patients receiving end of life care.
- DNACPR records had been signed and dated by appropriate senior medical staff and there was a clear documented reason for the decision recorded. This included relevant clinical information. In the majority of cases, discussions with families were documented in the medical notes.
- We saw that risk assessments, such as moving and handling, risk of falls, pain control and tissue viability were effectively completed and filed in patients' notes. We saw actions were documented to take place where risks were identified, for example, a hoist requested for a patient with deteriorating mobility.
- Intentional rounding was in place on the wards to monitor peoples' needs. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. Care needs such as changes required to medication or the need to commence mouth care was monitored by staff during these checks.

Nursing staffing

- There were 9.79 WTE clinical nurse specialists in palliative care based at the hospital. This was made up of clinical nurse specialists and a lead nurse. The SPCT told us that they were at full establishment at the time of inspection. The staffing levels met the NICE recommended guidance for staffing. The SPCT nursing team provided a Monday to Friday 9am to 5pm service within the hospital.
- The SPCT clinical nurse specialists held daily handover, review meetings to discuss new referrals, review their workload and discuss patients seen and allocate new referrals.
- We saw there were link workers for end of life care on most wards. Two wards we visited who did not have a link worker at the time of inspection, due to staff movement, were in the process of identifying a suitable link worker. Link workers attended end of life specific training quarterly.

Medical staffing

- A palliative care consultant who was hospital based 2.5 days a week led the team. The team also had support from a specialty doctor one day each week. This did not meet the NICE guidance for end of life care staffing that recommends that there is one whole time equivalent consultant/associate specialist in palliative medicine per 250 hospital beds. The SPCT had produced business cases to request funding for an additional consultant post. At the time of inspection the SPCT were unable to identify when these business cases would be reviewed. However, in addition to the hospital based medical cover, an out of hours consultant led palliative care advice service was available through the local hospice 24 hours a day, seven days per week.
- There were arrangements in place to cover the acute palliative care consultant post when they were on leave, by the specialty doctor and medical staff who worked at the local hospice.

Other staffing

- The trust employed a resuscitation team that comprised one full time senior resus officer and two part time resus officers (one 0.4 WTE and one 0.6 WTE). A 0.4 WTE administrator also supported the team. The team provided the basic life support and immediate life support training on site. They attended emergency calls within the hospital where resuscitation was likely to be required.
- The mortuary team comprised one full time mortuary manager, and one full time technician. The mortuary was working at full establishment. Since the September 2015 inspection, a new reporting structure had been introduced. The mortuary manager reported to the histopathology manager, who reported to the surgical directorate. This allowed issues and concerns about the mortuary to be addressed.

End of life care

- The trust employed one full time bereavement officer, who was available Monday to Friday 9am to 5pm. The bereavement officer was part of the complaints and patients advice and liaison team (PALS). This meant that when the bereavement officer was on leave, the staff from the PALS service were able to provide cover for their role.
- The trust employed a Church of England chaplain 15 hours a week. The chaplain, with the support of volunteers, covered all Christian denominations. The chaplaincy team had access to contacts in the community for other religions. The chaplaincy team were in the process of applying to the trust's charitable fund to increase the chaplaincy hours by an additional 15 hours per week.

Major incident awareness and training

- The trust had a major incident plan in place. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT and mortuary staff we spoke with were aware of this.
- We looked at the mortuary's storage contingency plans. The mortuary had the capacity to store 40 deceased patients. There was an additional foldable racking system available on site that could be used to increase storage facilities. The manager told us that the hospital had arrangements with local funeral directors in the case of a major incident if more capacity was required.

Are end of life care services effective?

Good

We rated end of life care services as good for effective because:

- The trust had instigated and embedded a replacement for the Liverpool Care Pathway (LCP) called the multidisciplinary care record for adults for the last days of life (MCR). This ensured that patients had a clear care plan that specified their wishes regarding end of life care. The care plan was an end of life care bundle.
- We looked at 33 completed do not attempt cardio-pulmonary resuscitation (DNACPR) forms across all ward areas, all were completed accurately, in line with trust policy. There was evidence staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). This had improved since the September 2015 inspection.
- Policies and procedures were accessible and based on national guidance. We saw improvements since the September 2015 inspection, with regard to only one DNACPR policy being accessible to staff on the intranet.
- The specialist palliative care team (SPCT) staff were competent in their roles and supported by some effective processes for ongoing professional development. SPCT staff had attended appraisals and group supervision.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 published March 2016. The trust achieved five of the eight organisational key performance indicators (KPIs) and scored better than the England average in four of five of the clinical audit KPIs.
- The service had local audits in place to measure the effectiveness and outcomes of the service.
- Patients had access to appropriate equipment such as syringe drivers and pressure relieving equipment.

However:

- The service did not provide face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday. This did not meet recommendation from the National Institute for Health and Care Excellence (NICE) guidelines. However, further advice could be sought through the local hospice 5pm to 9am, seven days per week.
- The trust could not demonstrate they had documented evidence that the needs of the person important to the patient were asked about.
- We saw three complaints made to the ward teams about slow response to request for pain relief.
- We did not see evidence of formal supervision for mortuary staff or regular team meetings in the mortuary.

Evidence-based care and treatment

- The trust took part in the NCDAH 2014/15, published March 2016. The trust did not achieve three of the eight organisational KPI's.
  - The trust did not have a lay member on the trust board with a responsibility for end of life care.

End of life care

- The trust was unable to offer access to face-to-face specialist palliative care for at least 9am to 5pm Monday to Sunday.
- The trust did not have one or more end of life care facilitators as of 1 May 2015.

- However:
  - The trust did seek bereaved relatives' or friends' views during the last two financial years (from 1 April 2013 to 31 March 2015).
  - The trust did provide formal in-house training, which included communication skills training for care in the last hours or days of life for medical staff, nursing staff, both registered and non-registered, and allied health professionals.
- The trust scored better than the England average in four of five of the clinical audit KPIs.
  - The trust could demonstrate there was documented evidence, within the last episode of care, and it was recognised that the patient would probably die in the coming hours or days.
  - There was documented evidence within the last episode of care, that there was health professional recognition the patient would probably die in the coming hours or days and imminent death had been discussed, with a nominated person important to the patient.
  - There was documented evidence that the needs of the person important to the patient were asked about.
  - There was documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care. However, the trust did not demonstrate documented evidence that the patient was given an opportunity to have concerns listened to.
- We saw that the trust had produced an action plan to address the shortfalls and issues raised by the NCDAH 2014/15, which the SPCT monitored and reviewed on a monthly basis. Since the audit, the trust had addressed one of the issues; they had appointed a non-executive director on the trust board with a responsibility for end of life care and additional communication training was provided.
- The service had carried out an audit on preferred place of death for patients known to SPCT. The end of life care record document of 122 patients, known to the SPCT who had died at the hospital between April 2015 and June 2016 had been reviewed. This showed 100 patients (82%) had died in their preferred place of death. The service used the audit to evaluate the quality of the information collated in the care plan and tailored training needs.
- The trust had taken action in response to the 2013 review of the LCP. We saw that the multidisciplinary care record was evidence based, providing individual care plans for patients believed to be dying. This was used to communicate care and treatment. This was in line with the recommendations published June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), NICE QS13 End of Life Care for Adults and NICE CG140 Opioids in Palliative Care. The care record was embedded across the hospital and was seen as a care bundle. (Care bundles are evidence-based, that provide a structured way of improving the processes of care and patient outcomes, a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.) It was stored with all other care bundles on each ward, which made it visible and accessible to all ward staff.
- The SPCT were working with the staff on the intensive care unit to develop a multidisciplinary care record that was more appropriate for patients cared for in the intensive care unit.
- The trust's DNACPR policy was updated in September 2015. It had been developed in line with the Resuscitation Council Framework. The resuscitation team audited the quality of the documentation twice a year. This was usually carried out by junior doctors as part of their research projects. Action plans were produced and this information was fed back to the staff teams via their line managers. The last audit, carried out in May 2016, identified the need for MCA training in relation to decisions about DNACPR. We saw training had been commissioned from an outside provider. 127 medical staff were provided with specific training focusing on the four questions required to assess mental capacity. We saw evidence of the impact of this training in practice; we saw MCA assessments in place for the decisions about DNACPR and evidence of MCA assessments in discussions with patients about other significant decisions. The medical director had supported this training, informing all staff of the importance of the MCA assessment and set expectations for their practice.

End of life care

- We saw the standards of practice for the mortuary, which were based on national guidelines. There was an evidenced based standard of practice procedure for transferring deceased patients from the ward to the mortuary. This provided staff with necessary guidance.
- There were palliative care resource box files on each ward. These pink box files were easily identifiable and contained information such as 'how to' packs for completing the MCR, flow charts for the end of life care process, and contact numbers of SPCT and out of hours contacts. Staff told us that these were a useful resource.

Pain relief

- Medicines were prescribed following the Wye Valley NHS Trust formulary and a web accessible West Midlands palliative care formulary, which was in line with NICE CG140 Opioids in Palliative Care. The service used comprehensive prescription and medication administration record charts for patients. These charts facilitated the safe administration of medicines. Specialised prescription charts supported prescribers to follow the agreed protocols for patients who had medicines administered via syringe pumps. We saw medicines delivered via syringe pumps were prescribed appropriately.
- Patients under the care of the SPCT had their pain control reviewed daily and ensured that as required medication was prescribed to manage any breakthrough pain. This is pain relief that is given in between regular, scheduled pain relief. However, during inspection we were told of three occasions where patients' pain had not been managed well. These occasions were due to medications not being administered by ward staff because the appropriate medication was unavailable on the ward or there was an error in the prescription. Staff had reported these incidents, using the electronic reporting system. An investigation of these events would be carried out. We did not have any updated information about the investigations at the time of the report.
- There were tools in place to assess and monitor pain. We saw guidance for staff on the use of recognised pain assessment tools for use with patients with dementia and learning disabilities.
- National Care of the Dying Audit for Hospitals (NCDAH) 2014-15, report published March 2016 identified there was evidence documented in the patient notes reviewed that in the last 24hours of life, pain was controlled in 94% of cases.
- The SPCT audited pain relief as part of their review for patients cared for using the multidisciplinary care record for adults for the last days of life between September 2015 and March 2016 the results were:
  - The plan of care including pain management was discussed with the patient and were appropriate family in 88% of cases.
  - Appropriate anticipatory analgesics were prescribed in 97%.
  - Patient's comfort and symptoms were reviewed regularly by nursing staff throughout their shift in 66% of cases.
- There was an action plan following the review of the results. The results were disseminating to medical and nursing staff electronically and by presentation at the trust audit meetings. The results were presented at the care group governance and risk management meetings. The results were used to inform palliative and end of life care education sessions provided by the SPCT.

Equipment

- Staff and the relative we spoke with told us patients had access to appropriate equipment, such as pressure relieving mattresses and syringe drivers, to keep them safe and comfortable.

Nutrition and hydration

- The NCDAH 2014/15 found 65% of patients had received a review of their nutritional requirements; this was better than the England average of 61% and an improvement in the trusts' score on 38% in the 2014 NCDAH. The NCDAH 2014/15 also identified that 80% of patient's hydration requirements had been reviewed, which was better that the England average of 67%.
- Patients risk of malnutrition was routinely assessed using the Malnutrition Universal Screening Tool (MUST). The nursing records, such as nutrition and fluid charts were thorough and summarised accurately.

Patient outcomes

- The SPCT response to referral met the trust target, the SPCT aimed to see all patients referred within 24 hours. Between April and June 2016 100% of patients were

seen within 24 hours of referral. The trust took part in the NCDAH 2014/15. The results were published in March 2016. The trust achieved five out of eight of the organisational KPIs:

- The trust sought bereaved relatives' views.
- In house training included specifically, communication skills training for care in the last hours or days of life for medical staff.
- In house training included specifically, communication skills training for care in the last hours or days of life for registered nursing staff.
- In house training included specifically, communication skills training for care in the last hours or days of life for unregistered nursing staff.
- In house training included specifically, communication skills training for care in the last hours or days of life for allied health professional staff.

However:

- The trust did not have a lay member on the trust board with responsibility or role for end of life care. However, since the audit the trust had appointed a non-executive director.
- They did not have face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday.
- The trust did not have more than one end of life care facilitator.
- The trust scored better than the England average on four out of the five clinical audit quality indicators:
  - The trust had documented evidence within the last episode of care that it was recognised the patient would die in the coming hours or days.
  - The trust had documented evidence within the last episode of care, health professionals recognised the patient would die in the coming hours or days and it had discussed with a nominated person important to the patient.
  - The trust had documented evidence the patient was given an opportunity to have concerns listened to.
  - The trust did have documented evidence that a holistic assessment of patient's needs regarding an individual plan of care was available to the patient in the last 24 hours of their life.

However:

- The trust did not have documented evidence the needs of the person important to the patient were asked about.
- The service had carried out an audit of the use of the multidisciplinary care record. The team had reviewed the multidisciplinary care record of 122 patients known to the SPCT who had died at the hospital between April 2015 and June 2016. The service used the audit to evaluate the quality of the information collated in the care plan and used the information obtained to target training needs. The SPCT identified staff within particular ward areas that missed opportunities to discuss or document preferred place of death. The SPCT would meet with the ward staff to support them to address the issues preventing them from communicating with the patient or documenting patients' wishes.
- The trust contributed to the FAMCARE 2 Project, a post bereavement survey of relatives about the care and support they and their relative received. Data was submitted for bereaved relatives known to the palliative care team and the trust. There was a positive response about the SPCT.

Competent staff

- The SPCT had arrangements in place for supporting and managing staff. We saw records that demonstrated that 100% of SPCT staff had an appraisal in the last 12 months and the SPCT had received clinical supervision. The SPCT had regular minuted team meetings where staff were updated on changes within the trust and caseload reviews were carried out. All staff were trained to degree level or were undertaking a degree in a relevant subject. All staff had undertaken additional training relevant to their role in palliative or end of life care.
- We saw evidence the SPCT consultant, specialty doctor and the SPCT clinical nurse specialists were up to date with revalidation.
- The SPCT provided training on using the multidisciplinary care plan for the dying person document. They provided advanced communication skills courses covering all aspects of difficult communication scenarios, such as skills for supporting families and those close to dying patients. They provided communication skills training to secretarial

and administration staff. The team also provided a teaching session on end of life care at junior doctors' induction and an advanced communication skills training for consultants.

- Wards had a pink box file that contained information about end of life care. This box file contained all the information and equipment required by ward staff following a death. For example, relevant policies such at the last offices policy, (guidelines for staff on procedures performed to the body of a deceased person shortly after confirmed death), frequently asked questions for the bereavement office sheet and information leaflets for the family. We saw these box files on wards we visited. Ward staff told us this was a useful resource. The end of life link nurse maintained the box file on the wards.
- We did not see evidence of formal supervision for mortuary staff or regular team meetings in the mortuary.
- The mortuary manager provided training for porters in the trust's procedures for transporting bodies to the mortuary and the use of equipment. For example, the trolley used to transport the deceased from the wards to the mortuary. The porters told us that they felt they had the necessary training, they supported each other with training needs and an experienced porter accompanied new staff to ensure protocols were followed.

Multidisciplinary working

- The SPCT team had established close links with other providers in the local area of end of life care including the local hospice, charitable organisations, primary care providers and community nurses. The aim of this was to improve patients' experience as they moved across care settings. We saw documented evidence of a multidisciplinary approach to care. We reviewed 10 sets of notes and we saw documented examples of communication of planned care between health care professionals. Medical staff told us they sought guidance and acted upon advice from the specialist palliative care team.
- The SPCT regularly attended the specialist teams' multidisciplinary team (MDT) meetings such as respiratory care, gynaecology, haematology and neurology to provide support and guidance.
- We saw the referrals to the SPCT came from a wide source of wards across the hospital. The SPCT told us they worked hard to build up a good working relationship with all ward teams. They told us staff on all wards had been supportive of the SPCT.
- The bereavement office's main professional contacts were doctors, nurses, mortuary staff, SPCT, coroner's officers, police, registrar of births, deaths and marriages, hospital chaplains and funeral directors.
- The chaplaincy team had access to contacts in the community for support for all religions.

Seven-day services

- The trust did not provide face-to-face access to specialist palliative care 9am to 5pm, Monday to Sunday. This did not meet the recommendation from the NICE guidelines for 'End of life care for adults', which states "Palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week". The out of hours palliative care advice service was a phone advice service only, available 9am to 5pm Saturday, Sunday and bank holidays. Further advice could be sought through the local hospice 5pm to 9am, seven days per week. As a result, the trust did not achieve the NCDAH 2014/15 organisational KPI. Plus, provisions did not meet the recommendation from the NICE guidelines for 'End of life care for adults', which states "Palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week".
- The mortuary staff worked Monday to Friday 8am to 4:30pm. They provided an on-call rota that covered the 24-hour period. The mortuary manager told us they rarely had to come in out of hours.
- The bereavement office was open from 9am until 5pm Monday to Friday. The service told us arrangements were in place to issue death certificates out of hours on the grounds of religious or cultural needs. The on-call hospital site manager coordinated this.

Access to information

- Trust policies, procedures and guidelines were available to nurses, doctors and support staff who were able to access them when necessary. Documents such as policies, standards for practice, SPCT referrals documents and information about five priorities of care,

information for patients and relatives and information sheets for equipment were available on the intranet. All staff had access to this information 24 hours a day, seven days a week. Staff we spoke with on the wards were able to direct us to this information and stated that they used it to support their practice.

- During the September 2015 inspection, we found there were two DNACPR policies on the intranet, which could have resulted in confusion for staff. On this inspection, we found the trust had removed the old DNACPR policy; only one policy was accessible to staff.
- Once in place, the multidisciplinary care record document stayed with the patient including on discharge. The community team received the care of the dying care plan document on the patients' discharge to ensure continuity and access to relevant information. We saw information needed for the patient's ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- At the time of the September 2015 inspection, we saw there was no countywide information technology system between Wye Valley NHS Trust, mental health services, GPs and primary care teams. There was a risk some information would not be shared effectively. The risk had been mitigated by SPCT staff maintaining phone contact with the patients' GPs, ensuring appropriate referrals were made and use of the multidisciplinary care record between services. The SPCT had their own database of patients referred to the service across the acute and community setting, encompassing both hospital and community based components of the team.
- The DNACPR forms were at the front of the patients' notes, allowing easy access in an emergency. We saw that forms stayed with the patients following them into the community and back into hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted a significant improvement in the documentation since the September 2015 inspection. At the last inspection, we saw three DNACPR forms where the patient or relatives were unaware of or involved in the DNACPR decision. In 21 cases, we saw that decisions had been made about a patient's capacity, but there was no evidence that a mental capacity assessment had been completed in the DNACPR decision-making process or that this information was documented in the patients notes. This was not line with trust policy or the MCA.
- On this inspection, we looked at 33 completed DNACPR forms across all ward areas, all were completed accurately, in line with trust policy and the MCA.
- We saw that decisions were recorded on two types of forms. Forms instigated on the current admission were white with a red border. Forms instigated in the community, normally by the patient's GP, were completely red. All forms were in the front of the patient's medical notes, allowing easy access in an emergency. Of the 33 forms we looked at five had not been reviewed and endorsed by a consultant or most senior health professional. However, the trust policy stated, "the consultant must sign to endorse the form at the earliest opportunity, usually at the next ward round". We reviewed these forms post ward round and on revisit, all the forms had been signed in line with trust policy.
- All DNACPR forms had evidence that patients, or where appropriate their relatives were aware of or involved in the DNACPR decision.
- In 15 cases, we saw that decisions had been made that the patient lacked capacity. We saw in seven cases, a specific mental capacity assessment form had been completed. In three cases, we saw a capacity assessment had been completed on the DNACPR form. In five cases we saw recognition of the patients' previous diagnosis to assist with the decision making process. For example, where a patient had a known diagnosis of dementia and mental capacity had already been assessed and there was no evidence of a change to the patients' cognitive ability.
- Safeguarding team had been involved in the implementation of the MCA with regard to the trust's DNACPR documentation.
- All clinical staff received training on the MCA policy at induction and then annually within essential skills training. Staff we spoke with demonstrated knowledge of consent and decision making requirements of legislation and guidance, including the MCA.
- Further training had been delivered in the form of presentations at doctors meetings, senior nurses meetings and other local groups and departmental

meetings. All training was based on current national guidance produced by the British Medical Association, Royal College of Nursing, Resuscitation Council UK and MCA.

Are end of life care services caring?

Good

We rated end of life care services as good for caring because:

- Feedback from patients and those who are close to them was positive.
- Patients and those close to them were involved in their care. Patients were supported to make decisions and plan their care.
- Patients were treated with dignity, respect and kindness by staff, relatives told us they had positive relationships with specialist palliative care team (SPCT) staff.
- Patients and those close to them were communicated with and were provided with information in a way that they could understand.
- Patients were responded to compassionately. When they needed help, staff supported them to meet their basic personal needs as and when required. Patient's privacy and confidentiality was respected at all times.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Staff understood and respected patients' personal, cultural, social and religious needs. Multidisciplinary care records were accessible to all staff and ensured that patients had a clear care plan that specified their wishes regarding end of life care. We saw that these documents detailed discussions with patients and their relatives. Records we saw on the wards indicated the patients' preferred place of care and place of death. Staff had documented the wishes and preferences of patients and their families.
- Staff took time to interact with patients and those close to them in a respectful and considerate manner. Staff carried out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks. We saw that staff spent time talking to patients and those close to them. A patient we spoke with told us the team were "very supportive, caring and kind."
- Staff responded to patients in a compassionate and appropriate way.
- We observed SPCT staff that were respectful and maintained patients' dignity; there was a person centred culture. We saw staff going out of their way to respond to patients' wishes. During our inspection, we saw a patient had complained about a noisy door to the SPCT clinical nurse specialist; they had arranged for this to be repaired, making the patient's stay more comfortable.
- Porters told us ward staff handle bodies of the deceased with dignity and respect before they were transferred to the mortuary. Nursing staff were provided with training regarding how to perform procedures respectfully.
- The mortuary staff told us they had no concerns about the condition of bodies of the deceased when they arrived in the mortuary.
- Mortuary staff were observed to handle bodies in a professional and respectful way.
- We saw cards in the mortuary, in the SPCT office and in the chaplaincy office from relatives of deceased patients thanking staff for the care they had provided.

Understanding and involvement of patients and those close to them

- Patients' notes we looked at and people we spoke with told us staff communicated with them so that they understood their care, treatment and condition. We reviewed 10 sets of notes and each demonstrated people were kept actively involved in their own care and relatives were kept involved.
- A relative told us about the excellent relationships they and their relative who was a patient had with the SPCT clinical nurse specialists.
- The results of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 (published in March 2016) showed that 87% of patients had been recognised as dying at the end of their life and this had been discussed with the patient's nominated individual. This meant that in most cases there was documented evidence that a professional had informed a relative that the patient was expected to die in the coming hours or days. The trust scored better than the England average of 79%.
- The trust had submitted data to the FAMCARE 2 Project, a post bereavement survey of relatives about the care

and support they and their relative received. Data was submitted for deaths known to the palliative care team. There had been a positive response about the SPCT. The majority of relatives felt satisfied with:

- The patient comfort
- The way in which the patient's condition and likely progress had been explained by the palliative care team
- Information given about side effects of treatment
- The way in which the palliative care team respected the patient's dignity
- Meetings with the palliative care team to discuss the patient's condition and plan of care
- Speed with which symptoms were treated and the palliative care team's attention to the patient's description of symptoms
- The way in which the patient's physical needs for comfort were met
- Availability of the palliative care team to the family
- Emotional support provided to family members by the palliative care team
- The practical assistance provided by the palliative care team
- The doctor's attention to the patient's symptoms
- The way the family was included in treatment and care decisions
- Information given about how to manage the patient's symptoms (e.g. pain, constipation),
- How effectively the palliative care team managed the patient's symptoms
- The palliative care team's response to changes in the patient's care needs
- Emotional support provided to the patient by the palliative care team

- The mortuary staff and bereavement officer arranged visits for relatives who wished to view the deceased. They ensured that people could take the time they needed to say goodbye to their relatives and ask any questions they may have.

Emotional support

- Staff understood the impact that a patients care, treatment or condition had on their wellbeing and on those close to them emotionally. The SPCT told us emotional, psychological and bereavement support and advice for families was an important component of the service. People we spoke with told us the SPCT had provided them with emotional support.
- The chaplaincy team offered spiritual support to patients of all or no faiths.
- We saw patients who did not have family, friends or carers to support them who had received end of life care and had been supported emotionally. The chaplaincy team provided company and support to patients who had limited social support.
- A counselling service was provided by the SPCT with the support of a clinical psychologist.
- The bereavement officer was available from Monday to Friday 9am to 5pm, with a telephone message service outside of these hours. They provided relatives with information on how to register a death as well as other useful information, such as cremation papers and the coroner's office. They returned property to family and carers and liaised with them around the issue of death certificates.

Are end of life care services responsive?

Good

We rated end of life care services as good for responsiveness because:

- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 published in March 2016. The trust scored better than the England average in four out of five of the clinical audit KPIs.
- The service was collecting information on the percentage of patients who died in their preferred location. 82% of patients had died in their preferred place of death. This data collection had improved since the inspection in 2015.
- There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life.
- The specialist palliative care team (SPCT), chaplaincy or mortuary team had not received any complaints in the past 12 months (June 2015 to June 2016). We saw letters and cards of thanks from relatives/carers addressed to the SPCT and the chaplaincy.
- The trust had guidance for staff on the use of recognised pain assessment tools for use with patients with dementia and learning disabilities.

End of life care

- We saw an improvement in the arrangements for transporting deceased patients to the mortuary. Since the September 2015 inspection, the trust had purchased a new trolley suitable to transport bariatric patients to the mortuary.

However:

- The trust did not collect effective information on the percentage of patients who were discharged to their preferred place within 24 hours. This had not improved since the inspection in 2015.

Service planning and delivery to meet the needs of local people

- The SPCT saw 450 patients between April 2014 and May 2015. The majority of all patients the team saw in 2014/15 had cancer (80%). The SPCT were concerned that some patients with conditions other than cancer were not been identified as requiring the support of SPCT. The SPCT were in the process of writing a business case for setting up joint cardiology and respiratory clinics to increase the opportunities of patients requiring the support of SPCT being referred.
- 100% of patients were seen within 24 hours of referral between April and June 2016. Patients who were identified as requiring end of life care were referred to the SPCT by individual consultants or ward staff.
- The hospital did not have any designated beds for end of life care, the staff delivered end of life care in most wards with support from the SPCT.
- We saw that menus catered for cultural preferences.
- Reduced parking fees for relatives of patients receiving end of life care could be arranged by staff, so relatives could spend the maximum amount of time with their relative.

Meeting people's individual needs

- We saw an improvement in the arrangements for transporting deceased patients to the mortuary. At the time of the last inspection, we saw the trust did not have a specific trolley used for transporting bariatric patients. Deceased bariatric patients were transported to the mortuary on their hospital bed concealed with a cover. Staff expressed a need for a bariatric trolley to transport deceased bariatric patients to the mortuary as they felt this would be more dignified. Since the last inspection, the trust had purchased a new trolley suitable to transport bariatric patients up to 190kg to the mortuary. Patients over 190kg were still transported to the mortuary on their hospital bed concealed with a cover.
- Patients reaching the end of their life were nursed on the general wards in the hospital. The hospital did not provide a designated ward area for those patients requiring end of life care. Staff told us, whenever possible, patients were cared for in side rooms in order to offer quiet and private surroundings for the patient and their families. However, they also said some patients at their end of life were cared for on open wards as use of single rooms was prioritised for patients who required isolation.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. There were four designated overnight accommodation facilities on site, wards could also provide recliner chairs for those who wished to remain at their relatives' bedside. Some wards made their day room available for relatives to use on such occasions.
- The trust had leaflets available: A leaflet outlining the changes that may occur in patients in the hours before death for families and those people that are important to them. A leaflet explaining local procedures to be undertaken after the death of a patient for relatives or friends. A Department of Work and Pensions (DWP) leaflet 1027, 'What to Do After a Death in England and Wales'.
- We did not see information in any other language than English. Staff told us if information was required in other languages or suitable for people with visual impairments they would be able to request it. Staff also told us they had access to translatory services.
- We saw guidance for staff on the use of recognised pain assessment tools for use with patients with dementia and learning disabilities.
- The trust took part in the NCDAH 2014/15 published March 2016. Out of the five clinical audit quality indicators, the trust scored better than the England average:
  - The trust had documented evidence within the last episode of care that it was recognised the patient would die in the coming hours or days.

- The trust had documented evidence within the last episode of care health professionals recognised the patient would die in the coming hours or days and it had discussed with a nominated person important to the patient.
- The trust had documented evidence the patient was given an opportunity to have concerns listened to.
- The trust had documented evidence that a holistic assessment of patient's needs regarding an individual plan of care was available to the patient in the last 24 hours of their life.

However:

- The trust did not have documented evidence the needs of the person important to the patient were asked about. The service had devised an action plan in response to the NCDAH 2014/15. Training for staff on advanced communication was offered to staff, to address the issue raised.
- Staff and the relative we spoke with told us patients had access to appropriate equipment, such as pressure relieving mattresses and syringe drivers, to keep them safe and comfortable. Necessary equipment was accessible within a few hours for patients at the end of life whose discharge was fast tracked.
- There was a chapel, a multi-faith room and a chaplaincy team at the hospital. The team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Patients could refer themselves or staff alerted the chaplaincy team if a patient asked to see them. For patients who wished to take communion, but could not attend the chapel, the chaplain or an authorised member of the team brought communion to their bedside. There was a book for people to write their prayer requests in. The chapel and multi-faith room were open 24-hours a day and were used by patients, relatives, carers and staff. There were also regular services held in the chapel.
- The mortuary viewing area was clean and bright and was suitably decorated with comfortable chairs. There was information accessible in this area produced by the trust for relatives. One booklet provided a guide through the practical tasks that need to be tended to during the early stages of bereavement. Another booklet contained information regarding dealing with a sudden death, coroner's post mortem and inquests. The viewing facility was available for relatives' viewings on an appointment only basis. These were usually in the afternoons between 2pm and 4:15pm due to workflow through the mortuary in the morning.
- The bereavement officer liaised with bereaved families and coordinated the issue of the medical certificates, so that the death could be registered and the funeral arranged.

Access and flow

- The SPCT collected information on preferred place of death for patients known to SPCT; the SPCT reviewed the multidisciplinary care records on a monthly basis. On the September 2015 inspection, the SPCT informed us that information technology problems had hindered the audit on preferred place of death for patients known to SPCT so they were unable to give us detailed information. On this inspection, we saw an audit had been carried out. The team had reviewed the multidisciplinary care records of 122 patients, known to the SPCT who had died at the hospital between April 2015 and June 2016. This showed 100 patients (82%) had died in their preferred place of death. The service used the audit to evaluate the quality of the information collated in the care plan and used the information obtained to target training needs. The SPCT identified that there were instances where ward staff missed opportunities to discuss preferred place of death. The SPCT met with the ward staff to support them to address the issues preventing them from communicating with the patient or documenting patients' wishes.
- The trust had a protocol for rapid discharge, this included a local guideline and checklist for discharging a patient home whose anticipated prognosis was days to a short number of weeks. We saw evidence of the protocol for rapid discharge being used. Staff we spoke with told us they had used this process. They told us delays in discharging a patient home could occur because of the lack of available community care packages, particularly in the more rural areas. We saw evidence that reported incidents regarding failed rapid discharge had been investigated and actions were in place to address issues where possible.
- On the current inspection, as noted at the September 2015 inspection the SPCT did not effectively collect information of the percentage of patients that had been discharged to their preferred place of death within 24

hours. The SPCT did collect information on patients known to them who were fast tracked for a care package or care home placement but the information did not include time from referral for fast track to discharge. Without this information the trust was unable to monitor effectiveness of the rapid discharge process or if they needed to improve this.

- We saw the SPCT had a triage and prioritising system for referrals. 100% of patients were seen within 24 hours of referral between April and June 2016. Patients were referred directly to SPCT on their ward visits or via telephone referral system. Ward staff told us there were no delays for patients to be seen. The SPCT were visible on the wards. All ward staff we spoke with could identify the SPCT clinical nurse specialists and consultant.
- The SPCT clinical nurse specialists picked up referrals and phone messages for the SPCT were each time went back to the office. Staff told us that patients required end of life care were identified at daily ward rounds. Once identified, the ward team would refer the patient for specialist care.
- The results of the National Care of the Dying Audit for Hospitals 2014/15 published in March 2016 showed that 96% of patients had been recognised as dying at the end of their life. This meant that in most cases there was documented evidence, within the last episode of care, by at least one health professional, that the patient was expected to die in the coming hours or days. The trust scored better than the England average of 83% and this result was an improvement from their results of 64% in the 2014 audit.
- Porters told us that they were able to respond promptly to requests to transfer deceased patients to the mortuary. This was usually within 20 minutes and they were able to prioritise accordingly. We spoke with ward staff who told us they did not have concerns about response times.

Learning from complaints and concerns

- There had been no complaints specifically about the SPCT, chaplaincy or mortuary team between June 2015 and June 2016. The complaints team forwarded any complaints from other services where end of life care had been provided. We saw two complaints from another service, where the patients had received end of life care. Investigations had been completed and learning had been shared. The SPCT reviewed these complaints and discussed within their multidisciplinary team to see if improvements to services could be made and to identify needs for future end of life care training they provided to hospital staff to ensure lessons were learnt. Trust wide complaints were shared via a 'safety bites' communication. Safety bites was a document shared by the trust of issues around the trust to promote learning from events. Staff we spoke with told us that when a complaint was received, a manager from another department investigated the complaint so that an independent view was taken.
- We saw letters and cards of thanks from relatives and carers addressed to the SPCT and the chaplaincy team.

Are end of life care services well-led?

Good

We rated end of life care serviced as good for well led because:

- The trust had executive and non-executive board representatives for end of life care that provided representation and accountability for end of life care at board level. End of life care services received coverage in board meetings and in other relevant meetings that reported to the board.
- Specialist palliative care team (SPCT) staff we spoke with told us there was good leadership in the SPCT.
- The SPCT had a strategy work plan for end of life care for 2016. The strategy was realistic to achieve the priorities and delivering good quality care. The strategy was reviewed monthly by the team at end of life care meetings.
- The service had local audits in place to measure the effectiveness and outcomes of the service.
- There were effective plans in place to address outcomes of audits such as the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 published in March 2016.
- We saw evidence of lessons learned.
- Since the September 2015 inspection the trust had addressed a number of issues that were identified, including:
  - The trust had recruited a non-executive board representative for end of life care.

- We saw an improvement on do not attempt cardio-pulmonary resuscitation (DNACPR) documentation; all DNACPR forms were completed accurately and in line with trust policy.
- Maintenance issues in the mortuary had been addressed and we saw effective monitoring of mortuary risks on the support service risk register.

However:

- The portering staff service level agreement (SLA) did not ensure that the porters received safeguarding training.
- Although we saw a new governance structure had been introduced to the mortuary, we could not evidence that the new arrangements were embedded. We did not see any evidence of mortuary department meetings, appraisals or supervision in place.

Vision and strategy for this service

- The SPCT felt their work was a high priority with in the trust. At the September 2015 inspection, we saw the trust did not have a non-executive director to provide representation of end of life care at board level. At this inspection, we saw end of life care had representation from the medical director from the executive team, a non-executive director and we saw evidence of issues around end of life care raised at board meetings.
- The SPCT had an annual general meeting where they discussed and agreed their operational policy, work plans and priorities for the following year. We saw a copy of the meeting held in December 2015.
- We saw a copy of the team's strategy work plan for end of life care and priorities for 2016. The main priorities were listed as improvement of documentation supporting multidisciplinary care record, education and audits/surveys/guidelines. The SPCT also identified the need for engagement with the trust's quality improvement plan subsequent to the trust's allocation to special measures in 2014. The strategy was realistic to achieve the priorities and delivering good quality care. The strategy was reviewed monthly by the team at end of life care meetings. The trust had contributed to the development of the Herefordshire end of life care strategy, compiled by the Herefordshire end of life forum chaired by the Clinical Commissioning Group. The service told us, it was anticipated the trust would adopt the Herefordshire end of life care strategy once it was published.
- The multidisciplinary care record document and the associated training ensured that end of life care services were assessed, monitored and managed on a day-to-day basis and reviewed regularly.
- We saw the trust values displayed in a number of areas we visited. However, the values had not been officially launched; as a result, only some staff we spoke with were able to tell us about them.

Governance, risk management and quality measurement

- The SLA for the portering staff did not ensure the porters received safeguarding training We saw porters had attended a competency based training module specific for the staff attending the mortuary. The facilities management company provided the training; while it was not specifically safeguarding training, it identified the need to raise any concerns about the treatment or condition of deceased patients to the mortuary staff and their line manager. Without safeguarding specific this training, there was a risk that portering staff did not understand their responsibilities in identifying safeguarding concerns. This was not identified on the support services risk register.
- SPCT had recently moved to a different directorate, the ambulatory care division of medical services. Whilst the change to the reporting structure was new, it had only been implemented in the few weeks prior to our inspection; the team felt they were well placed for the support required
- At the September 2015 inspection, we did not see any evidence of team meetings, supervision or appraisals within the mortuary team. Since the September 2015 inspection, a governance structure had been introduced in the mortuary. The mortuary manager could discuss any concerns or issues with their line manager. However, we did not see any evidence of mortuary department meetings, appraisals or supervision in place.
- At the September 2015 inspection, intermittent maintenance issues with the mortuary fridges resulted in one bank of fridges not staying at the required temperature since May 2015. The issue with the bank of fridges had not been entered on to the mortuary or trust risk register. On this inspection, we saw the mortuary had an up to date risk register. Staff and management

teams we spoke with were able to articulate key risks for the service. We saw actions had been taken to address risks and where risks remained, mitigating actions had been taken to reduce the impact.
- We saw evidence of regular supervision, appraisals and professional development within the SPCT. Group supervision was provided and supported by a clinical psychologist approximately six weekly.
- The SPCT had an end of life strategy with action plans. The service was working in a timely way to achieve the actions identified.
- We reviewed the service's risk register. There were two current risks identified on the divisional risk register related to SPCT. Concerns about continuation of the educational SPCT post and the requirement for a second consultant to comply staffing requirements provided by the NICE CMG42 guidance for commissioners on end of life care for adults objectives December 2011. The SPCT had produced business cases to request funding for these posts. At the time of inspection the SPCT were unable to identify when these business cases would be reviewed.
- We saw the SPCT had monthly team meetings where governance and risk issues were discussed.

Leadership of service

- SPCT staff we spoke with told us there was good leadership in the SPCT. The team was led by the palliative care consultant and the specialist palliative care nurse team leader. Staff felt their line managers had the capacity, capability and experience to lead the service effectively. The SPCT felt supported by their line management.
- The medical director was the board representative for end of life care, there was also a non-executive director lead that provided representation and accountability for end of life care at board level.
- All staff we spoke with were aware of who their immediate managers were and were aware of the roles of the senior management team.
- The mortuary staff, the chaplain and bereavement officer told us that they felt supported and listened to by their line management. We saw evidence of succession planning within the mortuary.
- All of the ward staff we spoke with knew who the leads were for end of life care.

Culture within the service

- Staff told us they felt respected and valued. Staff were committed to provide safe and caring services and staff spoke passionately about the care they delivered.
- We observed SPCT staff that were respectful and maintained patients' dignity; there was a person centred culture. We saw staff going out of their way to respond to patients' wishes.
- We saw evidence that behaviour and performance was consistent with the vision and values in the trust.
- There were mechanisms in place to address behaviour and performance that was inconsistent with the trust's vision and values.

Public engagement

- The trust had contributed to the FAMCARE 2 Project, a post bereavement survey of relatives about the care and support they and their relatives received. There had been a positive response about the SPCT.
- The SPCT organised an event within the hospital during the national Dying Matters Awareness Week in May 2015. This was to raise awareness about end of life care to staff, patients and those close to them.

Staff engagement

- The SPCT held regular team meetings where information and learning from safety and quality audits was shared.
- Staff who attended courses provided by the SPCT were asked for feedback and this was used to develop future training. Staff we spoke with felt that the training they had provided them with the necessary skills and gave them confidence.
- The trust carried out staff satisfaction surveys, although these did not specifically identify end of life care results.

Innovation, improvement and sustainability

- We saw evidence of lessons learned. The team used feedback from mortality meetings, bereavement questionnaires, training feedback and complaints to improve the service and target training needs.
- The SPCT were in the process of writing a business case for setting up joint cardiology and respiratory clinics as there was a were concern that patients with conditions other than cancer were not been identified as requiring the support of SPCT. The aim of the clinics was to increase the opportunities for all patients requiring the support of SPCT being referred.

End of life care

- The SPCT had produced a business case to request appointment of a second palliative medicine consultant post and were exploring the role of a SPCT allied health professional post. At the time of inspection there was no timescale identified for these changes.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Inadequate
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Wye Valley NHS Trust provides outpatient and diagnostic imaging services to the population of Herefordshire and parts of Powys, Worcestershire, Gloucestershire, Shropshire and Monmouthshire. Outpatient service provisions include ophthalmology, trauma and orthopaedics, ear, nose and throat (ENT), dermatology, cardiology and urology. Whilst the diagnostic services cover; multi-slice computerised tomography (CT), magnetic resonance imaging (MRI), plain film radiography, nuclear medicine, fluoroscopy and breast imaging. The diagnostic laboratories services include pathology, biochemistry and microbiology.

During our inspection we visited outpatient clinics and diagnostic imaging services held across Hereford Hospital.

Outpatient clinics are available from 8.30am to 5.30pm, Monday to Friday, with additional Saturday clinics.

Outpatient clinics are held in the Oxford and Eign Suites, Fred Bulmer Clinic and the Diabetes Centre. The Oxford and Eign Suites are located on the ground floor of the Hereford Hospital. The Fred Bulmer Clinic and Diabetes Centre were situated a short distance from the main site. Each area had its own reception and waiting areas.

The diagnostic imaging department was open for appointments from 8am to 8pm, Monday to Friday, with additional evening and weekend appointments as required. Diagnostic laboratories offered a 24 hours a day, seven days a week service.

During January to December 2015 the trust facilitated 283,428 outpatient appointments at Hereford Hospital.

We carried out an announced inspection at Hereford Hospital from 5 to 8 July 2016. We also carried out an unannounced inspection at the Victoria Eye Unit on 18 July 2016. We visited a number of the outpatient clinics and diagnostic services, including radiology, cardiology, dermatology, trauma and orthopaedics, ophthalmology and diabetes.

We spoke with 24 patients and their relatives and 89 staff, including consultants, radiographers, radiologists, nurses, healthcare assistants, allied health professionals, reception staff and medical secretaries. We also reviewed the trust's performance data.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients and diagnostic imaging services as requires improvement. We rated the service inadequate for being responsive, requires improvement for being safe and well-led, and good for caring. CQC do not have the methodology to rate the effective domain. The service was judged to be requires improvement overall because:

We found:

- There were long waiting lists for the majority of specialities and the trust had not met all cancer targets for referral to treatment times.
- Although the trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list, we saw there were approximately 28,000 open patient pathways still to review. Therefore, there continued to be a risk that the trust did not have full oversight of the risk to patients on open pathways.
- Mandatory and safeguarding training levels did not always meet the trust's target and not all staff had received an annual appraisal.
- We could not be assured that learning from incidents was cascaded to all staff within the outpatient department.
- Patient records were not always stored securely in some areas of outpatients.
- Whilst the formal complaint rate for outpatients was low, complaints were not always responded to in a timely way.
- The outpatients department had been restructured within the surgical division and whilst governance systems were in place to monitor and manage risks identified within the department, these were not yet established within the new structure.
- The trust had developed a comprehensive quality improvement plan in order to improve the patient experience and reduce waiting times. However, the trust had not yet met the majority of objectives and actions it had set and had fallen behind the completion schedule.
- There were effective systems in place for the management of medicines throughout the outpatient department, although not all medicines were stored in accordance with trust polices and national guidance.

However, we also found:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Incidents were investigated and patients were informed when things went wrong. This had improved since our September 2015 inspection.
- The trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- All clinical areas we visited were clean and there was good adherence to infection control policies and personal protective equipment.
- Patient records were generally stored securely and effective systems were in place to ensure clinicians had access to appropriate and up to date patient information.
- The diagnostic and imaging service had systems in place to ensure the safe administration of ionising radiation for staff and patients and these systems were regularly audited and reviewed.
- We saw effective multidisciplinary working across outpatient and diagnostic services.
- Patients were treated with kindness, dignity and respect and spoke positively about the care they had received.
- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- The outpatient department was well represented at board level and leadership within the department was strong, supportive and visible. Staff felt confident to report concerns to senior management.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall, we rated the outpatient and diagnostic imaging service as requires improvement for being safe because:

- Although the trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list, we saw there were approximately 28,000 open patient pathways still to review. Therefore, there continued to be a risk that the trust did not have full oversight of the risk to patients on open pathways.
- We could not be assured that learning from incidents was cascaded to all staff within the outpatient department.
- Not all staff had completed mandatory and safeguarding training and there was a risk that staff did not have up-to-date knowledge in order to protect patients, visitors and staff from potential harm. This had been identified as an issue during our September 2015 inspection.
- We were not provided with evidence to show when staff had completed BLS training. Therefore, we could not be assured that staff had completed this training when required. The Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training (2013) states that all healthcare staff should undertake resuscitation training at regular intervals to maintain knowledge and skills.
- We observed that medicines were not always stored in line with national guidance.
- Patient records were not stored securely within the administration areas and there was a potential risk that they could be accessed and/or removed by unauthorised members of staff out of hours. We also observed that there was a risk that patient records could be removed by unauthorised persons from the Victoria Eye Unit. However, we did observe that patient records were stored securely in all other outpatient areas we visited.

However, we also found that:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Incidents were investigated and patients were informed when things went wrong. This had improved since our September 2015 inspection.
- Good standards of cleanliness and hygiene were maintained and the department was compliant with infection prevention control audits.
- Improvements had been made to some areas of the outpatient environment, which included the refurbishment of the Fred Bulmer Clinic.
- Equipment in the radiology department was well maintained and had been screened to ensure it was fit for purpose.
- The radiology department had effective systems in place for the management of medicines, which included the safe prescribing, administering, recording and storage of medicines. This had improved since our September 2015 inspection. However, the controlled drugs stored within the department were not always reconciled in line with trust policy.
- The department had introduced effective systems to ensure appropriate and up-to-date information was made available for clinicians to review patients who attended outpatient appointments.
- There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
- Despite staff shortages across outpatient departments, shortfalls or pressures were identified and addressed so that patients received safe care and treatment.

Incidents

- Patients were generally protected from abuse and avoidable harm, as staff were confident to report incidents. There were arrangements in place to implement good practice and an open culture to encourage focus on patient safety and risk management practices.
- The outpatients department reported four serious incidents (SIs) through the Strategic Executive Information System (STEIS) between March 2015 and February 2016. One incident related to three patients with wet age-related macular degeneration (AMD) whose vision had deteriorated to a point below the National Institute for Health and Care Excellence (NICE) guidelines, due to a delay in treatment following

referral. AMD is a common eye condition and a leading cause of central vision loss amongst people over the age of 50 years. One incident related to a medicine error, whereby two patients received the wrong contrast media for magnetic resonance imaging (MRI) arthrograms (a series of images of a joint after injection of a contrast medium). Two incidents related to a delay in diagnosis following test results. The trust completed investigations into these incidents to highlight any actions that could be completed to prevent reoccurrence. We saw evidence that actions had been identified and had been taken either with individual staff or through the development of processes to prevent reoccurrence. For example, in order to increase the ophthalmology department's capacity to treat wet AMD, two nurse practitioners had been recruited and trained to carry out this treatment.

- There had been no never events reported for this service from March 2015 to February 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- From April 2015 to May 2016 there were 102 incidents reported through the National Reporting and Learning System (NRLS) for the outpatient department. Incidents were graded in severity from low to no harm, or moderate to severe harm. 97 of the 102 incidents (95%) were graded as low or no harm (12% and 83% respectively). These included incidents such as, delays in receiving medical notes for clinics, poor access to appointments, rejected blood samples and mislabelled diagnostic requests. The remaining five incidents were all categorised as moderate harm, with no particular themes identified. One of the incidents categorised as moderate harm related to a patient who had attended the gastroenterology clinic for an urgent blood test. The staff nurse was unable to obtain the blood sample and told the patient to make an appointment for the blood test with their GP. We saw evidence that the patient was contacted by staff after being sent home as the blood test was urgent; the blood test was later taken at the hospital. This resulted in a letter being given to every member of staff within the department outlining that under no circumstances were patients to be referred back to their GP for blood tests. Guidelines in place stated that if a member of staff was unable to obtain the required blood sample they must inform the clinician who requested the test.
- A teaching session on venepuncture (venepuncture is the procedure of inserting a needle into a vein for the purpose of withdrawing blood) was also undertaken within the department due to the number of rejected blood sample incidents reported, such as mislabelled samples and the use of incorrect blood bottles. Senior nursing staff told us they had not had any further incidents concerning blood tests for patients.
- The service used the trust wide electronic incident reporting system to report incidents. Staff were aware of the system and how to use it to report an incident.
- During our inspection we attended a radiology audit meeting and observed detailed discussion of an incident that had been investigated. The incident had been reviewed by a multidisciplinary team. Lessons learnt were shared across departments and actions had been taken to minimise the risk of this incident reoccurring.
- Staff working in the outpatients department told us that learning from incidents was fed back via team briefings, which were held at the start of each shift, and local meetings. These were facilitated by the matron or senior nursing staff. The team briefings were not minuted, as evidence that learning from incidents was cascaded to all staff. Some staff we spoke to were able to describe examples of learning from incidents within their speciality. However, there was insufficient evidence to confirm that learning from incidents was shared across the outpatient department.
- The trust were using a new system to inform staff throughout the hospital, about key safety actions taken following serious incidents. We saw that a document called 'safety bites' was available for staff to read.
- The Ionising Radiation (Medical Exposure) Regulations, or IR(ME)R, are a framework which deals with the safe and effective use of ionising radiation when exposing patients and are designed to minimise the risk of unintended, excessive or incorrect medical exposure. The service had not reported any incidents related to radiation between June 2015 and June 2016.
- The Ionising Radiation Regulations 1999 (IRR99) aim to protect staff working with ionising radiation. This

legislation requires radiology services to produce 'local rules', which is a set of rules describing what systems and processes are in place in individual services to protect staff. The radiology service had developed their 'local rules' and these were displayed in all relevant areas of the department.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. We reviewed the investigation of six serious incidents and saw they had been managed in line with the duty of candour regulation.
- We saw that there were paper copies of the trust's guidance on the duty of candour in outpatient areas.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- All areas we inspected, including clinical and waiting areas, were visibly clean and tidy. We saw completed cleaning schedules in place, which confirmed areas had been cleaned. Staff told us that the areas were cleaned daily by nursing staff and an external provider, which cleaned the department in the evening. Any issues regarding the cleanliness of the outpatients department were reported to the external provider via a helpdesk.
- Trust data for June 2016 showed completed infection control training rates varied across departments. For example, in outpatients 100% of nursing staff had completed infection control training at level one and 72% had completed it at level two. In radiology, 100% of staff had completed infection control training at level one and 83% had completed it at level two. The majority of medical staff were not meeting the trust target for infection control training of 90%. For example, compliance rates for cardiology medical staff were 43%, gastroenterology were 50%, orthopaedics were 75% and radiology were 80%. Medical staff within the dermatology department were 100% compliant. Therefore, we were not assured that all staff had completed infection control training and there was a risk that staff did not have up-to-date knowledge of infection control measures in order to protect patients, visitors and staff from potential harm.
- The outpatient department conducted monthly hand hygiene audits in line with the trust's infection prevention control programme. From April 2015 to March 2016 (excluding the month of January 2016 when no data was collected) compliance to monthly hand hygiene audits in outpatients averaged 99%. The trust target was 95%.
- The infection prevention team carried out an annual audit of services within the outpatients department based on the infection prevention quality standards. The audits were carried out between January and February 2016 and included compliance with; infection prevention and control management, waste management, personal protective equipment and staff knowledge. Any areas of non-compliance were added to an action plan for each service to complete and progress was monitored at the monthly infection prevention committee. For example, we saw evidence that the Oxford Suite scored a compliance of 93% against the infection prevention standards target of 90%. A total of 26 areas of non-compliance were identified by the infection prevention team and all the actions required had been completed in a timely manner.
- Toilets were clean and well equipped with hand washing gels and paper towels.
- Staff complied with infection prevention and control policies. All clinical staff adhered to the provider's 'bare below the elbow' policy to enable good hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. We saw posters in waiting areas and other communal areas advising patients and visitors to use hand gel dispensers. The entrance/exit to Oxford Suite had signage on the floor reminding visitors to "STOP Clean Your Hands".

Outpatients and diagnostic imaging

- We inspected 20 consulting rooms and noted all had gloves, aprons and hand washing facilities available.
- We saw all clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. All sharps boxes were clean, were not overfilled and had temporary closures in place to minimise the risk of needle stick injuries.
- We saw staff in the radiology service clean equipment between each patient use.
- We saw fabric covered chairs in the waiting area of therapy services. These did not comply with infection prevention and control guidance, which recommends that furnishings should be easy to clean, disinfect and maintain (Infection control in the built environment, 2002). We were told by the head of therapy services that the fabric covered chairs had been identified as a risk and had been placed on the departmental risk register. We requested a copy of the risk register to confirm this but the trust did not provide us with this evidence following our inspection. Therefore, we were unable to corroborate that the fabric chairs had been identified as an infection control risk and what actions the trust had taken to mitigate this risk.
- There were no designated rooms for seeing patients with communicable diseases, such as influenza or tuberculosis. Staff told us that if it was necessary to isolate a patient an appropriate consultation or treatment room would be designated for their use. The patient would not be seated in the waiting area, in order to reduce the spread of any known communicable diseases to other patients and visitors. The room would then be thoroughly cleaned prior to any other patient use. This was in line with infection control procedures.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe.
- We saw improvements had been made to some areas of the outpatient environment from our June 2014 and September 2015 inspections, when the Arkwright Unit was used as temporary accommodation for outpatient services. We found it was cramped and had insufficient soundproofing to protect patients privacy. We found on this inspection the Arkwright Unit was no longer used by the trust for outpatient services.
- Outpatient clinics were held in the Oxford and Eign Suites, Fred Bulmer Clinic and the Diabetes Centre. The Oxford and Eign Suites were located on the ground floor of Hereford Hospital. The Fred Bulmer Clinic and Diabetes Centre were situated a short distance from the main building. Each area had its own reception and waiting areas.
- The Fred Bulmer Clinic had been refurbished since our September 2015 inspection. Further capacity had been created by the addition of four clinic rooms and a dedicated phlebotomy room, which included equipment to measure patient's weight and height.
- We observed that the corridor where patients waited for their consultation and treatment in the Victoria Eye Unit was crowded with patient record trolleys. This posed a risk to patients with visual difficulties.
- The radiology service had a separate reception and waiting area and imaging services provided designated male and female changing areas.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Bins were not overfilled.
- We examined the resuscitation trolleys located throughout the department and found evidence that regular checks had been completed and documented to ensure the equipment was fit for use. For example, oxygen cylinders were available on the resuscitation trolleys and were all in-date.
- The maintenance of equipment was completed via a service level agreement with the manufacturer or the trust's estates department. A schedule of work was in place and equipment was assessed annually as safe for use. We saw evidence of maintenance checks for equipment in x-ray and imaging, and ear, nose and throat (ENT) clinic areas. However, there was no evidence that equipment had been checked in all outpatient departments, such as the Oxford Suite and Fred Bulmer Clinic.
- The schedule of work records showed that some equipment within the Eign Suite, such as the field analyser (a tool used for measuring the human visual field) and the stereo tester (which analyses how each eye may see an object from different angles) were due for service in June 2015. The records had no outcome measures to identify that these services had been carried out. This meant that we could not ensure that all equipment was suitable for purpose.

- The equipment we saw in the Oxford and Eign Suites, Fred Bulmer Clinic and Diabetes Centre were visibly clean and "I am clean stickers" were used to indicate when equipment had been cleaned and was ready for use.
- The radiology service had clear guidelines on which specialised PPE should be used for specific procedures. We saw evidence that an external radiation protection audit had been carried out in May 2016, which highlighted PPE as a point of good practice. The audit reported that all PPE was stored appropriately and was routinely screened to ensure it was still effective. Records of screening for all items of PPE were available. We observed the service had carried out an annual audit of specialised PPE to ensure it was appropriate for use.
- We saw access to appropriate PPE, including lead gowns and thyroid shields, in the x-ray department. A thyroid shield protects the neck area from radiation.
- This was an improvement in the condition of specialised PPE in the radiology department compared to our September 2015 inspection, when we found that 80% of lead gowns, used to protect staff from the effects of radiation, had not been checked for damage since October 2010. It is recommended that this PPE is checked annually. Previously we also found damaged gonad shields, used to protect the pelvic area from radiation, being used for patient care. During our inspection we saw that these concerns had been addressed by the trust.
- Clear signage and safety warning lights were in place in the x-ray department to warn people about potential radiation exposure.

Medicines

- Generally, there were effective systems in place regarding the handling of medicines.
- Outpatient staff had some medicines available within the clinic areas and could access specific medicines from pharmacy, if necessary.
- There was an established system for the management and storage of medicines to ensure they were safe to use. Medicines that needed to be kept below a certain temperature were stored in designated refrigerators in outpatient departments.
- The ambient room temperatures and fridge temperatures were checked by staff in line with trust policies and procedures. The temperature records we reviewed were completed and contained minimum and maximum fridge temperatures, which alerted staff when they were not within the required range. Staff we spoke to were aware of the procedure to follow when temperatures were not within the required range.
- FP10 prescription pads were stored securely. We saw that monitoring systems were in place to ensure that all prescriptions were accounted for.
- Patient group directions (PGDs) were used in the ophthalmology service to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. The ophthalmology service had 11 PGDs in place. We saw that these had been authorised and signed appropriately.
- The plaster room contained a cylinder of nitrous oxide and oxygen for patients who required analgesia when they had a plaster cast fitted. This gas is a ready-to-use medical gas made up of half oxygen and half nitrous oxide and is used where analgesia with rapid onset and offset is required. This gas was only given to patients when it had been prescribed by a doctor.
- The cylinder of nitrous oxide and oxygen was stored in a cupboard within the plaster room and was in-date. However, there was no signage on the door to indicate that a compressed gas was stored in the plaster room. The Department of Health has produced guidance on the storage of medical gases and recommends that the designated room should be clearly labelled with the types of cylinder contained and "no smoking" warning signs (Medical gases. Health Technical Memorandum 02-01: Medical gas pipeline systems. Part B: Operational management, 2006). This meant that the service had not complied with the Department of Health guidance on the safe storage of compressed gases.
- We saw a trolley, which contained samples of skin creams for patients who attended the dermatology clinic, stored in a corridor between consultation rooms in the Oxford Suite. Staff said they kept sight of this trolley at all times to ensure samples were not taken by unauthorised persons. However, during our inspection we observed the trolley left unattended, which meant there was a risk that samples could be taken by unauthorised persons.

Outpatients and diagnostic imaging

- We saw an improvement in the management of medicines within the radiology service from our September 2015 inspection. For example, previously we found staff were administering contrast agents without authorisation and that radiology and diagnostic staff were regularly administering different contrast agents with no prescriptions. Furthermore, the protocols which outlined how contrast agents should be used did not specify the dose or type of contrast to use.
- Senior staff told us that since the September 2015 inspection they had recognised that there were issues with medicines management within radiology. The service had engaged with pharmacy staff to address the problems that were highlighted in our report. During this inspection, we saw evidence that controlled drug audits had been completed in the x-ray department. The department was 96% compliant with the required standards in December 2015 and 90% compliant in March 2016. However, the audits undertaken showed that the department was non-compliant on the same standard; that controlled drugs should be reconciled at least once every 24 hours. The pharmacy assessor commented that improvements had been made and there was much more regularity in the reconciling of controlled drugs but that this must be completed at least once every 24 hours.
- Patient specific directions (PSDs) were in place for the administration of contrast agents and had been signed by authorised personnel. A PSD is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis (Medicines and Healthcare Products Regulatory Agency 2014).
- We reviewed the prescription records of 14 patients who had received a contrast agent. We found the records were fully completed. The type and dose of contrast used, patient allergies and/or contraindications and weight were clearly documented. All were signed by an authorised prescriber.
- Protocols for radiographers had been updated and included information on the dose and type of contrast to use.
- A medicine error was reported by the radiology service as a serious incident in September 2015, when two consecutive patients were injected with the wrong contrast media for MRI arthrograms. We saw evidence that a root cause analysis was conducted and actions were highlighted to prevent reoccurrence. Radiology staff had all been assessed as competent following mandatory training in the medicines code by pharmacy. We saw the stock room for the storage of contrast agents was well organised and contrast agents were clearly labelled. We observed that two members of staff checked the correct contrast agent had been selected before it was administered to patients.
- Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff in a monthly MedsTalk newsletter.

Records

- We saw an improvement in the storage of records within the outpatient department compared to the September 2015 inspection when we found records were not stored securely.
- During this inspection we saw that the records of patients who attended outpatient clinics were stored securely in trolleys. The trolleys were secured by means of a lock and staff had to enter a key code in order to remove patient records as required. We did not find any trolleys unsecured during our inspection.
- Each area within the outpatient department had separate storage facilities for patient records. Oxford Suite, for example, had a dedicated room where patient records were received and prepared and could be securely stored until they were required in clinic or before being sent to the appropriate medical secretary or returned to medical records. This room was locked and had a key code access.
- The Victoria Eye Unit did not have a dedicated room for the storage of patient records due to limited space within the department. Patient records were stored in lockable cupboards by the clinic desk before they were placed in trolleys. Staff told us that these cupboards were locked when a member of staff was not present at the clinic desk. We saw the cupboards were unlocked during inspection and observed staff were constantly present at the clinic desk to ensure records were not accessed by unauthorised persons. However, on our unannounced inspection we observed that the clinic desk was left unattended at times. Therefore, there was a risk that patient records could be removed or viewed by unauthorised persons and staff would be unaware.
- We observed tamper proof bags being used to transport patient records between departments.

Outpatients and diagnostic imaging

- When we inspected the outpatient department in September 2015 we had been told that the hospital did not collect data on unavailable patient records in clinics. We were told by nursing staff that at least three or four sets of patient records would be unavailable out of a total of 13 patients booked at each clinic.
- During this inspection nursing and administration staff told us that it was uncommon for patient records to be unavailable for clinics. We saw evidence that Oxford Suite, Fred Bulmer Clinic and the Diabetes Centre had collected data on unavailable patient records from January to April 2016. However, the data submitted was not complete for all days within this period and no reason was provided for these omissions. The audit showed that 129 patient records were unavailable for the clinics for this period. However, no total number of patients seen in clinics for those days was recorded. Therefore, we were unable to determine whether the number of unavailable patient records was significant or not.
- In all but two cases, temporary patient records were used by the seeing clinician. In the other two cases an incident form had been submitted for the unavailable patient records but no other information was provided. Therefore, we were unable to determine whether these patients were seen on that day or had appointments rescheduled.
- The potential harm to outpatients due to inadequate, inaccurate or missing health records had been identified as a moderate risk on the trust risk register since June 2013. We saw evidence that this had been reviewed in January 2016 and was included on the trust quality improvement programme. The quality improvement programme detailed specific objectives the outpatient department were required to meet in order to improve patient experience; this included a review of the unavailability of patient records in clinic. Following this review, an action plan and recommendations would be made to improve the availability of patient records so that clinicians would have access to essential patient information and could make informed judgements on patients care and treatment. We saw evidence on inspection that senior staff in the Oxford Suite were auditing the number of patient records that were unavailable for clinics. This information was recorded daily for every clinic session. However, at the time of inspection this data was not available for review, nor was it clear whether this audit was undertaken in all outpatient departments. Furthermore, the trust had intended to complete this review by April 2016 and at the time of our inspection this review was still outstanding. Therefore, whilst the trust had taken some action to address the unavailability of patient records for outpatient clinics, we were unable to determine what impact the review would have on the unavailability of patient records or when the trust expected to complete this review.
- When we inspected the outpatient department in September 2015 we found there was no formal process in place to ensure temporary records were filed with the patient's permanent medical record. Furthermore, we reported that there was a risk that clinicians would make judgements on the care and treatment a patient was to receive without having complete patient information available to them.
- Since the September 2015 inspection a standard operating procedure had been produced to ensure temporary notes were filed correctly with the original patient notes and where temporary notes were used, that appropriate information was made available for clinicians to review patients attending outpatient appointments. As a minimum, all temporary records were required to include a set of patient demographic labels, the latest referral letter, the last consultation letter (if applicable) and results of any investigations undertaken. Therefore, the trust had taken action to ensure that clinicians could make informed decisions about the care and treatment of patients based on current patient information.
- When we inspected the outpatient department in September 2015 administration staff told us there were delays of approximately a month in typing patient and GP letters. They also told us that they had to store records in unlocked rooms as there were no facilities to securely store patient records within the administration environment.
- During this inspection administration staff in cardiology told us that urgent letters to patients and GPs were typed within one day and routine letters were typed within one week. This was supported by evidence we saw during our inspection, where we saw approximately 50 notes waiting to be typed and filed and the oldest only dated back to the beginning of the week of inspection (4 July 2016).
- The administration environment was cramped and cluttered and notes were stored in the corridor, on

desks, shelves and the floor. The administration staff recognised that space was a problem within the hospital, but no member of staff reported concerns to CQC about the environment during inspection. Whilst the patient records were stored where space was available, we were told that they were kept secure as the entrances to the administration areas were locked and could only be accessed by a secure key pad. However, there was a potential risk that unauthorised members of staff with knowledge of the key code could access and/or remove patient records out of hours because they were not stored securely within the administration area.

- The outpatient department used paper medical records. We were told that the trust planned to introduce electronic patient records next year.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures. However, not all nursing and medical staff had had appropriate levels of children's safeguarding training.
- The training data for June 2016 showed varied compliance rates for safeguarding adult's level one training. For example, compliance rates for outpatient nursing staff were 95%, ophthalmology, nuclear medicine, oral and orthodontics were 100% and radiology were 91%. However, compliance rates for trauma and orthopaedics were 88%, MRI were 75% and CT scanning were 67%. These did not meet the trust target of 90%.
- The compliance figures for safeguarding children level two training were also varied. For example, compliance rates for outpatient nursing staff were 76%, radiology were 79%, and oral and orthodontics were 86%. These did not meet the trust target of 90%. Nursing staff within ophthalmology and trauma and orthopaedics were 100% compliant, meeting the trust target.
- The majority of medical staff were not meeting the trust target for safeguarding children level two training. For example, compliance rates for cardiology were 57%, dermatology were 83%, diabetes were 50%, gastroenterology were 50%, respiratory were 40%, ENT were 17%, ophthalmology were 75%, oral and orthodontics were 75%, orthopaedics were 43%, radiology were 50% and urology were 25%. These did not meet the trust target of 90%. Medical staff within rheumatology were 100% compliant, meeting the trust target. Therefore, we were not assured that all staff had up-to-date knowledge in order to protect patients, visitors and staff from potential harm. We reported this as an action the trust must take in our previous report.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns. Information and relevant contact numbers for safeguarding were seen in outpatient clinic areas and public areas.
- Staff were aware of safeguarding procedures and knew how to escalate concerns. Information and relevant contact numbers were seen on staff noticeboards and in public areas. Staff could give us examples of when they had made safeguarding referrals.
- Since our September 2015 inspection, the radiology service had introduced the World Health Organisation (WHO) Five Steps to Safer Surgery checklist, which was designed to prevent avoidable harm. Radiology staff were required to confirm the patient's name, date of birth, the imaging they were expecting and consent before starting treatment. We reviewed a sample of the Five Steps to Safer Surgery checklists and found they were fully completed. We also saw evidence that the Five Steps to Safer Surgery checklist was audited quarterly. The results for March to May 2016 demonstrated 100% compliance with completion of the checklist.

Mandatory training

- Mandatory training covered a range of topics, which included health and safety, manual handling, infection prevention control, fire safety, equality and diversity and basic life support (BLS). All staff within the outpatient and diagnostic imaging service were aware of the need to attend mandatory training.
- Training was completed as e-learning modules with some face-to-face sessions, such as mental capacity awareness.
- Senior staff within outpatient services could not provide mandatory training compliance figures for the department. The trust's electronic staff record system provided alerts to staff when their mandatory training updates were due.
- The trust target for completing mandatory training was 90%. Trust data for June 2016 showed completed mandatory training rates varied across departments. For

example, the nursing staff for outpatient and imaging departments met the trust target for health and safety training. However, 75% of nursing staff in outpatients were compliant for fire and information governance training. The majority of medical staff across all specialities did not meet the trust target for mandatory training. For example, with regards to fire safety training compliance rates for cardiology medical staff were 29%, diabetes were 0%, gastroenterology were 83%, ENT were 50% and oral and orthodontics were 75% compliant. The medical staff in ophthalmology and dermatology were compliant with the trust target of 90%, with 94% and 100% compliance rates respectively.

- The compliance rates were similar for information governance training. For example, compliance rates for cardiology medical staff were 29%, diabetes were 0%, gastroenterology were 67%, ENT were 50%, oral and orthodontics were 50% and ophthalmology were 69% compliant. The dermatology medical staff were 100% compliant with information governance training. Therefore, we were not assured that all staff had up-to-date knowledge in order to protect patients, visitors and staff from potential harm. We reported this as an action the trust must take in our previous report.
- We were not provided with evidence to show when staff had completed BLS training. Therefore, we could not be assured that staff had completed this training when required. The Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training (2013) states that all healthcare staff should undertake resuscitation training at regular intervals to maintain knowledge and skills.

Assessing and responding to patient risk

- When we inspected the outpatient department in September 2015 we found there was no system in place to monitor and manage the risk to patients on the waiting list.
- On this inspection the trust provided evidence that they had reviewed the records of 3,000 patients who had waited over 18 weeks for an appointment. The reviews were overseen by the medical director and service unit director. The relevant consultants were required to ensure that patient reviews were conducted within five days of escalation. Patients who were found to have been caused potential harm as a result of any delays in treatment, were identified and appropriate action taken. These cases were reviewed internally and sent to the medical director of a neighbouring trust for independent scrutiny.
- We were told that a total of eight patients (0.26%) had been found to have been caused potential harm as a result of waiting over 18 weeks for treatment. Therefore, whilst some patients had to wait over 18 weeks to access some services, the trust had taken action to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- However, we saw evidence in the trust's "referral to treat confirm and challenge 22/06/2016" that the team had approximately 28,000 open patient pathways still to review. Staff told us that they planned to have reviewed 15,000 by September 2016 and the remainder within the next 12 months. The trust had identified this as an issue. However, there continued to be a risk that the trust did not have full oversight of the risk to patients on open pathways.
- We saw evidence that patients who attended the ophthalmology department for procedures had risk assessments completed appropriately, which included venous thromboembolism (VTE) risk and pressure ulcer risk. The National Early Warning Score (NEWS) was used as required to record routine physiological observations, such as blood pressure, temperature and heart rate. NEWS is a standardised physiological assessment tool, designed to alert the clinical team of any deterioration in a patient's condition and prompt a timely response. A NEWS chart would be commenced on patient's who presented with an acute illness and required hospital admission. This was in line with national guidance (Royal College of Physicians, NEWS. Standardising the assessment of acute-illness severity on the NHS, 2012). The emergency response team within the hospital could be summoned rapidly when required.
- The WHO Five Steps to Safer Surgery checklist, designed to prevent avoidable harm, was in use for patients undergoing invasive procedures and diagnostics.
- The trust had identified radiation protection supervisors, whose main role was to ensure that staff complied with the requirements of IRR99 and the local rules. We observed these displayed on a list in each department.
- IRR99 requires all radiology departments to consult with a radiation protection advisor (RPA) to ensure the

regulations are met. The radiology department had an RPA who assisted with risk assessments. We reviewed current risk assessments undertaken and found they were comprehensive and any actions identified had been completed.

- We observed radiographers following the IR(ME)R regulations that require radiographers to routinely check previous images before continuing with a scan or x-ray.
- The radiology department had guidelines to ensure that female patients and staff of childbearing age were asked if they were, or might be pregnant. This was in line with IR(ME)R regulations. We observed a radiographer asking a female patient this question before they proceeded with the planned investigation.
- We saw evidence that renal protective measures were in place and followed to prevent contrast induced nephropathy. Contrast induced nephropathy occurs when patients display symptoms of acute kidney injury after receiving intravascular contrast agents (sometimes used in urology and other specialities to enhance imaging results) and where there is no other reasonable explanation for the suspected injury. Patients at risk of contrast induced nephropathy were referred to the Fred Bulmer Clinic for intravenous hydration (where fluids are administered to a patient directly into a vein) prior to any investigations being carried out. This was in line with the NICE and Royal College of Radiographers guidelines.

Nursing staffing

- There is no national baseline acuity tool for nurse staffing in outpatients. The manager had developed a staff ratio calculator to determine staffing requirements across outpatient services. This was used to calculate how many nursing and healthcare assistant staff were required to cover the speciality clinic sessions held per week.
- At the time of inspection we were told that outpatient services had a 5% staff vacancy rate. According to the planned staffing requirements developed by the manager for outpatients, 37 whole time equivalent (WTE) nurses were required to staff outpatient departments. However, data provided by the trust reported that 27 WTE nurses were in post as of 31 March 2016; this equated to a 27% nurse staffing vacancy rate. We requested confirmation from the trust as to what the actual nurse staff vacancy rate was at the time of inspection. We were not provided with this information. Therefore, we were unable to determine the nurse staffing vacancy rate within outpatient services.
- Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank staff or permanent staff who volunteered to work over and above their contracted hours. Trust bank employed staff on an ad hoc basis. No agency staff were used within the department.
- We observed that there were reception and nursing staff available to support all clinics running during the inspection.
- New bank staff were inducted locally using a checklist and would be allocated to work with a 'buddy' to support them.
- Since the September 2015 inspection, we saw that the senior sister for Oxford Suite had introduced an induction and competency pack for all new substantive staff. All new starters underwent a four week induction process and there was a 'buddy' system to support new staff during induction. Induction training included mandatory training, a period of shadowing and a workbook which had to be signed off to confirm competency levels. Examples of the induction and competency packs were observed during inspection.
- Data provided for March 2016, showed there was a shortage of eight WTE posts for registered staff in the diagnostic imaging department. This equated to 19% of total planned registered staff requirements. The diagnostic imaging service met the establishment requirements for support staff. The manager for radiology told us they had recently recruited six registered members of staff to the radiology team and one sonographer. The radiology department had also used locum staff to support service provision, when required.

Medical staffing

- During our inspection we found that staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- In the outpatient department medical staffing for clinics was arranged by the individual specialities, such as rheumatology, cardiology, trauma and orthopaedics and endocrinology. Some of the clinics were held by

visiting consultants from other trusts. For example, the plastic surgery service was covered by medical staff from a local NHS trust, in accordance with the service level agreement.
- The individual specialities arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- We asked the trust to provide information on the number of times locum staff were used and how the trust ensured locum staff received appropriate induction. We were not provided with this information. Therefore, we were unable to determine how often locum staff were used and whether the outpatient department had appropriate arrangements for locum staff in place to ensure people were kept safe at all times.
- Data for March 2016 showed there was a vacancy rate of 10 WTE consultant (or equivalent) posts across the trust; this equated to 9% of total planned staff requirements. For all other grades of medical staff there was a vacancy rate of 16 WTE posts; this equated to 9% of total planned staff requirements. We were told that there was a shortage of consultants across all specialities, including endocrinology, geriatric medicine, trauma and orthopaedics and ophthalmology. This meant there could be a delay in patients being seen for new or follow-up appointments. The trust had identified a recruitment and retention strategy in the quality improvement programme to address staffing vacancies. However, recruitment continued to be a challenge for the trust.
- The radiology department provided a consultant on-call service 24 hours a day, seven days a week.
- The trust had recognised that recruitment was difficult and were actively promoting the hospital to recruit suitably qualified staff.
- Consultants were supported by junior colleagues in clinics where this was appropriate.

Major incident awareness and training

- There was good understanding amongst nursing and medical staff with regards to their roles and responsibilities during a major incident.
- The trust had a comprehensive major incident policy and staff were able to tell us where this was located on the trust website. We also saw a hard copy of this policy in the Oxford and Eign Suites, which included details of who to contact in the event of a major incident. This information was stored securely within the departments. However, it was noted that the trust wide major incident policy was due for review in 2014 and had not been updated since it was published in 2013. According to the intranet the trust was in the process of updating this policy.
- Within the radiology service there were effective arrangements in place in the event of a major incident occurring within the department. This included the 'local rules', which provided clear guidance on what to do in the event of a radiation or radioactive incident. The 'local rules' were clearly displayed in every area we visited.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the service for effectiveness.

We found that:

- Care and treatment was delivered in line with national guidelines.
- The radiology department was compliant with national ionising regulations. Dose reference levels had been audited and appropriate actions were taken to minimise the risks associated with radiation exposure. This had improved since the September 2015 inspection.
- The occupational therapy and diabetes services had a formal supervision process in place to support and develop staff.
- Staff were proactively encouraged and supported to develop new skills to improve service provision.
- All teams reported effective multidisciplinary working and we saw evidence of joint working to improve service provision.
- The outpatient department had introduced a standard operating procedure to ensure that appropriate and up-to-date information was made available for clinicians to review patients who attended outpatient appointments, when the patient records were unavailable.
- Staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.

However, we also found:

- Compliance rates for staff who had received an appraisal varied across departments and the majority of specialities did not meet the trust requirement.
- There was no formal supervision process in place for nursing staff.

Evidence-based care and treatment

- We saw evidence that specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. For example, the radiology department had developed a protocol for the prevention of contrast induced neuropathy in line with national guidance. We observed this protocol was followed during inspection.
- Protocols were in place that followed national guidance for cardiology examinations, such as management of myocardial perfusion test and transthoracic echocardiogram.
- Staff we spoke with demonstrated how to access policies and procedures on the trust intranet.
- We saw that two vision lanes, used to assess patient's vision, had been set up in a corridor in the Victoria Eye Unit because of a lack of appropriate space. The service had previously carried out sight assessments in designated consultation rooms with vision lanes at a distance of 2.9 metres. However, the standard for a vision lane is three metres. This had been risk assessed and the corridor was identified as the only space the unit could install vision lanes at the correct distance. At the time of inspection there was no means of protecting patient's privacy because the corridor was accessible to staff, patients and their relatives or friends. Senior nursing staff told us that a screen had been ordered to protect patient's privacy when undergoing sight assessments.
- When we inspected the radiology department in September 2015 we found that diagnostic reference levels (DRLs) were not routinely displayed in rooms. This meant that the department was not compliant with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) regulations. During our July 2016 inspection we saw that this concern had been addressed by the trust. The radiology department manager was responsible for ensuring that DRLs were displayed in each appropriate area and regular audits were carried out with action taken when necessary. DRLs should be set in line with IR(ME)R guidelines to ensure that patients received the minimum radiation exposure as was reasonably practicable.
- We saw evidence that an external audit of DRLs had been undertaken in January 2016. The audit concluded that the local diagnostic reference levels (LDRLs) were adhered to, with the exception of the computerised tomography (CT) urogram examination, for which an increased LDRL had been suggested following the availability of more data. A CT urogram is an imaging exam used to evaluate the urinary tract system. The audit also reported that the national diagnostic reference level (NDRL) was higher than the recommended level for the proctogram examination. A proctogram is an x-ray test which is used to investigate patients who have problems emptying their bowel. In response, the radiology department had introduced a new technique to reduce the DRL for proctograms. This was audited in March 2016 and the DRL had been reduced from a mean dose of 3,100 DAP/Dose (μGym^2) to 1,564 DAP/Dose (μGym^2). The NDRL was 1,400 DAP/Dose (μGym^2). The department recognised that there was still potential to reduce the dose further and planned to re-audit in six months. Therefore, we were assured that DRLs were regularly audited and that appropriate and effective action was taken to minimise the risks to patients.
- Staff working with ionising radiation at the trust were required to wear a dosimeter, in line with IRR regulations. A dosimeter is used to detect and measure the quantity of ionizing radiation that a person may have absorbed or been exposed to. We saw evidence that regular audits were carried out to ensure that effective measurements were in place to protect staff.

Nutrition and hydration

- Patients who attended clinic or diagnostic appointments were not generally in the department for long periods of time, therefore beverages and food were not provided.
- The Diabetes Centre did have facilities to make patients hot drinks if required. They also had glucose drinks available for patients with diabetes when required. Glucose drinks are recommended when a patient has a

'hypo' and needs to increase their blood glucose levels rapidly (a 'hypo' is commonly used to describe hypoglycaemia, which is where the blood glucose level of a patient with diabetes falls below the normal range).
- Intravenous hydration was given to patients at risk of contrast induced nephropathy before diagnostic investigations were carried out, in order to protect renal function. This was in line with national guidelines.

Pain relief

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy department as required.
- Hereford Hospital did not have a pain management clinic on site. Patients could either be referred to the chronic pain service at a local NHS trust or the pain self-management service, which ran clinics in community based centres in Hereford.
- One patient that we spoke with during our inspection said that "the clinic had been very good with pain relief".
- Outpatient clinics had access to simple analgesia (such as paracetamol and codeine) and local anaesthetic preparations when required. Senior nursing staff told us that any pain relief needed by patients who attended the clinics in the Oxford Suite was prescribed by a doctor before it was administered and recorded in the patient's record.

Patient outcomes

- The follow-up to new appointment rate at the hospital was in line with the England average during the period January to December 2015. At the time of inspection the follow-up to new appointment rate was approximately 2.6; the trust target was 2.1.
- There is no national target for patients to be seen by a clinician within a specific time. Therefore, the outpatient department did not audit the number of patients who waited over 30 minutes to see a clinician.
- Specialities participated in national benchmarking clinical audits, where appropriate, such as bowel cancer screening, diabetes management and chronic pulmonary obstructive disease (COPD). This was in line with NICE recommendations.
- The outpatient and diagnostic department did not participate in the imaging services accreditation scheme or improving quality in physiological services.

Competent staff

- Managers and staff told us there was good availability of training opportunities and staff were encouraged to take responsibility for organising their own training. Staff we spoke to confirmed that they had received updates on mandatory training. However, the mandatory training data for June 2016 showed varied compliance across all specialities within outpatient departments. Therefore, we were not assured that all staff had completed mandatory training when required.
- The trust appraisal policy stated that all staff were required to have an annual appraisal using the job description and person specification for their post. Staff we spoke to told us it was a useful process for identifying any training and development needs. Trust data for June 2016 showed completed appraisal rates varied across departments. The trust had recognised that appraisals were not completed annually for all staff and had included this as an objective to be met in their quality improvement plan. At the time of our inspection the trust had a target of 75% of staff to have completed an appraisal. They planned for this target to be increased to 90% by the end of September 2016.
- Nursing staff in radiology were 87% compliant with appraisals and medical staff were 89% compliant. In outpatients, 50% of nursing staff had completed an appraisal. In ophthalmology, the compliance figure was 76% and in trauma and orthopaedics it was 13%. The compliance figures for occupational therapy and physiotherapy were 97% and 76%, respectively. The majority of appraisal compliance figures for administration staff did not meet the trust requirement. For example, 0% of administration staff in ophthalmology, trauma and orthopaedics and ear, nose and throat (ENT) had completed an appraisal and 62% of reception staff in outpatients had completed an appraisal. Therefore, it was evident that not all staff within outpatient departments received an annual appraisal. We reported this as an action the trust must take in our previous report.
- Medical revalidation was introduced in 2012 with the aim to ensure that all doctors are up to date and remain 'fit to practise'. We asked the trust to provide us with evidence that all doctors had revalidated in accordance with the General Medical Council requirements. We were not provided with this information. Therefore, we were

unable to determine whether the trust had appropriate measures in place to monitor medical revalidation and to ensure that all doctors were up to date and remained 'fit to practise'.

- Revalidation was introduced by the NMC in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration. The trust had appointed a lead for revalidation. Workshops had been held to support nursing staff with revalidation. There was also a sample revalidation folder, which staff could access for guidance. Several nursing staff within outpatients had revalidated in 2016.
- We saw evidence of proactive succession planning in the cardiology and radiology department. Two nurses with specialist cardiac training were retiring from the service in December 2016. In order to ensure the service was not compromised by a lack of suitably trained staff, two radiographers were undertaking specialist training in electrocardiogram (ECG) interpretation (an ECG is a simple test that can be used to check your heart's rhythm and electrical activity). They were also shadowing the heart and lung cardiologists. Once their training was completed the lead cardiac nurse would assess their competency to undertake these additional skills.
- Staff were encouraged to identify additional training they wished to undertake to enhance their skills and professional development. For example, one nurse had requested to undertake a mentorship course, which prepares registered nurses to support the learning and assessment of student nurses on clinical practice, in accordance with the Nursing and Midwifery Council (NMC) Standards for pre-registration nursing education (NMC, 2010).
- Specialist clinic areas provided additional training for staff to ensure competence in the speciality. Bespoke competencies were in place, as well as specific clinical skills required for specific specialities. For example, we saw staff working within the ophthalmology service had annual training on the use of laser equipment to maintain competence.
- All cardiac physiologists working within the hospital were accredited to the British Society of Echocardiography. This meant the trust followed good practice guidance and ensured patients received care from appropriately trained staff.
- The occupational therapy department had a formal supervision process in place to support and develop staff. All occupational therapists were allocated a supervisor, who they met with on a regular basis. Senior staff were given a mobile and bleep so that junior staff could contact them for additional support and advice when required. We saw evidence that supervision records were meaningful and up to date.
- Diabetes specialist nurses had a supervision process in place. They held weekly one-to-one sessions where they could discuss any issues with practice and identify development needs.
- We saw no evidence that nursing staff received formal supervision and this was supported by the nursing staff we spoke with. This was noted as an action the trust must take in our previous report. The trust had identified supervision as an objective within the quality improvement programme and actions had been identified so that a formal process of supervision could be introduced. According to the quality improvement programme the trust had expected to have developed the supervision policy by the end of April 2016. However, this policy was still outstanding at the time of inspection. Therefore, we were unable to determine when the trust would have a formal supervision process in place.
- Staff that were not formally trained in radiation were assigned to mentors throughout the diagnostic department and practice was supervised. This was in line with legislation set out under Ionising Radiation (Medical Exposure) Regulations, or IR(ME)R, regulations. We observed a student supervised during inspection.
- Since our inspection in September 2015, the senior sister for Oxford Suite had introduced an induction and competency pack for all new substantive staff. This was observed during this inspection. All new starters underwent a four week induction process.

Multidisciplinary working

- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- During our inspection we attended a joint cardiology and radiology multidisciplinary team (MDT) meeting and heard evidence of joint working to improve service provision. For example, the service previously reported normal scan results via medical secretaries, which

meant patients would wait 12 weeks on average for their result. Following MDT review the process was changed and the radiology service distributed patient reports directly to the GP within one week.

- Rheumatology and radiology services were developing a one-stop rheumatology clinic to reduce waiting times and increase the number of patients who received early diagnosis and treatment. Staff were undergoing training in bone densitometry in order to support this service. Bone densitometry is a type of x-ray used to measure bone loss and is commonly used to diagnose osteoporosis.
- We saw evidence of regular MDT meetings being held. These included urology, dermatology, radiology, rheumatology and ophthalmology.
- The outpatient department had service level agreements with neighbouring trusts to provide some speciality services. For example, medical staff from another local NHS trust held respiratory and cardiology clinics at Hereford Hospital.
- The service offered cardiac rehabilitation group sessions to patients who had suffered a cardiac event. We saw that a variety of specialists were involved in delivering sessions to patients, such as, physiotherapists, dietitians and specialist nurses.
- The outpatient department had some specialist nurses in clinics to support service provision. Examples included: respiratory services, which had oxygen therapy nurse specialists to support patients with COPD; the ophthalmology department had nurse specialists who were trained to administer ranibizumab treatment to patients with wet age-related macular degeneration; the orthodontics department was supported by dental nurse specialists.
- Physiotherapists, occupational therapists and hand therapists worked collaboratively with the rheumatology department to provide outpatient services for patients with hand injuries and symptoms of long term conditions, such as rheumatoid arthritis.

Seven-day services

- Outpatient clinics were available from 8.30am to 5.30pm, Monday to Friday. Staff had been working additional hours to provide outpatient clinics on a Saturday and occasionally on a Sunday, in order to meet patient demand.
- Radiology services were available from 8am to 8pm, Monday to Friday with some extended sessions to 10pm. The CT and ultrasound service worked seven days a week from 8am to 8pm, Monday to Friday and 8am to 7pm (CT) and 8am to 5pm (ultrasound) at the weekend.
- The ophthalmology department ran a dedicated 24hour emergency service. This was available from 8am to 6.30pm Monday to Friday and 8am to 4pm at the weekend. Out of these hours patients would be seen in the emergency department by the on-call ophthalmologist.

Access to information

- Staff generally had the information they needed to deliver effective care and treatment to people who used services.
- We saw an improvement in the availability of medical records for patients who attended clinic appointments from our September 2015 inspection. Where temporary patient records were used appropriate information was made available for clinicians to review patients attending outpatient appointments. This included a copy of the latest referral letter, the last consultation letter (if applicable) and results of any investigations undertaken. Staff would also contact the relevant medical secretary and patient's GP for additional information as required. Staff we spoke to said it was uncommon for patient records to be unavailable for clinic appointments.
- During our September 2015 inspection, staff told us there were not enough administration staff to manage the workload. This meant GPs did not always receive information on the patient's condition in a timely manner. We saw evidence that the backlog of patient records waiting for secretaries to type letters to inform patients and their GPs of their consultation had improved. For example, the administration staff in cardiology told us that urgent letters to patients and GPs were typed within one day and routine letters within one week. We saw approximately 50 notes waiting to be typed and filed and the oldest only dated back to the beginning of the week of inspection (4 July 2016). A consultant in the ophthalmology service told us that the typing backlog had improved as a result of increased administration support. Letters to patients and GPs were generally typed in four to five days, but this could be varied with some taking three to four weeks to be typed and sent.

Outpatients and diagnostic imaging

- Diagnostic imaging departments used the picture archive communication system to store and share images, radiation dose information and patient reports. Staff were trained to use this system and were able to access patient information quickly and easily. Staff used the system to check outstanding reports and were able to prioritise reporting and meet internal and regulator standards. Urgent results were also faxed to the relevant consultant if requested.
- Clinic rooms had computer terminals which enabled staff to access patient information such as x-rays and blood results via the electronic reporting system.
- Staff had access to the trust intranet to obtain information relating to trust policies, procedures, NICE guidance and e-learning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust followed the Herefordshire safeguarding adult's board policies to ensure that staff were meeting their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff could access these policies from the trust intranet.
- Staff we spoke to were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- Staff said that they had some training in MCA and DoLS as part of their mandatory training. However, some staff told us that they had difficulty booking this training as there were not enough spaces available. Staff training did not always meet the trust target of 90%. For example, senior radiologists were 83% complaint with DoLS training and 72% compliant with MCA training; and registered nurses in ophthalmology were 79% complaint with DoLs and MCA training.
- Nursing, diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. We observed radiographers followed the trust policy on consent. Consent was obtained before procedures or scans were undertaken.
- Doctors discussed treatment options during consultations and where written consent was required this would be obtained at the time of the outpatient appointment. The trust had four standard consent forms and some specialities had also produced consent forms for specific procedures, such as ophthalmology and radiology. These included information on the possible risks and complications of the proposed treatment.
- Patients told us that staff were good at explaining planned procedures or examinations before they were asked to consent to them being carried out. Leaflets were available for specialist conditions and procedures; these were not available in other languages but all services had access to the on-site and/or telephone interpreter services when needed.

Are outpatient and diagnostic imaging services caring?

Good

We rated outpatient and diagnostic imaging services as good for being caring because:

- We saw and were told by patients that all staff working in the service were kind, caring and compassionate at every stage of their treatment.
- Staff treated patients with respect and maintained patients dignity.
- Staff involved patients and those close to them in aspects of their care and treatment. Information about treatment plans was provided to meet the needs of patients.
- Patients we spoke with were very positive about the way they were treated.
- All staff were sensitive to the needs of all patients and were skilled in supporting patients with a disability and complex needs.

However, we also found:

- Patient confidentiality was not maintained at all times because patients could be overheard when they gave their personal details to reception staff.

Compassionate care

- We saw patients were treated with compassion, kindness, dignity and respect.
- We observed reception staff greet patients in a courteous and friendly manner and direct them to the appropriate waiting area.

Outpatients and diagnostic imaging

- We saw the NHS Friends and Family Test (FTT) questionnaires throughout outpatient departments with posters, which encouraged patient's to leave comments about the service. The FFT was launched by the NHS in 2013 for all acute trusts. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. The feedback gathered is designed so that services can improve patient experience. We reviewed the FFT data reported to NHS England by the outpatient department for May 2016. 94% of patients would recommend the service to friends or family. The national average for this period was 93%. However, the response rate was poor with only 86 responses received out of a potential 17,430; this equated to a 0.49% response rate. The response rate was one of the lowest in the country. Staff in the ophthalmology department told us that the majority of patients they saw were unable to complete the feedback forms due to difficulties they had with their vision. We were not provided with any other explanations as to why they department had such a low response rate, nor of any initiatives the department had introduced to encourage patient feedback.
- We observed good examples of caring, considerate staff throughout all areas of outpatient and diagnostic imaging departments.
- We observed two patients undergoing magnetic resonance imaging (MRI) scans and saw good and caring interactions between staff and patients. The radiographer explained the procedure to the patient's and offered them headphones, to reduce the noise from the MRI scanner. The radiographer talked to the patient's throughout their MRI scan to ensure they were comfortable and kept informed of what was happening.
- We observed radiology staff introduce themselves to patients upon admission to the department.
- Patients were provided with the option of being accompanied by a friend or relative during consultations. Chaperones were also available if required. The trust had a policy on the use of chaperones which stated that, wherever possible, the chaperone should be of the same sex as the patient.
- Patients told us that "everybody is so friendly, that's what makes the difference, it's the attitude" and "staff are very, very good, very helpful, they're lovely, they do everything they possibly can".
- One patient informed us that they had attended an appointment at the hospital, and had left the car window open due to the hot weather. During the appointment, the weather had changed and it started to rain. On their return to the car, the patient found that car parking staff had covered the window with plastic and left a note, stating that they had noticed the open window and did not want the patient to return to a wet car.
- Patients who arrived at the reception areas stood in a queue before they were called forward to the reception desk. We saw a poster in Oxford and Eign Suites that requested patients wait to be called forward; this was to reduce the risk of confidential information being overheard when patients were asked to confirm their personal details by the reception staff. However, when we visited the reception areas throughout outpatient departments we heard patients give their personal details (such as date of birth, address and contact telephone number) to reception staff. Therefore, we were not assured that patient confidentiality was maintained at all times.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment. One patient told us they "could not fault their treatment, I've always felt that they answered all our questions and I was able to make an informed decision".
- Patients generally understood when they would need to attend the hospital for repeat investigations or when to expect a follow up outpatient appointment. One patient told us that the service had been "really good at rearranging appointments around my holiday and all changed appointments had been confirmed in writing".
- We observed reception staff checked that patients knew which clinic they were attending and which clinician they were going to see.
- We observed notice boards in outpatient and diagnostic imaging departments contained information about domestic abuse and safeguarding.

Emotional support

Outpatients and diagnostic imaging

- Staff could access the patient advisory liaison service if a patient required a chaperone or advocate as needed.
- There was access to local advisory groups to offer both practical advice and emotional support to patients and carers. Examples included the Herefordshire low vision scheme, which provided support and assistance to people with vision difficulties and the diabetes UK Herefordshire support group.
- The hospital ran an expert patients programme throughout the year, from various locations in the local community. The course was designed for anyone who had a long term health condition and who wanted to find ways of managing their illness more positively in order to improve their quality of life. The course was free and consisted of six weekly sessions. Topics covered include managing symptoms, relaxation techniques, diet, exercise and communication skills.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated outpatient and diagnostic imaging services as inadequate for being responsive because:

- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment. There were long waiting lists for the majority of specialities including gastroenterology, dermatology, neurology and ear, nose and throat. The length of time patients were waiting to access the majority of services had remained unsatisfactory since our September 2015 inspection.
- The trust did not consistently meet all cancer targets for referral to treatment times.
- Whilst the trust had reviewed 42,000 open patient pathways they still had approximately 28,000 open pathways to review. This meant there was a risk that the trust did not have full oversight of the risk to patients on open pathways.
- Some patients told us that it was difficult to rearrange or cancel appointments.
- Complaints were not always responded to in a timely manner.

However, we also found:

- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend and meant they had access to timely assessments, diagnosis and treatment.
- The ophthalmology department had developed some services in the local community so that patients could be seen and treated in a location that was convenient to them and reduced the number of patients attending the hospital.
- All patients who required diagnostic assessment and/or treatment were seen within six weeks of referral.
- The trust had introduced a monthly bulletin for GP practices to keep them updated on waiting times per speciality.
- The trust were keeping patients on long waiting lists informed of the likely waiting time and escalated patients for urgent appointments if they needed to be seen sooner.
- Translation services were available to patients.
- Feedback from complaints was fed back to staff and we saw evidence of improvements to service provision in response to complaints received.

Service planning and delivery to meet the needs of local people

- The catchment area for Hereford Hospital was rural and remote and more than 80% of people who use services lived five miles or more from Hereford. We saw evidence that some specialities had developed services to meet the needs of the local population by introducing one-stop clinics to reduce the number of appointments patients would be required to attend. Examples of this included the one-stop cardiology clinic for patients newly referred for early assessment and investigation of symptoms, such as breathlessness, chest discomfort and palpitations. The clinics were led by clinical nurse specialists in cardiology and cardiology clinical assistants. As the assessments and diagnostic tests were usually done at the same time, any further investigations (such as coronary angiography) could be commenced without delay. In April 2016 the outpatient department introduced a one-stop breast clinic. This service was held once a week and meant that patients would only need to attend the hospital once to obtain a diagnosis and discuss treatment options, where appropriate.

Outpatients and diagnostic imaging

- There was evidence that other specialities were developing one-stop clinics to reduce appointments and waiting lists, such as the rheumatology service. However, these had not been established at the time of inspection.
- The ophthalmology service and Clinical Commissioning Groups (CCGs) for Herefordshire and Shropshire had established a primary eye-care assessment and referral service, known as PEARS. The service was provided by local accredited opticians in various locations within Herefordshire and Shropshire. People who experienced eye problems could self-refer to their local accredited optician, who would assess their condition and would offer treatment, where appropriate. Patients who required further investigation would be referred to the hospital service. The service had reduced the number of patients who attended the hospital and has meant that patients could be seen and treated in a location that was convenient to them.
- Since our inspection in September 2015, a clinic for patients with epilepsy had been introduced by the trust. This was commissioned by Herefordshire CCG in order to reduce the number of patients attending the emergency department, reduce the length of stay in hospital and reduce admissions by stabilising patients with epilepsy in clinic. The service was provided by a nurse specialist and was supported by a consultant neurologist. The service offered six clinic sessions a week; patients were also able to contact the nurse specialist for advice via a dedicated telephone service. The nurse specialist had also informed other departments of the service, including the emergency department, in order that patients could be referred directly to the clinic, where appropriate. The nurse specialist had kept the CCG involved of progress made and at the time of our inspection the service had treated 130 patients with epilepsy and planned to develop this further to a caseload of 500.
- The ophthalmology service told us they had an unprecedented demand for ranibizumab treatment. Ranibizumab is a prescription medicine given by injection into the eye. It is recommended by the National Institute for Health and Care Excellence (NICE) as a possible treatment for problems with sight due to wet age-related macular degeneration and diabetic retinopathy. Three incidents were reported in April to July 2015 where patients had not been able to have this treatment due to delays in them being seen. In response to the increased demand for this service, the trust had employed and trained two nurse specialist practitioners to carry out this treatment. A ranibizumab treatment programme had also been introduced at a local community hospital in order to reduce the number of patients attending Hereford Hospital and to better meet the needs of patients in the local surrounding area. A mobile unit was planned to be installed at Hereford Hospital in August 2016 to increase the physical capacity of the unit to carry out this treatment. We were told on our September 2015 inspection that the additional mobile unit was planned to open in October or November 2015.
- The rheumatology department had recently undertaken an audit to assess what types of service provision patient's wanted. Two-thirds of patient's who responded said they would like the option of telephone appointments so they did not have to attend the clinic in person. The rheumatology department were in the process of developing a telephone appointment service. However, this had not been introduced at the time of our inspection.
- The Victoria Eye Unit was located within the Eign Suite and had a separate waiting area for children, which contained toys and books. There were no other children friendly waiting areas within the main outpatients department. The hospital did have a separate outpatient department for children, which was located on the second floor. This was inspected under services for children and young people.
- There was adequate seating and equipment available in all areas of the outpatient department we visited.
- Patients attending the hospital had access to visitors' car parking, which was usually a short distance from the outpatient clinic areas. Staff would issue patients with a car parking concession if they were in outpatients for more than two hours.
- During inspection we observed patients were offered appointments at a time that suited them.
- There was clear signage to outpatient areas and receptions were manned during clinic times to assist patients with directions.
- Water was available for patients and visitors in all outpatient clinic areas.
- A café and shop was situated by the main entrance of the hospital, which patients and their relatives or friends could visit to purchase hot and cold drinks, snacks and meals if they wished.

Outpatients and diagnostic imaging

Access and flow

- We were not assured that patients had access to care and treatment in a timely way. In September 2015 we reported that the trust must ensure there are robust systems in place to collect, monitor and meet referral to treatment times (RTT) within outpatient services.
- The RTT within 18 weeks for non-admitted patients was in line with the England average during March 2015 but the trust performed worse than the England average for incomplete pathways during this same period.
- We spoke with the referral management team directly who gave us the waiting times for specialities at the time of inspection. This showed there were long waiting lists for the majority of specialities. For example, in July 2016 the average RTT by speciality was:
  - Gastroenterology 45 weeks
  - Dermatology 44 weeks
  - Neurology 40 weeks
  - Ear, nose and throat (ENT) 35 weeks
  - Trauma and orthopaedics ranged from nine to 26 weeks
  - Urology above 18 weeks
- However, the trust did meet the target RTT for ophthalmology, with patients waiting an average of 12 to 15 weeks to be seen.
- In July 2016 the average RTT by speciality for urgent two week wait appointments was:
  - Dermatology 24 weeks
  - Urology eight to 10 weeks
  - ENT six to eight weeks
  - Ophthalmology six to eight weeks
  - Gastroenterology six to eight weeks
  - Neurology four to six weeks
- Data published in the board report for May 2016 showed that the trust did not consistently meet all cancer targets regarding RTTs. For example:
  - 88% of newly referred patients were seen within two weeks of GP referral against a target of 93%
  - 80% of patients commenced treatment within 62 days following urgent GP referral against a target of 85%
  - 85% of patients with breast symptoms were seen within two weeks following urgent GP referral against a target of 93%
- However, the trust met the target of 96%, for patients who had commenced treatment within 31 days from diagnosis. Furthermore, the trust exceeded targets for patients who received second or subsequent treatment (surgery) within 31 days (target 94%; actual 100%) and for patients who commenced treatment following referral from screening within 62 days (target 90%; actual 100%).
- At the time of inspection the trust had 941 patients at some point in the 62 day cancer pathway; 50 of these patients (5%) had breached the 62 day target.
- We saw an improvement in the percentage of patients who waited six or more weeks for diagnostic assessment and/or treatment from our September 2015 inspection. Data provided by the trust for diagnostic wait times showed that from October 2015 to May 2016, no patients waited more than six weeks for diagnostic assessment and/or treatment; this included ultrasound, X-ray, magnetic resonance imaging, computerised tomography scan and nuclear medicine. The majority of patients waited one to two weeks (33%), two to three weeks (26%) and three to four weeks (20%).
- The trust had started to send a monthly bulletin to GP practices to update them on waiting times per speciality. GPs could then consider these waiting times and whether they felt it was safe for the patient to wait, whether they needed an urgent referral or whether they could be referred to an alternative provider.
- The trust had sent an acknowledgement letter to all patients for whom the waiting time for their first appointment would exceed 12 weeks and patients were informed of the likely waiting time.
- In collaboration with the trust, the Herefordshire CCG had established a telephone line for patients who were likely to face long waits for appointments at Hereford Hospital. The service provided advice for patients on how they could access alternative faster treatment.
- The role of the revalidation team was to review all historic data related to open patient pathways on the patient administration system. This was to enable the trust to identify the number of patients who were waiting to be seen and where this was identified, what the potential harm to the patient was as a result of delayed waiting times. This review would also provide the trust with an accurate picture of patient demand and would enable the trust to start reporting RTT status. Staff told us that the trust planned to start reporting RTT again in September 2016.
- At the time of inspection, we were told that the validation team had reviewed 42,000 open patient pathways; some of which dated back to 2006. However,

we saw evidence in the trust's "RTT Confirm and Challenge 22/06/2016" that the team had approximately 28,000 open pathways still to review. Staff told us that they planned to have reviewed 15,000 by September 2016 and the remainder within the next 12 months. The trust had identified this as an issue. However, there continued to be a risk that the trust did not have full oversight of the risk to patients on open pathways.

- Trajectory data provided by the trust showed a predicted number of patients on the waiting list and the percentage of patients that would be seen within the RTT. For example, at the time of our inspection in July 2016, the trust predicted a total waiting list of 10,028 patients. This meant 65% of patients would be seen within the target RTT. According to the trajectory data, the trust would not meet its RTT target of 90% until February 2017. However, this data was based on the predicted number of patients, not the actual number of patients because the trust still had patients on open pathways that needed validating.
- The RTT validation team had been commissioned by Herefordshire CCG to contact all patients who had waited longer than 18 weeks for their first outpatient appointment. In May 2016 the team had reviewed and contacted 538 outpatients; of these, 179 confirmed they had appointments booked in the near future, 23 patients said they no longer wanted the appointment and two patients had been escalated and appointments were booked.
- Therefore, whilst the trust had taken some action to address patient waiting times, we were not assured that patients had access to care and treatment in a timely way and that the trust had identified all patients on the waiting list.
- The majority of referrals and appointments were managed centrally by the referral management centre. Referrals were triaged upon receipt to ensure that urgent patients were prioritised. If patients could not be booked within the required timeframe the relevant consultant would be contacted and asked if it was clinically acceptable for the patient to wait to be seen. If it was not, the patient would be regraded so that an appointment could be arranged within the required timeframe.
- The referral management centre was responsible for booking 70% of appointments. These included appointments for cardiology, dermatology, urology and trauma and orthopaedics. Some specialities, such as gynaecology, paediatrics and geriatrics, were booked by the individual speciality. Medical secretaries also booked some appointments. Approximately 40% of specialities used e-Referral (formerly known as Choose and Book) whereby patients could book, change or cancel an appointment on-line. According to information provided by the trust, there were not enough appointment slots for the number of e-Referral requests made. These patients would then be manually added to the waiting list and an appointment booked via telephone, letter or text by the referral management centre. We asked the trust to provide us with the number of patients who were waiting for an appointment per speciality. We were not provided with this information. Therefore, we were unable to determine the actual number of patients waiting to be seen and were not assured that the trust had full oversight of patient waiting lists.
- Patients who required an urgent two week wait appointment were given a 0800 telephone number to call to book their appointment.
- One patient told us they required appointments from several specialities as a result of an accident. They could not get an appointment for ENT or rheumatology for several months and so they paid for private appointments as they felt they could not wait this long. Whilst they received an ophthalmology appointment in a timely manner, they were also advised to see a neurologist. They were told that the waiting list for this speciality was 35 weeks.
- Some patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult. One patient said, "sometimes it's a job to get through, you have to ring half a dozen times".
- Since our September 2015 inspection, the trust had implemented initiatives to reduce patient waiting lists. For example, the manager for outpatients had developed a standard operating procedure to address the overbooking of clinics and to ensure that clinic templates were booked as planned. Data gathered on overbooked clinics was reported monthly to the RTT steering group. This information would provide the outpatient department with accurate information on how many clinics were required to meet patient demand per speciality. This initiative had been implemented in June 2016. Therefore, we were unable to determine the impact this initiative would have on reducing patient waiting times.

Outpatients and diagnostic imaging

- Information provided by the trust stated that specialities constantly put on additional clinics to meet urgent patient demand and reduce backlogs. This was supported by all staff we spoke to during our inspection and we saw evidence that additional clinics were routinely held on Saturdays, and some Sundays.
- Consultants we spoke to told us that they would try to cover any medical staff shortages, for example due to sickness, by seeing additional patients on their clinic lists. Data provided by the trust for the period April 2015 to March 2016, showed that a total of nine clinics were cancelled due to staff sickness.
- According to data provided by the trust, a total of 1,152 clinics had been cancelled from April 2015 to March 2016. Over 50% of these clinics were cancelled due to consultant annual leave; of which 10% of clinics were cancelled with less than two weeks' notice. The other main reasons given for cancelled clinics were due to consultant on-call commitments (13%) and study leave and training (12%). The data provided did not show the total number of patients who had appointments cancelled. Therefore, we were unable to determine the impact of cancelled clinics on service provision.
- Data provided by the trust for the period of 12 June to 3 July 2016 showed that 2,588 patients cancelled new or follow up appointments; this equated to 10% of all new or follow up appointments for this period. An average of 55% of these appointments had been rebooked; no explanation was provided as to when the remaining 45% of patients would be rebooked. In the same period, the trust cancelled 1,141 new or follow up appointments; this meant that 5% of patients had appointments cancelled by the trust.
- The trust did not collect data on the waiting time from arrival to being seen in clinic. Therefore, we were unable to determine whether services ran on time. We observed that most patients were called in to their consultation shortly after they arrived. Some patients we spoke to said they did not have to wait long to be seen. Whilst other patients told us they had waited over two hours for their appointment.
- Patients told us they were generally kept informed of the clinic waiting times. Some departments had white boards, which nursing staff updated with clinic waiting times. Staff also informed patients when clinics when running late and we observed that nursing staff announced clinic waiting times during inspection.

Meeting people's individual needs

- The trust employed a Polish interpreter who also managed any interpreting requests. The local diversity team was used to provide face to face interpreting for appointments where complex clinical information was discussed. Staff could also access interpreting services via a dedicated telephone translation service and Deaf Direct for patients who used sign language.
- Hearing loop was available within the outpatients department.
- We saw a wide range of information leaflets for patients in all areas of outpatients. Some leaflets had been produced by the trust and some were from national organisations, such as the National Osteoporosis Society, Arthritis Research UK and the Royal National Institute of Blind People. The leaflets we saw were all in English. The trust had an interpreting service on site, which had produced a standard set of questions and answers in other languages for non-English speaking patients to use.
- Staff we spoke to had good awareness of patients with complex needs and those patients who may require additional support. Staff told us that patients with dementia or a learning difficulty would be prioritised and seen as soon as possible to reduce anxiety during their visit to outpatients. The Oxford Suite had one dementia champion and outpatient departments planned to train more staff to undertake this role. We saw a dementia awareness folder was available for staff to use as a resource, if they required guidance.
- The outpatient clinics we visited were generally accessible to patients living with physical disabilities and wheelchair users. However, the corridor where patients waited for their consultation and treatment in the Victoria Eye Unit was crowded with patient record trolleys. This meant that trolleys had to be moved to allow wheelchair users access to consultation and treatment rooms and was not a conducive environment for people with visual difficulties.
- The plaster technicians had a designated room in the Oxford Suite for completing plaster cast renewals. There was a variety of plasters available for children so they could choose what colour and/or design they wanted.
- We saw posters displayed in the radiology department to remind patients of the importance of notifying the radiologist of any associated risks. For example, if patients were pregnant.

Outpatients and diagnostic imaging

Learning from complaints and concerns

- The trust reported that there were 17 complaints regarding all outpatient and diagnostic areas between April 2015 and May 2016. Themes included values and behaviour of staff, clinical treatment and appointment waiting times.
- The complaints team allocated complaints which required investigation to the outpatient's manager. The outpatient manager contacted each complainant to apologise and speak with them directly about areas of the service they were unhappy with before they formally responded to the complaint. The outpatient manager told us of a recent complaint they had received, whereby the patient felt they were ignored by nursing staff, who appeared more concerned with the patient records than the patient's themselves. The outpatient manager raised this at the patient forum, which was a quarterly meeting held by the trust where patients and members of staff were invited to attend to discuss their experience of care and how care could be improved. This was also discussed with staff in outpatients to raise their awareness of how their actions could be negatively perceived by patients. Staff we spoke to confirmed they were aware of complaints and had received feedback via team meetings.
- In response to complaints about the length of time patients waited to be seen in clinic, the Victoria Eye Unit had changed the appointment letter it sent to patients. The original wording of the letter stated an appointment time, which patient's presumed was the time they would see the clinician. However, the majority of patients seen in the Victoria Eye Unit required vision tests and/or the administration of eye drops prior to their appointment with the clinician. This meant patients were in the department for longer than they expected and were not seen by the clinician at the appointment time stated in the letter. The letter was changed to reflect this and included information about various tests that might be required and that patients could be in the clinic for some time. Senior staff told us that this had reduced the number of complaints received about waiting times in clinic.
- From April 2016, the percentage of complaints responded to trust wide within 25 days was 70%; the trust target was 90%. The response rate had worsened since our September 2015 inspection, when we reported that 72% of complaints were responded to trust wide within 25 days. Therefore, we were not assured that all complaints were dealt with in a timely manner and in accordance with trust policy.
- If staff were unable to deal with a patient's concerns satisfactorily, they would be directed to the patient advisory liaison service.
- Information was available on the trust website and also throughout the hospital, which provided details of how patients could raise complaints about any aspect of care they had received.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated outpatient and diagnostic imaging services as requires improvement for being well-led because:

- Staff had some awareness of the trust vision, mission and values but this had not been formally rolled out to all staff at the time of our inspection.
- The trust had recognised the risks within the outpatient department and had developed objectives and actions to manage these risks. However, these were not expected to be completed until later in the year.
- The outpatient department had developed a clear strategy to improve patient experience and reduce waiting times. All objectives were detailed in the quality improvement programme and were supported by actions and timescales. However, the majority of objectives were behind completion date.
- Governance systems were in place to monitor and assess risk, but these were not established due to the restructure of outpatients within the surgical division.
- Public engagement with the outpatient department was limited and patients were generally not involved in shaping and improving the services.

However, we also found that:

- The outpatient department was well represented at board level and staff felt that leadership was strong, with visible, supportive and approachable managers. This was an improvement since the September 2015 inspection.

Outpatients and diagnostic imaging

- Staff were proud to work at the hospital and passionate about the care they provided.
- The trust had invested in outpatient services, which included the purchase of new imaging equipment and the refurbishment of some clinical areas.
- Specialities were focussed on developing services to improve patient care.

Vision and strategy for this service

- The trust had implemented a vision, mission and values which was focussed on providing quality care and improving the health and wellbeing of people in Herefordshire and surrounding areas. The trust vision, mission and values had been developed in September 2015 but had not been formally rolled out to all staff. We saw the vision, mission and values displayed in various areas of the hospital. Staff we spoke to had some awareness and understanding of the vision and values.
- The strategy for outpatients was focussed on developing physical and human capacity in order to deliver improved patient flow and reduced waiting times. Staff we spoke to demonstrated an understanding of the departmental strategy.
- The trust had developed a quality improvement plan, which detailed the transformation programme the trust had undertaken to address areas for improvement raised by the CQC in the September 2015 inspection. The quality improvement plan encompassed the strategy for outpatients and detailed specific objectives the department were required to meet in order to improve patient experience, ensure safe care and treatment was provided and reduce waiting times. These objectives had been devised in accordance with actions the CQC had reported that the trust must and should do, following our September 2015 inspection. Progress against the objectives was monitored weekly by the chief operating officer and monthly by the trust board. Whilst some progress had been made the trust did not expect to complete this programme until later this year. Therefore, at the time of inspection we were unable to determine whether the trust would be able to deliver the quality improvement programme and what impact it would have on service provision.
- Staff we spoke with were aware of the quality improvement plan and understood their role and responsibilities in achieving it.

Governance, risk management and quality measurement

- Managers told us that the governance structure for the department had changed in June 2016, resulting in the restructure of outpatients within the surgical division. At the time of our inspection, governance meetings were held every two weeks, but it was expected that these would be held monthly once the division was established. Governance meetings were chaired by the divisional nurse director and all senior managers within outpatients attended. The matron would meet with senior nursing staff on a weekly basis to discuss governance issues and risks within the department. Information was fed back to staff at the monthly team brief meeting. Senior nursing staff would also share information with staff on a daily basis, prior to the start of each clinic.
- Senior staff we spoke to felt that outpatients was represented at board level. The chief operating officer was the executive lead for the outpatient quality improvement programme. We saw evidence that regular reviews were held to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department.
- The quality improvement programme detailed performance measures for the outpatient department. These included the audit of start and finish times for outpatient clinics, the monthly outpatient clinic utilisation report, the number of incidents reported due to overbooking of clinics and the number of complaints reported due to long waits in clinic. We saw evidence that senior staff in the Oxford Suite were auditing what clinic rooms were used and by whom, the time the clinic room was ready for use, the time the first patient entered the clinic, the time the last patient left the clinic, the time the clinic finished, the longest waiting time, the number of patient notes that were unavailable for the clinic, the number of temporary notes used in the clinic and whether an incident form was completed. This information was recorded daily for every clinic session. However, at the time of inspection this data was not available for review, nor was it clear whether this audit was undertaken in all outpatient departments. The data provided by the trust showed that all of these performance measures, with the exception of one, were overdue the completion date set by the quality improvement programme. Therefore, whilst the trust

had identified service performance measures, we were not assured that these were reported and monitored in a timely manner and that action was taken to improve performance.

- We saw evidence that managers and administration leads met regularly to discuss clinic capacity, clinic utilisation and associated risks within the department. Issues concerning capacity and scheduling were discussed by individual speciality, such as trauma and orthopaedics, dermatology and urology, and actions were identified to address the issues. We saw evidence that progress was generally reported. The minutes and action plans we reviewed for meetings held in March and April 2016 showed that the majority of actions had not yet been completed. We did see evidence that an audit of clinic templates by speciality and clinician had been commenced. Present clinic times, the number of templated clinic slots available and whether multiple patients had been booked per slot had been reviewed for a total of 489 clinics. Actions had been identified where appropriate. For example, some clinics had been extended to increase the number of clinic appointments available and restructured, to allow more time for clinicians to see new patients. Some actions were still outstanding at the time of our inspection and because the review of clinic utilisation and capacity was ongoing, we were unable to determine what impact it would have on patient waiting lists.
- Since our September 2015 inspection, we saw evidence that incident reporting had improved in the outpatient department. Staff told us they were confident to report incidents. Learning from incidents was fed back via team briefings and local meetings. These were facilitated by the matron or senior nursing staff. Staff we spoke to were able to give us examples of changes to practice that had been made as a result of lessons learnt from incidents.
- Serious incidents were reported to the quality and safety lead, who then allocated the serious incident to an appropriate clinician or senior member of staff to investigate. We reviewed the root cause analyses of six serious investigations; all were related to the outpatients department. We saw detailed root cause analyses had been completed and included recognition of care and service delivery problems, contributory factors, lessons learned and actions to be completed to reduce the risk of further incidents. We also saw evidence that patients were informed and the duty of candour was followed, where appropriate. The investigations that we reviewed demonstrated that the majority of actions identified to minimise the risk of further incidents were completed. Staff were able to give us examples of lessons that had been learnt from incidents and we observed that lessons learnt were shared across relevant departments when we attended a radiology audit meeting.
- We saw there was some alignment between what staff identified as the main risks within outpatients and the trust risk register. For example, staff told us that there was a shortage of medical, nursing and administration staff within the department, which meant staff would often work additional hours to cover clinics. Recruitment and retention of staff was listed on the trust risk register and was recognised as the biggest risk the trust faced. The trust had included the retention and recruitment of staff in the quality improvement programme and had developed initiatives in order to address this risk. The trust had held recruitment sessions in London, recruitment open days, overseas recruitment events and had developed a new recruitment website in a bid to attract new members of staff to work at the trust. Staff also told us that referral to treatment waiting times and inadequate, inaccurate or missing health records were a risk and we saw evidence that these were listed on the trust risk register and had all been included in the quality improvement programme, with associated improvement actions devised.
- The radiology department completed regular audits, in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). We saw evidence that the radiology department had improved its service provision following the audit of dose reference levels.
- Since our inspection in September 2015, there was evidence that some outpatient departments had audited the number of notes unavailable for clinic appointments. The trust provided data that the availability of notes had been audited for January to April 2016. However, it was unclear from the data provided whether all outpatient departments had undertaken this audit. Furthermore, the data submitted was not complete; no reason for the omissions was provided and no total number of patients seen in clinic was recorded. Therefore, we were unable to determine whether the number of unavailable notes was

significant or not. This meant there was a risk that the trust was unaware of the extent of the problem and that the audit in place was not effective. We reported this in our previous report.

Leadership of service

- The outpatient department had recently been restructured and was now managed by the surgical division. Staff we spoke to were aware of the recent restructure. The division was managed by the divisional general manager, associate medical director and divisional nurse director. The outpatient and diagnostic department was managed by the clinical support directorate and had a general manager, clinical director and matron. Each clinical area had a nominated lead that worked and managed the clinical speciality. However, at the time of our inspection the trust had not yet appointed the associate medical director for the division, the clinical director for the clinical support directorate and clinical leads in radiology, pathology and the vascular unit.
- The imaging service had radiology superintendents, who were senior clinicians and able to offer support and advice to the team. This ensured staff had access to clinical experts when required.
- Staff reported that leadership within the department was strong, with visible, supportive and approachable managers. Staff felt there was a positive working culture and in all areas we visited staff felt there was a good sense of teamwork.
- We saw evidence that the department was proactive in the future planning and development of staff. The ophthalmology service had recruited and trained two nurse practitioners to carry out wet age-related macular degeneration treatment, in order to increase the capacity of the service. This was also notable in cardiology and radiology services, where two members of staff were undergoing specialist electrocardiogram training in order that the service was not compromised when two members of the team retire later in 2016.
- Staff told us that local leadership was good and felt they could approach managers with concerns. Managers told us they had an 'open door' policy and they encouraged staff to share any issues, concerns or ideas they may have. Staff we spoke to confirmed this during our inspection. We observed good, positive and friendly interactions between staff and local managers.
- Staff felt that line managers communicated well with them and kept them informed about the day to day running of the clinical areas and any issues or concerns that had been raised. We observed that managers and senior staff were regularly visible in each area.
- Staff told us that they knew the executive team and that they were visible on the 'shop floor' at times. The chief executive officer had introduced an 'open door' policy for staff; whereby all staff were invited to email them, with ideas or concerns they had. We spoke with one member of staff who had emailed them and they felt supported by the response.

Culture within the service

- All staff we spoke with were proud to work at the hospital. They were passionate about the care they provided for their patients and felt they did a good job.
- Nursing staff told us that although they were stretched at times they were able to provide good and safe patient care.
- Multidisciplinary teams worked collaboratively and were focussed on improving patient care and service provision. During our inspection we attended two multidisciplinary team meetings and observed positive and dynamic interactions between all members of the team. We heard of recent improvements to service provision as a result of collaborative working, such as the direct reporting of scan results to GPs. This initiative had reduced the time it took for normal scan results to be reported from 12 weeks to one week.
- Staff we spoke to reported an open and honest culture within the outpatient department. Senior managers were supportive and approachable and staff felt confident to escalate concerns and report incidents.
- Staff recognised that the outpatient department was the first and sometimes the only point of contact patients had with the hospital. They felt it was their responsibility to make patients feel welcome and that they experience good care and treatment.
- Staff did not express concerns about bullying or harassment to the CQC team during our inspection.

Public engagement

- NHS Friends and Family Test questionnaires were available for patients in clinic waiting areas and we saw posters displayed, which encouraged patient's to leave comments about the service. However, the response

rate was one of the lowest in the country. Therefore, we were not assured that people who used the services were engaged by the department to shape and improve them.
- Patients and relatives we spoke with were generally positive about the service and care they received in outpatients.
- The newly introduced clinic for patients with epilepsy had enlisted the support of a patient with epilepsy; their views had helped the clinic develop so that the needs of patients were met.

Staff engagement

- Outpatient and diagnostic services held regular team meetings, which all staff were invited to attend. Staff we spoke to said they felt informed of plans for outpatient services and were encouraged to share ideas of how to improve the services.
- Throughout the inspection staff were welcoming and willing to speak with us. All staff we spoke to were proud of the department and the hospital. Staff were committed to improving services and had worked hard to address the concerns raised by the CQC on the September 2015 inspection.
- The trust published a newsletter which was distributed throughout the hospital and updated staff on current issues and future plans.

Innovation, improvement and sustainability

- The outpatient department had agreed objectives and action plans in order to develop and improve service provision; these were detailed in the quality improvement plan. Plans were related to improving the patient experience and reducing patient harm. We saw evidence that the trust had made some progress towards achieving its plans. For example, since our September 2015 inspection the trust had reviewed the records of 3,000 patients who had waited over 18 weeks for an appointment. Patients who were found to have been caused harm as a result of any delays in treatment were identified and appropriate action taken. This process was ongoing at the time of our inspection. However, it was evident that the trust was behind its proposed schedule for meeting some objectives, such as the review of causes of cancelled clinics and recommended action plans. These were scheduled to have been completed by the end of March 2016 and were still outstanding at the time of inspection. Therefore, we were unable to determine whether the trust would be able to deliver its proposed improvement plan.
- The outpatient department was proactive in training staff to meet the demands of the service. For example, ophthalmology, radiology, cardiology, dermatology and rheumatology services had all invested in training staff in additional skills and competencies, in order to increase capacity and improve services for patients.
- Some specialities had developed services since our September 2015 inspection. These included the introduction of a clinic for patients with epilepsy and one-stop breast clinic. There was also evidence that specialities were developing services in order to meet patient demand. For example, a new ophthalmology unit was planned to be installed in August 2016. This would provide the service with additional clinic space so that they could increase the number of patients they treated for wet AMD.
- We saw evidence of trust investment in the outpatient department since our September 2015 inspection. For example, a second computerised tomography scanner had been purchased and the Fred Bulmer Clinic had been refurbished, with an additional four clinic rooms created. This had enabled some services to increase capacity and reduce waiting times.

Outstanding practice and areas for improvement

Outstanding practice

- Services for children and young people were supported by two play workers (one was on maternity leave at the time of inspection). The play workers regularly made arrangements for long term patients to have days out to different places, including soft play areas or bowling. An activity was arranged most months and the play workers sourced the activities from local businesses who donated their good and/ or services. This meant that patients with long term conditions could meet peers who also regularly visited the hospital. Patients found this valuable and liked the opportunity to meet patients who had shared experiences.
- There was a children's and young people's ambassador group which was made up of patients who used or had used the service. We spoke with some members of the ambassador group who told us that they were involved in the service redesign when developments took place and improving the service for other patients.
- The respiratory consultant lead for NIV had developed a pathway bundle, which was used for all patients requiring ventilator support. The pathway development was based on a five-year audit of all patients using the service and the identification that increased hospital admissions increased patient mortality. The information gathered directed the service to provide an increased level of care within the patient's own home. Patients were provided with pre-set ventilators and were monitored remotely. Information was downloaded daily and information and advice feedback to patients by the medical team. This allowed treatments to be altered according to clinical needs. The development had achieved first prize in the trust quality improvement project 2016.
- The newly introduced clinic for patients with epilepsy had enlisted the support of a patient with epilepsy; their views had helped the clinic develop so that the needs of patients were met.
- Gilwern assessment unit was not identified as a dementia ward, however, this had been taken into consideration when planning the environment. The unit had been decorated with photographs of "old Hereford" which were used to help with patients reminiscing. Additional facilities included flooring that was sprung to reduced sound and risk of harm if patients fell, colour coded bays and wide corridors to allow assisted mobility. Memory boxes were available for relatives to place personal items and memory aids for patients with a history of dementia, and twiddle mittens provided as patient activities. The unit provided regular activities for patients, which included monthly tea parties and games.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that all staff receive safeguarding children training in line with national guidance, in particular in the emergency department.
- The trust must ensure that enough staff are trained to perform Doppler assessments, to ensure patient receive timely safe care and treatment.
- The trust must ensure there are enough sharps bins available for safe and prompt disposal of used sharps.
- The trust must ensure that patients' weight is always recorded on patients' prescription charts, to ensure the correct prescribing of the medicine.
- The trust must ensure that medicine records clearly state the route a patient has received medicine, in particular, whether a patient has been given the paracetamol orally or intravenously.
- The trust must ensure all medicines are stored in accordance with trust polices and national guidance, particularly in outpatients.

Outstanding practice and areas for improvement

- The trust must ensure that all patients receive effective management of pain and there are enough medicines on wards to do this.
- The trust must ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust must ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- The trust must ensure staff receive appraisals which meet the trust target.
- The trust must ensure that patients are able to access surgery, gynaecology and outpatient services in a timely way for initial assessments, diagnoses and/or treatment, with the aim of meeting trust and national targets.
- The trust must continue to take action to address patient waiting times, and assess and monitor the risk to patients on the waiting list.
- The trust must ensure the time taken to assess and triage patients within the emergency department are always recorded accurately.
- The trust must ensure effective and timely governance oversight of incident reporting and management, particularly in children and young people's services.
- The trust must ensure all policies and procedures are up to date, and evidence based, including the major incident policy.

The trust must ensure that all risks are identified on the risk register and appropriate mitigating actions taken.

Action the hospital SHOULD take to improve

- The trust should ensure all vacancies are recruited to.
- The trust should continue to complete mortality reviews with the aim of reducing the overall for the service.
- The trust should ensure patient records are stored appropriately to protect confidential data.
- The trust should ensure all patient records are fully completed, including stroke pathway documentation and communication detailing interactions and treatments provided within the care plan evaluation sheets.
- The trust should ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for emergency departments.
- The trust should ensure delays in ambulance handover times are reduced to meet the national targets.
- The trust should ensure initial patient treatment times are reduced to meet the national target for 95% of patients attending the emergency department to be admitted, discharged or transferred within four hours.
- Ensure that each service has a local vision and strategy which is disseminated and understood by all staff so that it is embedded within the service.
- The trust should ensure that systems and processes are in place to ensure cleanliness of equipment within the emergency department.
- The trust should ensure that systems are in place to provide adequate nutrition and hydration to patients in the emergency department and clinical assessment unit.
- The trust should ensure treatment bays in the emergency department resuscitation area protect patients' privacy and dignity.
- The trust should review staff safety and provision of an alarm call system in the rapid assessment area.
- The trust should review its arrangements for transporting patients home if they need to travel on a stretcher, with emphasis on improving patient flow.
- The trust should ensure that electronic discharge letters are completed in a timely manner to prevent delays in the preparation of patient's medication to take home and delays in patient discharge.
- The trust should ensure where possible, patients are placed in the most appropriate clinical area.

Outstanding practice and areas for improvement

- The trust should consider implementing a checklist for transferring patients between wards, to ensure transfer is appropriate and maintains patient safety.
- The trust should consider implementing a risk assessment for the admission of medical patients to outlying wards, to ensure admission is appropriate and maintains patient safety.
- The trust should ensure unnecessary patient moves are minimised at night.
- The trust should continue to work with local stakeholders to improve the discharge pathway and facilitate timely patient discharge.
- The trust should ensure mixed sex breaches are prevented.
- The trust should consider employing a lead nurse for learning disabilities to support patients.
- The trust should ensure that all staff are aware of the trust structure and who their managers are.
- The trust should ensure that patents privacy and dignity is protected at all times, in particular during handover on Leadon ward.
- The trust should ensure that there are action plans as a result of audits, to promote improvements.
- The trust should ensure that cancelled operations are prevented; and if cancelling an operation is essential, patients are then treated within 28 days as per NHS England standard.
- The trust should ensure staff are aware of the trust mission, vision, and strategic objectives.
- The trust should consider a follow-up clinic for patients discharged home after an intensive care unit admission, as recommended in National Institute for Health and Care Excellence guidance.
- The trust should ensure that flow is maintained throughout the hospital to ensure there is capacity to admit patients that required critical care services and discharge patient in a timely manner.
- The trust should ensure there are systems and processes in place to keep patients safe, particularly in maternity services where, the anaesthetic room used as a second theatre on the delivery suite was not fit for purpose.
- The trust should ensure there is clear oversight of outcomes and activity in maternity services.
- The trust should ensure measures are in place to reduce the caesarean section rate.
- The trust should ensure that meeting minutes clearly record recommendations and lessons learnt from incidents.
- The trust should ensure that appropriate transition arrangements for children are clearly defined.
- The trust should ensure there is an acuity tool to be used to determine patient dependency levels and staffing requirements in paediatrics.
- The trust should ensure that there is oversight of the service arrangements for the mortuary team to ensure that staff training and supervision is in place.
- The trust should ensure that effective information on the percentage of patients who were discharged to their preferred place within 24 hours is collected.
- The trust should ensure that corridors where patients wait for their consultation and treatment in the Victoria Eye Unit do not pose a risk to patients with visual difficulties.
- The trust should ensure there is signage on the doors to indicate if a compressed gas is stored in the room, in line with the Department of Health guidance (Medical gases. Health Technical Memorandum 02-01: Medical gas pipeline systems. Part B: Operational management, 2006).
- The trust should ensure that complaints are responded to within the trust target of 25 days.
- The trust should minimise the percentage of outpatient clinics cancelled.
- The trust should ensure all equipment has safety and service checks in accordance with policy and

Outstanding practice and areas for improvement

manufacturer' instructions and that the identified frequency is adhered to, particularly in outpatients, the emergency department and the intensive care unit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2)(a)(b)(c)(g) HSCA 2008 (Regulated Activities) Regulations 2014 **Safe care and treatment** 1. Care and treatment must be provided in a safe way for service users — a. Assessing the risks to the health and safety of service users of receiving the care or treatment. b. Doing all that is reasonably practical to mitigate any such risks c. Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. g. The proper and safe management of medicines. The level of safeguarding children's training that staff in certain roles received was not compliant with intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) in the emergency department. There were not enough staff trained to perform middle cerebral arterial Doppler assessments, to ensure patient receive timely safe care and treatment. There was not enough sharps bins available for safe and prompt disposal of used sharps. There was not always proper and safe management of medicines because patients' weight was not always recorded on patients' prescription charts, to ensure the

Requirement notices

correct prescribing of the medicine. It was not always clear on medicine records, the route a patient had received medicine, in particular, whether a patient has been given the paracetamol orally or intravenously.

Medicines were not always stored are stored in accordance with trust polices and national guidance, particularly in outpatients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** 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— 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 The regulation was not being met because risks were not always identified and all mitigating actions taken in all areas of the hospital. Effective systems and processes were not in place to improve the quality of services provided, including the quality of the experience of service users in receiving these services. Patients were unable to access surgery, gynaecology and outpatient services in a timely way for initial assessments, diagnoses and/or treatment. Access to services did not consistently meet trust or national targets, and were significantly worse. Times taken to assess and triage patients within the emergency department were not always recorded accurately.

This section is primarily information for the provider

Requirement notices

Incidents were not always reported or investigated in a timely way, particularly in children and young people's services.

Not all risks were identified on the risk register.

Policies were not always up to date or evidence based, particularly in services for children and young people but not exclusively.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 **Staffing** 2. Persons employed by the service provider in the provision of a regulated activity must— a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform The regulation was not being met because not all staff were compliant with mandatory training, supervision and appraisals as required by the trust's policies.