Care Quality Commission

Wye Valley NHS Trust

Hereford Hospital

Quality Report

County Hospital
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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	Inadequate
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

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 slightly more than 180,000 people in Herefordshire. The trust also provides urgent and elective care to a population of more than 40,000 people in mid-Powys, Wales. The trust provides a full range of district general hospital services to its local population, with some links to larger hospitals in Gloucestershire, Worcestershire and Birmingham

The trust's catchment area is characterised by its remoteness and rural setting, with more than 80% of people who use the service living five miles or more from Hereford city or a market town.

Wye Valley NHS Trust provides services from Hereford Hospital and community healthcare settings. There are approximately 289 beds within the hospital.

We inspected the trust in June 2014 and gave an overall rating of 'Inadequate', with particular concerns about the provision of services in both A&E and medical care services. The inspection led to the trust being placed in special measures by the Trust Development Authority in October 2014.

We carried out an announced comprehensive inspection of the trust from 22 to 24 September 2015. We undertook one unannounced inspection on 1 October 2015 at Hereford Hospital and attended the trust board meeting. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, allied health professional, domestic staff and porters. We also spoke with staff individually.

Overall, we rated Hereford Hospital as inadequate with two of the five key questions which we always rate being inadequate (safe and responsive). Improvements were needed to ensure that services were safe and responsive to patient's needs. We found that effectiveness and well led required improvement and the caring was good.

Five of the eight core services at Hereford Hospital were rated inadequate for safety.

The outpatient and diagnostic services at Hereford Hospital were rated overall as inadequate. All other services at Hereford Hospital were rated as requires improvement.

Our key findings were as follows:

- Staff were kind and caring and treated people with dignity and respect.
- Overall the hospital was clean, hygienic and well maintained.
- In July 2015 there were 128 whole time equivalent (WTE) (14%) band 5 to 7 qualified nursing vacancies, 16 WTE (13%) consultant vacancies and 23 WTE (13%) other medical staffing vacancies within the trust. This was a high risk on the trusts risk register. A recruitment programme was ongoing and changes had been made to speed up the recruitment process. Oversees recruitment had taken place.
- Nursing vacancies in some areas was very high and in excess of 40%, such as Lugg ward and the acute assessment unit.
- There was an over reliance on bank nursing staff. Between January and May 2015 the average use of agency nurses across the trust was 13%, higher than the national average. There were occasions were temporary staff were more that 40% of the workforce on a ward.
- The trust told us for August 2015 the use of agency nurses accounted for 17% of total nurse expenditure.
- It is worth noting that at the Quality Oversight Review Group Meeting on 4 November 2015 the trust had a trajectory to reduce their nursing vacancies to 64 WTE by the end of 2015 and had established an internal agency that had reduced external agency use by over 50% (approximately 500 shifts). Subsequently, this had reduced expenditure.

Summary of findings

- In July 2015 there were 16 WTE consultant vacancies and 23 WTE other medical staffing vacancies. Between January and May 2015 the average use of locum medical staff across the hospital was 8.4%. The emergency department, radiology and medical services used over 25% locum medical staff.
- Patient's pain was well managed and women in labour received a choice of pain relief. Patients at the end of life were given adequate pain relief and anticipatory prescribing was used to manage symptoms.
- Monitoring by the Care Quality Commission had identified areas where medical care was considered a statistical outlier when compared with other hospitals. The trust reported on their mortality indicators using the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). These indicate if more patients are dying than would be expected. The SHMI indicator, which covered the 12 month period April 2014 to March 2015, showed mortality was above the expected range of 100 with a value of 114. However, the data for March 2015 reported a 12 month rolling figure of 117. The data for the trust was higher than expected and its overall level of HSMR for the 12 month period April 2014 to March 2015 was 132. 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.
- Like many trusts in England, Wye Valley NHS Trust was busy. Between July 2014 and March 2015, bed occupancy for the trust averaged 92%. This was above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The trust were not consistently meeting the national targets set regarding patients access to treatment and they had failed to meet the 18 week target for access to treatment for many specialities.
- The trust were not meeting the standard for patients being admitted, referred or discharged from the A&E department within four hours.
- Staff generally felt they were well supported at their ward or department level.

We saw several areas of outstanding practice including:

- 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 recently introduced a 'Saturday club' and had been involved in the ED Patient-Led Assessment of the Care Environment audit (PLACE) aiding the redesign of the children's waiting area. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.

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

Importantly, the trust must:

- Ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must ensure safeguarding referrals are made as appropriate.
- The trust must ensure all staff have the appropriate level of safeguarding training.
- 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 and appraisal to meet the appraisal target of 90% compliance.
- The trust must ensure there are enough suitably qualified staff on duty within all services, in accordance with the agreed numbers set by the trust and taking into account national recommendations.
- The trust must ensure there are the appropriate number of qualified paediatric staff in the ED to meet standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing.

Summary of findings

- The trust must ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum.
- The trust must ensure processes in place are adhered to for the induction of all agency staff.
- The trust must ensure ligature points are identified and associated risks are mitigated to protect patients from harm.
- The trust must ensure risk registers reflect the risks within the trust.
- The trust must ensure all incidents are reported, including those associated with medicines.
- The trust must ensure effective and timely governance oversight of incident reporting management, including categorisation of risk and harm, particularly in maternity services.
- The trust must review the governance structure for all services at the hospital to have systems in place to report, monitor and investigate incidents and to share learning from incidents.
- The trust must ensure that all trust policies and standard operating procedures are up to date and that they are consistently followed by staff.
- The trust must ensure all medicines are prescribed and stored in accordance with trust procedures.
- The trust must ensure patient records are stored appropriately to protect confidential data.
- The trust must ensure patient records are accurate, complete and fit for purpose, including Do Not Attempt Cardio-Pulmonary Resuscitation forms and prescription charts.
- The trust must ensure risk assessments are completed in a timely manner and used effectively to prevent avoidable harm, such as the development of pressure ulcers within ED and pain assessments for children.
- The trust must ensure that mortality reviews are effective with the impact of reducing the overall Summary Hospital-level Mortality Indicator (SHMI) for the service.
- The trust must ensure there are robust systems are in place to collect, monitor and meet national referral to treatment times within surgery and outpatient services.
- The trust must ensure there are systems in place to monitor, manage and mitigate the risk to patients on surgical and outpatient waiting lists.
- The trust must ensure staff check the "site" of the operation to ensure this is appropriately marked, prior to the operation; and ensure that the "site" of the operation is documented on the 5 Steps to Safer Surgery checklist.
- The trust must ensure all incidents of pressure damage are fully investigated, particularly within ITU.
- The trust must ensure there is a policy available to ensure safe and consistent practice for parents to administer medicines to their children.
- The trust must ensure there is a system in place to recognise, assess and manage risks associated with the temperature of mortuary fridges.
- The trust must ensure clinicians have access to all essential patient information, such as patients' medical notes, to make informed judgements on the planned care and treatment of patients.
- The trust must ensure outpatients patients are followed up within the time period recommended by clinicians.

In addition the trust should:

- The trust should ensure all vacancies are recruited to.
- The trust should ensure that complaints are responded to within the trust target of 25 days and lessons learnt shared.
- 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.
- The trust should ensure all equipment is portable appliance tested annually.
- The trust should ensure there is an effective audit program and the required audits are undertaken by the services.
- 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 EDs.
- The trust should ensure delays in ambulance handover times are reduced to meet the national targets.

Summary of findings

- The trust should ensure initial patient treatment times are reduced to meet the national target for 95% of patients attending ED to be admitted, discharged or transferred within four hours.
- The trust should ensure re-attendance rates within ED are reduced to meet the target set by the Department of Health.
- The trust should ensure the changes to manage overcrowding and patient safety in ED are sustainable.
- The trust should ensure infection controls risks, associated with environmental damage within ED, are mitigated.
- The trust should ensure changes continue to achieve adequate patient flow and capacity to accommodate emergency admissions in a timely way, ensure surgery cancellations are reduced and enable patients to be discharged from ITU in a timely way.
- The trust should ensure patients privacy and dignity is maintained when cared for the in the ED corridor.
- The trust should ensure the improvement of mental health service provisions within ED to prevent delays in specialist care.
- The trust should ensure that the ED Escalation Management System (EMS) is used accurately and effectively to help the hospital identify the pressure within the ED and appropriate steps taken to reduce pressure as required.
- The trust should ensure that appropriate plans in place regarding all patients being assessed and treated as requiring a deprivation of their liberty safeguard.
- The trust should ensure unnecessary patient moves are minimised at night.
- The trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.
- Action should be taken to ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.
- The trust should ensure on the day surgical cancellations met the standard target.
- The trust should consider a follow-up clinic for patients discharged home from after an ITU admission, as recommended in NICE guidance.
- The trust should ensure the frequency of ward rounds on critical care meet core standards for critical care units.
- The trust should consider the critical care outreach team providing 24-hour cover for the hospital as recommended in the Guidelines for the Provision of Intensive Care Services 2015.
- The trust should ensure nutritional supplements are disposed of as per product guidance.
- The trust should implement the use of the NHS Maternity Safety Thermometer, and ensure robust analysis.
- The trust should ensure measures are in place to reduce the caesarean section rate.
- The trust should consider developing an early warning tool for neonates.
- The trust should ensure that all appropriate equipment is cleaned in line with trust policy to prevent the spread of infection.
- The trust should ensure a policy on restraint or supportive holding is developed; and provide staff training in restraint
- The trust should ensure that there is a system in acute paediatric services to check competencies of permanent staff.
- The trust should ensure there are a suitable number of points for high flow oxygen on the paediatric ward to meet patient need.
- The trust should ensure the trolley used for transporting bodies to the mortuary is fit for purpose.
- The trust should ensure cancellation of outpatient appointments are reviewed and necessary steps taken to ensure that issues identified are addressed and cancellations are kept to a minimum.
- The trust should ensure a suitable digital archiving system for cardiology department is provided.

Following the inspection we issued Hereford Hospital with a warning notice under section 29a of the Health and Social Care Act 2008.

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 	The emergency department (ED) at Hereford Hospital required improvement. The department was not consistently meeting national targets, which meant that patients remained in the department much longer than they should. The primary cause of this was a lack of available hospital beds. There were occasions when the number of patients exceeded the number of available spaces. This meant patients were sometimes cared for in the corridor. Whilst staff had taken steps to mitigate the risk in this and limited the number of patients, the environment was not suitable for patient care. There was a shortage of consultants and cover was provided 15 hours per day, seven days per week. Most patients told us they felt well cared for though they felt staff were very busy. The level of compliance with staff training was constantly low and none of the doctors working in the department had undergone child safeguarding training. Staff told us they found the online patient record system very effective and managers were able to audit performance in a very detailed way on a monthly basis. Staff told us that they felt the rest of the hospital did not understand the pressures that they had to work under and when the department became very busy that response of the rest of the hospital was slow and ineffective. There was clear leadership both from the senior doctor and senior nurse and staff told us that they were well supported. However, the department relied on a few key individuals and there was a lack of contingency planning should these members of the team become unavailable.
Medical care (including older people's care)	Requires improvement 	Overall, we rated the service as inadequate for safety, and requiring improvement for effectiveness, responsiveness and being well led. We rated the service as good for caring. Incidents were reported, but there was inconsistent evidence of learning from incidents being

Summary of findings

embedded in ward practice. Staff were not always aware of preventative actions that could reduce the risk of avoidable harm to patients. The service did not always recognise and respond swiftly for some patients at risk of deterioration.

There was a high level of nursing staffing vacancies within some teams and an over reliance on agency staff. Nursing staffing levels did not always meet patient needs at the time of our inspection. There were not always effective systems in place for agency staff induction and we saw evidence of this negatively impacting upon patient care.

Appropriate systems were in not always in place for the storage, administration and recording of medicines.

The environment was generally clean and well maintained but some potential risks to patient safety had not been addressed. Wards generally had effective systems in place to minimise the risk of infections.

Records, and associated risk assessments, were not consistently well completed.

The majority of staff had had the mandatory training required. Only 30% of nursing staff were compliant with children's safeguarding training to level two was 30% and 55% with safeguarding adults training. This did not meet the trust's target of 90%.

Medical staffing was in line was national guidance. There was an effective system in place for medical handovers and these did occur in the mornings.

The service had implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) in line with national guidance.

Patients did not always receive effective care and treatment that met their needs. Performance and outcomes did not meet trust targets in some areas.

Mortality ratios were higher than those of similar trusts and the service had a range of actions in place to address this concern.

Care was mostly provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was effective. There was some evidence of progress to providing seven day a week services.

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Most staff said they were supported effectively. However, there was a lack of formal supervisions with managers. Appraisal rates for doctors and nurses varied.

We found that staff understanding and awareness of assessing patient's capacity to make decisions about their care and treatment was variable. Appropriate plans were not in place for those patients' assessed as requiring a Deprivation of Liberty Safeguard.

Overall, medical inpatient services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients told us that the staff were caring, kind and respected their wishes. Most patients' we spoke to during the inspection were complimentary, and full of praise for the staff looking after them

Patient's's needs were not consistently met through the way services were organised and delivered. There was an elevated demand on bed availability at times, and there were high numbers of patient moves at night. Some problems with the effective discharge of patient's were highlighted across the medical care service, and the service was seeking to improve this process.

The leadership and culture did not always promote the delivery of high quality person-centred care as governance and risk management systems were not fully embedded throughout the service.

The visibility and relationship with the middle and senior management team was not clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust, and said work pressures, due to higher patient dependencies, was an area of concern.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they were not involved in improvements to the service and did not receive feedback from patient safety incidents.

The medical care service was generally well led at a ward level, with evidence of effective communication within ward staff teams.

Summary of findings

All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible.

Surgery

Requires improvement

We found safety within the surgical services required improvement.
Medical staffing was appropriate and there was good emergency cover. However, there was a shortage of nursing staff and a high number of vacancies. The skill mix of nursing was not always appropriate for patients, and nursing staff did not always have time to meet patients' care needs.
There was a culture of incident reporting, but some staff said they did not receive feedback on incidents submitted. However, staff said they received consistent feedback and learning from serious incidents generally. The environment was visibly clean and most staff followed the trust policy on infection control.
Treatment and care were provided in accordance with evidence-based national guidelines. However, we observed variance in the outcomes such as the National Joint Register. For the 12 month period from April 2014 to March 2015 (published October 2015), the trust's Summary Hospital Mortality Indicator (SHMI) was identified as 'higher than expected' with a value of 117 (compared to 100 for England).
There was good practice, for example in pain management and the monitoring of patient nutrition and hydration in the perioperative period. Multidisciplinary working was evident. Although staff had access to training, they said this was often cancelled due to staffing shortages. Staff said they received annual appraisals, but trust records showed that appraisal levels were below the required target. Ward sisters were aware of the shortfall in clinical supervision and said they were reviewing ways to ensure staff received regular supervision. Consultant-led, seven-day services had been developed and were embedded into the service.
Most staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
Patients told us that staff treated them in a caring way and that they were kept informed about and

Summary of findings

involved in treatments received. We saw patients treated with dignity and respect. We observed staff provide good emotional support during our visit to the day case unit (DCU).

We found surgical services did not record or report waiting times for surgery. In April 2015 the trust board requested suspension of national reporting for non-admitted and incomplete pathways as a result of concerns over quality data. From April 2015 onwards, the admitted RTT performance was the only measure reported. Although priority was given to patients with two weeks wait and urgent care, the surgical waiting lists were not risk assessed and patients did not have their conditions reviewed. The trust did not report the 18 weeks between referral and surgery. Services were developing to improve the response to increasing demand, and patients had surgery based on clinical need. However, capacity issues remained and a lack of available beds resulted in patients spending longer periods in the theatre recovery areas.

Patients stayed longer than 23 hours on the surgical day unit. There were various inefficiencies in discharge arrangements for surgical patients, with the result that many were discharged later in the day than planned. There was guidance in place within the trust to ensure that patients did not remain on the day surgery unit for longer than 48 hours. When a patient was required to remain on the day ward for longer than 48 hours then the staff completed an incident report for every further 24 hour period.

There was support for patients with learning disabilities, including reasonable adjustments that could be made to the service. However, information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were resolved.

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Surgical services required improvement to be well-led. Some staff said they felt pressurised when patient admissions fluctuated and that they received poor support during stressful periods. There was poor awareness among staff of the values and expectations for patient care across the trust. Staff were not aware of outcomes regarding

their allocated key performance indicators and the trust did not ensure that staff monitored the outcomes of the patient care involvement plan. Strategic plans were addressing capacity issues, and risks were identified and managed or appropriately escalated. Staff could speak openly about issues and serious incidents but said they did not receive feedback on incidents submitted.

Critical care

Requires improvement

Critical care services required improvement to be safe; responsive to patient's needs and well led. We found the service good for caring, and effective.
The senior nurse in charge of ITU often reported patient safety concerns rather than the staff involved. There was limited evidence of improvements taking place following incidents. For example, regarding prevention of pressure ulcers. When staff introduced changes there was no process for evaluating the effect of the alteration. Minutes of mortality and morbidity meetings were incomplete, so could not provide assurance of actions taken. The medical staffing did not comply with core standards for ITU. This was because a consultant specialising in intensive care was not always available.
Arrangements for governance and performance management did not always operate effectively. There was a limited approach to obtaining the views of people using the services and the service did not meet National Institute for Health and Clinical Excellence (NICE) guidance regarding provision of a follow-up clinic for patients following discharge. Where changes or improvements were made, the impact on the quality of care was not adequately monitored or reported.
There were no toilet or shower facilities for patients within the ITU. This was particularly relevant for patients who were improving following critical illness and awaiting transfer to a ward.
The ITU was contributing to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) and national

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potential organ donor audits. However, there were no planned local audits, to evaluate policies or effectiveness of treatment, interventions or care provided.

Nurse staffing had improved since the previous inspection and was in line with core standards. The unit had strong links with the critical care networks' educational group. National competencies for critical care nurses were used. However, staff told us that study leave for completing courses such as the critical care post-registration award was limited. There were gaps in support arrangements for staff, highlighted by low appraisal rates for nursing staff (50% were up- to-date at August 2015). Some mandatory training rates were lower than the trust target of 90%.

Staff could access information they needed to assess, plan and deliver care effectively. Consent to care and treatment was obtained in line with the Mental Capacity Act (2005), and evidence of appropriate use of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) was seen.

Patients were unanimously positive about the care they received. Inspectors saw many kind and caring interactions. Staff maintained the highest regard for patients' dignity and privacy. Relatives and visitors were happy with the level of emotional care and treatment they and their loved ones had received. The unit reported no acquired infections in the six months ending June 2015, and was visibly clean. Records were stored and manged securely.

There were occasions when patients were delayed in transferring to a ward bed when they no longer required critical care. Sometimes when a bed became available patients were relocated during the night.

It was unclear whether patients could always access an ITU bed when required. The trust stated that information about occasions when level two (HDU) patients cared for outside of ITU was not collected. However, there had been a clear focus to reduce elective surgery cancellations due to a lack of ITU bed availability. The ITU and surgical teams had achieved this through rationalising elective booking procedures and being proactive, especially at a senior nursing level.

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Maternity and gynaecology

Requires improvement

We saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment. However, we also saw that the clinical governance system was not robust. Senior staff within the maternity unit did not manage incidents in a timely manner and in accordance with best practice.

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out policies in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Patients told us they had a named midwife. The ratio of clinical midwives to births was one midwife to 27 women which is similar to the national average of 1:28. Staff told us that they offered all women one to one care in labour but were not always able to provide this. Although this was recorded on the electronic system, staff could not show the percentage of women who actually received one to one care. Women told us they felt well informed and were able to ask staff if they were not sure about something.

Services for children and young people

Requires improvement

Services provided to children and young people were not safe or effective and the directorate was not responsive or well-led. However, we found the services to be caring to patients' needs.

Staff did not always support incidents with by taking appropriate action or recording appropriate action taken or share lessons learned.

Patient records contained good detail. However, the members of staff who completed the records did not always sign and date them. Staff did not securely store patient records.

The level of care provided to patients with mental health needs was not adequate. Arrangements were in place for reporting safeguarding concerns. However, safeguarding referrals were not always made for children who require a referral. Although most staff had completed some form of safeguarding training, there was a lack of knowledge amongst trust staff with whom we

spoke about when safeguarding referrals should be made. This meant that service users were not always protected from abuse in accordance with regulatory requirements.
Some equipment was not locked away securely, including sharp objects.
The trust set minimum staffing levels for each shift. However, a staffing needs analysis for nursing staff on the paediatric ward determined that the minimum levels did not meet Royal College of Nursing guidance. A staffing needs analysis had not been undertaken for the SCBU. The staff we spoke with told us that staff shortages did not impact on patient care and that all members of the team worked hard to ensure patients were cared for safely.
Compliance with completion of mandatory training and completion of appraisals for nursing and medical staff was poor and did not meet the trust's target.
Existing policies were not dated, out of date and/or not always appropriately referenced.
Audits were not always undertaken in line with agreed plans and learning was not implemented or evidenced.
Service plans for the year ahead lacked detail and risks were not always identified and recorded.
Governance arrangements were not effective. The trust failed to demonstrate that areas of concern were sufficiently discussed or that agreed actions were carried forward.
Patients were generally very satisfied with the level of care they received and made few complaints made about their care and treatment.

End of life care — **Requires improvement**

We found that staff providing end of life services were caring. End of life services required improvement across the safe, effective, responsive and well-led domains.
During our inspection we found there to be maintenance issues with the mortuary body storage units (fridges), resulting in one bank of fridges reaching temperatures above the guidelines. The staff in the department had not escalated this risk or instigated alternative storage arrangements.

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We found two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) policies on the trust's intranet with differences, which could confuse staff. We saw evidence that the trust had a replacement for the Liverpool Care Pathway (LCP) and was this is use on all wards. The resulting Multidisciplinary Care Record for adults for the last days of life (MCR) ensured that patients had a clear care plan that specified their wishes regarding end of life care.
The SPCT had recently begun a process to monitor the quality of the service effectively. For example, we saw an audit looking at whether there were any obstacles to patients' discharge, and to monitor whether patients died in their preferred location. Information from these audits was fed back to the team and we saw evidence of changes to practice. We saw that they had introduced a new document for anticipatory medication. This was written in hospital before a patient's discharge for use by district nurses when the patient returned home to prevent delayed medication. We also noted the SPCT worked proactively with local providers of end of life care and tried to influence how services were delivered to the local population.
The SPCT members were competent and knowledgeable. We saw examples of good multidisciplinary team working. The palliative care team was visible on all wards and nursing staff knew how to contact them. The team regularly attended other specialty multidisciplinary meetings such as respiratory, gynaecology and haematology to provide support and guidance.
The SPCT team had a person-centred culture, and staff we observed were respectful and maintained patients' dignity. We saw staff responding to patients' wishes. The SPCT members felt supported in their work and they worked well as a team. Staff were clear about their roles and their involvement in decision-making. The patients we spoke with said they had the right pain relief and told us they were happy with the food and drink offered. They said staff were caring and compassionate.
Feedback from ward staff, medical staff, patients and relatives suggested that the SPCT and chaplaincy team staff supported families effectively and with compassion.

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The trust gave us the statistics for the time between a patient's referral and the SPCT's first response, covering the period between 1 April 2015 and 30 September 2015. We saw there were 233 referrals during this time. The average number of days to first response was 0.36. The SPCT saw 73% of patients on the same day as the referral, 23% were seen the day after the referral was made.
Ward-based staff, medical staff and relatives we spoke with reported a timely turnaround from referral to response.
The SPCT planned to develop the service providing more support to non-malignant illnesses such as renal and respiratory diseases and were writing a business case to support the increased staffing that this would require.
All SPCT staff we spoke with were doing further training in areas such as advanced symptom control, counselling and Master's level clinical assessment. All these demonstrated evidence of further skills and competency development.
At the time of inspection, the trust did not have an on-executive director who could provide representation of end of life care at board level.

Outpatients and diagnostic imaging

Inadequate

We found outpatient and diagnostic imaging services to be inadequate.
We found the hospital was struggling to meet the demand for outpatient appointments. There were long waiting lists for appointments across most clinics. There were not effective systems in place to monitor and manage the risk to these patients. The lack of systems meant that patients were waiting longer than appropriate to be seen. The hospital failed to assess, monitor and mitigate risks relating to the health, safety and welfare of patients on the waiting list.
Patient appointments were often cancelled by the trust and patients experienced delays when waiting for follow up appointments. The trust did not meet the national referral to treatment target time for 95% of patients 18 weeks for outpatient services.
The trust was unable to mitigate risks regarding referral to treatment times (RTT) as it did not have effective oversight of these risks across all specialities.

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Outpatient and diagnostic staff showed a good understanding about reporting incidents. However, staff were inconsistent in reporting incidents and incidents were not always reported in line with trust policy. These issues meant the trust did not have an oversight of all incidents that occurred within outpatient and diagnostic imaging services. We saw that learning from incidents was inconsistent across the specialities and incidents were not always shared across the outpatient department as a whole.

Patients' personal identifiable information was not always kept confidential or stored securely. We saw patient records left in open plastic boxes and on top of trolleys in some clinics unobserved by staff. This meant there was a risk of patient records and personal details being seen or removed by unauthorised people.

The facilities in the Arkwright (temporary) Suite were inappropriate. The suite was cramped with insufficient soundproofing to protect patient privacy. However, there was a risk assessment and action plan to mitigate risk until the service relocated.

Some equipment had not been checked and maintained in line with manufacturers' recommendations. For example, we found risk assessments were not completed and radiology staff did not follow infection control processes.

Risk management and quality measurement systems were reactive and not proactive.

Outpatient and diagnostic imaging services did not identify all risks to patients or effectively manage risks that had been identified.

Patients in radiology were routinely given contrast agent without prescriptions or a patient group directive. A contrast agent is a substance used to enhance the contrast of fluids within the body in medical imaging. All the radiology staff we spoke with were unaware that prescriptions were needed.

Patients received a caring service. Patients were treated with dignity and staff were kind, respectful and supportive. Staff gave clear explanations of treatments and most patients were positive about the care they received.

Summary of findings

Managers of outpatient departments were accessible and respected by staff. Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of, policies and procedures.

Hereford Hospital

Detailed findings

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Medical care (including older people's care); Surgery; Specialist burns and plastic services; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Hereford Hospital

Hereford Hospital is a small hospital with 312 beds. It is part of Wye Valley NHS Trust established in April 2011 by the merger of acute, community health and adult social services in Herefordshire. In September 2013 adult social services became the responsibility of Herefordshire Council. The trust also provides urgent and elective care to a population of more than 40,000 people in mid-Powys, Wales.

The trust's catchment area is characterised by its remoteness and rural setting, with more than 80% of people who use the service living five miles or more from Hereford city or a market town.

Hereford Hospital provides a full range of district general hospital services that include: A&E; elective surgical procedures; critical care (level 3); medical care (including care to older people); maternity; children and young people's services; end of life care; and outpatient services.

We inspected the hospital in June 2014 and gave an overall rating of 'Inadequate', with particular concerns about the provision of services in both A&E and medical care services. The inspection led to the trust being placed in special measures by the Trust Development Authority in October 2014.

We carried out an announced comprehensive inspection of the trust from 22 to 24 September 2015. We undertook one unannounced inspection on 1 October 2015 at Hereford Hospital and one unannounced inspection on 25 September 2015 at Leominster Community Hospital minor injuries unit. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, allied health professional, domestic staff and porters. We also spoke with staff individually.

Our inspection team

Our inspection team was led by:

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

Team Leader: Helen Richardson, Care Quality Commission

The team included 13 CQC inspectors and a variety of specialists including governance leads, medical consultants and nurses, senior managers, a trauma and orthopaedic consultant and nurse, a critical care consultant and nurse, paediatric nurses, a consultant obstetrician, midwives, allied health professionals, an

end of life care specialist nurse, a palliative care consultant, a child safeguarding lead, junior doctors, a student nurse and experts 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 to people's needs?
- Is it well led?

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, the Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event in the evening before the inspection where people shared their views and experiences of services provided by Wye Valley NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an unannounced inspection of Hereford Hospital on the 1 October 2015 and attended the trust board meeting.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professionals, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services.

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

Hereford Hospital provides care to a population of slightly more than 180,000 with more than 80% of people who use the service living five miles or more from Hereford city or a market town. Almost 2,500 employed staff provide acute and community services to the people of Herefordshire and Powys in mid-Wales.

The hospital has 312 beds, received 51,717 emergency department attendances and had 71,650 new and 167,373 follow up outpatient attendances for the year 2014/15. All activity had increased compared to 2013/14, with the exception of elective spells that had reduced by 15%. Between July 2014 and March 2015, bed occupancy for the trust averaged 92%. This was above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

There had been a number of recent changes at board level. The chief operating officer and medical director had been in post since March 2015.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) has four main areas: minors with two cubicles; two dedicated paediatric cubicles; two 'see and treat' rooms; majors with eight cubicles and four beds in an overspill area; a resuscitation area with three beds, one of which was set up for paediatric emergencies. There are two waiting rooms, one available for children.

The ED saw 58,899 patients, of which 15% were children, during April 2014 to April 2015 which put it in the lowest quarter of attendances for trusts across England. During our inspection we visited the ED on two weekdays during normal working hours as well as late at night and early in the evening. We spoke to 42 patients and relatives and 22 members of staff, including nurses, doctors, healthcare support workers and administrative staff. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's ED performance data.

The department also supports two minor injury units (MIUs) at Leominster Community Hospital and **Ross** Community Hospital. Between the 1 January and 9 July 2015 there were 554 and 547 patient attendances at Leominster and **Ross** Community Hospitals, respectively. The units are staffed by emergency nurse practitioners and provides a range of treatments for patients with minor injuries. Patients with a wide range of minor injuries including **cuts, grazes, wounds, sprains, strains, minor burns** and **broken bones** can be treated at the MIU. We also carried out an unannounced inspection visit to Leominster Community Hospital MIU on 1 October 2015.

Summary of findings

The emergency department (ED) at Hereford Hospital required improvement. The department was not consistently meeting national targets, which meant that patients remained in the department much longer than they should. The primary cause of this was a lack of available hospital beds.

There were occasions when the number of patients exceeded the number of available spaces. This meant patients were sometimes cared for in the corridor. Whilst staff had taken steps to mitigate the risk in this and limited the number of patients, the environment was not suitable for patient care. There was a shortage of consultants and cover was provided 15 hours per day, seven days per week. Most patients told us they felt well cared for though they felt staff were very busy.

The level of compliance with staff training was constantly low and none of the doctors working in the department had undergone child safeguarding training.

Staff told us they found the online patient record system very effective and managers were able to audit performance in a very detailed way on a monthly basis.

Staff told us that they felt the rest of the hospital did not understand the pressures that they had to work under and when the department became very busy that response of the rest of the hospital was slow and ineffective.

Urgent and emergency services

There was clear leadership both from the senior doctor and senior nurse and staff told us that they were well supported. However, the department relied on a few key individuals and there was a lack of contingency planning should these members of the team become unavailable.

Are urgent and emergency services safe?

Inadequate

The emergency department (ED) at Hereford Hospital was inadequate to support safe care. There were occasions when the number of patients arriving exceeded those that were being discharged and therefore patients were cared for in the corridor leading to the department. Whilst staff had taken steps to ensure this practice was as safe as possible the corridor lacked basic facilities such as a sink.

Whilst safeguarding was considered by staff, the process of reviewing records did not take place in the department leading to delays and potential for slow action on safeguarding concerns. Data provided by the trust showed that none of the doctors and 21% of nurses working in the department were compliant with child safeguarding training.

Consultant cover did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations and did not provide the recommended consultant presence in ED. The department had an insufficient number of nursing staff who had been trained to care for children. Whilst this had been recognised and competency documents were at an advanced stage on the day of our inspection, staff had not undertaken any further competencies to care for unwell children.

The majority of staff were not compliant with the trust requirements for training, and as a result patients were often treated by staff that were not up to date with training.

In some areas we noticed there was damage to walls and floors which could harbour bacteria, the beading around the departments slit lamp was also degraded, raising the risk of bacterial colonisation and making it difficult to clean.

The ED had not met the national standard of having no patient handovers carried out over 30 and 60 minutes of patient arrival by ambulance between January to September 2015.

Urgent and emergency services

We found there was a strong culture of incident reporting and senior members of the department met regularly to discuss incidents. There was also effective ways to inform most junior members of staff about incidents.

Incidents

- We spoke to both full time medical and nursing staff and found there was a culture of reporting incidents. Nurses and doctors were able to tell us how they would report incidents and this corresponded with the trust policy.
- Since 1 March 2015, ED staff reported 265 incidents. Eighty-two percent had been classed as low or no harm caused to patients. One incident was classed as severe, which involved a patient being given a specific treatment in contradiction to clinical guidance. There was documentation and staff confirmed that they had been notified of this event.
- The largest two categories of incident related to overcrowding and lack of space within the ED. These incidents, while generally classed as low harm, represented 31% of the total number of incidents.
- The department had an action plan to manage incidents with senior members of the clinical team assigned to investigate and provide recommendations. This ensured that there was a clear understanding among staff as to who was investigating and suggesting actions.
- Senior staff undertook a review of incident investigations to ensure they were good quality and to protect patients from repeated similar incidents. Every incident reporting form was reviewed by the senior clinical team which gave them an understanding of the issues within the department.
- The clinical lead and lead nurse were able to give examples of incidents that had occurred during the care of a patient. They described the thorough investigation that they undertook and the changes they made as a result of the investigation. We found that all the changes had been made and staff understood the reason behind them. For example, following an incident where a child became seriously unwell in the waiting room, the department installed emergency call bells so that people could raise the attention of staff quickly.
- From May 2014 to April 2015 there had been no incidents described as 'never events' and nine serious incidents requiring investigation (SIRI). We looked at the reports that examined these incidents these were detailed and included steps that had been taken to reduce the risk of the event reoccurring. Senior staff completing the report had also graded the possibility of a reoccurrence in a simple way.
- The department did not have a separate mortality and morbidity meeting, but did include this in their monthly clinical governance meeting. The minutes for this meeting showed detailed discussion of the items on the departments risk register and names of senior staff associated with action points. Staff were able to read the meeting minutes online or by hard copy left in the staff room.
- Serious incidents were discussed at the ED clinical governance meeting.
- Staff told us that they did receive learning from incidents, though how this happened varied. Doctors told us that feedback was verbal, however nurses received feedback via e-mail and a noticeboard in the departments resource room. We saw data from the department that showed that there were learning points identified from a number of incidents and we saw evidence that this learning had been shared with staff.
- Nurses in the department also received emails regarding lessons learnt from incidents, however many of those who worked in the department worked for an agency and did not have access to email, we could not be sure that learning was shared amongst all staff groups.
- The senior staff in ED held a daily meeting which included any incidents that had occurred and incidents were escalated to senior members of the trust team at bed meetings which happened three times a day.
- There was a system for reporting fractures that had been missed in the ED; however staff told us this was slow and sometimes took two weeks following the initial treatment of the patient. Staff had attempted to reduce the risk this posed patients by having a daily review clinic to review patients where the diagnosis was unclear. Data from the department showed that since 1 March 2015 there had been no incidents of missed fractures.
- Whilst not all staff were clear about the term 'duty of candour' all those we spoke with were aware of the principles and the importance of informing patients if mistakes were made.
- Staff at the MIU's were clear about how to report incidents and had reported one incident related to patient aggression.

Urgent and emergency services

Pressure areas

- Staff told us that some of their patients waited a long time to be admitted to a ward and that if they knew patients were going to be delayed they would transfer them to a hospital bed to reduce the risk of pressure damage, although there was no set time when this occurred. There was no trust guidance to aid this decision. We saw examples where there were inconsistencies in the length of time patients took to be transferred to beds.
- The lead nurse told us that after six hours in the department staff would use a scoring tool, known as a waterlow score, to identify those at risk of developing a pressure sore. This meant that for those patients who waited for less than six hours there was no routine documented assessment of pressure area care.
- Data from the department's incident records showed there had been 18 incidents of pressure ulcers in ED. However all of them had occurred prior to arrival within the ED. Documentation showed that upon identification staff had taken appropriate steps to ensure there was no further pressure area breakdown.
- We looked at 35 patient records and saw that 10 had waited longer than six hours to be seen, all of whom had a Waterlow score. We found that in four cases the Waterlow score indicated that a pressure reliving mattress or air bed was required; however, there was no documentation to show that this had happened. In one case, following a Waterlow score indicating the need for a pressure reliving mattress, staff did not provide one until an hour and a half later.
- Staff we spoke to were clear about the types of patients that were at risk of pressure area breakdown and the actions they should take.

Cleanliness, infection control and hygiene

- On the days we inspected we observed that the department was visibly clean and there was minimal dust on surfaces.
- We observed staff using personal protective equipment when required and staff told us that they were able to access this easily.
- We observed that the vast majority of staff washed their hands in accordance with the World Health Organisation guidance (Five Moments for Hand Hygiene).
- Not all areas had domestic waste bins that had lids. In the triage areas we saw that waste bins were open, leaving the potential for children to reach inside them. Throughout the department staff segregated clinical waste effectively in all areas.
- The department had a number of side rooms in which patients with potentially infectious conditions could be cared for in a way that maintained the safety of other patients using the service.
- At times of high activity some patients were cared for in the corridor leading to the majors' area of the department. There was a nurse allocated solely to this area. However there was no direct access to a sink, which meant that the nurse had to leave the patients unattended in order to wash their hands.
- Staff told us that they cleaned equipment in accordance with trust guidance, during the course of our inspection we saw that this cleaning was being undertaken and documented by a green sticker attached to the equipment. In one case we saw that the sticker was placed over the display of a defibrillator making it very difficult to see what the monitor was displaying.
- In some areas we noticed there was damage to walls and floors, which could harbour bacteria. The beading around the department's slit lamp was also degraded, raising the risk of bacterial colonisation and making it difficult to clean.
- We saw staff, in both the ED and the MIUs, clean trolleys in between patients.
- Infection control training data provided by the ED showed that 66% of nurses, 46% of medical staff, and 30% of additional clinical service staff had undergone infection control level 2 yearly training within the last year. This meant that not all staff were up to date with infection control practices.

Environment and equipment

- We inspected 25 items of medical equipment, all of which had been portable appliance tested within the last year, in accordance with trust guidance.
- We looked at the checklists that staff completed daily to ensure equipment was present and ready for use. The majority of these were completed in accordance with the department policy for at least the preceding three months. The two items that had not been checked on the day we visited were the departments' resuscitare and biers block anaesthetic machine.

- The treatment rooms and resuscitation area were small and due to a lack of storage there was very limited space for staff to deliver care. Staff told us that during resuscitation, when there were many staff involved in caring for a patient, it was sometimes very cramped, although they did not feel that this had delayed care.
- In the resuscitation area some equipment was stored in locked cupboards; however the staff working in these areas did not always carry the keys which meant that care was delayed for a brief period whilst the keys were collected from the majors' area.
- The department had a quiet room used for treating patients with mental health conditions. This room had two doors for staff entry or exit and was furnished with heavy furniture that could not be easily lifted. The room had a false ceiling, which represented a ligature point and therefore a risk to patient safety. This had not been identified by the trust we notified senior staff about this on the day of our inspection.
- We saw that the emergency department's ligature cutters were taped to the back of the door to the staff room. This meant that the department was not storing the cutters securely and there was a risk that the cutters could fall off the door, go missing and not be immediately available if required.
- In the last year the department had opened a separate children's waiting area. There was a door hinge protector to ensure children were not injured by the closing door.
- The department used a computer based documentation system. We saw occasions when staff delivering care had to walk to a different area of the department to access the computers. On more than one occasion staff were seen writing down clinical observations on disposable hand towels prior to uploading them. There was a risk that patient clinical information could be lost through this process.
- Equipment in the MIU's was stored correctly and locked away when required.
- We saw that there was appropriate signage in both the ED and MIU's to warn patients and staff when x-ray machines were in operation.

Medicines

- We observed staff administer a controlled drug to a patient in the majors area, this was completed in accordance with trust guidance and the Medicines Act (2012).
- In the MIUs there was no pharmacist permanently on site. Medication orders were faxed to the Hereford Hospital and delivered the next working day. Staff were responsible for ordering medication; they rotated stock to prevent wastage. All medicine we looked at was in date.
- We found that overall medicines were stored securely within the ED and MIUs. 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.
- Patients' medicine history was recorded directly onto an electronic recording system in the ED. This information was then transferred to the ward on patient admission. Any prescribed medicine was recorded directly onto the electronic system which detailed the name of the prescribing clinician.
- Patients' own medicines were not always transferred with the patient to the admitting ward. We observed that medicines for two patients who were no longer in the department were stored in a locked cupboard. We were told that patients own medicines should follow them but this did not always happen.

Records

- The department used a computer based system. Staff told us this had improved the communication in the department as they no longer had to read handwritten notes.
- In some cases paper was still used, generally for notes that would go on to form part of a pathway document used by other teams in the hospital. We saw that these were scanned into the patients' computer record within 24 hours.
- All records were held on a central server which meant they could be accessed instantly by staff if patients re-attended, this ensured that information was readily available to staff.
- We saw documentation for monthly audits, the latest from August 2015. These audits included risk assessments for assessing pressure areas and children's safeguarding which showed that in August 2015 there was above 95% compliance with the standard set by the department leads. The system allowed senior staff to

investigate individual cases when the standard had not been met and we saw evidence that this was being undertaken and, where necessary, staff were being informed.
- Staff accessed records via fixed computer terminals in the department, we noted that these were not always password protected and locked which meant information was visible to anyone entering these areas.
- There was a plan in place in the eventually that the computer system failed. Staff told us and we saw evidence that paper care records could be printed and uploaded once the system was back online. This ensured that in an incident such as a power failure staff were still able to document care in an organised way.
- Agency workers were given a unique log in number for the computer system which meant that the documentation they inputted was directly linked to them. This ensured that all staff were accountable for the electronic documentation they recorded. Staff told us that they had to collect this log in code in another area of the hospital which meant they were often delayed by half an hour at the start of their shift, leaving the department short of staff.

Safeguarding

- We reviewed 35 patient notes and saw that, when appropriate, staff had raised safeguarding concerns and documented this in the patients' documentation.
- Staff told us they were aware of the importance of safeguarding both vulnerable adults and children and knew how to make referrals to local social services.
- This had been noted in the CQC inspection of June 2014 which found that only 29% of nurses had undergone mandatory child safeguarding training, data we saw on this inspection showed that compliance with this standard was now worse than a year before. Data provided at the time of inspection by the trust showed that none of the doctors and 21% of nurses in the department were compliant with child safeguarding training. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request. We could therefore not be assured that children were protected by appropriately trained staff.
- The department did not have a health visitor or school liaison role. Staff told us that this was problematic as it meant that communication between community children's services and the department was not very effective and they never received feedback on the referrals they had made.
- Every child and young person that attended the department was asked if they were known to social services, however no further check was made to ensure that the information that had been given was correct. If there were any concerns about the safeguarding of a child, the registrar or consultant would assess the child rather than a junior doctor.
- The departments' computer records system included a mandatory field for all patients under the age of 18 which documented any consideration for clinical staff about safeguarding.
- Documentation of child's attendance in the ED was sent for review via secure link to children's community services, referred to by staff as 'child health'. The information was provided as a short summary of the episode of care, which meant those in the child health team could not assess all aspects of the treatment as they did not have the full record to review.
- Staff told us that this review process took more than two weeks and therefore any urgent safeguarding concerns that were identified in this process were subject to potentially unsafe delays. There was no guidance for staff to assist them when this problem occurred.
- Staff in the MIU's were clearer about their referral pathways and felt they had a good working relationship with community staff and social services.
- Administration staff had received training in both adult and child safeguarding, however we witnessed one occasion when next of kin details for a child were changed without consideration for any potential safeguarding implications.
- Data from the trust showed that that 62% of doctors had undergone adult safeguarding training. The level of training for nurses was 58%. This fell well below the trust target of 90% and meant that vulnerable adults who attended the ED had the potential risk of not being protected against abuse.
- There had recently been a new pathway developed for those patients who were brought to the department as a place of safety under section 136 of the Mental Health Act (2007). Staff told us that this meant, under the new pathway, that patients would be taken to a place of

safety. However due to the pathway not being ratified by all agencies staff said that patients were frequently brought to the department. This meant that the pathway for patients in this category was not clear.

Mandatory training

- We saw data that showed that 10 of the staff who worked in the department had undergone conflict resolution training. The data showed that none of these individuals were doctors and three were nurses. This represented 6% of the departments nursing workforce. This meant the majority of clinical staff had received no training in conflict resolution training.
- Mandatory training was divided into 10 different topics including fire safety, equality and diversity and dementia. Data provided by the trust showed that in the case of doctors there was an average of 41% completion of this training across all topics. In the case of nurses and ancillary health workers the completion average was also 41%. Ancillary health workers averaged the lowest with only a 30% completion average for mandatory training. This meant that the majority of staff were not compliant with the trust requirements for training and as a result patients were often treated by staff that were not up to date with training.
- We saw data that showed that 44% of nurses working in the ED had not received dementia awareness training. The proportion of doctors who had undergone this training was 38%. This meant we could not be sure that patients with dementia were cared for by staff that had undergone extended training in their condition.

Assessing and responding to patient risk

- The department had access to an alcohol/substance misuse liaison team who would visit the department once a week to collect referral letters and could be contacted in office hours for advice.
- Due to a lack of cubicle spaces within the department and poor patient flow through the organisation the ED sometimes could not accommodate all of its patients within a cubicle and had to care for some patients who arrived in the department in a corridor. Staff told us this was limited to three patients and there was a nurses assigned permanently to look after them. When we spoke to staff they told us that this situation occurred on 'most days'.
- The department had a standard operating procedure to help guide staff when patients had to be cared for in the corridor. This included a maximum number of patients who could be cared for in the corridor and what provision should be made if more arrived. During our inspection we saw that at all times the procedure was being adhered to by staff. Staff told us that the escalated concerns to the nurse in charge who would then contact the hospital site team. Staff in the corridor were also able to ask ambulance staff to remain with the patient they had brought in until the patients had been moved into the main department. We saw a number of occasions when this happened as staff had described it.
- We saw two examples when a forth patient arrived in the corridor and saw that ambulance staff remained to undertake care until the nurse could take over.
- Although we did not see delays in patient corridor care, the environment did not always protect patient's privacy and dignity.
- Staff were using recognised national early warning scores (NEWS) and paediatric early warning scores (PEWS). We saw, in the notes we reviewed that this was in accordance with the department standards and was clearly documented.
- We also saw documentation that showed that when there was an increase in score, indicating deterioration in the patient's condition had communicated this to the appropriate clinician.
- In four cases the documentation indicated that escalation had taken longer than the standard outlined in the departments' policy. This meant we could not be sure that all patients who deteriorated in the department were reviewed rapidly.
- There were escalation systems in place, including a scoring system entitled Escalation Management System (EMS), which was designed to help the hospital see effectively the pressure the ED was under and take steps to offer assistance as required. We spoke to three senior staff who oversaw the flow through the hospital. They told us that the definitions used in this scoring system had been changed in late 2014 in order to correspond with neighbouring trusts. The information collected as part of this scoring system had also broadened to include other areas of the organisation including elective surgery cases. Staff told us that as a result of this the scores had reduced.
- We looked at the definitions of what each score meant on the days of our inspections and observed that the scoring did not reflect the reality of the workload being undertaken in the department. On one afternoon we

were told that the EMS indicated that the department was showing 'early signs of pressure'. At that time performance indicators showed that more than a third of the patients in the department had been there longer than the four hour standard, there were no cubicles available to patients in the majors area, three patients were being treated in the departments corridor, and 15 patients were in the waiting room with minor injuries. We asked senior staff if they felt this represented 'early signs of pressure'. They told us they felt the scoring was unhelpful as it did not reflect the reality of the situation and meant that the rest of the organisation was unaware of the pressure the ED was under.

- Senior staff who monitored the flow through the organisation told us that the EMS score was calculated four times a day and often had to 'catch up' with the reality of the situation in the hospital.
- Senior staff in ED told us they had raised this issue with members of the trust board a number of times but it remained unsolved. There was a feeling amongst senior members of the ED team that the response from the rest of the trust only occurred once the ED had become very busy indeed and that more help was required in the early stages of pressure to avoid this situation.
- Staff at the MIU's understood the pathway for assessing and referring a patient who was too unwell to be safely cared for at the MIU. Staff were able to tell us what actions they would take in the event of a deteriorating patient. We asked the trust to provide the policy that covered the transfer of a sick child if they present at a MIU. The trust provided a paediatric assessment of wheeze document, but no policy.
- Guidance issued by the RCEM (triage position statement dated April 2011) states that a rapid assessment should be made to identify or rule out life-/limb-threatening conditions to ensure patient safety. This should be a face-to-face encounter within 15 minutes of arrival or registration, and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected. The percentage of patients meeting 15 minute presentation to assessment target for the ED and MIUs between April and October 2015 was 53% for arrivals by ambulance and 48% for all arrivals. This meant that not all patients were assessed within 15 minutes from arrival to identify or rule out life-/limb-threatening conditions to ensure patient safety.

Ambulance handovers

- Ambulance handovers generally took place in the majors or resus area. At times of high activity it took place in the corridors. We witnessed a number of handovers between ambulance crews and hospital staff, these were detailed and included information such as the patients living arrangements allowing hospital staff to better plan their care.
- Doctor and nurses handover took place at different times as their shift times differed. Staff were not clear about how information from each handover was communicated with the other group. We saw one example of information that was important to the medical team, which was mentioned in nursing handover and only escalated because a doctor happened to be in the room where the handover was taking place. While handover between nurses and doctors was detailed we could not be sure that the handover between both groups was comprehensive.
- The trust board meeting minutes for 2015 showed that the trust's ED key performance indicators for the ED had not met the national standard of having no patient handovers carried out over 30 minutes of patient arrival by ambulance between January and September 2015. Patient handovers over 30 minutes were between 115 (April 2015) and 164 (February 2015) per month.
- The ED had not met the national standard of having no patient handovers carried out over 60 minutes of patient arrival by ambulance between January and September 2015. Patient handovers over 60 minutes were between 7 (June 2015) and 33 (February 2015) per month. The trust board papers did not convert the handover figures into percentage of patients or provide the average waiting time.

Nursing staffing

- The lead nurse had recently conducted a review of staffing using the National Institute for Health and Care Excellence (NICE). This had found that staffing was within recommended limits both during normal working hours and nights and weekends.
- Staff were using an acuity tool in order to understand the needs of the patients within the department. We

saw senior staff become involved in direct patient care when there was an increase in the acuity of the patients. This ensured that those receiving care did not suffer delays in their treatment when the department became busier.

- The trust patient care improvement plan dated 21 September 2015, showed that seven whole time equivalent (WTE) registered nurses were recruited in October 2014 to improve staffing and leadership within ED. However, there was a 21.4% registered nursing staff vacancy rate in data provided by the trust for July 2015. There was a 32.4% administrative and clerical vacancy rate. A trust wide recruitment programme was underway.
- The department had three paediatric qualified nurses this meant that for the majority of the time there was no member of nursing staff with the correct qualification to look after children. This meant the majority of children who attended the department were not cared for by staff that had undergone training into their specific health needs. This did not meet the standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing who recommend a minimum of one registered paediatric nurse to be present at all times.
- Senior staff in the department had recently recognised that this represented a risk to safety and have increased paediatric practice development support for nurses in the department.
- We saw evidence that competencies for skills relating to the care of children were at an advanced stage, although on the day of our inspection staff had undergone no further training in the care of unwell children.
- Staff in the MIU had undergone training to see and treat children.
- Staff told us that they would sometimes ask for support from the paediatricians and paediatric nurses on the ward. We spoke to nurses on the ward who told us they would attend the department if requested to do so. However they also said they were unfamiliar with where equipment and medicines were stored.
- Senior staff told us that they found it difficult to recruit full time members of nursing staff and as a result the department relied heavily on nurses who worked for agencies. We spoke to two agency nurses who told us they felt well supported in their roles and able to ask for help when required.
- Staff told us that there were occasions when the number of nurses on a night shift that were from an agency was more than 50% of the total.
- Senior staff told us that they undertook an induction to the department for any agency nurses who worked there and we saw evidence that this was happening. Both agency nurses we spoke to told us they found this helpful.
- Data from the department showed that there were no vacancies in the senior nursing rota and only 1.6 WTE post vacant at band 6 level. However, at band 5 staff nurse level the rate was 13.5 WTE this represented 47% of the band 5 workforce and meant that the department was heavily reliant on agency.
- The departments' minors' area was staffed almost entirely by emergency nurse practitioners (ENP's) and was open from 8am to 9.30pm. The department had an establishment of four whole time equivalents and was staffed to this number with permanent staff. This meant that the minor's area was run by a stable workforce.
- There was a local induction process in place for bank and agency nurses, the induction consisted of a checklist used to ensure temporary staff who had not worked in the ED previously were familiar with the environment and policies used by the trust. Senior staff in the unit kept a record of staff who had been fully inducted. We spoke to two agency nurses who confirmed they had received an induction.

Medical staffing

- Senior staff told us that the department had a planned establishment of six WTE consultants; however, only three posts were filled with the shortfall being made up through locums and staff working overtime. This did not meet the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in EDs for 16 hours a day, 7 days a week as a minimum. The view of the RCEM is that such rotas require a minimum of 10 WTE consultants in every ED.
- We saw clear plans to recruit more consultants although no formal job offers had been made on the day of our inspection. Consultants were available in the department on weekdays from 8am to 7pm and available on call outside of those hours.

- At weekends consultants were in the department 8am until 4pm and available on call outside of these hours. When they were not in the department clinical leadership was provided by a middle grade doctor.
- There was no consultant with a specialist qualification in the care of children.
- The department had a shortage of middle grade doctors and as a result relied heavily on locum doctors. Senior staff told us the department had the funding for 10 WTE middle grade doctors though currently had 4.6 WTE in post. The shortfall was made up by locums.
- The locum usage rate in ED had increased. Between January and May 2015 the locum usage rate was 28%, compared to 21% between July and December 2014.
- Senior staff told us that they tried to use locums who had regularly worked in the department and the majority of their locum doctors were regular workers. We saw rotas which confirmed this.
- The clinical lead told us that the number of shifts that they could not fill had improved in recent months. Data provided by the trust showed that the number of shifts that were unfilled in July 2015 was 18% of the total, which had fallen to 5% by September 2015.
- The department had 10 WTE junior doctors who had recently started working in the department; we spoke to two junior doctors who told us that they felt supported by their senior colleagues and had received a full induction.
- The MIUs was nurse led and there were no doctors on the rota.

Major incident awareness and training

- We reviewed the trusts most recent major incident plan overdue for review in October 2014.
- We were told that regular major incident training took place and that chemical radiological, biological and nuclear (CRBN) exercises took place regularly where staff would practice erecting the decontamination tent and putting on CRBN protective suits.
- In line with requirements from the Civil Contingencies Act 2004 the trust were required to undertake a major incident practical exercise once every three years. We requested summary findings from these events. The last exercise took place in September 2014 and included managers from the ambulance service. The report highlighted a number of issues such as reduced patient flow and appropriate staff attendance at bed management meetings; however, there was no documentation regarding an action plan of how to address many of the concerns raised. In the case of a lack support from transport services the action point was to review contractual obligations although there was no further detail than this and no discussion regarding how long this discussion would take.
- We also saw the debrief from a patient who arrived with a suspected infectious disease that needed careful management in isolation. This review was very detailed and highlighted areas of improvement to practice including identifying the core team delivering care. As this event is rare, there had not been another opportunity to test the organisation's response. However, we did see evidence that many of the action points had been completed.
- There was a policy in place for treating patients with Ebola and Middle Easter respiratory syndrome coronavirus (MERS–Cov). Staff were able to tell us their responsibilities in the event of a patient with these conditions arriving. They were supported by an up to date policy.
- We reviewed the major incident equipment which was stored in a cupboard. It was clearly organised and well set out allowing staff easy access to everything they required. The kit was within date and clean.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The effectiveness of the ED required improvement.

We found that there was inconsistency in the protocols available to staff with differences between those found on the hospital intranet and those on paper in the department.

Appraisal arrangements were in place and 88% of doctors had received an annual appraisal, we were not provided with evidence of appraisal data for nurses and ancillary health staff.

Urgent and emergency services

The ED had a comprehensive audit plan for 2015 and many national audits including those required by the Royal College of Emergency Medicine (RCEM) had taken place during the previous year. Completed audit reports discussed ways of improving results.

Patient pathways and national guidance for care and treatment had been followed for all the patients we reviewed. For example, we saw that documentation for patients with suspected strokes was clear and well presented.

Pain assessments were completed and evidence of pain relief given was recorded. However, there were some instances when documentation showed a delay in pain relief being given.

There were arrangements for referring patients to mental health teams.

Evidence-based care and treatment

- The department was using a number of nationally recognised pathways known as Clinical Standards for Emergency Departments' guidelines including those for sepsis, stroke and diabetic ketone acidosis.
- We reviewed the documentation of 10 patients who required treatment for conditions covered by these guidelines. We found that care was completed in accordance with these guidelines. This meant that patients were receiving the correct care in a prompt manner.
- We were told by staff that they sought policies for various conditions either in folders in the department or on the trust intranet. We saw that policies on paper and those on the computer were not identical which meant that treatment could vary depending on what guidance was used.
- In the department there were a number of folders with paper documents, these were not organised in a consistent way. In the case of the folder in the resuscitation area we found two different guidance documents for the preparation of intravenous insulin. One of these documents was dated 1997 and differed from the other guidance available. This meant that patients who required treatment may receive care that is not in line with current best practice.
- Other guidance was stuck to the walls in the majors' area and staff room. Staff could not tell us the rationale behind this.
- The computer records were not in a specific ED folder and staff told us it was sometimes difficult to find the correct document. The guidance that was available online was clear and concise, although no review dates were included. We could not be assured that the guidance available to staff was the most recent.
- On one of the days of our inspection the department suffered an information technology (IT) failure which lasted for just under an hour. In that time staff were unable to access online guidance and in some cases, for example treating deep vein thrombosis, the paper guidance was missing. This meant that in the event of IT failure treatment for certain conditions was delayed.

Pain relief

- All the patients we spoke to had been asked about their level of pain and offered pain relief if they required it.
- The ED had a scoring tool to record patients' pain levels. Pain was scored from 0-10 with 0 being 'not in pain' and 10 being the worse pain the patient had ever had. Adult patients were asked (where possible) what their pain rating was. The 35 records we examined showed that pain scoring was being undertaken. However, in two cases, both out of normal working hours, there was a delay of more than one hour before pain relief was administered.
- Paediatric patients were asked to score their pain using a similar numbered score, with pictures available to aid children in their decision making. We saw that this was well documented and acted on accordingly.

Nutrition and hydration

- All of the patients we spoke to in the majors' area of the department said they had been offered food and we saw a number of care interactions where staff assisted patients with their food.
- Due to the nature of their conditions some patients were nil by mouth during their time in ED. This was documented on a sign next to the patient. For those who could eat, the last food they had eaten was also documented using a number of symbols on this board. We saw these boards were kept up to date and ensured that all staff were aware of each patient's nutritional status.
- We saw that patients who required it were given appropriate equipment with which to eat and drink. For example we saw an elderly patient with a tremor being supported to drink with a non-spill beaker.

- Records about each patient that we reviewed showed that staff had documented food intake effectively.

Patient outcomes

- We saw a number of patients with suspected sepsis had received antibiotics within an hour of arrival, in accordance with the RCEM guidance.
- We witnessed a patient with suspected stroke who was treated with an anticoagulant drug within 20 minutes of arrival, well within the RCEM guidance of four hours from the start of symptoms.
- The trust provided us with re-attendance rates to ED within seven days between January 2013 and March 2015. This showed that the department was similar overall to the national average of 7.3%. This was worse than the standard of 5.5% set by the Department of Health. The trust had a protocol in place in the event that a child did not wait to be seen by a clinician and we saw evidence that this was used in practice. There was no similar policy in the case of vulnerable adults and this meant that similar safeguards were not in place.
- We saw data from the Trauma Audit and Research Network reports from March and July 2015. These showed that the trust performed slightly better than the regional average in terms of the proportion of survivors 30 days after a traumatic injury.
- The department had undertaken a number of RCEM audits. These included 'initial management of the fitting child audit 2014/15' and 'cognitive assessment of the older person 2014/15'. In the case of the fitting child audit this showed that the department performed better than average in providing the advocated treatment for febrile convulsions but slightly worse for the documentation of low blood sugar. In 24% of cases in the department this was not completed compared to 16% nationally. We saw evidence that this had been discussed at the department's safety meeting.
- In the case of the 'cognitive assessment of the older person 2014/15 audit' the department met all of the standards expected and in some cases exceeded the national average. In particular 96% of patients that attended received a cognitive assessment compared to a national average of 16%.

Competent staff

- The way nurses revalidate their registration will change in 2016 and require much more input from their managers compared to the current system. Senior staff told us they were aware of the changes and were beginning to plan how best to implement them.
- Staff told us that they did receive informal one to ones. Data provided by the trust showed that 88% of doctors working in the department had had an annual appraisal. We asked the department to provide us with data for nurses annual appraisal but this was not provided. However, after the inspection the trust told us that there were updated figures available that showed appraisal data for nurses and ancillary health staff was 60% but were unable to provide evidence to support this on our request. Doctor, nurse and ancillary health staff appraisal rates did not meet the trust target of 90%.
- Staff at the MIU also completed shifts within the Hereford Hospital ED to ensure their skills and competencies were up to date. They attended competency training with the ED team.

Multidisciplinary working

- Staff working in the unit told us that they found external multidisciplinary team working problematic at weekends and in the evenings. One example they gave was Child and Adolescent Mental Health Services which did not accept referrals from Friday evening until Monday morning. This meant that children and young people had to be admitted to the children's ward over the weekend and mental health assessment and support was delayed.
- The department was not supported by a frail elderly team and as a result staff made referrals to social services for help in discharging frail elderly patients. Staff told us and we saw examples of these referrals being delayed at weekends. Staff told us this meant patients had to be admitted to the ward at weekends when during the week they could be supportively discharged home.
- Patients aged over 18 requiring psychiatric assessment and treatment could be referred to the psychiatric liaison service. Staff told us that this service was effective during the week days, however it was less effective over the weekend when the psychiatric team also had to cover the community. Staff told us and we

saw records which showed that patients requiring this input over the weekend sometimes waited in excess of six hours in the department before they were assessed by this team.
- Staff told us that within the hospital they worked closely with the clinical assessment unit and aimed to avoid unnecessary admissions to hospital.

Seven-day services

- We looked at rotas for both doctors and nurses covering the last three months. These showed that there was no reduction of nurses or junior doctors over the weekends.
- The department had set up a referral pathway for an out of hours GP service that was based in the hospital. This meant that those requiring access to a GP outside of the operating hours of their surgery were able to do so through the department.
- The department had access to x-ray and CT services at all hours of the day and night. This meant there was no delay for patients who required imaging.

Access to information

- Staff, including agency staff, could access further clinical guidelines and pathways on the trust intranet.
- A discharge summary was sent to GPs when patients were discharged from the department.
- Staff at the MIU's could refer to clinical information displayed around the unit, for example, the treatment of an anaphylactic reaction and asthma management guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw multiple examples of staff asking patients for permission before undertaking clinical interventions. Every patient that we spoke to said that staff had asked their permission prior to undertaking treatment.
- We spoke to four junior staff about the key elements of the Mental Capacity Act 2005 or Deprivation of Liberties they showed a sound understanding of the key principles of the act and how it related to their care.
- We spoke to three staff regarding the care of principles of competence and consent in children; they were able to describe the key elements of consent in relation to children.
- We witnessed a discussion between a junior doctor and their senior college regarding the capacity of a patient to consent to a treatment. The discussion was detailed and demonstrated that both understood their role in ensuring that the patient had capacity to make decisions about their care.

Are urgent and emergency services caring?

Good

The quality of caring provided to patients within the ED was good.

All of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff were working very hard. We saw a number of examples where staff went over and above their duties to ensure that patients were comfortable. Patients and relatives were kept informed of care and treatment plans.

However, when all the cubicles in the ED were full, patients who arrived by ambulance had their initial assessment and treatment undertaken in a corridor. This did not always protect patient's privacy and dignity.

Compassionate care

- We spoke to 42 patients and their relatives. The feedback was universally positive, a number of patients praised the calm way that care was delivered and the time staff had taken to explain their treatment to them.
- When all the cubicles in the department were full, patients who arrived by ambulance had their initial assessment and treatment undertaken in a corridor. This involved a clinical handover from ambulance crew to nursing staff also being undertaken in a corridor where other patients were waiting. Staff accepted that this did not protect patient's privacy and dignity sufficiently. One member of staff told us 'obviously we don't want to treat patients like this'. We spoke to three patients who were waiting in the corridor prior to being moved into the main area of the department. They told us that whilst they did not wish to be cared for in a corridor it was only for a short time, and staff had made them as comfortable as possible. They all confirmed that they had overheard the clinical handovers for the other two patients in the corridor; one patient told us. However, 'it's no different to a hospital ward where you just have a curtain between you and somebody else'.

Urgent and emergency services

- Staff used movable screens if they had to undertake any personal care to one of those waiting in the corridor. We saw three examples when these were used during the course of our inspection. In this way staff attempted to limit the loss of privacy whilst patients were cared for in an inappropriate area.
- We saw a number of very positive care interactions between staff and patients both in the ED and the MIUs. In one case we saw staff crouching down to speak to a small child so as to meet them at eye level rather than stand over them. This had a visibly reassuring effect on the child.
- In other example we saw three staff show compassion and significant skill when caring for a patient who due to a medical condition was behaving aggressively. The three staff members showed compassion and empathy in very challenging circumstances. When we spoke to the patients relatives they told us that they felt staff had been 'absolutely first class'.
- The '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. The trust board September 2015 meeting minutes showed that feedback from patients through the Friends and Family Test for June and July 2015 was 71% and 75%, respectively. This was worse than the national average of 88% for both months. The trust had the lowest recommendation rate in the West Midlands, with the West Midlands average 85% for June and 86% for July 2015. The Quality Committee reported the key themes derived from the comments made showed that waiting times were the primary concern amongst patients. A long term action plan was in place regarding the urgent care pathway and a key focus for the trust was the impact of waiting times in ED.

Understanding and involvement of patients and those close to them

- We spoke to eight relatives during the course of our inspection. They told us that staff had kept them informed of their loved ones treatment and plans of care.
- All of the patients in the majors' area were aware of their plans for care and if they were waiting they were able to tell us the reason for the wait.

Emotional support

- We saw documentation that outlined how staff could access the chaplaincy service either during working hours or weekends and nights. There was also a policy in place for accessing religious leaders from other faiths. Staff we spoke to were clear about how to access this service.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

The ED required improvement in its responsiveness to patients' needs.

Patients did not always receive timely care and treatment. There were delays in patients entering the main area of the department and being admitted to the hospital. The main reason for this was poor patient flow through the organisation including delays in discharge. The ED was consistently failing to meet the national standard that 95% of patients be discharged, admitted or transferred within four hours of arrival. There had been an increase in 12 hour breaches compared to the same period the previous year.

The department met the national target that less than 5% patients left the department before being seen by a clinical decision-maker.

Translation services were available, although we saw an occasion when this was delayed. There was a complaints system in place and learning was fed back to staff.

Service planning and delivery to meet the needs of local people

- Lack of available bed capacity caused overcrowding in ED. The trust had identified on the corporate risk register that it was unable to maintain the urgent care pathway and breached four hour waits during the year 2014/15, which impacted on elective care and on occasion resulted in sub-optimal service provision to patients. 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. Although control measures had been implemented this remained the trusts largest risk on the register.

- The patient care improvement plan (PCIP) outlined objectives to help tackle capacity issues. The board had approved a business case to secure investment in an additional 16 bed capacity at Hereford Hospital. Also, a pilot commenced at the end of August, running until the end of September 2015 for all GP expected patient admissions to be sent direct to the CAU. This was to be evaluated. However, within the PCIP, it stated this had been completed the end of March 2015, yet the objective was ongoing.
- The department had recently completed a children's waiting room and had redecorated two cubicles in bright colours which were designed to be more child friendly. These were set away from the main area of the department, which meant that children could receive care without being treated next to adult patients.

Meeting people's individual needs

- If a patient died whilst in the department there was no separate room for relatives to view the body and spend time with them. Staff told us that they tried to ensure that privacy was maintained however they accepted that not having a viewing room made this difficult.
- Staff told us that they could access translation facilities through a telephone translation services (LanguageLine). We saw one example where this service was used to translate for a patient who was undergoing treatment. Translation was delayed for more than an hour as staff looked for the correct pin number to access the account with the translation company. This meant we could not be sure that patients using the service could access translation services quickly.
- Senior staff in the department told us they had a number of members of staff who spoke different languages and they could use them to translate if required, although no formal training had been undertaken to help them translate effectively. Staff said that occasionally they would use patients friends although they accepted that there were confidentiality and quality issues associated with this.
- Staff in the department had identified that in the last few years they had seen an increase in seasonal workers from Eastern Europe. Following this, they had included information in a number of Eastern European languages on the department's matrix board in the waiting room that explained the process for waiting for treatment.
- The staff we spoke with had a good understanding of how to care for patients with dementia. Some staff told us that patients with dementia would need to be spoken with calmly and cared for in a quiet area and we saw them undertake this in practice. When the ED was busy it was noisy and it was not always possible to provide patients with a quiet place to wait. There had not been an audit to examine how dementia-friendly the department was.
- There were information leaflets about specific accidents, injuries/and emergency conditions within the department. However, leaflets were only available in English.
- We looked at the children's waiting area where children their parents/carers waited for treatment. This area included bright children's chairs and soft furnishings and had toys for children to play with.
- We asked staff about their ability to access equipment designed for bariatric patients for whom some standard equipment such as hoists would not be suitable. Staff told us that this was available from a nearby ward and we saw that this was the case.
- Those who arrived via their own transport first gave their details to a receptionist who sat at a desk near the waiting room. There were signs and markings on the floor which asked people to remain a sufficient distance from the reception area until they were asked to come forward to give their details. This reduced the risk of patient's confidential information being overheard.

Access and flow

- The national target for patients attending ED is for 95% of them to be admitted, discharged or transferred within four hours. The quarterly ED activity and emergency admissions statistics for between 4 January and 29 March 2015 showed that 80% of patients were seen in four hours or less from initial arrival. This was worse than the England average of 88%.
- During our inspection we observed that some patients remained in the ED for excessive periods of time. Department of Health guidance states that a patient must be admitted to a ward within 12 hours of a clinician's decision to admit them. We saw that the department was meeting this standard. However, we saw examples of delays of two to three hours in a decision being made to admit the patient. This meant that whilst the Department of Health standard was

being met this was only due to a delay in a clinician making a decision to admit the patient. This meant that from the time of their arrival patients waited longer than 12 hours within the ED prior to admission.

- Between January 2014 and July 2014, 46 patients had waited longer than 12 hours in the ED. This number had fallen from January 2015 to September 2015 to four.
- We were told that the main cause for patients remaining in the department for too long or waiting for a decision to be made about their care was due to a lack of beds and delays in specialists from other departments coming to assess patients. The clinical site team kept a log of the reasons why patients were delayed although it was not clear how this information was used by the trust to improve the service.
- This was corroborated in the trusts board September 2015 meeting minutes, which stated that the poor performance was driven by a lack of available inpatient capacity to accommodate emergency admissions in a timely way or by delays in the 'system' resulting from 'congestion' as a direct result of poor patient flow.
- Many staff said that when beds did become available it was quite late in the day. This meant that staff had to transfer the majority of patients at a time when there increased numbers of patients in ED and therefore an increased workload. We witnessed this lead to further delays in transferring patients to the ward as staff were busy with other duties.
- While waiting no more than four hours from arrival to departure is a key measure of ED performance, there are other important indicators such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The trust had met the target, averaging 55 minutes between July 2014 and February 2015. This was worse than the England average of 53 minutes for the same period.
- The department consistently met the national target that less than 5% of patients leave the department before being seen by a clinical decision maker (which is recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait). Between July 2014 and February 2015, the proportion of patients leaving before being seen averaged 2.7%. This was slightly worse than the England average for the same period of 2.6%.
- Staff in charge of the department were not sure of the level of performance compared to national standards. For example staff were not able to tell us how many patients had been in the department longer than the four hour target.
- MIU staff told us that they could access X-ray services four and a half days per week. Out of hours, the staff felt that generally patients could return for an X-ray but if it was urgent patients would need to go to Hereford Hospital to access X-ray services.

Learning from complaints and concerns

- Patients in the department understood the process for making a complaint, though none had felt the need to do so.
- Junior staff we spoke to were able to describe how they would handle a patient who wished to make a complaint. They told us they would escalate the situation to the person in charge of the shift.
- There was active learning from complaints. The lead nurse selected a complaint and resulting action plan which was displayed on a notice board in the units resource room and discussed at staff meetings. We saw an example of a patient who had complained about poor communication and a lack of pain relief, an action plan had been included on the display and was included in the staff meeting. In this way we could see that complaints were used to improve the service.
- Senior doctors and nurses had recently started a morning meeting where staffing and complaints were discussed. This meeting had been in existence for only a short time prior to our inspection so it was not possible to see what effect it was having on the amount or type of complaints
- The complaints log for the ED included a senior member of staff who was responsible for investigating and responding to the individual complaint. This ensured there was accountability for the complaint and senior oversight of its investigation.
- We were provided with data that showed that there had been eight complaints to the ED in July, August and September 2015. Two of these complaints related to delays in ED. The complaints tracker was clearly organised and responses had been sent in all cases, although these were not dated.

Urgent and emergency services

Are urgent and emergency services well-led?

Requires improvement

The ED required improvement in the way it was led.

An escalation policy, which aimed to improve the flow and service provided within ED, was in place. However, staff told us they rarely saw tangible help from senior members of the trust when they escalated.

ED key performance indicators were not forecast to significantly improve within the coming year. The department monitored some of its performance on a day to day basis but staff told us that when they escalated they did not feel the rest of the trust reacted swiftly when they were under pressure. Staff felt the ED's performance challenges were still viewed as very much to do with the ED's processes rather than the whole trust.

A governance committee structure was in place and minutes showed that a range of issues were discussed, however performance data was not always available for senior staff to discuss and act on.

Senior medical and nursing leadership was visible and supportive. Staff told us they felt their immediate managers understood their problems and were approachable. At a more senior level staff did not feel very supported by members of the trust team.

Patients and staff were given the opportunity to provide feedback about the service. In the case of children we saw an outstanding example of using young people to inform the way the service was delivered.

Vision and strategy for this service

- The clinical lead and lead nurse were clear about their vision for the department and junior staff told us that they understood the vision outlined by the departments leadership,
- The patient care improvement plan (PCIP) outlined various objectives to improve the ED service. Many of the objectives referred to staffing, capacity and flow issues within the ED and the wider trust. For example, the recruitment of a consultant ED post which was overdue in June 2015; and a pilot scheme commenced at the end of August, for all GP expected patient admissions to be sent direct to the CAU. However, within the PCIP, it stated this had been completed the end of March 2015, yet the objective was ongoing.

Governance, risk management and quality measurement

- ED key performance indicators were monitored and discussed at each trust board meeting. However, the forecast for meeting the ambulance handover targets and ED four hour wait target within the next 12 months was RAG (red, amber, green) rated as red. This indicated that key performance indicators were not forecast to significantly improve within the coming year.
- The department held a monthly governance and mortality and morbidity meeting. Minutes from this showed that items including clinical governance and medical and nursing staffing. It was noted in the minutes that performance indicators were not available to be discussed in the meeting and thus it was not clear in what forum senior staff were able to discuss this.
- The governance meeting was held in a meeting room away from the department which meant that many of the staff were not able to attend**.** Although learning was shared by minutes and email staff felt it would be more beneficial if they could attend regular meetings in person.

Leadership of service

- Junior doctors and nurses told us they felt they had good managers and praised the lead doctor and nurse's commitment and dedication.
- We spoke to five junior doctors who had recently begun work in the department. They told us that their senior colleagues were supportive, visible in the department and approachable.
- Junior nurses felt that their senior colleagues were supportive, one described the lead nurse as 'fantastic'.
- During our inspection we saw that the nurse in charge wore a badge, which made them easily identifiable. The doctor in charge was not easily identifiable, particularly at night when this role was often filled by a locum doctor.
- We spoke to two middle grade doctors who were responsible for the care overnight with support from an on-call consultant. They told us that they felt able to ring the consultant during the night and they would come in to the department if required.

- None of the staff we spoke with told us that they had been encouraged or undertaken any form of leadership training. However, the trust told us that there was a leadership programme for staff in place.
- Due to vacancies, particularly in the consultant rota, there was a reliance on a small number of key individuals to lead and manage the service.
- Previous inspections had highlighted that working relationships were sometimes strained. Both junior and senior staff told us that working together had much improved and this had helped to improve the service.

Culture within the service

- We saw very positive interactions between all staff groups.
- Staff told us that the department had been under sustained pressure for an extended period of time. However, they told us that the team worked well under this pressure and they had seen a lot of improvement in the last year.
- All staff we spoke to felt able to raise concerns regarding care to their senior managers.
- Staff, particularly nurses, told us that they felt that support from the rest of the trust was sometimes not very effective and that there was sometimes a lack of support and positive action from the rest of the organisation when the ED became busy.

Public engagement

- The department had utilised a trust wide programme of children's ambassadors aged between 11 and 16, which began in November 2014. The ambassadors had been involved in Patient-Led Assessment of the Care Environment audit (PLACE). This had been incorporated into the redesign of the children's waiting area.
- Staff were concerned that the MIUs had closed three times in the past year due to staffing pressures within the ED, hence, MIU staff worked at the ED instead to support that service. Although the closure was always communicated to the public, staff felt that the reopening of the MIU was not always made clear to the public. This meant patient contacts would reduce initially post a closure. This meant that the public were not always sighted about when services were open or not.

Staff engagement

- We reviewed the latest staff survey from July 2015 the data was presented as results from staff who work both in urgent care and care close to home. This meant it was not possible to identify specific issues relating solely to the ED.
- The staff survey showed that 44% of staff had experienced harassment, bullying or abuse from members of the public, this compared to a NHS average of 29%. Senior staff told us that they had increased security within the department. We saw signage in the patient waiting area informing people about the importance of treating staff with respect.
- The survey showed that the proportion of staff who felt support from their immediate manager was the same as the NHS average.
- The survey showed 98% of staff who responded felt able to report accidents and incidents, 8% higher than the UK average.
- Staff we spoke to felt part of the department and said they felt they were part of improving the department's performance.

Innovation, improvement and sustainability

- Staff told us they recognised that the department had required improvement in the past and felt they had worked hard to address many of the concerns. Senior staff accepted that there was still work to do in this area and key performance indicators highlighted this.
- There was evidence that those leading the department were innovating the service. One example of this was the role of domestic violence advocate which was to be implemented in October 2015 and would support staff that were treating patients who had suffered suspected domestic violence.

Medical care (including older people's care)

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

Information about the service

Wye Valley NHS Trust provides inpatient medical services. There were four medical wards, plus an acute assessment unit, a clinical assessment unit and a discharge lounge. There were approximately 124 medical beds and nine inpatient cubicles in the clinical assessment unit. We visited the following wards:

- acute assessment unit (AAU/Frome ward);
- the clinical assessment unit (CAU);
- respiratory and cardiac medicine ward (Arrow);
- diabetes, endocrine and gastroenterology(Lugg);
- stroke medicine ward (Wye/stroke unit);
- the coronary care unit (CCU) specialising in caring for people with cardiac conditions;
- the discharge lounge;
- and the endoscopy service.

During our inspection, we visited all ward areas and discharge lounge. We spoke with 30 patients, 55 staff, and 12 people visiting relatives. We also looked at the care plans and associated records of 30 people. We held focus groups with nursing, medical staff and ancillary staff, as well as speaking to senior doctors and nurses. We also carried out an unannounced inspection visit to Lugg ward on 1 October 2015.

Summary of findings

Overall, we rated the service as inadequate for safety, and requiring improvement for effectiveness, responsiveness and being well led. We rated the service as good for caring.

Incidents were reported, but there was inconsistent evidence of learning from incidents being embedded in ward practice. Staff were not always aware of preventative actions that could reduce the risk of avoidable harm to patients. The service did not always recognise and respond swiftly for some patients at risk of deterioration.

There was a high level of nursing staffing vacancies within some teams and an over reliance on agency staff. Nursing staffing levels did not always meet patient needs at the time of our inspection. There were not always effective systems in place for agency staff induction and we saw evidence of this negatively impacting upon patient care.

Appropriate systems were in not always in place for the storage, administration and recording of medicines.

The environment was generally clean and well maintained but some potential risks to patient safety had not been addressed. Wards generally had effective systems in place to minimise the risk of infections.

Records, and associated risk assessments, were not consistently well completed.

Medical care (including older people's care)

The majority of staff had had the mandatory training required. Only 30% of nursing staff were compliant with children's safeguarding training to level two was 30% and 55% with safeguarding adults training. This did not meet the trust's target of 90%.

Medical staffing was in line was national guidance. There was an effective system in place for medical handovers and these did occur in the mornings. The service had implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) in line with national guidance.

Patients did not always receive effective care and treatment that met their needs. Performance and outcomes did not meet trust targets in some areas. Mortality ratios were higher than those of similar trusts and the service had a range of actions in place to address this concern.

Care was mostly provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was effective. There was some evidence of progress to providing seven day a week services.

Most staff said they were supported effectively. However, there was a lack of formal supervisions with managers. Appraisal rates for doctors and nurses varied.

We found that staff understanding and awareness of assessing patient's capacity to make decisions about their care and treatment was variable. Appropriate plans were not in place for those patients' assessed as requiring a Deprivation of Liberty Safeguard.

Overall, medical inpatient services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients told us that the staff were caring, kind and respected their wishes. Most patients' we spoke to during the inspection were complimentary, and full of praise for the staff looking after them

Patient's's needs were not consistently met through the way services were organised and delivered. There was an elevated demand on bed availability at times, and there were high numbers of patient moves at night. Some problems with the effective discharge of patient's were highlighted across the medical care service, and the service was seeking to improve this process.

The leadership and culture did not always promote the delivery of high quality person-centred care as governance and risk management systems were not fully embedded throughout the service.

The visibility and relationship with the middle and senior management team was not clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust, and said work pressures, due to higher patient dependencies, was an area of concern.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they were not involved in improvements to the service and did not receive feedback from patient safety incidents. The medical care service was generally well led at a ward level, with evidence of effective communication within ward staff teams.

All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Overall, we rated the service as inadequate for safety.

Incidents were reported, but there was inconsistent evidence of learning from incidents being embedded in ward practice. Staff were not always aware of what preventative actions could reduce the risk of avoidable harm to patients. The service did not always recognise and respond swiftly for some patients at risk of deterioration.

There was a high level of nursing staffing vacancies within some teams and an over reliance on agency staff. Nursing staffing levels did not always meet patient needs at the time of our inspection. There were not always effective systems in place for agency staff induction and we saw evidence of this negatively impacting upon patient care.

The majority of staff had had the mandatory training required. Only 30% of nursing staff were compliant with children's safeguarding training to level two was 30% and 55% with safeguarding adults training. This did not meet the trust's target of 90%.

Records, and associated risk assessments, were not consistently completed in accordance with trust policy. Appropriate systems were in not always in place for the storage, administration and recording of medicines.

Wards generally clean and had effective systems in place to minimise the risk of infections.

All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance but staff did not show awareness of this or how it influenced their practice.

- Medical staffing was in line was national guidance.

Performance boards across the wards were seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Regular audits were carried out on the main risk areas.

Incidents

- There were 61 serious incidents reported across the medical care service during the period May 2014 to April 2015. Pressure ulcers at grade 3 were the most commonly reported type of serious incident (32), followed by sub optimal care of the deteriorating patient (10). Audits had been carried out on the completion of records regarding the recognition of deteriorating patients and the service had an action plan in place.
- No never events (incidents that are defined as "wholly preventable, where 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") were reported by the trust for medicine in the previous 12 months. One never event was reported in the medical care service but was a surgical never event that occurred in January 2015 when a guide wire remained in place following insertion and connection of a chest drain.
- The majority of staff were aware of how to report incidents and near misses using the trust's computer incident reporting system. Most staff were encouraged to report incidents and felt they were treated fairly when they did. Most but not all staff told us they received feedback from reported incidents.
- We saw that staff on Lugg ward had reported skin damage incidents appropriately. We saw that staff in the discharge lounge had raised three recent incident reports and had received an acknowledgement of the report and were awaiting feedback.
- Senior staff told us there were regular monthly governance meetings within the medicine division that reviewed service safety and quality issues, including incidents, complaints, the risk register, and patient mortality and morbidity concerns. Actions taken regarding incidents were reviewed and then feedback was given to ward managers, for onward cascade to staff teams. We saw this reflected in team meeting minutes.
- Some wards, for example Arrow ward, produced regular staff newsletters for all staff that included learning shared from incidents and audits.
- On Frome ward, not all nurses had access to the trust's email system so were not always able to receive information on safety and quality issues via email. Not all staff were clear about the service's governance and feedback mechanisms so not all were not able to demonstrate how learning from incidents was shared.

- On Arrow ward, we saw that patients at risk of falls had a discrete sign of a falling leaf by their beds to indicate their risk off falls sensitively. This was an example of ward practice changing due to shared learning from incidents.
- We identified on Lugg ward there had been a medicine omission for a patient under the care of an agency nurse. As a result an incident report had been raised. Appropriate actions were taken immediately to address the concern. We saw the service used a specific escalation form that was submitted to the relevant agency, to report concerns about agency staff competence.
- Most, but not all, wards had regular team meetings where patient safety and quality issues were discussed. We saw some team meeting minutes did include governance and incidents issues recorded as discussed on Arrow ward.
- Wards did not maintain their own risk registers. Serious risks were included on the divisional risk register. Senior staff said the main risks identified for the service were regarding staffing pressures.
- Some ward offices had posters on display giving staff guidance on reporting patient safety concerns and duty of candour.
- Staff had an awareness of duty of candour and were able to tell us the ward protocols for supporting patients regarding incidents.

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 on pressure ulcers, falls and urinary tract infections (for patients with catheters), and blood clots (venous thromboembolism, VTE). Not all staff were aware of the findings from these audits and how changes had been made on the wards to improve outcomes for patients.
- NHS Safety Thermometer data showed the service had reported incidents of 33 pressure ulcers, 21 falls and 14 catheter associated urine infections per 100 patients surveyed from June 2014 to June 2015.
- The trust had implemented a SKIN "care bundle" with a collection of five interventions to promote effective skin care and senior staff said they undertook in depth investigations and had accountability meetings with nursing staff for all cases of grades 3 and 4 pressure ulcers to learn from any errors or omissions made. Wards carried out monthly audits on pressure ulcer prevention.
- Senior staff told us there was no online ward based safety dashboard but that all ward managers were given monthly outcomes for the NHS Safety Thermometer and the service's quality and safety information. The service produced monthly quality and safety performance reports (nurse sensitive indicators) which summarised individual ward performance in meeting trust targets for harm free care, complaints and patient feedback.
- NHS Safety Thermometer data for September 2015 showed the service had achieved 95% harm free care.
- The medical care service had achieved the trust target of 95% for the completion of VTE assessments in September 2015.
- Wards had noticeboards showing recent safety and quality information. For example, Wye ward had not had a hospital acquired pressure ulcer for over six months and the last fall where the patient sustained harm was 19 months ago. Lugg ward had not had a hospital acquired pressure ulcer for three days and the last fall where the patient sustained harm was 442 days ago.
- Not all staff were fully aware of the nurse sensitive indicators or what actions were planned to ensure harm free care, such as pressure ulcer prevention. Staff had a limited understanding of patient safety concerns and areas of risk, and what actions needed to be taken to reduce risks.

Cleanliness, infection control and hygiene

- Ward areas were generally visibly clean and tidy and sanitising hand gel was available throughout the units. Cleaning cupboards were stocked with appropriate cleaning materials and equipment. The hospital used a colour coding systems for mops and buckets and we saw posters on display in staff areas regarding this.
- Equipment had 'I am clean' stickers on them which were easily visible and documented the last date and time they had been cleaned.
- Generally staff worked in accordance with best practice for infection control, this included good hand hygiene, wearing personal protective equipment (PPE) when appropriate and being bare below the elbows. Posters about effective hand hygiene were also on display.
- Infection control audits were carried out monthly, including bed mattress checks.

- Ward performance noticeboards showed outcomes of infection control audits and when the last cases of infectious diseases were. For example, Wye ward had not had a case of C. difficile (Clostridium difficile) for eight days and had not had a case of MRSA (Methicillin-resistant Staphylococcus aureus) for 941 days. The coronary care unit (CCU) had not had a case of MRSA for over 16 months.
- As the hospital did not provide a discrete isolation ward, Lugg was the designated ward to provide isolation side rooms for patients with infectious diseases. The ward had 10 side rooms available. Two of these were designated for neutropenic patients and were on the opposite side of the ward corridor to the other side rooms. Neutropenia is a condition with abnormally low count of neutrophils, a type of white blood cell that helps fight off infections, patients are at an increased risk of acquiring infections. Separate staff cared for neutropenic patients to those caring for patients with an infection. This reduced the risk of cross infection. Isolation protocols signage was on display on all side room doors.
- Nursing staff were observed to challenge other staff within the endoscopy unit when they entered into "bare below the elbow" zone, whilst wearing jackets and long sleeve shirts.
- Routine water sampling was conducted within the endoscopy unit to ensure the water supply was not contaminated. Further, regular protein quality checks and random checks of endoscopes were carried out to ensure they were effectively decontaminated.
- There were processes and procedures in place for tracking each endoscope which had been used. Decontamination records were filed in the relevant patient notes to ensure that equipment could be traced, including details of the staff members responsible for operating and decontaminating them.

Environment and equipment

- Emergency equipment, including equipment used for resuscitation was checked every day. Wards had robust systems in place for ensuring resuscitation equipment was checked daily. On Arrow ward, we checked and found that records of equipment checks had been maintained daily for the month up to our visit.
- Pressure relieving equipment was available for patients. We checked a random sample of equipment in all areas and noted that all equipment was fit for purpose. Staff on Lugg ward told us that there were no delays in obtaining pressure relieving equipment when requested and it was usually provided within half an hour.
- Firefighting equipment had been tested regularly on all wards.
- Portable electric equipment had been tested regularly to ensure it was safe for use and had clear dates for the next test date on them.
- In the dirty utility rooms (or sluice room) on Lugg ward and therapy services department, and in the unlocked cleaning cupboard near to the discharge lounge, we found that chemicals hazardous to health had not been locked away. This was not in accordance with trust policy and presented a potential risk of a patient or visitor was to have access to these chemicals. This was brought to the attention of senior nurses, who took action to address this concern.
- There were radiation warning signs and lights outside any areas that were used for diagnostic imaging including within the endoscopy suite where a portable c-arm was used for procedures (c-arms are a form of mobile x-ray technology which is used to produce medical images).

Medicines

- Appropriate systems were in not always in place for the storage, administration and recording of medicines.
- We looked at five patients' drug charts on Lugg ward. On one patient's drug chart, we saw that two medicines had been crossed out to indicate they had been stopped, but that this had not been signed or dated by the appropriate clinician which was not in accordance with trust policy.
- We found on another patient's drug chart that a medicine had been given for three days, but the prescription on the chart had not been signed by the doctor. We also found gaps in the recording of medicines given for the day before our visit in three out of the five records we looked at. This was reported to the nurse in charge, who reported this as an incident and ensured the doctors were informed of the omissions.
- On Frome ward, we found one newly admitted patient had controlled drugs (requiring secure storage) in their bedside cabinet and that there had been a three hour

delay in checking this patient's belongings. We reported this to ward staff and it was addressed immediately to ensure the medicines were recorded and stored securely.

- The discharge lounge had a system for storage for medicines to take home but did not have a controlled drugs cabinet. Therefore controlled drugs were stored in a controlled drugs cabinet on a nearby ward.
- On Frome ward, we checked three patents' drug charts and saw that allergies had been recorded appropriately and patients had wrist bands to indicate their allergy status. Staff we spoke with knew the trust policy for managing risk of adverse reactions.
- On Wye ward, we saw on four patients drug charts that allergies were clearly identified.
- We observed nurses administer medicines on a drug round on Wye ward and all protocols were followed to ensure patients received the correct medicines at the correct time. Nurses wore red tabards to alert staff that they were administering medication and should not be disturbed.
- We saw in the Care Closer to Home and Urgent Care Service Unit Governance Meeting minutes on 10 June 2015 that medicine errors had risen from the previous month to 19 including errors on CAU, Arrow, Lugg and Wye wards. Action plans were in place to address these concerns and were monitored. Pharmacy audits were undertaken and results shared with ward leaders for action.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators and records showed that they were kept at the correct temperature.
- Pharmacists visited wards regularly to review medications and carry out reconciliations.
- Overall, we found that medicines and intravenous (IV) fluids were stored securely in locked cupboards on the wards.

Records

- During our inspection we observed that some medical records were securely stored in either a locked cabinet or dedicated rooms. However, not all notes' trolleys in wards were lockable. The service did not use an electronic patient record system but was considering options for implementing this within the next two years.
- During our inspection we looked at the care records of 30 patients across the service. Most records 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.
- We looked at five sets of patients' records on Lugg ward and found not all nursing records, including food and fluid charts, observation charts, National Early Warning Scores (NEWS) and drug charts and were fully completed and up to date. One patient had not had three sets of observations recorded in a 24 hour period which was not in accordance with trust policy. One out of five patients had had no record of any nutritional input recorded for two days in the six days' records we looked at. One patient did not have two four hourly reposition changes recorded in a 24 hour period. The patient was at high risk of skin damage according to the skin damage risk assessment. We also found that a patient's wound assessment chart had not been recorded as updated for five days, when it should have been reviewed daily according to trust policy.
- On Lugg ward, six out of 11 fluid balance charts did not have daily fluid balance totals. This was not in accordance with trust policy.
- Wards carried out audits on NEWS record completion and we saw that Arrow and Lugg wards had both identified some concerns that not all patients' records and care plans contained appropriate guidance for staff when NEWSs had been 3 or above. Senior nurses had fed back the outcome of these audits to staff teams and were monitoring this issue on an ongoing basis.

Safeguarding

- Generally, we found there were effective safeguarding policies and procedures which were understood and implemented by staff.
- Staff were able to tell us the process for reporting safeguarding concerns and knew where they would access the safeguarding policy and procedures.
- Safeguarding information was displayed on the wards. This included out of hours contact numbers for the local safeguarding authority.
- Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse, how to raise an alert and that the trust had a whistleblowing policy in place.
- The majority of staff had received safeguarding training during their induction training. However, not all staff were able to tell us how they report a concern outside

the organisation if required. Across the medical care wards, nursing staff compliance with children's safeguarding training to level two was 30% and safeguarding adults training was 55%. This did not meet the trust target of 90%.

Mandatory training

- Most wards were meeting the trust's target for staff having had mandatory training.
- Staff told us that mandatory training generally met their needs.
- Ward leaders had access to an electronic system for recording and monitoring staff training records and said they were able to plan ahead in terms of staff requiring training.
- We looked at Wye ward's staff training records which showed most staff were up to date with the trust's mandatory training for the year. We saw training sessions had been booked for those staff still requiring this training.
- Most staff had had mandatory fire safety training for the year. We saw plans were in place to ensure staff needing this training would be booked onto a training session.
- Across the medical care wards, 94% of nurses had had health and safety training which was better than the trust target of 90%.
- 57% of nurses had received manual handling training; 75% of nurses had received information governance training; and 75% of nurses had received infection control training. These did not meet the trust target of 90%.

Assessing and responding to patient risk

- In accordance with the trust's deteriorating patient policy, staff used the NEWS to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitor 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. On Arrow ward, we looked at 11 patient's NEWSs and found they had been completed in accordance with trust policy and that escalation for medical review had taken place when required.
- On Lugg ward, we looked at 10 sets of NEWSs for patients and found not all had been completed in accordance with trust policy. On one patient's NEWS record, the overall score had not been completed twice in the 19 times it had been due. This patient also triggered a NEWSs of 2, which according to trust policy, meant that the next set of observations should have been completed four to six hours later. However, no observations had been completed until a day later. This meant that there was a risk that staff would not have been able to recognise deterioration in this patient's condition as the required level of observations had not been completed.
- On Lugg ward, in a second patient's NEWS record, there was no evidence that the ward had taken appropriate action to request a medical review when the NEWS had triggered 3 on seven sets of four hourly observations. Nurses we spoke with about this said that doctors were aware of the patient's condition and were monitoring the patient but there was no entry in the nursing notes to reflect this. The medical notes did reflect the patient's NEWS but there was no written guidance for nurses to follow should the NEWS remain high. This meant that there was unclear guidance in place for staff to follow regarding the ongoing monitoring of this patient's condition.
- On Lugg ward, in a third patient's nursing records, we found that the skin damage risk assessment had not been completed in full and no overall risk score was calculated. Trust policy was for all skin damage risk assessments to be completed within six hours of admission to the ward. There was no repositioning chart in place as the notes stated the patient was independent. However, there was no updated skin damage risk assessment in place and unclear guidance for staff as to the level of risk and support the patient required to minimise the risk of skin damage.
- On Lugg ward, we found another patient had deteriorated but as there had not been a medical review for three days, this deterioration had not been identified appropriately. There was no written record of a medical review for three days in this patient's notes. However, once the patient had been medically reviewed, appropriate care and treatment plans were then put in place. This had not been reported as an incident.
- Falls assessments were carried out to identify those patients at risk of falls and care plans were generally in place to minimise the risk. All falls were recorded and

reported and care plans and assessments reviewed to minimise risk of further falls. However, we did find one instance on Lugg ward where a nursing care plan was not in place for a patient who was at risk of falls.

- The hospital provided up to six beds for patients requiring non-invasive ventilation (NIV). This service had moved from the acute assessment unit (AAU), to Arrow ward the week prior to our inspection. There had been an average of two to three patients requiring NIV in the month prior to the inspection. We saw that there had been some near harm incidents reported as a result of this relocation. The concerns had been addressed immediately in terms of provision of competent staff to oversee these patients. These patients were cared for by a band 6 or above nurse and all clinical decisions about treatment were made by respiratory registrars and NIV management trained. The ward had a total of 12 nurses with NIV competencies and maintained a minimum of two NIV competent nurses every shift. The service maintained a risk assessment to reflect that NIV patients required a 1:2 qualified nurse ratio. This was on the service risk register and was monitored. There was no evidence that staffing levels did not meet this ratio at the time of inspection. However, staff were concerned that there was a significant reliance on agency staff to deliver this level of care and there was a risk of appropriate staffing levels could not always be met.
- The ward was supported by two respiratory consultants. Doctors said NIV patients were supported by registrars, consultant support would be requested for potential resuscitation concerns or for when transfers to critical care was potentially needed. This was in line with guidance published by the British Thoracic Society.
- Patients transferred from the emergency department (ED) to a general ward were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week. Only newly admitted patients were seen by a consultant during the weekends.
- The hospital had on-site access to level 3 critical care (intensive therapy units with full ventilator support).
- In the AAU, prioritisation for medical assessments was based on senior nursing clinical assessments and the patient's NEWS. Doctors were present in the AAU day and night so patients could be referred for an urgent medical assessment when needed.
- On Wye ward, we saw that VTE assessments had been completed in a timely manner for four patients' records we looked at.

Nursing staffing

- There was a high level of nursing staffing vacancies across the service. Lugg ward had a registered nursing vacancy rate of 42%. AAU had a vacancy rate of 42% for registered nurses with an overall staff vacancy rate of 30%. Arrow ward had a registered nursing vacancy rate of 19%. Wye ward had a vacancy rate of 18% for registered nurses. The tissue viability nursing team vacancy rate was 48%. The clinical nurse specialist (CNS) cancer vacancy rate was 18%, the CNS respiratory and cardiac rehabilitation vacancy rates were 6%.
- The service had ongoing recruitment plans in place but was experiencing difficulties in recruited registered nurses. The trust was taking a series of actions to address the longstanding nursing vacancies but this was an ongoing challenge for the service.
- All areas reported planned and actual staffing levels using the trust's safe staffing protocols. Wards displayed the number of nurses and health care assistants on duty. Patient dependency levels were reviewed as part of staff rota planning.
- In the nursing staffing report dated 27 August 2015, it was reported that all wards had achieved fill rates of between 90 and 100% for registered nurses and that in some areas, the fill rate for health care assistants was 140%, as more health care assistants were used at times to provide cover when wards were short of qualified nurses. We found on inspection that a number of wards had increased numbers of health care assistants on duty as they ward was short of registered nurses.
- Wye ward had five nurses and four or five healthcare assistants during the day to care for 30 patients, giving a nurse to patient ratio of 1:6. The ward had four registered nurses not five when we visited but had an extra health care assistant on duty. One nurse was from the hospital's bank register. The night shift was staffed as planned when we visited with five qualified nurses and three healthcare assistants.
- Lugg ward had the planned three nurses and three healthcare assistants on duty when we visited in early morning. The ward had 30 patients so the registered nurse to patient ratio was 1:10, for this night shift. We found that there was one agency health care assistant on duty, but that the ward had not completed a written

induction checklist for this staff member. During the day, Lugg ward planned to have five registered nurses on duty; when we visited mid-morning, there were three registered nurses and six healthcare assistants on duty. The needs of the patients were met at this time.

- There was an over reliance on bank nursing staff. Between January and May 2015 the average use of bank staff was 28% on CAU, 23% on Wye and Lugg ward, 21% on Frome ward, and 16% on Arrow ward. On CAU there were occasions were temporary staff were more that 40% of the workforce. On inspection, we found that Lugg ward was staffed with 50% agency nurses.
- There was a trust wide process in place to induct agency staff, however, this was not consistently used. On medical wards, such as Wye and Lugg ward, we found agency staff were not always inducted and evidence of this impacting on patient care. On 24 September 2015 on Lugg ward we reviewed five patients' drug charts and noted that one patient had not had their prescribed medication the previous evening, including enoxaparin, verapamil and metformin. When we raised this with staff, it was found that these medicines had not been given as the agency nurse on duty had not checked the second (of two) drug charts. There was no documented evidence that this agency staff member had received a ward induction. On Wye ward there was no induction checklist or written induction information for agency staff. This meant that there were no processes in place to ensure competent and experienced agency staff were caring for patients within the hospital.
- Frome ward had 15 whole time equivalent vacancies. Three nurses had been recruited and the ward block booked agency staff to maintain staffing levels. We saw evidence of agency induction process in place.
- Nursing staffing ratios on the Frailty unit was one nurse to five patients which met patient needs.
- Arrow ward, the nursing staffing levels met patients' needs and the planned rota. The ward had three registered nursing vacancies and was in the process of recruiting to these posts. Patients on Arrow ward told us that nurses responded very quickly to call bells and requests for support and said staffing levels were adequate.
- Staff said nurses and healthcare assistants were sometimes moved between wards when required to cover vacancies and that staffing pressures were escalated to the clinical site supervisor when required. Ward sisters did not always work their supernumerary shifts when there were gaps on the ward rota. Staffing pressures were reported as an incident but wards did not always receive timely feedback.
- The ratio of qualified to unqualified nursing staff on wards was generally 60% to 40%.
- There were two cardiac failure nurses based in the CCU. Cardiac nurses visited other wards daily to identify patients with cardiac conditions and then to liaise with bed managers to arrange transfers to Arrow ward. This was in response to concerns raised at the June 2014 inspection when there were untimely referrals of cardiology patients to the cardiology ward.
- Junior staff said that whilst the hospital supported the provision of extra staff to provide patients with one to one care when needed, these extra staff were not always found. This had not affected patient care staff told us. We did not see any reported incidents where patients had experienced poor care and treatment due to reduced staffing levels. However, we did see in one patient's nursing notes that four days prior to our visit, the patient had been nursed in bed as there was insufficient staff on duty to provide appropriate support for the patient to be transferred out to a chair using a hoist.
- We observed a nursing handover in the morning on Lugg ward. It was thorough and respectful of patients. Clear guidance was provided for all staff with the focus on patient safety.
- The discharge lounge could support up to 13 patients at any one time. It had one qualified nurse from 9am to 12.30pm, and 4.30pm to 8pm, and two nurses on duty in the afternoons. The lounge also had one healthcare assistant in the morning, three in the afternoon and two in the evening. Planned staffing levels were met according to the rota on the day of our visit. The unit had recently recruited two new registered nurses to cover the staffing vacancies and was in the process of recruiting to the vacant healthcare assistant posts. Staff generally said staffing levels were appropriate but at times, one staff member could be responsible for 10 patients whilst their colleague left to collect a patient from a ward. At weekends, the lounge was staffed predominantly by temporary staff, not all of whom had access to the trust's electronic system, causing a backlog of paperwork to be processed on Mondays.

- The service had one newly started clinical stroke nurse specialist and another two had been recruited and were waiting to start employment.

Medical staffing

- The trust had undertaken a review of medical staffing against the Royal College of Physicians' Guidance in July 2015 and a proposed new medical staffing model was to be introduced in November 2015. Six consultant posts had been advertised.
- Medical staffing was in line was national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality standards in the AMU" dated June 2012, and staff said there was effective out of hours and weekend medical cover provided. Doctors said the level of medical cover in the evenings and weekends was sufficient but the service risk register included the risk the lack of on site consultant cover at the weekends.
- The proportion of consultants (36%) was about the same as the England average (34%), and the proportion of junior doctors (31%) was higher than the England average (22%). The proportion of registrars (30%) was lower than England average (39%).
- Consultants carried out full ward rounds on a Monday, Wednesday and Friday. Board rounds were carried out on a Tuesday and Thursday, where patients that had deteriorated were reviewed in addition to new patients.
- The stroke unit had one substantive consultant, one locum consultant and one vacant consultant post that interviews were planned for in the week after our inspection. There were three cardiology consultants. The service had two health care of the elderly consultants (one full time and one part time), a locum consultant and one vacancy. There were three gastroenterology consultants with a fourth having been recruited and due to start in December 2015. The respiratory service had 2.6 whole time equivalent consultant posts, which were all filled. The acute medical service had two vacancies and recruitment plans were ongoing. Senior staff said recruitment of consultants was an ongoing concern.
- There was one consultant on site from 8am to 8pm during the day over the weekend and would carry out a daily ward round for the patients newly admitted. There was no separate respiratory rota for the weekends. There was no dedicated cardiology consultant on site at weekends but a consultant was on call over the weekends. One medical registrar covered the CCU at weekends from the weekend medical team.
- The stroke unit held daily 9am board rounds during the working week and all patients were reviewed by the consultant daily. Full ward rounds were held three times a week on Mondays, Wednesday and Fridays. Initial thrombolysis (treatment for blood clots) was commenced in the ED on admission.
- Lugg ward had daily board rounds led by a consultant. Ward rounds were carried out for all medical specialties on Mondays and Wednesdays on this ward. Consultants normally started at 9am and junior doctors worked 8am to 5pm during the week. All newly admitted patients were seen by doctors on the day of admission to the medical care wards.
- Arrow ward had a cardiology ward round daily at 8am during the working week and a registrar was available at all times to review any patients showing signs of deterioration.
- Morning handovers generally took place on wards at 9am and were consultant led. A post take ward round took place every weekend morning and new patients were reviewed onwards throughout the day until 8pm. We observed a night medical staffing handover at 9pm. The medical handover at night that we observed was efficient, and there was effective communication displayed regarding patient's conditions. There was a system in place for recording and handing over those patients at risk of deterioration and for those newly admitted patients requiring assessment. There was a tracking system for every medical patient as well as "take" list which showed diagnosis of conditions and actions required. Doctors confirmed these systems worked well. A general medical consultant out of hours on call rota was operated with one consultant on call.
- The service had implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) as recommended NHS Patient Safety toolkit in June 2005 "Hospital at night".
- On Fridays at 4pm, a full medical handover meeting took place to focus the weekend team's activities on management of patients ready for discharge and those requiring monitoring and review due to deterioration. At weekends, the hospital had a registrar covering all medical wards with 120 medical beds and a second registrar focusing on discharges. A third registrar was

based in the AAU. Cover for medical wards was two junior doctors from 5pm to 9pm, with one junior doctor covering the medical wards at night from 9pm to 8am. Junior doctors said the workload was busy, but manageable with support from the nursing staff. Specific handovers did not take place at weekends. The weekend medical team was also supported by a senior nurse from critical care acting as an outreach nurse from 8am to 8pm.

- The hospital had implemented the recommendations for improved, standardised handover protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011. Doctors told us that the electronic tracking and medical update system for all patients were working efficiently.
- An effective on call rota was in place to manage gastrointestinal bleeds.

Major incident awareness and training

- The major incident plan was available on the trust's intranet. The major incident plan was overdue for review in October 2014.
- The trust had appropriate plans in place to respond to emergencies and major incidents including staffing escalation plans. Plans were practiced on a regular basis.
- All the ward sisters we spoke with were aware of the trust's major incident plan and business continuity plans to ensure minimal disruption to essential services. Some staff were aware of the service's plans to meet winter pressures, which including an enhanced focus on discharge planning. However, some junior staff were unware of major incident planning and had not received any major incident training.
- 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. Staff on Arrow and Lugg wards were able to tell us of the ward's fire evacuation plans but not all staff had read the trust's fire safety policy, which was available on the trust's intranet.
- Wards had ward specific based evacuation plans in place in the event of a fire. However, not all wards had immediate access to the fire risk assessment for their own ward.
- 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

Overall, we rated this service as requiring improvement for effectiveness.

Patients did not always have good outcomes as they did not always receive effective care and treatment that met their needs. Performance and outcomes did not meet trust targets in some areas. Mortality ratios were higher than those of similar trusts and the service had a range of actions in place to address this concern.

Multidisciplinary team working was effective. Most staff said they were supported effectively, but there were no opportunities for regular formal supervisions with managers. Appraisal rates for doctors and nurses varied.

We found that staff understanding and awareness of assessing patient's capacity to make decisions about their care and treatment was variable. Appropriate plans were not in place for those patients' assessed as requiring deprivation of liberties.

Care was mostly provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. There was some evidence of progress to providing seven day a week services.

Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain.

Evidence-based care and treatment

- Assessments for patients were generally comprehensive, covering all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was generally planned and delivered in line with evidence based guidelines. However, nursing care plans were not generally patient centred, particularly those for patients living with a dementia.
- 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.
- Arrow ward had a draft care plan for care and treatment of NIV patients, based on national guidance, devised by the lead NIV consultant.
- We saw on Arrow ward that the trust SSKIN care bundle (a nationally recognised plan standing for Surface, Skin inspection, Keep moving, Incontinence and Nutrition) for minimising the risk of skin damage was effectively followed for three patient records we looked at. Appropriate pressure relieving equipment was in place and we saw that patients had been reviewed by a tissue viability nurse (TVN) when required.
- Wye ward had policies in place that followed NICE guidance for care and treatment of patients with a stroke with evidence of effective goal settings to promote rehabilitation. Staff showed awareness of the service's stroke care pathway and we saw effective treatment planning in nursing and medical records. We saw evidence that the ward's standardised therapy assessments tools were based on national guidance, for example use of the Montreal Cognitive Assessment (MOCA) tool and Barthel Index.
- Health care assistants on Wye ward used communication charts to support effective communication with patients that had had a stroke.
- The hospital following 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 ED. 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 service had appropriate guidance in place dated May 2014 that was based on national guidance.
- The service had a care bundle in place based on national guidance for the management of acute kidney infections.

Pain relief

- Patients said that they received pain relief medication when they required it.
- Wards used an assessment tool to determine if patients were in pain. For patients who were not able to communicate, staff told us the assessment of pain depended on the experience of nurse using the tool.
- We saw that patients' pain was assessed on NEWS charts on wards. Records examined showed that patient's pain relief was reviewed regularly and appropriate pain relief was generally given as prescribed when required. However, on Lugg ward we looked at five sets of records, for one there was no record of a pain assessment completed in six out of 19 occasions it had been due. A second patient had had a pain assessment recorded once in the 17 times it had been due. However, according to this patient's drug chart, pain relief had been given three times a day for the previous two days so appropriate pain relief had been offered and given.
- One patient on Lugg ward, who had a complex medical condition and expressed concern about the lack of effective ongoing pain management given by the service. They were referred to another NHS trust's pain clinic.

Nutrition and hydration

- Across all of inpatient services we saw patients were screened for risk of malnutrition on admission to hospital using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST).
- Most wards had protected meal times and patients generally had a choice of meals.
- Wards had appropriate systems in place to ensure that patients' food and fluid intake was recorded when required. We saw evidence that most care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.
- Dietetic support on the wards could be arranged if required. Appropriate finger foods were provided when required for patients living with a dementia.
- The discharge lounge provided sandwiches and drinks to patients awaiting transfer but did not generally have access to hot meals.
- We saw that the wards used red trays and red jugs to indicate when patients were at risk of malnutrition or dehydration.

Patient outcomes

- 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 April 2014 to March 2015 was significantly higher than expected, with a value of 132. At March 2014, the trust's published HSMR for the period January 2013 to December 2013 was 109. 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 the most recent publication of the SHMI indicator, which covered the 12 months period April 2014 to March 2015 mortality was above the expected range of 100 with a value of 114. However, the data for March 2015 reported a 12 month rolling figure of 117. 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.
- In the hospital Intelligent Monitoring (IM) report for May 2015, the trust was flagged as an elevated risk for infectious diseases and nephrological conditions in the in-hospital mortality indicator.
- The trust results for the national Sentinel Stroke National Audit Programme (SSNAP) showed poor results for stroke unit (band E) and speech and language therapy (band E). Overall the most recent published SSNAP audit (March to June 2015), the overall score was band D. This was the second lowest score in the audit with A being the best and E being the worst and was the same overall score as the previous year. The service had an action plan to address these concerns which included the recruitment of clinical staff and the establishment of a hyper acute stroke service.
- Initial thrombolysis (treatment for blood clots) was commenced in the ED on admission. A transient ischaemic attack (TIA) treatment service was provided during weekdays only and was accessed via GP and ED referral.
- As part of the inspection, we tracked the care and treatment for two patients that had been admitted to the ED with a suspected stroke. Both had had timely assessment by doctors in ED and had been admitted to Wye ward stroke unit within 12 hours of admission. Both had been seen by a stroke consultant on arrival to the ward and that all diagnostic tests had been completed in a timely manner.
- The service had improved the proportion of patients that had had a TIA receiving scans and treatment within 24 hours from 20% in February 2015 to 62% in July 2015.
- The service was above the trust target of 80% for patients spending 90% of their time on the stroke unit at 89% in July 2015.
- The hospital performed worse than the England average in nine out of 10 indicators in the Heart Failure Audit for 2013 to 2014 including input from cardiologists and specialists. An action plan was in place to enhance this service and progress was monitored by senior clinicians.
- The hospital performed in line with the England average in the most recent published Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14. 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 lower 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%).
- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2013, Hereford Hospital performed better that the national average in 6 out of the 20 audit measures. One of the 14 areas where hospital performed worse than the England average was insulin errors at 44% against the England average of 21%. Senior nurses were not aware of the findings of this audit or what plans were in place to address the concerns.
- The relative rates of readmission for the service for the period December 2014 for February 2015 showed that for elective respiratory and cardiology patients' readmission rates were the same as the England average. The readmission rates for elective clinical haematology patients were significantly lower than the

England average. For non-elective respiratory readmission rates were less than half the England average and overall for the service, non-elective readmission rates were 20% below the England average.
- The Frailty unit provided 10 physiotherapy and occupational therapy sessions per week for each patient.
- Lugg ward was undertaking a pilot project regarding falls reduction with frequent physiotherapist assessments carried out to review the risk of patients' falling. This was co-ordinated by a designated member of staff and at the time of the inspection, there had not been a fall where a patient had sustained harm for 442 days.
- Local audits were carried out by wards to assess compliance with completion of nationally recognised assessments such as the venous thromboembolism (VTE) and the MUST.
- On Wye ward, stroke patients received a rehabilitation review meeting within six weeks from onset of treatment.

Competent staff

- Generally, we found there were effective induction programmes for new permanent staff, not just focused on mandatory training, for all staff, including students. The learning needs of staff were identified but training was not always put in place to have a positive impact on patient outcomes. We looked at a newly staff member's personnel file on Arrow ward and saw a comprehensive induction process had been completed. A competency course and framework was in place for nurses in cardiology. The service had access to a 12 week induction and competency based course for nurses recruited from overseas.
- The trust did not have clear mechanisms in place to ensure appropriate levels of formal supervision of all staff. Staff at all levels said there was no structured approach for regular operational and clinical supervision. Some senior staff said they had not had operational supervision regularly in the past year.
- The majority of staff said informal support from their managers was effective and provided when they needed it. Senior staff said they received excellent informal support from their line managers.
- Some staff said there where were limited opportunities for professional development.
- Most staff said they had had annual appraisals with a discussion about their learning and development needs, whilst others said they had one booked for the near future.
- The trust provided training for staff to be dementia champions and was a six day external course. The service had 27 dementia champions. Dementia awareness training was available as on online learning package for all staff and at the time of the inspection, 62% of staff had completed this. The training department was looking at producing a more robust new training package for dementia awareness.
- Nurses generally had had an appraisal that linked their training needs to personal development plans. However, on Frome ward, only 25% of staff had had an appraisal in the past year. Staff reported time pressures due to the need to maintain staffing levels as the main factor in this performance. In CCU, 100% of nurses had had their appraisal. On Lugg ward, 33% of nursing staff had had an appraisal but we saw that appraisals had been booked on a rolling basis for the other staff.
- Junior doctors said senior support was effective and that generally the quality of teaching was very good. Protected teaching time every Monday for junior doctors was in place in the service.
- Appraisal rates for doctors varied from 33% for general medical doctors to 100% for gastroenterology doctors. In terms of revalidation, the trust reported that all doctors had undertaken a revalidation process at the time of the inspection.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across some wards. We observed effective MDT working in the wards we inspected. MDT meetings took place on the wards on a regular basis to review the progress of each patient towards discharge. MDT assessments on complex cases generally took place within 24 hours.
- Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway.
- We saw effective MDT working with effective rapport and contribution from all members of the team on Arrow ward. Therapists on Arrow ward held daily morning meetings with nursing staff to prioritise patients to be seen. Doctors said there were not always daily MDT meetings on Lugg ward.

Medical care (including older people's care)

- The Frailty unit held daily MDT meetings at 12 midday Mondays to Fridays with the focus on effective treatment and discharge planning for patients living with a dementia. Therapists were an integral part of the MDT.
- Nurses said that relationships with doctors and other professionals were inclusive and positive and facilitated effective MDT working.
- Pharmacists generally attended wards rounds and were a visible presence on wards.
- Therapists were an integral part of the MDT on the stroke unit.
- Staff were aware of which clinician had overall responsibility for each patient's care.

Seven-day services

- Senior staff said the service was looking at ways to fully adopt a seven day a week working practice for doctors. Newly admitted patients were seen by the on call consultant at weekends as required, but there were not generally full ward rounds at the weekends.
- The service was considering having two consultants on site at weekends as part of the move to seven day working. There was one consultant on duty during daytime at weekends from 8am to 8pm.
- At weekends, the hospital had a registrar covering all medical wards and a second registrar focusing on discharges. A third registrar was based in AAU. Cover for medical wards was two junior doctors from 5pm to 9pm, with one junior doctor covering the medical wards at night from 9pm to 8am. Junior doctors said the workload was busy, but manageable with support from the nursing staff. Not every patient had a medical review over the weekend, as the medical team focused on reviewing newly admitted patients to the service. Doctors were reliant on nursing teams to escalate any patients on medical wards requiring a review.
- At weekends, the on call junior doctor worked 9pm to 9am, with a second junior doctor working 4pm to 8pm to support assessments of newly admitted patients to medical care wards.
- As there was not a dedicated cardiology team on duty at weekends, the cardiology service held a formal handover meeting on Friday afternoons to identify those patients that may require urgent review over the weekend.
- There was a consultant on call 24 hours a day, seven days a week to respond to urgent cases of gastro-intestinal bleeds.
- The discharge lounge was open on Saturdays and Sundays from 9am to 6pm.
- The pharmacy closed at 12 midday at weekends which meant medical staff had to focus on discharge planning in the mornings at weekends to ensure timely requests for medicines to take home for discharge.
- Diagnostic services were available over the weekend and out of hours.
- On the Frailty unit, there was no specific therapy provision at the weekends. Nurses would follow therapy plans when required.

Access to information.

- The trust told us that electronic patient records were to be implemented within the next two years. Doctors completed electronic discharge summaries (EDS) to ensure appropriate information was available to healthcare professionals regarding patients' discharges.
- Generally, doctors and nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.
- There was a process in place for ensuring that when the electronic record systems were unavailable, clinical staff could access a back-up system, as well as using a range of alternative databases in order to obtain relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. Most wards had trust posters on display giving information regarding mental capacity and Deprivation of Liberty Safeguards (DoLS).
- Therapists told us that a patient's verbal consent was always obtained before carrying out treatment plans.
- We did not see robust evidence of meaningful mental capacity assessments being carried out and recorded on the trust's own capacity assessment documentation in some areas.

Medical care (including older people's care)

- Staff on Wye ward said mental capacity act and DoLS training was via the trust's online learning system and that had competed it.
- On Wye ward, we found that one out of three patients, that were cared for by staff as having a DoLS authorisation in place, did not have a record of a completed mental capacity assessment to inform the DoLS application. This was not in accordance with trust policy. In all three cases, nursing staff told us that the patients were cared for as though a DoLS authorisation was in place, but we found that in none of these three cases had an authorised application by the local supervisory body. There were no nursing care plans in place to reflect the fact these patients were on a DoLS, or were awaiting authorisation. This meant that the patients were, in effect, deprived of their liberty without a standard DoLS authorisation in place. We raised this with the trust's safeguarding adult's lead, who confirmed that the trust did not have a written process or guidance for staff around this delay in the local supervisory body arranging for assessment of the DoLS standard authorisation. "Staff should have been caring for people as it was in their best interests to have a DoLS in place", we were told. However, there were no nursing care plans to reflect this and all staff we spoke to stated that the care was given as "a DoLS was in place".
- At the time of the inspection, there were 22 patients being treated as though a standard authorisation for DoLS was in place, but only two of these applications had been authorised by the local supervisory body. The trust had not undertaken any audits on the efficacy of MCA assessments or DoLS applications.
- This meant that due to the reported delays in the Best Interests assessments as part of the standard authorisation process, patients were, in effect, being deprived of their liberty as they had no process or care plans in place regarding this position.

Are medical care services caring?

Good

Overall, we rated this service as good for caring.

Overall, medical inpatient services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. We saw that staff interactions with patients were generally person-centred and unhurried.

Patients told us that the staff were caring, kind and respected their wishes. Most patients' we spoke to during the inspection were complimentary, and full of praise for the staff looking after them.

The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams.

Compassionate care

- Patients and those close to them were generally treated with respect, including when receiving personal care.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with patients and those close to them. Staff spent time talking to patients, or those close to them. Patients generally valued their relationships with staff and experienced effective interactions with them.
- Staff generally respected patient's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- We spoke with 30 patients and 12 relatives. Patients were positive about their experience within the inpatient services. We observed staff spoke in a kind and considerate manner with patients.
- The majority of patients were positive about the care they received on the wards. Staff were proud of the positive feedback they received from patients.
- A patient told us on Lugg ward; "staff are very caring and very patient".
- Patients on the Wye ward told us; "the care is second to none" and "they explain the tests to me clearly so I know what is happening".
- Confidentiality was generally respected at all times when delivering care, in staff discussions with patients and those close to them and in any written records or communication.

Medical care (including older people's care)

- Some staff said that handovers did not always respect patients' confidentiality as sometimes staff talked about confidential matters in front of other patients. We observed some nurses on Lugg ward discussing patients in front of other patients at a handover.
- The trust had a 20% better response rate than the England average in the Friends and Family Test (FFT).
- In the Friends and Family Test, bar a two month period in May and June 2014, results were on par with, or better than, the national average.
- All wards had a performance noticeboard on display with showed the most recent FFT scores. For example, Lugg ward had a response rate of 72% for August 2015 and an overall recommendation percentage of 95%.
- For August 2015, all medical care wards achieved the trust target of 95% recommendation percentage, apart from Wye ward, which achieved an overall recommendation percentage of 83%. Arrow ward had a 100% positive recommendation rate for this month.
- The discharge lounge did not take part in the FFT but this was being considered.
- In the patient-led assessments of the care experience the trust was performing about the same as the national average.
- The performance in the CQC inpatient survey, published in May 2015, was about the same as other trusts in all questions. 470 people took part in the survey.
- The trust participated in the National Cancer Experience Survey, which was published in September 2014. Between 1 September and 30 November 2013, 327 eligible patients from the trust were sent a survey, and 204 questionnaires were returned completed. This represented a response rate of 66% once deceased patients and questionnaires returned undelivered had been accounted for. The national response rate was 64%.
- The trust scored in the top 20% nationally for nine of the questions including choice of treatment, and patients' views being taken into account by doctors when planning treatment. The trust was in the middle 60% of trusts for their performance against 17 indicators.
- However, there were eight questions for which the trust's responses were in the bottom 20%. These included the questions relating to a lack of information about side effects of treatments, and a lack of written information about operations.

Understanding and involvement of patients and those close to them

- Most patients felt involved in planning their care, making choices and informed decisions about their care and treatment. However, we found that generally, patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge.
- Staff generally communicated in a way that patients could understand and was appropriate and respectful.
- Verbal and written information that enabled patient's to understand their care was available to meet patient's communication needs.
- We observed therapists supporting and involving patients appropriately with their therapy assessments on the stroke ward.
- Wards had a named nurse system so patients and their relatives generally knew who was looking after them.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition which meant that patient's understood why rehabilitation or changes of arrangements were required prior to safe discharge. Not all patients said doctors explained their treatment options for them.
- Patients and relatives on the stroke ward said they had been fully involved in decisions about their care.
- Some patients were not always clear about their plan of care.
- We found there was little activity for patients who had been admitted for many weeks.

Emotional support

- Most patients we spoke with were very positive about the support they had been offered by the multidisciplinary team.
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- Psychologist support from the community was available when required.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement

Overall, we rated this service as requiring improvement for responsiveness.

Patient's needs were not consistently met through the way services were organised and delivered. There was an elevated demand on bed availability at times, and there were high numbers of patient moves at night

Some problems with the effective discharge of patient's were highlighted across the medical care service, and the service was seeking to improve this process.

Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning to provide effective person-centred dementia care.

Cancer referral to treatment times were on a par with the national average.

Medical patients in outlying wards were generally effectively managed. There was a policy in place regarding the management of outliers.

Concerns and complaints procedures were established and generally effective. Information was available for patients regarding how to make a complaint.

Service planning and delivery to meet the needs of local people

· The service was not providing a hyper acute stroke service, which was provided by another local NHS trust. The service was planning with commissioners to open six hyper acute stroke beds within the next few weeks following a business case that had been prepared in October 2014 with a redesign of the service's stroke pathway. An early supported discharge initiative for stroke patients had commenced with early identification of those patients that could be appropriately transferred to community settings. A second computerised tomography (CT) scanner was planned to be operational in December 2015, which would improve the time to scan performance within the service.

· The service provided six coronary care beds and a cardiac catheter laboratory which was for diagnostic tests only. Another local NHS trust provided the acute cardiac interventional service which meant some patients were taken by ambulance on a 45 minute journey to this other hospital to receive treatment and then transferred back to this hospital when stable. The service had an in reach cardiology nursing team but this did not provide an outreach service to the patients in the community.

· The hospital provided a clinical assessment unit for both medical and surgical patients that could accommodate up to 16 patients (9 beds spaces and 5 chairs).

· Patients requiring care and treatment for acute renal failure were transferred to another local NHS trust for haemodialysis and subsequently transferred back to the hospital.

· The trust had a dementia care strategy and policy which was produced in 2014, with the long term aim of the hospital becoming dementia friendly. However, senior doctors and nurses told us that there was no formal designated lead driving the strategy forward so it had "stalled". In part this was due to the loss of hospital based social workers some three years ago.

· The trust's winter pressures plan including the opening up of new purpose built 16 bedded Frailty unit with a nurse to patient ratio of one to five. This was due to open in November 2015.

· The discharge lounge had appropriate facilities to meet needs of up to 11 seated patients and two patients requiring care on a hospital bed. However, the lounge had no access to a hoist; the referral criteria to this lounge reflected that patients needing mechanical assistance to transfer could not be accommodated.

Access and flow

· The trust was meeting most of the cancer standards in July 2015. Performance on the two week wait 'all cancer' indicator improved to 95% against the 93% target. 31 day performance for first treatment had improved to above the target of 96% in July 2015 to 98%. The Department of Health has recently reiterated the pre-eminence of the 62 day cancer standard from urgent referral to treatment. For the trust, 62 day performance for first treatment for GP referrals had improved to 86% in July 2015 above the 85% national target.

Medical care (including older people's care)

· Due to bed capacity and high level of patient admissions, at times there was ineffective patient flow through the hospital. There were high numbers of patient moves between wards at night and significant numbers of patients awaiting discharge.

· Referral to treatment data within 18 weeks by specialty (for the period April 2013 to April 2015) showed the trust was meeting the standard for 6 out of 7 specialities. Referral to treatment within 18 weeks percentages were consistently above standard and England average apart from between November 2014 to February 2015 where it was worse than both the standard and the England average.

· The average length of stay in the service was similar to England average for non-elective and better than average for elective stays as reported in the period January to December 2014.

· The trust's bed occupancy rate had been, on average, around 10% higher than the national average. However between January and March 2015, it had dropped below the average. At the time of the inspection, bed occupancy was 96%.

· In the period April 2014 to April 2015, 25% of patients had not moved to a different ward during their stay at the hospital, which was about the same as the previous year. Nearly 7% of patients had been moved four times or more during this period, a slight increase on 5% total for the previous year.

· The trust had held a "perfect week" initiative called Focus on Flow in July 2015 prior to the inspection with the focus on patient flow and discharge planning. The medical team was supported by a general practitioner in CAU on the ED which was effective in managing the flow of patients from ED to medical care wards. This initiative was being reviewed and outcomes considered as part of an ongoing review into level of medical cover and staffing rotas to promote effective patient flow through the service.

· Bed management meetings were held four times a day to discuss and prioritise bed capacity and patient flow issues. The service used a bed capacity "predictor tool" to forecast bed capacity and demand.

· 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. The hospital also had a registrar on duty at weekends with the focus on discharge planning for patients. The hospital had an average need for 30 or 40 medical beds per day for new admissions and had a patient flow escalation policy in place to provide guidance for staff managing bed capacity concerns. Doctors completed electronic discharge summary letters (EDS) usually after the morning ward rounds so at times, these EDS letters were completed whilst he patient was in the Discharge Lounge.

· The service had on average 12 patients per day that were assessed as fit for discharge over the past month. The trust told us that the majority of delayed transfers were awaiting appropriate care packages or beds in the community. Staff told us morning consultant ward rounds mostly included discussions about patient discharges. This generally allowed for an early assessment of the patients plan of care, discussions with the patient and their relative and, to identify any potential barriers to discharge.

· The hospital had a complex discharge team that co-ordinated the discharge planning for those patients requiring enhanced community support. This team liaised with social services and six local community hospitals and attended twice weekly multidisciplinary meetings with partner organisations to focus and facilitate on those patients with complex discharge arrangements. The complex discharge team worked Mondays to Saturdays and was planning to provide a full seven day service the week following the inspection. In the event of the need for additional bed capacity due to significantly high demand, the hospital had plans in place regarding the use of the medical day case unit which had the appropriate facilities to be able to provide an additional 16 beds, ideally for surgical patients. The trust had reviewed this escalation policy in May 2015 and any instances whereby this escalation procedure was required, would need to be authorised by the director on call, in liaison with site supervisor and bed management team. Patients were assessed by their named consultant or registrar as whether they were suitable for transfer to this escalation area.

· Some wards had their own discharge nurses during the week: for example, Lugg ward had a discharge nurse working from 8am to 3pm on Mondays to Fridays.

Medical care (including older people's care)

· The average length of stay of patients on the Frailty unit was up to 10 days, with a 72 hour target. However, given the complex discharge planning arrangements for patients living with a dementia, the unit's consultant's preferred option was to maintain this group of patients in the one unit, as opposed to transferring them to general medical wards.

· The hospital had staff acting as patient flow trackers and their role was to visit wards and to identify patients potentially ready for discharge and liaise with the bed management team and discharge lounge to facilitate appropriate discharges. These staff also supported with internal ward transfers.

· We visited the discharge lounge as part of the inspection, which could accommodate up to 13 patients, including two requiring care on a hospital bed. This lounge was open from 9am to 8pm Mondays to Fridays and at weekends from 9am to 6pm. The discharge lounge had a policy in place governing the requirements for referrals to the lounge and this contained appropriate admission criteria to this lounge as guidance for staff to follow. Staff confirmed that they would report any inappropriate referrals to this lounge using the trust's electronic incident reporting procedures. Feedback was received and learning shared at team meetings. The average waiting time in the lounge was five to six hours and this could be due to waiting for transport, discharge letters or medicines to take home.

· The CAU also provided up to two trolleys for medical day case patients for planned treatments such as blood transfusions as a measure to prevent some hospital admissions. They also provide chair capacity when required.

· There were 16 medical patients outlying in other speciality beds on the day of inspection. The average was 11 patients outlying in other service beds in August 2015. There was a policy in place governing the management of outlying medical patients (dated May 2014) and this included guidance for the assessment and ongoing monitoring of those patients. Senior staff said these patients were discussed during ward rounds and seen as part of the round. We saw from medical notes that patients were reviewed by doctors, but not always consultants during the week or at the weekends.

· Trust policy stated that patients' moves at night should not occur after 10pm, unless a critical condition meant it was necessary. In the week before our inspection, there was between 16 and 25 patient moves at night per day. The information we were given by the trust did not specify which moves were for urgent clinical reasons or which were for bed management issues. The trust did have a policy in place regarding patient moves including risk assessment of the necessity and impact of such moves. We saw that these had been completed in both records we looked at regarding this.

Meeting people's individual needs

· Care plans were not consistently personalised or holistic to enable patient's to maximise their health and well-being. Not all patients were able to describe what their care was and how it was delivered to meet their needs. The needs of patient's living with a dementia were not always detailed in care plans and assessments and most assessments and care plans lacked a person centred, individualised approach.

· The service used an admission tool to screen patients for delirium and dementia but this was under review and a new system was being considered as staff considered it could be improved.

· Some nursing care plans focused on specific identified needs, for example: falls, nutrition, pressure area care. Information from the trust's "Important things about me" documentation for care of patient's living with a dementia, was not consistently transferred through to meaningful nursing care plans to provide clear guidance for patient's living with a dementia.

· Whilst most medical records showed that a delirium and dementia screen assessment had been completed where required, on Lugg ward, we found one such assessment for a patient living with dementia was incomplete with the assessment form not completed apart from the word "dementia" written on it.

· The Frailty unit provided beds for up to 14 patients living with a dementia. Staff had had dementia awareness training and the unit had a dementia champion, as well as access to therapy services and dietician support. The purpose of this unit was to act as an assessment unit for patients living with a dementia and other frailty conditions.

· The service had a dementia support worker based on the trust's quality and safety team whose role was to visit all wards to provide support for the care and treatment for patient's living with a dementia.

· The service used appropriate, discrete signage, to indicate where patients had a diagnosis of dementia, for example the use of the "forget me not" flower.

· The needs and wishes of patient's with a learning disability or of patients who lacked capacity were understood and taken into account. On the Frailty unit, we saw how a patient with a learning disability had been supported effectively by the staff and saw good communication between staff and the patient's own carers.

· On Lugg ward, a health care assistant had won a trust ward for their work on supporting a patient with a learning disability by producing an individualised information sheet regarding this patient's specific needs.

· There were five mixed sex breaches reported in CCU in June 2015 and mitigating actions as agreed by the Trust Development Agency were the use of dignity screens.

· Staff on the stroke ward told that if patients required information in other formats, they could request communication aids from therapists.

· Staff told us they knew how to access interpreting services and how to use them to improve communication with patients.

· Patient information leaflets were available and staff told us they were given to patients on admission.

· Visiting times could be flexed to allow for relatives of elderly patients to maintain family contact throughout long periods of admission.

· In most wards patients had minimal stimulation or activities provided beyond access to a television or radio.

· Some wards had quiet areas for discussion with patients and relatives. Patients had access to a chapel and multi faith room on site.

· Patient care records showed that the spiritual, ethnic and cultural needs were assessed on admission. Staff told us patient care would be tailored according to their needs. We saw cultural information files available, with details of religions and their naming conventions, beliefs, rites and rituals and end of life beliefs. Staff said they have had training and support in this area.

· Patients generally said the meals provided were good and they were offered a choice appropriate to their dietary preferences.

Learning from complaints and concerns

· Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.

· Complaints procedures and ways to give feedback were in place. Lugg ward had comment cards, complaints leaflets and Patient Advisory Service (PALS) information readily available.

· Patients were supported to use the system and to use their preferred communication method. This included enabling people to use an advocate where they needed to. Patients were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures.

· The trust reviewed and acted on information about the quality of care that it received from patients, their relatives and those close to them and the public.

· We saw many compliment letters and thank you cards displayed in ward areas.

· There was a complaints procedure on display in the wards. Staff told us that during their admission process patients were routinely given a leaflet containing information on how to make a complaint.

· Information about compliments and complaints was on display on the ward notice boards. For example, Wye ward had had one complaint in the previous month.

· Between January to July 2015, there had been 82 complaints within the service and the service was meeting the trust target for complaint responses within 25 days.

Medical care (including older people's care)

· Staff said complaints and incidents were not regularly discussed at team meetings so the wards were not always able to show how lessons had been learning and shared from complaints. Patient satisfaction surveys were carried out in all areas.

· Staff said senior nurses investigated complaints and the outcomes were usually discussed with staff. Wards had performance boards on display so visitors and patients could see how their comments were acted upon.

Are medical care services well-led?

Requires improvement

Overall, we rated this service as requiring improvement for being well led.

The leadership and culture did not always promote the delivery of high quality person-centred care as governance and risk management systems were not fully embedded throughout the service.

Some staff did not receive feedback from patient safety incidents.

The visibility and relationship with the middle and senior management team was not clear for junior staff.

Not all staff felt able to contribute to the ongoing development of their service.

Not all junior staff were fully aware of the vision and strategy of the trust.

Most staff felt valued and listened to and felt able to raise concerns.

The medical care service was generally well-led at a ward level, with evidence of effective communication within ward staff teams.

All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible.

Vision and strategy for this service

- The trust overall had a statement of vision and values, but not all staff at all levels were fully aware of this vision.
- There was no service specific written strategy for the medical care service.
- Seniors managers told us of the service's aspirations for cross county integrated working with effective links to community care support.
- All the ward sisters told us they felt part of the trust and some staff described a trust that listened to, valued and supported staff.
- All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed.
- Not all staff were aware the trust's values and vision, though some were very aware and stated that the vision and values had been part of their interview process.

Governance, risk management and quality measurement

- Local wards did not have their own risk registers in place. Ward managers were aware of how to escalate risks to the divisional risk register. However, junior staff did not have a full awareness of this governance process and not all staff were aware of the service risk register.
- On some wards we found that there was a lack of understanding in relation to how learning from incidents was implemented as not all staff were not aware of learning from incidents being regularly discussed at team meetings.
- At a local level, there was variation in arrangements to investigate and learning from incidents. Risk management processes were not fully understood at all levels in staff teams.
- Lead nurses and heads of nursing said senior nurse meetings were held monthly discussed special mortality reviews, patient concerns, serious incidents and how to implement ward based changes to learn from incidents.
- Staff said performance information and learning from complaints was discussed regularly at team meetings, but this was not consistent across the service.

Leadership of service

- Staff and leaders in the wards generally prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership within the division had recently provided a fresh impetus in terms of resolving some longstanding concerns in the division. The HSMR and SHMI had been high for some time and the service had not been proactive in managing this risk previously.

- Senior leaders understood what the challenges were to delivering high quality care and but had not always taken action to address them. Middle managers had not always communicated the significant quality and safety issues throughout all staff teams.
- The majority of staff felt respected, valued and supported. Local ward leaders communicated effectively and were visible to teams and staff.
- Lead nurses and heads of nursing had met most, but not all of the executive team, and most said they were visible on the wards. Senior staff met the divisional managers regularly, but junior staff said this was infrequent.
- Most staff said the chief executive and senior leaders were visible. Most staff said feedback from middle and senior managers was improving but was varied.
- Health care assistants said the director of nursing was visible and visited ward areas often and was approachable.
- Junior doctors said there was a supportive culture on the wards, with senior doctors and lead nurses and heads of nursing available and approachable. A weekly meeting for junior doctors with some consultants was held every Monday morning.
- Some wards, for example the Frailty unit, had weekly operational management meetings with the focus of ward performance.
- Local teams generally had clearly defined tasks, membership, roles, objectives and communication processes.
- Nursing staff reported that they generally felt supported by their manager within the endoscopy unit.

Culture within the service

- Across all wards staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Most staff were aware of the trust's values.
- Most staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings, and receiving newsletters.
- Senior managers said they were well supported and effective communication with the executive team.
- Senior staff said there was generally a cohesive style throughout the division. Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.
- Senior nurses on Arrow and Lugg wards were proud of their staff and of how effective team working was.
- Sickness rates for the service were generally better than the trust target of 3.5%

Public engagement

- The trust and all staff recognised the importance of the views of patients and the public. A standard approach was taken to seek a range of feedback with participation and involvement with both the public and staff including surveys, comment cards and questionnaires.
- Information on patient experience was reported and reviewed alongside other performance data but not all staff felt patient feedback was used to make informed d decisions about the service.
- Patient's views about the care they received were displayed on a performance board on wards. Some wards showed examples of making changes as a result of feedback. For example, in CAU, in response to patients' comments, staff had undertaken an analysis of the average discharge waiting time and that in May 2015, it was six hours. This information was displayed on the performance board.

Staff engagement

- Some staff generally did not feel actively involved in making decisions about the service. There were instances of effective ward leadership and support but not all staff felt their views were heard at more senior levels. Some staff said there that best practice was not always effectively shared across the trust.
- Not all areas had regular team meetings where information and learning from safety and quality audits could be shared.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.
- Some junior staff generally felt communication was "top down" and did not always feel their views were listened to at senior levels in the service.
- Some senior nurses had access the trust's people leadership programme and said it would promote enhanced team working in their teams.
- Some senior staff said non-executive directors visited wards on a monthly basis and found this to be supportive.

Innovation, improvement and sustainability

Medical care (including older people's care)

- Generally, there was not significant evidence of innovation, improvement and sustainability across the service.
- Senior therapists were planning a rehabilitation focused staff roadshow to promote rehabilitation for nurses and health care assistants.

Surgery

Safe	Requires improvement
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. Surgical service provision covers specialisms including orthopaedics, trauma care, ear, nose and throat (ENT), dermatology and ophthalmology.

There were seven operating theatres as well as pre-assessment and day case surgery areas. The trust has a fully equipped mobile day surgery unit at Hereford Hospital that opened in November 2014. The Kenwater Surgical Unit has the capacity to treat seven morning and seven afternoon minor surgical cases.

The hospital performance summaries for 2014/15 show that there were 3,897 elective spells (continuous stays of patients using hospital beds) and 16,459 day case spells. The 'hospital provider spells' identified that 53% of surgical services were day cases, 17% were elective cases and 30% were emergency cases.

We visited all surgery services as part of this inspection and spoke with 31 staff including health care assistants, doctors, consultants, therapists and ward managers. We also spoke with 13 patients and examined 13 patient records, including medical notes.

Summary of findings

We found safety within the surgical services required improvement.

Medical staffing was appropriate and there was good emergency cover. However, there was a shortage of nursing staff and a high number of vacancies. The skill mix of nursing was not always appropriate for patients, and nursing staff did not always have time to meet patients' care needs.

There was a culture of incident reporting, but some staff said they did not receive feedback on incidents submitted. However, staff said they received consistent feedback and learning from serious incidents generally. The environment was visibly clean and most staff followed the trust policy on infection control.

Treatment and care were provided in accordance with evidence-based national guidelines. However, we observed variance in the outcomes such as the National Joint Register. For the 12 month period from April 2014 to March 2015 (published October 2015), the trust's Summary Hospital Mortality Indicator (SHMI) was identified as 'higher than expected' with a value of 117 (compared to 100 for England).

There was good practice, for example in pain management and the monitoring of patient nutrition and hydration in the perioperative period. Multidisciplinary working was evident. Although staff had access to training, they said this was often cancelled due to staffing shortages. Staff said they received annual

appraisals, but trust records showed that appraisal levels were below the required target. Ward sisters were aware of the shortfall in clinical supervision and said they were reviewing ways to ensure staff received regular supervision. Consultant-led, seven-day services had been developed and were embedded into the service.

Most staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Patients told us that staff treated them in a caring way and that they were kept informed about and involved in treatments received. We saw patients treated with dignity and respect. We observed staff provide good emotional support during our visit to the day case unit (DCU).

We found surgical services did not record or report waiting times for surgery. In April 2015 the trust board requested suspension of national reporting for non-admitted and incomplete pathways as a result of concerns over quality data. From April 2015 onwards, the admitted RTT performance was the only measure reported. Although priority was given to patients with two weeks wait and urgent care, the surgical waiting lists were not risk assessed and patients did not have their conditions reviewed. The trust did not report the 18 weeks between referral and surgery. Services were developing to improve the response to increasing demand, and patients had surgery based on clinical need. However, capacity issues remained and a lack of available beds resulted in patients spending longer periods in the theatre recovery areas.

Patients stayed longer than 23 hours on the surgical day unit. There were various inefficiencies in discharge arrangements for surgical patients, with the result that many were discharged later in the day than planned. There was guidance in place within the trust to ensure that patients did not remain on the day surgery unit for longer than 48 hours. When a patient was required to remain on the day ward for longer than 48 hours then the staff completed an incident report for every further 24 hour period.

There was support for patients with learning disabilities, including reasonable adjustments that could be made to the service. However, information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were resolved.

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Surgical services required improvement to be well-led. Some staff said they felt pressurised when patient admissions fluctuated and that they received poor support during stressful periods. There was poor awareness among staff of the values and expectations for patient care across the trust. Staff were not aware of outcomes regarding their allocated key performance indicators and the trust did not ensure that staff monitored the outcomes of the patient care involvement plan. Strategic plans were addressing capacity issues, and risks were identified and managed or appropriately escalated. Staff could speak openly about issues and serious incidents but said they did not receive feedback on incidents submitted.

Surgery

Are surgery services safe?

Requires improvement

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

There was a high number of nursing staff vacancies in surgery. Safe staffing levels were achieved by the use of bank and agency staff. Staffing was a concern, as agency staff did not always receive an appropriate induction and patients on wards were treated by nurses who were sometimes not from the appropriate specialty to provide skilled care.

There was access to appropriate equipment to provide safe care and treatment. Surgery staff told us they were encouraged to report any serious incidents, which were then discussed at team meetings. However, most staff said they did not consistently receive feedback from localised incidents reported. The hospital's surgical safety checklist was fully completed for all patients.

We observed that most records included loose pieces of paper that were at risk of being misplaced or lost. Some records were stored inappropriately within the wards, which meant they could be accessed by people visiting the wards.

We saw that training levels were below the recommended target set by the trust. Some staff could not access the trust's electronic learning system as they did not have smartcards. Bank staff also had access to the trust's training programme, but ward staff did not always check this access to ensure that bank staff were competent in their roles.

Medicines were appropriately managed and stored within the service. The five steps to safer surgery surgical checklists were completed. However, we observed that the checklists were not always completed correctly, for example by the appropriate staff member being absent or by failing to mark and identify the relevant surgical sites.

The service had procedures for reporting all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm-free care.

Staff had an understanding of safeguarding, but training levels in this area were below the trust's acceptable targets.

The environment was visibly clean and staff followed the trust policy on infection control.

Patients were appropriately escalated if their conditions deteriorated. Medical staffing was appropriate and there was good emergency cover. Medical handovers were well structured within the surgical wards visited.

Incidents

- There had been two 'never events' in the trust between May 2014 and April 2015 which occurred within the surgical services. 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.
- We saw that one never event which occurred in May 2014 had been reviewed with a full root cause analysis (RCA) of the incident. Staff within the surgical services were able to identify and discuss the incident. We saw team meeting minutes in place to discuss the outcomes of all serious incidents. A revised guideline has been produced in relation to the insertion and removal of a guide wire.
- Staff told us they were aware of the second never event which occurred in April 2015. They told us this was being investigated in accordance with the trust's framework and they would be informed of any actions to be considered when the RCA was completed.
- Between May 2014 and April 2015, surgical services reported 10 serious incidents through the Strategic Executive Information System (STEIS). We saw that the most frequently reported incident related to grade 3 pressure ulcers and slips, trips and falls.
- All serious incidents were analysed to ensure lessons were learnt. For example; the review of assessments for patients in respect of slips, trips and falls. Staff within the surgical services told us they were informed of serious incidents and we saw copies of team meeting minutes which showed that incidents in surgical services had been addressed in a timely manner. However, staff told us they did not receive any feedback regarding any localised incidents they may have submitted.

- Ward sisters understood their responsibilities with regard to the duty of candour legislation. The duty of candour legislation requires an organisation to disclose and investigate mistakes and offer an apology. The ward sisters described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. However, some staff were unable to describe the process to follow which involved a conversation with a patient, a parent or carer by explaining what had happened and how they would provide assurance this would not occur again.

Safety thermometer

- NHS Safety Thermometer information was displayed at the entrance to each ward so that all staff and relatives were aware of the performance. This included information about infections, new pressure ulcers, friends and family results, staffing levels and number of patient falls.
- For surgical services overall, there were 11 C.UTIs from June 2014 to September 2014. During October 2014 and January 2015 there were none recorded, but the records show a steady increase of at least one a month since then.
- Between June 2014 and June 2015, there was a total of nine pressure ulcers level 2, 3 or 4 recorded for all surgical wards with one a month occurring in six of the last seven months. There have been four falls recorded from November 2014 to June 2015.

Cleanliness, infection control and hygiene

- The surgical wards visited were visibly clean, with the appropriate green 'I am clean' sticker on the equipment being used.
- Hand hygiene gels were available outside the wards, bays and side rooms. Hand-wash basins were also available in bays and side rooms.
- Instructions and advice on infection control were displayed in the ward entrances for patients and visitors which included how to prevent and reduce infection. Personal and protective equipment, such as gloves and aprons, were available in sufficient quantities.
- There was awareness among staff about infection control and we observed most staff followed the trust policy on infection control which included the washing of hands and the use of hand gel between treating patients. During our visit to the day case unit (DCU) on 22 September 2015 we observed that not all staff followed the infection control policy. For example during a handover, we observed staff picking up several sets of notes and touching patient's beds without washing their hands. This was brought to the attention of the sister in charge. During our re-visit on 23 September 2015 we observed staff following the infection control guidelines. There was adherence to 'bare below the elbow' policy in clinical areas.
- In each ward area, staff had audited their performance to infection prevention and control measures; reports were shared with staff at meetings and on noticeboards. We saw outstanding actions which included for example; repairs to damaged walls in the ward areas.
- There were no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) recorded since May 2014. The trust told us that patients in all specialities were screened for MRSA on admission which was identified in the records read. However, we found that the medical outliers records read on Teme ward did not identify the results of MRSA screening. Staff were aware of this and told us that medical patients were not placed within the same bays as surgical patients to minimise any risk.
- Following the discharge or transfer of medical patients from Teme ward, the records showed that a full and appropriate deep clean of the ward and bays had been carried out prior to the admission of any other patient.
- The DCU did not have an isolation room. One patient was barrier nursed at the bedside as no side rooms were available to transfer the patient. This meant there was a risk of other patients within close proximity developing an infection.
- In operating theatres, there were dedicated cleaning rotas with clear responsibilities; their work was checked and reviewed by senior management.

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.
- There was sufficient equipment to maintain safe and effective care.
- Equipment had portable appliance testing (PAT) stickers with appropriate dates. A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use.

- The doors to operating theatre 2 were found to be not working properly. This was brought to the attention of the trust for urgent action. We noted the matter had been resolved within 24 hours.
- We visited the orthopaedic theatre and found the building to be well ventilated and the theatres to be very organised. However, the theatres had insufficient store rooms and we found an arthroplasty kit kept in the corridor. An arthroplasty kit is utilised during joint replacements.
- Within the theatres we observed white boards in use with patient details outlined.
- The trust received 160 alerts during 2014/15 from the Central Alerting System (CAS). This includes safety alerts, drug and equipment alerts from agencies such as the Department of Health, the Patient Safety Agency and the Medicines and Healthcare products Regulatory Agency. We saw the quality report for 2014/15 which stated that the trust had responded appropriately to all CAS alerts within the appropriate timeframe.
- Staff within the recovery unit said they had all the emergency equipment they required at hand. We observed sufficient equipment available during our visit to the recovery unit.

Medicines

- Medicines were checked and reconciled by staff weekly. We saw completed monthly audits in relation to checking stock and utilisation.
- Pharmacy staff allocated to wards checked medicine charts daily through weekdays, and provided advice on, for example, doses and contraindications.
- Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs). We examined the CD registers and found these to be appropriately completed and checked.
- Medicines within the wards were stored correctly, including in locked cupboards or fridges when necessary.
- The temperature of medicine fridges were monitored daily. The medicine fridge on the DCU had been broken for over a week. The sister in charge told us this had been reported and they unit had access to medicines from Kenwater Surgical Unit if required. On the day of our visit to the DCU we observed the instillation of a new fridge.
- 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).
- Staff were able to outline the reasons for varying doses of medicines which ensured that patient's safety was maintained.
- We observed medicines were stored appropriately within the theatres visited with no issues or concerns identified.
- During our visit to Leadon ward we observed that specimens due for collection were not stored appropriately. This meant there was a lack of confidentiality as any person passing was able to view the information and there was a risk of specimens being accessed.

Records

- In surgical wards and theatres, we examined 13 patients' case records, which included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-assessments made on patients prior to admission.
- The records read showed that the five steps to safety surgery checklist records were completed for all patients.
- The wards had care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards had access to information on how to care for a patient. Care bundles were used for patients when appropriate.
- In ward areas, nursing and medical staff used the shared assessment record to ensure risk assessments were completed; examples included falls and nutritional risks.
- We found that all records viewed had loose sheets and noted that not all had the patient's details identified. This meant that most of the notes were prone to falling out with the risk of being lost or misplaced.
- Completion of documentation was variable within the wards/unit visited. For example, we found that found that records from ward rounds were not dated or timed and on Redbrook ward we saw undated renal protective measures to prevent contrast-induced nephropathy (CIN). CIN is defined as the impairment of renal function.
- All of the records read had incomplete discharge check-lists.

- Patient information and records were not stored securely on all wards. For example, we saw an unlocked room on Leadon ward which contained patient records which could be accessible by people visiting the ward as this was on the main thoroughfare.
- We observed that the records kept within the medical secretaries' offices were accessible as these were not locked during our visit.
- We saw there were documentation signature lists within the records read. However, we saw these were rarely used and the signatures were indecipherable. This was brought to the attention of the ward sisters.

Safeguarding

- 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 of vulnerable adults and children.
- Staff told us that they had been unable to attend some training due to ward staff shortages. For example, staff said that they were unable to attend safeguarding training the week commending 15 September 2015 due to staff shortages.
- The surgical teams were able to explain safeguarding arrangements, and when they might be required to report issues to protect the safety of vulnerable patients. We spoke with the safeguarding nurse on Redbrook ward who said that they were accessible to support the wards as required. This was confirmed by staff spoken with.
- The training records showed that 70% of staff had received their Level 1 and 3 training, whilst only 42% had received Level 2 training. The trust had an achievement target of 80% by the end of 2015.
- We saw posters on the walls by the nursing station providing contact details for any safeguarding concern.

Mandatory training

- All staff in surgical areas were aware of the need to attend mandatory training in issues such as moving and handling, and safeguarding.
- The records showed that 78% of mandatory training had been completed and future dates were booked. This was below the target set by the trust of 80%. We saw senior staff kept good records of staff's training needs and they were sent reminders via e-mail of any outstanding training.
- Senior management and nursing staff told us that several mandatory training sessions had been cancelled recently such as health and safety, manual handling and advanced life support. This meant there was a risk of patients being supported by staff who did not have the necessary skills to attend to their needs.
- Staff were given a choice of how they completed their annual mandatory training, whether by electronic learning, face-to-face or ad-hoc sessions for practical work. Some staff told us their dedicated learning days had been cancelled due to staffing shortages. This was confirmed by the senior nurses spoken with.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. The sisters in charge said that all new staff were allocated a "buddy" to work alongside them.
- The trust had an electronic learning system. However, this was not accessible to all staff as they did not have a smartcard. Staff told us the trust was looking at introducing this service to all staff.
- Bank staff had access to the hospitals mandatory training and senior staff said they were responsible for booking their own updates. However, this was not always checked by ward staff to ensure they were up to date.
- Staff had knowledge of distraction techniques which they told us they would use where appropriate. However, they said they had not received any conflict resolution training which was confirmed in the training records read. This meant that staff may not have the necessary skills to manage patients who may portray difficult behaviour.
- The records showed that 551 staff (80%) of staff had completed their advanced life support training. This was in line with the trust's target of 80%.

Assessing and responding to patient risk

- Many of the surgical wards had outliers or patients with non-surgical conditions; this included the day case unit, which had 12 beds, eight of which were occupied by medical outliers on the day of our visit. Some nursing

staff expressed concerns that they felt inadequate to support patients diagnosed with, for example, heart conditions. Staff felt they may not be able to respond to the risk of patients transferred to the unit.

- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- Staff told us of their awareness of a higher risk of outlier patients having slips, trips or falls. There were clear strategies for minimising the risk of patient falls on surgical wards. Staff on these wards demonstrated a good understanding of the causes of falls and how to avoid them.
- In operating theatres, the staff had implemented robust measures to reduce the likelihood of pressure ulcers developing during operations. Risk assessments were completed for patients having operations, and appropriate devices were used, such as heel pads and arm supports, to reduce pressure damage.
- The patient care improvement plan (PCIP) stated that medical outliers "would be assessed by medical doctors daily before 11am." Staff on the surgical wards visited told us this did not always happen with some medical patients not assessed until the afternoon. We saw nursing staff had completed incidents forms as required. However, they told us that they did not receive any feedback in relation to these incidents.
- Staff on Redbrook ward told us there was no joint pro forma for hip fracture. We saw they used the medical assessment pro forma for all patients.
- Staff were able to assess and respond to a deteriorating patient in line with policy and guidelines. The surgical wards used the national early warning score (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.
- We spoke with staff in the anaesthetic and recovery areas, and found that they 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 saw there was provision for patients with high NEWS who had been transferred from high dependency wards to surgical wards to be visited by the critical care team when required. We observed the critical care team giving advice to surgical nurses on the management of these patients.
- All theatre teams were using the five steps to safer surgery checklist, which is designed to prevent avoidable mistakes; this was an established process within the teams. We looked at the checklists which had been completed, which included, for example, the patient's identity and whether they had any known allergies. The hospital had provided audit information from April 2014 and March 2015 which confirmed a 100% compliance with the completion of the documentation. However, we found that during our visit the checklist was completed by the operating department practitioner (ODP) and the patient. The rest of the team were not involved and the surgeon was not present. This breached the standing operating procedures which said that the checklist should include the ODP and the anaesthetist bud good practice to involve the patient and surgeon.
- Operating theatre teams undertook discussions as part of the safer surgery guidance, which included asking if a patient may be pregnant prior to having surgery.
- We tracked a patient's journey from the surgical assessment unit to theatre. We observed theatre staff checking the patient's wrist band and consent form. However, we did not see staff checking the "site" of the operation to ensure this had been appropriately marked. We also noted that this site was again not checked prior to the operation. This meant there was a risk of a potential "never event" due to the lack of checking and the potential for the operation to be completed on the patient's wrong side.
- We observed on the DCU that a patient's compression stockings were not on properly. Compression stockings are specialized stocking, designed to help prevent the occurrence of venous disorders such as phlebitis and thrombosis. This was brought to the attention of the sister in charge who immediately arranged for the stockings to be placed properly on the patient's legs.
- We observed patient's valuables were taken prior to surgery and placed in a cupboard that was unlocked. This meant there was a risk of patient's belongings becoming misplaced or stolen.

Nursing staffing

Surgery

- Nursing numbers were assessed using the national safer nursing tool and there were identified planned staffing levels. The required and actual staffing numbers were displayed on the wards visited. The rotas seen identified that the number of staff actually on duty were in line with planned numbers.
- Staffing rotas demonstrated that staffing levels (registered nurse to patient ratio) were being achieved. However, staff on the wards told us staffing was a 'safety' concern due to staff being moved to other areas and replaced by agency and/or bank staff that may not have the appropriate skills to care for surgical patients.
- The records showed the current sickness level within the service was 4% which was worse than the trust target of 3%.
- Surgical vacancies were filled with bank and agency staff. The ward sisters told us that some staff picked up additional shifts to support the wards, and they used bank and agency staff. The sisters told us they requested the same agency staff to ensure continuity within the surgical wards. This was confirmed with agency staff spoken with.
- We saw completed induction booklets in place for bank and agency staff within the surgical wards and units.
- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. It was captured on both the wards and trust risk registers.
- The management team told of various measures they had undertaken, such as incentives to introduce staff and overseas recruitment initiatives, to decrease the vacancy factor. Staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff were seen as a priority by the trust.
- The discharge lounge was available from Monday to Friday from 9am to 8pm. During our visit to the discharge lounge we saw this service was being run by an agency nurse and a bank health care assistant. They told us the service was regularly run by temporary staff.

Surgical staffing

- Leadon and Monnow wards had dedicated ward doctors that were based on the wards. The other surgical wards were visited daily by the on-call teams and could bleep doctors when required.
- We attended two surgical handover. The handover reviewed patient care based on the severity of their condition and any anticipated problems.
- Consultants worked throughout the week within the surgical services, and were supported by specialist registrars during the weekends. Access to medical advice at night came from the surgical care group hospital at night team including nurse practitioners, an on-site registrar and an on call consultant.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents, winter pressures, and fire safety incidents.
- There was a bed management system that aimed to ensure patients' needs were met when there were increased demands on beds. Some medical patients were placed and cared for on the surgical wards.

Are surgery services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as requires improvement.

The service demonstrated that care was provided in accordance with evidence-based national guidelines and best practice. However, the hospital failed to meet the mortality standards for 2014 and 2015, which are measured using Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) figures. The trust's national joint report identified areas of improvement, for example; only 20% of patients had been reviewed by a geriatrician and 25% had not received a perioperative medical review within 72 hours of admission.

Policies and procedures were accessible and staff could guide us to the relevant information. Care was monitored to demonstrate compliance with standards and there were good outcomes for patients. Patient pain was appropriately managed, as was patient nutrition and hydration, particularly in the perioperative period.

Staff worked in multidisciplinary teams to co-ordinate patient care. This meant that patient's had the expertise of

various professionals readily available to them to ensure that they received quality care. Staff said they received annual appraisals. However, the records showed that staff were below the trust's target. Management across the service said they were aware of the shortfall in supervision and were reviewing the supervision structure. The surgical service had a consultant-led, seven-day service.

Most staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines. We found the Royal College of Surgeons' standards for emergency surgery and surgery out of hours were consultant-led and delivered.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- Recovery pathways were used to improve outcomes for patients in for example; general surgery, urology, orthopaedics and ENT. This focused on thorough pre-assessment, less invasive surgical techniques, pain relief, and the management of fluids and diet, which helped patients to recover quickly post-operatively. There was clear guidance for staff regarding the recording of pre-operative and post-operative information.
- The trauma and orthopaedic care group participated in national clinical audits, such as the National Joint Registry (NJR). This registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants. We saw the hospital had met 100% regarding compliance and consent. The trust had NJR accreditation until 31 January 2016. The accreditation scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The endoscopy group met fortnightly to ensure the trust were on track to meet all of the actions. There was a Joint Advisory Group (JAG) team visit planned for mid-January 2016.
- The surgical services adhered to the National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. Compliance with NICE guidance was assessed through the surgical governance process.
- Junior doctors told us that they felt the surgical/ handover paperwork was too separate and there should be documents that both teams could use across the services.
- Junior doctors said there were easily accessible protocols throughout the trust. The DCU had worked alongside the surgical departments for example; general surgery, urology, orthopaedic and ENT to review the surgical protocols at the hospital.
- The DCU had been engaged in creating a local protocol for postoperative care of patients. Areas covered included the observations to be recorded, assessments undertaken within accident and emergency and ensuring that NICE guidance were adhered to in patient safety.
- 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.

Pain relief

- Patients were assessed pre-operatively for their preferred pain relief.
- The records showed that patient's pain relief had been risk assessed using the pain scale found within the NEWS system. We also observed staff asking patients if they were in pain. Patient pain was discussed at handovers when appropriate.
- Patients told us they were provided with pain relief when required.
- Staff could access support from the pain specialist nurse, 9am-5pm during the week and contact the on-call anaesthetist outside these hours. We observed the pain nurse assessing patient needs and discussing pain management with the pharmacist, doctor and nursing staff.
- Ongoing pain management was provided by the acute pain clinical nurse specialist (CNS). When the CNS was not available the cover for acute pain management was covered by the anaesthetist.

Surgery

Pain management was included in the Acute Illness Management (AIM) course which was provided for registered nurses working in the acute hospital setting. Staff within Monnow told us they had been AIMS trained which was confirmed by the sister in charge.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration, when applicable. We observed that fluid balance charts were used to monitor patients' hydration status.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietician. We saw the regimes in place for patients who received their food enterally. The records showed these have been reviewed by the dietician. On Leadon ward the dietician visited a patient with specific needs and discussed the management with the nursing staff which was documented in the patient notes.
- The ward had introduced protected times when visiting was not allowed. This was during mealtimes. There were 'red trays' to identify patients who needed help with eating. We observed one patient with a red tray being supported by staff.
- All patients who displayed nausea and/or vomiting post-surgery were monitored within recovery. Where applicable, suitable analgesic and antiemetic (a drug effective against vomiting and nausea) regimes were prescribed, which were identified in the patient's records.

Patient outcomes

- Patient Led Assessments of the Care Environment (PLACE) are patient-led annual audits and are a snapshot of the hospital environment. The assessment looks at for example, cleanliness, food and privacy and dignity. We saw the PLACE scores for 2015 were better than the national average for cleanliness, privacy, dignity and wellbeing and condition, appearance and maintenance by achieving between 87% and 95%. However, the hospital was below the national average for food and hydration at 78%.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme, the national hip fracture database, and the national joint registry.
- We saw the Patient Led Assessment of the Care Environment (PLACE) results for August 2015. The results for 2015 showed that the hospital had improved from their previous score regarding food served to patients, cleanliness and the environment.
- The bowel cancer audit data (2014) showed that 100% of patients were seen by a CNS and had their case discussed at a multi-disciplinary meeting. The results showed that the bowel cancer indicators were better than expected.
- The lung cancer audit data (2014) showed that 100% of patients had their cases discussed at multi-disciplinary meetings and 98% of patients had received a computerised tomography (CT) scan which was better than the national average of 91%. A CT scan uses X-rays and a computer to create detailed images of the inside of the body.
- The National Hip Fracture Database (NHFD) is part of the national falls and fragility fracture audit programme. A review of the 2014 annual report indicated areas of good performance as well as areas of improvement. The main areas for improvement were identified as: 25% of patients had not received a medical review perioperative within 72 hours of admission and only 20% of patients had been reviewed by a geriatrician. The trust told us they were actively recruiting for an additional consultant orthogeriatrician to support the service.
- Hospital mortality rates are measured using Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) figures. The national benchmark for SHMI and HSMR is 100. For the 12 month period from April 2014 to March 2015 (published October 2015), the trust's SHMI was identified as 'higher than expected' with a value of 117 (compared to 100 for England).
- The Quality and Improvement Strategy for 2014/17 showed the trust's operational objective to achieve a HSMR and SHMI of 100 or below by April 2015 whilst maintaining and improving the established benchmark with similar sized trusts. The Quality Accounts report for 2015 showed the trust had not achieved this standard. We saw the quality reported had identified a number of

key areas to improve clinical effectiveness and patient safety. Examples included; the establishment of a new governance structure for mortality, the implementation of a sepsis screening tool and a review of coding in relation to capturing co-morbidities.

- We saw there were mortality and morbidity meetings occurring monthly across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The data was monitored by the central team and reported to the trust board.
- The trauma audit and research network (TARN) identified that 12 patients with severe head injuries were admitted between January 2012 and June 30 2015. Of these patients (8%) was transferred from the hospital to a neurosurgical unit, and 11 (92%) remained at the hospital. The hospital's survival rates were within the expected range.
- The trust was above the England average for elective readmission risks at 145 compared to the England ratio of 100 patients. The non-elective risks for readmission was below the England average.
- We saw that theatre utilisation between April 2014 and May 2015 averaged at 92%. However, the records showed that theatre 7 (general surgery), theatre 8 (obstetrics) and theatre 3 (Trauma/CEPOD) were being used more than 100% for the period March 2015 and May 2015.

Competent staff

- We saw annual appraisals were identified as a concern in the 2014 staff survey. Staff said they had received their annual appraisal. The records for July 2015 showed that 69% of staff had received their appraisals against a target of 90%. Most staff spoken with said they had received annual appraisals.
- We found inconsistencies within the service regarding clinical supervision. Most staff said they had not received regular clinical supervision. The ward sisters confirmed they were aware of the shortfall and were reviewing the way they could arrange supervisions.
- Staff within the recovery ward told us they had good training opportunities and some nurses had undertaken a recovery course with Birmingham University which was funded by the trust.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts. For the five key indicators: adequate training, induction, handover, educational supervision and clinical supervision, handover showed the least score at 67%, with clinical supervision being the highest at 90%.
- Nursing staff were often moved to help on other wards and replaced with agency staff, but senior staff could not guarantee the skills of the agency nurse were appropriate to meet the patient's needs. This meant that patients on wards were being treated by nurses who were sometimes not from the appropriate specialty. This could affect the quality of care for patients, because they were not being treated by an expert member of staff. The sisters we spoke with acknowledged that issues with skill mix were of concern.
- Junior doctors had specific personal development plans and clinical and educational supervisors. They told us they felt supported and the consultants were accessible, approachable and available when required.
- Doctors had completed mandatory training which included MCA, DoLS and breaking bad news.
- We saw the appraisal rate for surgical consultants as of August 2015 was 84% which was below the target of 90%.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required.
- We observed a good working relationship between ward staff, doctors, physiotherapy, occupational therapy and specialist nurses, such as pain nurses and critical care nurses during our visit.
- Staff said that they could access medical staff when needed, to support patients' medical needs.
- Junior doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards.
- Patients' records showed they were referred, assessed and reviewed by dieticians and the pain management team, when required.
- There was dedicated pharmacy support on all the wards we visited, which helped to speed up patient discharges with "to take out" (TTO) medicines.
- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us

they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Staff could access the learning disability lead, who was able to provide advice and support to the surgical teams.
- We observed an orthopaedic handover which was well organised and structured. The handover included theatre staff and anaesthetists. The majority of the meeting was based around teaching which junior doctors said was beneficial. However, we observed that the current inpatients were not discussed; only admissions from the previous day.

Seven-day services

- The pharmacy was available on weekdays as well as Saturday and Sunday mornings.
- Outside of these hours, thefre was an on-call pharmacist to dispense urgent medicines.
- The trust provided a seven day diagnostic service which included, for example, endoscopy.
- Surgical consultants worked weekends and carried out ward rounds.

Access to information

- Discharge summaries were dispatched by the medical secretaries to GP's.
- Staff had good access to patient-related information and records whenever required. Agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us that when patients were transferred between wards or teams, staff received a handover of the patient's medical condition. We observed on-going care information was shared appropriately at handovers.

Staff were able to demonstrate how they accessed information on the trust's electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training about the Mental Capacity Act 2005 (MCA) to ensure they were competent to meet patients' needs and protect their rights where required. This also included training regarding the Deprivation of Liberty Safeguards (DoLS). Staff were able to briefly describe how DoLS might be required; they gave an example of how a patient might become confused and need to be restricted to ensure their safety.
- Patients were asked for their consent to procedures appropriately and correctly. The records, where applicable, showed clear evidence of informed consent, which identified the possible risks and benefits of surgery.
- The ward sisters reported that on occasions they used a code word system which ensured that the correct person was contacted when telephoning patients' relatives/representative.
- Patients confirmed they had received clear explanations and guidance about the surgery, and said they understood what they were consenting to.
- We reviewed the records of two patients whose capacity had been assessed by the psychiatric team. The assessment records were not available within the records as they had been removed by the psychiatric team for processing. This had been documented on the nursing records read.
- The records read showed that the pre-operative assessment unit did not use a tool regarding a mental capacity assessment, dementia assessment or Edmonton scores for frailty assessment.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Staff were caring and compassionate to patient needs and treated patients with dignity and respect. Patients told us that staff treated them in a caring way and were flexible in how they supported them to access services.

Patients said they were kept informed about and felt involved in the treatment received. We observed good emotional support given by staff on the DCU.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We observed staff dealing with patients who were displaying agitated behaviours with compassion and empathy.
- The NHS Friends and Family Test (FTT) results were displayed within the wards. We saw posters encouraging patients to feedback their views, so they could improve the care provided. We saw that the wards did not record the number of patients who had responded to the FFT across the service. However, we saw the percentage rate between March 2014 and February 2015 of patients who would recommend the hospital varied for example, 31% for the DCU, 40% for Leadon ward and 81% for Teme ward. Staff at the DCU and Leadon ward told us they were aware of the shortfall in obtaining patient feedback and were in discussion with senior staff as to how they could measure patient response more effectively.
- We attended two ward rounds and saw that nursing staff introduced themselves appropriately. However, the curtains were not drawn to maintain patient privacy and dignity.
- Nursing handovers occurred at the change of shift. Handovers on the wards and the day case unit occurred at the patient bed side and patient privacy, dignity and confidentiality could not be maintained as other patients and relatives could overhear the patient information being discussed. However, we observed that handovers on the Redbrook ward were conducted outside of the bays to maintain confidentiality.
- Patients reported that staff treated them with compassion and empathy. One patient said that they were delighted with their overall care and felt the nurses were all "Florence Nightingales."

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Patients considered their outcomes as being good. One patient said the hospital "was the best they had been to" and another said they "would not have gone anywhere else."
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- The records had individualised care plans, which involved the patient in their planning.

Emotional support

- We observed staff providing emotional support to family members on the DCU.
- Staff told us that patients who may become emotionally stressed with attending theatre were given the opportunity to visit and have a look around to allay their fears. This was also confirmed with theatre staff during our visit.
- One patient told us the hospital chaplain had visited for a chat. This meant the hospital ensured the patient's spiritual and emotional needs were being met.

Are surgery services responsive?

Inadequate

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as inadequate.

The hospital was not formally recording or reporting waiting times for admitted surgery pathways. In April 2015 the trust board requested suspension of national reporting for non-admitted and incomplete pathways as a result of concerns over quality data. From April 2015 onwards, the admitted RTT performance is the only measure reported. Each consultant's medical secretary managed their own clinic and waiting lists. Staff told us the surgical lists were not risk assessed and the hospital did not reassess or review patients' conditions. This meant that the hospital could not identify, manage and mitigate the risks relating to the clinical safety of the patients waiting for.

Surgery

There were breaches in the 28-day rebooking standard, the threshold was set at 5% and we found the figures as of August 2015 at 23%.

Bed occupancy levels in the trust were high, and the lack of available beds resulted in patients spending longer periods in the theatre recovery areas. Services were developing to improve responses to increasing demand, which included increasing theatre use and patient admissions.

Length of stay was longer than the national average for elective general surgery, trauma and orthopaedics procedures. However, length of stay was lower than the national average for non-elective trauma, orthopaedics and general surgery procedures.

Discharge arrangements for elective surgical patients were inadequately planned, and many patients were discharged later in the day than anticipated. Patients stayed longer than 23 hours on the DCU. There was guidance in place within the trust to ensure that patients did not remain on the day surgery unit for longer than 48 hours. When a patient was required to remain on the day ward for longer than 48 hours then the guidance stated that staff must complete an incident report for every further 24-hour period.

There was support for patients with learning disabilities, including reasonable adjustments that could be made to the service. For example, patients were given longer preoperative assessment appointments to take account of any anxiety. Staff could refer any issues or concerns to the learning disability lead.

Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were resolved.

Service planning and delivery to meet the needs of local people

- The service had a day case unit (DCU), which enabled patients to have minor procedures without having overnight stays in hospital.
- On the day of their surgery, patients with elective (planned) surgery were admitted to the surgical admissions lounge. They were seen by the nurse, and processed for surgery and the post-operative ward.
- The early recovery pathway for colorectal surgery pathway was well established. This included a perioperative care pathway with the aim of reducing the stress of surgery and accelerating recovery.
- The surgical management team were working to increase theatre productivity, to improve referral to treatment times. Staff said they were undertaking evening and weekend lists to improve the number of patients waiting for surgery.
- The DCU had been involved in the management of the trial without catheter (TWOC) procedures which staff said had improved the service planning for procedures. They had worked alongside the surgical team to create and provide a leaflet to patients. We saw a copy of the leaflet on display within the unit.
- Theatre staff had a “huddle” every morning with bed management, sisters and managers. Any cancelled operations were discussed taking into account the intensive therapy unit’s capacity.
- 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 interviews with patients.
- The facilities and premises were appropriate for the services. We saw the trust’s strategic objective had identified that the hutted wards were past their intended useable life span and were no longer adequate. The recent failure of the fabric within Monnow ward resulted in the loss of beds. The trust had identified the effect which included; reduced bed capacity, the cancellation of elective surgery which impacted on the delivery of national targets such as waiting times.

Access and flow

- The hospital had a nurse led pre-operative assessment clinic with 36 booked appointments per day with a further five to ten urgent slots available if required.
- Patients had a pre-operative assessment, which included for example, testing for MRSA. However, we observed during our visit that 50% of the patients were being re-assessed due to time lapses following previous assessments. We saw that patients within the pre-operative assessment were being assessed without a “to come in” (TCI) date.
- Patients who attended the pre-operative assessment clinic were given information leaflets such as; you and

your anaesthetic, preventing thrombosis, a day case pack and ward specific information. We observed that the literature did not contain information on pain control with the exception of epidurals.

- Staff told us that should a patient not turn up for their appointment they would ring the patient and re-arrange the appointment or inform the chief administrative officer by e-mail of their non-attendance and send their notes for action.
- We tracked a patient's journey from the surgical assessment unit to theatre. We saw good interaction between the unit and theatre staff which included the handover of patient's notes.
- The service was under considerable and sustained pressure to meet the competing demands of emergency and elective surgery. The surgeons were conducting weekend and evening lists to reduce the backlogs.
- Staff within the theatres identified delays in the start of the theatre lists due to for example; lack of beds. Staff said records were regularly missing and were not transferred from other sites. We observed this during our visit to the theatres with the first patient not going into theatre until 10:15 hours resulting in over 30 minutes delay.
- There was only one porter working within the theatres which staff said often led to delays in start times. Staff said this was often a major concern with the access and flow of patients to theatre. Some staff said they had on occasion gone to fetch the patient themselves due to the lack of a porter. Staff confirmed they did not report delays in the porter service as an incident.
- Staff told us the discharge planning process started as soon as a patient was admitted onto the wards/unit. However, this was not reflected in the records read.
- Patients told us there were long delays between admitting a patient to the discharge lounge and the delivery of to take home (TTO) medicines. A patient said they had not been informed when they would be leaving as they were waiting for their medicines. We were informed there had been occasions whereby lunch time medicines had been missed by patients waiting in the discharge lounge.
- The DCU had created discharge criteria guidelines for staff. Areas included the encouragement of a light diet and fluids prior to discharge and the involvement of the identified carer.
- The DCU had been involved in a 23 hour urology pathway for the transurethral resection of the prostate (TURP) information leaflet. This is a surgical procedure that involves cutting away a section of the prostate gland. Areas covered were; what is a prostate gland and what will happen to me when I come for my operation.
- Staff told us the electronic pathway regarding blood results was often delayed due to the incompatibility of the systems.
- Recovery staff felt the area was well run. They said the main issues related to patient flow with patients being delayed due to capacity issues on the wards. For example, on the day of our visit one patient had been in the recovery room for 12 hours as there was another patient in their allocated bed. Staff told us that bed allocations were a common problem.
- The hospital was not formally recording or reporting waiting times for admitted surgery pathways. Each consultant's medical secretary managed their own clinic and waiting lists. Staff told us the surgical lists were not risk assessed and the hospital did not reassess or review patients' conditions. This meant that the hospital could not identify, manage and mitigate the risks relating to the clinical safety of the patients waiting for
- Each consultant's medical secretary managed the clinic and waiting lists. Priority was given to patient with two weeks waits and urgent care. The administrative staff told us the surgical waiting lists were not risk assessed and patients did not have their conditions reassessed or reviewed. Therefore, we could not guarantee the clinical safety of the patients waiting long times for surgery.
- The hospital had failed the England Admitted Pathways RTT 18 week standards target of 90% of patients being seen within 18 weeks from referral for the year 2014/15, with a performance of 64%. This was also worse than the trust's recovery trajectory of 72%. Of the eight specialty groupings only one, thoracic medicine, was meeting the standards for admitted RTT. The hospital had failed to achieve the NHS constitutional targets for 2014/15 which resulted in the non-achievement of targets in four areas which included RTT. The trust's annual report and account for 2014-15 referred to actions they had achieved regarding the PCIP. This is divided into six key work streams which includes; urgent care and reducing harm. However, patient's surgical RTT times are not reflected on the PCIP copy dated 21 September 2015 provided by the trust. The trust

acknowledged in their board meeting minutes that there was a risk of the trust not achieving the RTT target for 2015/16 which meant there was a risk of patients suffering avoidable harm.

- "On the day" cancellations of surgical procedures were managed by the service unit manager who liaised with the specialist manager who re-arranged new dates.
- We saw the key performance indicators for the surgical services was red, amber and greed (RAG) rated. For example; the number of non-clinical operations (elective) which had been cancelled on the day had a standard target of 10 a month. We saw the actual month figures for August 2015 were at 13 a month which meant they were rated as red.
- There were three breaches of the 28 day rebooking standard. An additional 20 procedures had been cancelled "on the day" due to clinical reasons and 15 cancelled by patients. The threshold was 5% regarding these breaches and we saw the trust had achieved 23% for August 2015.
- Nurses told us that patients on the DCU should not be in this unit for longer than 23 hours. We found instances where medical outliers had been transferred to the unit and had been in an allocated bed for more than two days. Nurses told us this length of stay was not unusual. During our visit to the DCU we saw that one patient had been on the ward for five days.
- Length of stay was longer than the national average for elective general surgery, urology and trauma and orthopaedic surgery. However, length of stay was lower than the national average for general surgery and non-elective trauma and orthopaedics.
- Staff on the acute surgical unit said diagnostics could be an issue, with only one computerised tomography (CT) scan available. This meant that patients who required a CT scan appointment were governed by availability. The trust had recognised this as a concern and were in the process of introducing a second CT scanner.
- Theatre staff said that there were issues with the administrative staff. They said there was a backlog with letter typing and on occasions this has resulted in delays to surgery. We were able to confirm with the administration staff that they were currently behind with their letter writing due to staffing shortages. However, the administration staff were not monitoring the length of time regarding the shortfall in letter writing.

Meeting people's individual needs

- During our visit to the recovery unit we observed that children were recovered in the same area as adults. There were two bays specifically for children and we saw there were always two members of staff with a child. Staff said parents and cares were encouraged to come into the recovery area once the area was secure. However, on the day of our visit we saw one child being very noisy and disturbing to an elderly lady. This meant the area was not always meeting patients individual needs to recover undisturbed.
- Patients were often delayed in recovery for extended periods for non-clinical reasons. We observed that there were no toilets or catering facilities within the unit. This meant that patients personal needs were not always met.
- Staff told us they could access bariatric equipment when required.
- The trust had a translation service, which staff said they were able to access when required.
- The trust had a named dementia and learning disability lead. Staff confirmed they were able to readily access the leads to discuss any concerns and to receive advice.
- Staff demonstrated an awareness of the 'Care Passport' scheme, whereby patients with a learning disability brought with them a document which outlined their care needs, preferences and other useful information, which enabled staff to support them.
- Staff told us that patients with learning disability or anxiety were encouraged to visit the hospital, so they could become comfortable with the process. Patients with a learning disability were given longer surgical preoperative assessment appointments, which took into account their anxiety.
- All staff within the surgical division told us they had not received any learning disability training. They felt this would enhance their abilities to support patients with a learning difficulty.
- Information leaflets and consent forms were not available in easy-to-read formats.
- A paper summary was sent to a patient's GP upon a patient's discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication.

Learning from complaints and concerns

Surgery

- Reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) 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.
- Staff told us that some complaints were managed on the wards and/or the DCU. They said these complaints were dealt with as soon as they occurred within the service and were not always reported. This meant that complaints were concluded at service level with no outcomes, themes or lessons learnt being cascaded to staff.
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- Complaints were managed on the wards and the DCU with verbally and not always reported.

Are surgery services well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as requires improvement.

There was limited awareness among staff of the services' values and expectations for patient care. Strategic plans were addressing capacity issues within the service. Some staff said they felt pressurised when patient admissions fluctuated.

The service held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. However, the outcomes of these meetings did not appear to cascade to the ward and unit levels as staff were unable to identify the outcomes of their key performance indicators.

The service did not monitor the outcomes of actions identified in the patient care involvement plan. Staff said they submitted incidents regarding any breaches but did not receive feedback.

There were comprehensive risk registers for all surgical divisions. The division was aware of its problems and addressed or escalated concerns where appropriate.

Staff could raise concerns and share experiences at monthly surgical clinics. Patients were engaged through feedback from the NHS Friends and Family Test. Innovation was encouraged from all staff members across all disciplines. Junior doctors were involved in audits, with the results shared within the department. Staff said they were encouraged to develop new ideas and make continuous improvements in the service provided.

Vision and strategy for this service

- The trust recently re-launched its values and objectives alongside the existing vision and mission statement. The ward sisters told us they had been involved in the creation of the new vision and values for the trust. They said they were proud of the work done. However, staff were unaware of the vision or strategy for the surgical services.
- Most staff said they were unaware of the trust's vision and values although they said they had seen posters recently put up.
- We saw the vision and values on display within the surgical division. The trust's vision was to "improve the health and wellbeing of the people" they serve and the new values were; compassion, accountability, respect and excellent.
- We saw the quality and safety improvement strategy for 2014/17. The aim of the strategy was to develop the care, education and research whilst improving the health of the people of Herefordshire. We looked at the improvement objectives which included for example; protecting people from abuse or avoidable harm and reducing mortality rates. We saw the operational actions the trust was expecting to achieve over a three year period.

Governance, risk management and quality measurement

- The service held monthly clinical governance meetings, where quality issues such as complaints, incidents and

audits were discussed. However, this did not appear to cascade to the wards and units. Staffs were unable to identify the outcomes of their key performance indicators.

- The patient care improvement plan (PCIP) identified the objectives and actions. However, we found that the outcomes were not being monitored, for example; all medical outliers within surgical wards were to be assessed by medical doctors daily by 11:00 hours. Staff confirmed this did not often occur and they did not receive any feedback on incidents submitted regarding these breaches.
- The surgical service had quality improvement initiatives which looked at, for example, theatre productivity and better access for patients.
- Nurses attended the quality delivery group and governance meetings and said they cascaded all relevant information to staff during staff meetings. Staff confirmed that senior staff informed them of any issues or concerns about the service.
- The division had quality dashboards for each service and ward area, and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The trust had completed local as well as national audits, such as a regular audit to ensure that staff record keeping and accuracy were compliant with national standards. However, senior staff said the quality team did not return information when a breach of the standard operating procedures were identified for example; longer length of stay on wards/units.
- There were comprehensive risk registers for all surgical divisions, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register, where they were presented to the trust's executive committee and were regularly reviewed. The register identified the risk, the impact to the patient, and the controls in place, with the exception of referral to treatment times.
- During our visit we saw that over 50% of the patients visiting the pre-assessment unit were being re-assessed. We observed that patients were being assessed without a "to come in" (TCI) date.
- Staff told us the discharge planning process started as soon as a patient was admitted onto the wards/unit. However, this was not reflected in the records read. Patients informed us they spent long delays whilst waiting for their medicines to take home (TTO) which had on occasions resulted in patients missing lunch time medicines.
- The hospital was not formally recording or reporting waiting times for admitted surgery pathways. We were informed the surgical list was not risk assessed to review patients' conditions. This meant that the hospital could not identify or manage the risks relating to the clinical safety of patients.

Leadership of service

- Most staff said they had awareness of the chief executive officer (CEO) and the director of nursing and quality (DoNQ) but felt their presence was scant. However, staff on Monnow ward told us they were aware of the DoNQ and the CEO who visited the ward regularly.
- Each ward had a lead nurse who provided day-to-day leadership to members of staff on the ward. Some ward sisters said that the restructuring of the leadership within the service had been difficult and did not feel the reporting structure was effective.
- Staff within the surgical division said they were well supported by their managers who they felt would look after their welfare.
- We observed the theatres were well led with good leadership to the service. We saw all staff working as a team with defined roles to ensure the safe care of a patient entering theatre.
- Recovery team volunteers were working with the paediatric team and showing children around the recovery ward, theatres and wards. This was for children aged five to teenagers. Children were given a certificate at the end of their visit. This was a monthly occurrence within the team.
- Ward sisters said they had access to leadership development programmes which they said was very good.

Culture within the service

- The quality accounts for 2014/15 showed that the trust had received 12,362 compliments. The majority of compliments related to quality of care and helpfulness of staff. We saw that two surgical wards Redbrook and Teme had received 273 and 248 respectively. During our visit to the wards we saw the number of compliments identified on the safety thermometer.

- During a focus group, surgical staff said that there was a culture of quality improvement within the trust, with regular meetings between the medical director and junior doctors.
- Staff were passionate and driven to provide good care to patients, but felt that this could not always be given, due to the pressure of work. We saw staff spending time talking to a patient who was confused and distressed. We also saw staff being supportive to a relative of a patient within the DCU.
- Staff we spoke with worked well together as a team, and said they were proud to work for the trust.
- Staff said they received information regarding serious incidents but did not receive feedback on incidents they had raised.

Public engagement

- Comments and suggestions boxes were stationed in all areas of the hospital. We saw boxes on entering the surgical wards.
- In 2014/15 18 patient experience walk rounds were undertaken. The walk round team was made up of an executive lead, a non-executive lead, a quality and safety representative, an infection control representative and a member of Healthwatch. The team spoke with both staff and patients and gathered views about how services could be further improved. A visit to Teme ward in July 2014 showed that patient's feedback was uniformly positive with patients describing staff and the care they received as caring, professional, and timely and that they had 100% trust in the doctors treating them. During a visit to the day case unit in October 2014, staff were observed to be friendly and positive in an uncluttered and clean environment. February 2015's visit to Leadon ward found that staff felt they worked in an open environment where they could raise concerns if they had any.

Staff engagement

- We saw the 2014 annual staff survey. A proportion of staff were asked to complete a questionnaire based upon their experiences whilst working at the trust. The response rate to the survey was 43%. It was noted that staff were positive regarding the reporting of incidents, and their health and safety training. However, staff were negative regarding the extra hours worked and said they were suffering from work related stress. We saw there was a decrease in staff opinion in their feeling of satisfaction with the quality of work and patient care they were able to deliver.
- The surgical divisional leads held monthly clinics, whereby staff could raise any concern or share an experience.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors were involved in audits and the results shared within the department.
- In the surgical admissions ward, staff were encouraged by improvements already made and the development of new ideas to make continuous improvement in the service provided. We observed that in all areas, staff had adopted national guidelines, and were aware of best practice for the conditions that their patients were admitted with.
- Theatre staff had contributed to the re-designing of the recovery paperwork with the anaesthetists. This included the altering of sections such as pain management, airways, drain management and arterial lines.
- The DCU had been involved in the management of the trial without catheter (TWOC) procedures. They had worked alongside the surgical team to create and provide a leaflet to patients. We saw a copy of the leaflet on display within the unit.
- The DCU had worked alongside the surgical departments for example; general surgery, urology, orthopaedic and ENT to review the surgical protocols at the hospital.
- The DCU had been engaged in creating a local protocol for postoperative care of patients. Areas covered included the observations to be recorded, assessments undertaken within accident and emergency and ensuring that NICE guidance were adhered to in patient safety.

Critical care

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

Information about the service

Critical care services are located at Hereford Hospital on the six-bedded intensive therapy unit (ITU). The ITU had 459 patients admitted in the 12 months ending September 2015.

During a previous Care Quality Commission inspection in June 2014, there were eight critical care beds in use, with two beds located on the coronary care unit used as an interim high dependency facility. The provider told us during the inspection it had recently permanently closed these.

During this inspection, which took place between 22 and 24 September 2015, the inspection team spoke with 15 members of staff including consultants, trainee doctors, different grades of nurses, allied health professionals, healthcare assistants and a member of the housekeeping team. 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.

Summary of findings

Critical care services required improvement to be safe; responsive to patient's needs and well led. We found the service good for caring, and effective.

The senior nurse in charge of ITU often reported patient safety concerns rather than the staff involved. There was limited evidence of improvements taking place following incidents. For example, regarding prevention of pressure ulcers. When staff introduced changes there was no process for evaluating the effect of the alteration.

Minutes of mortality and morbidity meetings were incomplete, so could not provide assurance of actions taken. The medical staffing did not comply with core standards for ITU. This was because a consultant specialising in intensive care was not always available.

Arrangements for governance and performance management did not always operate effectively.

There was a limited approach to obtaining the views of people using the services and the service did not meet National Institute for Health and Clinical Excellence (NICE) guidance regarding provision of a follow-up clinic for patients following discharge. Where changes or improvements were made, the impact on the quality of care was not adequately monitored or reported.

Critical care

There were no toilet or shower facilities for patients within the ITU. This was particularly relevant for patients who were improving following critical illness and awaiting transfer to a ward.

The ITU was contributing to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) and national potential organ donor audits. However, there were no planned local audits, to evaluate policies or effectiveness of treatment, interventions or care provided.

Nurse staffing had improved since the previous inspection and was in line with core standards. The unit had strong links with the critical care networks' educational group. National competencies for critical care nurses were used. However, staff told us that study leave for completing courses such as the critical care post-registration award was limited. There were gaps in support arrangements for staff, highlighted by low appraisal rates for nursing staff (50% were up- to-date at August 2015). Some mandatory training rates were lower than the trust target of 90%.

Staff could access information they needed to assess, plan and deliver care effectively. Consent to care and treatment was obtained in line with the Mental Capacity Act (2005), and evidence of appropriate use of mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) was seen.

Patients were unanimously positive about the care they received. Inspectors saw many kind and caring interactions. Staff maintained the highest regard for patients' dignity and privacy. Relatives and visitors were happy with the level of emotional care and treatment they and their loved ones had received.

The unit reported no acquired infections in the six months ending June 2015, and was visibly clean. Records were stored and manged securely.

There were occasions when patients were delayed in transferring to a ward bed when they no longer required critical care. Sometimes when a bed became available patients were relocated during the night.

It was unclear whether patients could always access an ITU bed when required. The trust stated that information about occasions when level two (HDU) patients cared for outside of ITU was not collected.

However, there had been a clear focus to reduce elective surgery cancellations due to a lack of ITU bed availability. The ITU and surgical teams had achieved this through rationalising elective booking procedures and being proactive, especially at a senior nursing level.

Critical care

Are critical care services safe?

Requires improvement

Critical care services were found to require improvement regarding safety.

The senior nurse in charge of ITU often reported patient safety concerns rather than the staff involved. There was a risk that this could act as a barrier to reporting incidents. There was limited evidence of improvements taking place following incidents, for example, regarding prevention of pressure damage. When staff introduced changes, there was no process for evaluating the effect of the change. The tissue viability team was not always involved in reviews and investigations when there were incidents of pressure damage.

Standard operating procedures and risk assessments, including safe storage of medications in fridges and intravenous fluids, were not kept up-to-date and required review. Major incidents and emergency preparedness policies needed further development.

Minutes of mortality and morbidity meetings, were incomplete and, therefore, could not provide assurance of actions taken. The medical staffing did not comply with core standards for ITU. This was because a consultant specialising in intensive care was not always available as the rota was split between critical care and anaesthetics. Further recruitment of consultant intensivists would be required in order to meet this standard.

Some mandatory training rates were lower than the trust target of 90%, which meant there was a risk that staff were not up-to-date with current practice.

The unit had low infection rates with no methicillin resistant staphylococcus aureus (MRSA) bacteraemia (bacteria in the blood) or cases of clostridium difficile on ITU between June 2014 and April 2015. It was visibly clean, and had recently been refurbished with new ceiling equipment pendants in bed spaces, for optimal safety. Records were stored and manged securely.

Nurse staffing had improved and was in line with core standards with a senior band eight nurse lead, a band seven in a professional development role and every shift having a supernumerary nurse in charge of the ITU.

Incidents

- Overall, there was one incident resulting in patient harm, and no reported unit-acquired infections or errors leading to patient harm in the six months ending June 2015. However, there were 10 reports of acquired pressure damage of varying severity to patients' skin between 6 March and 29 June 2015.
- There had been no incidents classed as 'Never Events' (serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented) in the 12 months ending August 2015.
- Serious incidents reported all related to the development of significant pressure damage to patients' skin (stage three) while in ITU. There were four cases between September 2014 and April 2015. Two of the incidents were device related, due to masks requiring a seal-tight fit to deliver non-invasive ventilation (NIV). The serious incidents were investigated and root cause analysis (RCA) proformas completed. The incidents were all deemed to have been unavoidable and did not contain any lessons or learning. There was one action identified, which was to continue to provide NIV mask fit training for trained nursing staff on the ITU. Tissue viability staff were not involved in RCA investigations and were only included on the distribution list of the report in one instance. Although the tissue viability team was aware there had been incidents of pressure damage on ITU, they were unable to tell us the details of the categories or how the damage had happened. They acknowledged they had not fully investigated this area of concern.
- Following the device-related pressure damage on noses from NIV masks, we were told new masks had been trialled and the ITU planned to explore alternative systems such as hoods. There were new dressings to put onto a patient's nose before applying the mask to prevent sores developing. We saw this new dressing was available in the clinical area, and a log was kept of all the patients it was being used on. We saw it in use for a patient during the inspection. There was no audit to evaluate this change in clinical practice. Not all staff we spoke to appeared aware of the device-related pressure damage.
- Waterlow scores (an estimated risk for the development of pressure damage in a given patient) were calculated daily. Evidence was seen of documenting

pressure-damage risk assessments on admission to ITU. We were told that there were link nurses for pressure ulcer prevention who advised the ITU team and attended relevant updates. Pressure relieving airbeds/ mattresses were used, along with rotation beds that mechanically moved the patient to prevent pressure ulcers. Changes in position at least once every two hours, prevents pressure ulcers. Due to critical illness, however, the repositioning of some patients might not always be possible without causing a deterioration in their clinical condition. We saw evidence that most patients were repositioned every four hours on the unit. Patients had a daily care plan but this did not prompt nursing staff to tailor the frequency for repositioning and inspection of skin. This was brought to the attention of the lead nurse for ITU who agreed to amend it.

- Pressure ulcers were staged, between one and two for superficial and three and four for deep damage. During the inspection, a patient on ITU was found to have developed new stage three pressure damage to their sacral area. We saw that a tissue viability nurse review had taken place and was documented in the patient's healthcare records. The tissue viability nurse assessed the pressure area prevention care provided by ITU and maintained that, in their clinical opinion, this had been appropriate. The damage was deemed unavoidable, due to the patient's deteriorating clinical condition. The nurse in charge of ITU reported the incident immediately.
- An electronic incident reporting system was used to record incidents. Staff were able to discuss which incidents should be reported, although we were told that incidents were usually reported by the nurse in charge of the ITU. Critical care outreach team (CCOT) staff told us that they reported incidents including escalation failures, and failure to recognise deteriorating patients. We spoke with a junior member of the nursing team that had not reported any incidents and was unsure how to find information relating to this. Completed RCA reports were not attached to the electronic reporting system for ease of access.
- Most staff felt they received feedback from incidents. Feedback provided was mainly from senior nursing staff but not all had received this. The awareness, for example, about how acquired pressure damage was sustained by patients on the unit, varied among junior nursing staff. We saw that incident reporting was discussed at ITU staff meetings. However, business meeting minutes for September 2015 did not contain reference to incidents. A brief overview of incidents reported the previous month had been recently introduced for staff information and was displayed using coloured bar charts outside the staff room. Feedback about recent incidents was also communicated at nursing handovers and was incorporated into key messages on the handover template.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. Staff we spoke with were generally aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. There was evidence from the completed RCA reports to support the fact staff were open and honest.
- Meetings were held approximately every month to discuss ITU patients' mortality and morbidity. These were chaired by the clinical lead consultant for ITU and the attendance averaged nine medical and nursing staff. We looked at four minutes of meetings that took place in March, April, June and July 2015 and noted that they were brief and incomplete. This meant that there was no record of discussions or decisions made regarding mortality and morbidity in these meetings. We were informed that this was due to a lack of access to administration support.

Safety thermometer

- Data on patient harm was required to be reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered hospital-acquired (new) pressure ulcers (including only the two more serious categories: stage three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms. Submitted safety thermometer data for November 2014 indicated there had been five pressure ulcers stage three or above, between June 2014 and June 2015. There had been no falls and one catheter related urinary tract infection.

Cleanliness, infection control and hygiene

- There were no unit-acquired infections reported in six months ending June 2015. Data reported by the ITU to

the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. The information board indicated that there had been no methicillin resistant staphylococcus aureus (MRSA) bacteraemia or cases of clostridium difficile on ITU between June 2014 and April 2015. During the inspection, an infection prevention officer attended the unit to discuss progress of a patient that was currently in a side room who was positive for MRSA.

- At the time of our inspection, the environment and equipment in the ITU were visibly clean and tidy. Bed linen was in good condition, visibly clean and free from stains. Many rooms and other items had been labelled to notify when they were last cleaned. There was a central cleaning and checking log for ITU 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.
- All disposable equipment was in sealed bags and placed in drawers or cupboards where possible to prevent damage to packaging. Equipment in store cupboards was on racks to enable the floor area beneath to cleaned.
- There was an abundance of alcohol hand gels throughout the unit and hand washing facilities, including in each bed space. Hand sanitising and personal protective equipment rules for staff were followed on the unit. This met guidance around safe hand washing from National Institute for Health and Clinical Excellence (NICE) statement QS61 Statement 3. Staff followed the policy by washing their hands between patient interactions and using anti-bacterial gel. Staff wore disposable gloves and aprons at the bedside when working with a patient or, fluids or waste products. Staff also used gel when entering and leaving the unit or moving between clinical and non-clinical areas. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the ITU.
- Sometimes the positioning of certain items/equipment seemed inappropriate. This included waste bins placed inappropriately close to clean apron dispensers and emergency oxygen cylinders for evacuation attached to the walls in racks, were stored in the dirty utility room. Sealed bags containing dirty linen, on a small plastic trolley was seen to be stored in the dirty utility under the sink. A plastic tray (the type used to carry sterile equipment for taking blood or administering intravenous medications) was also found in this room. There was a risk of spreading infection due to inappropriate storage. These were brought to the senior nurse's attention during the inspection and it was acknowledged that the waste disposal area was too small for linen to be stored for collection; therefore, the bags were collected from the sluice every three to four hours. The tray was removed immediately and an alternative place to store the oxygen cylinders would be explored in conjunction with the infection control and prevention team. An infection prevention audit visit to ITU in October 2014, found used linen bags/clinical waste on floor and action was taken to store the items on a trolley to aid cleaning. An unannounced infection prevention review was undertaken by the trust on 21 July 2015 and there were no issues identified requiring action.

Environment and equipment

- All checked equipment appeared to be well maintained, visibly clean and portable appliance tested (PAT). Storage areas were generally tidy and kept free of clutter. Some commode parts and chart tables were labelled as condemned awaiting disposal in a non-clinical area of the unit.
- Senior staff told us that business cases to update key equipment in the ITU were in progress. For example, three new ventilators had been obtained and a programme to replace the remaining ventilators for over the next two years was in place because they were between 10 and 15 years old.
- The ITU 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. The resuscitation trolley containing the emergency equipment had closed drawers but was not fully secured to prevent or indicate tampering with the contained drugs or other equipment between checks. However, the trust informed us that a risk assessment had been undertaken and the risk of the trolley not being fully secured had been balanced against the risk of a delay in accessing emergency medicines to treat an unstable patient.

- Documented evidence of a local Cleanliness, Environment, Maintenance Assurance Tool (CEMAT) used monthly was seen. Most items that were noted requiring attention appeared to have been rectified during recent decorating. These also showed that clear escalation occurred when on one occasion an area on ITU was found to be dusty/dirty.
- There were 'grab and go' boxes containing equipment required for ventilation and setting up a ventilator and emergency central venous devices and a box for high dependency unit (HDU) patients available on the unit.
- The main theatre complex was located close to ITU for accessing emergency support. The Emergency department was also located near 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 a good level of mobile equipment available including haemodialysis/ haemofiltration machines, an electrocardiography machine, defibrillator, non-invasive respiratory equipment and portable ventilators. There were two side rooms available on the ITU that had adjustable air pressures that could be used to isolate patients, if required, for infection control and prevention reasons.
- There was a range of disposable equipment available in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times.

Medicines

- Medicines were stored in locked cupboards in an unlocked clinical area adjacent to the main four-bedded area in ITU. The ambient temperature of the clinical room in the ITU was not always monitored. Intravenous fluids were also stored in this area on open shelving. This has been the subject of a local risk assessment.
- Medicines required to be refrigerated were kept at the correct temperature, and so would be fit for use. We checked the refrigeration temperature checklists in the ITU 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 medication fridge was unlocked in an unsecured area. There was a notice on the front of the fridge reminding staff to keep the fridge door unlocked and directed reference to a standard operating procedure (SOP) dated 2012. The SOP provided by the trust, which was beyond its review date (11 September 2014) confirms that the drug fridge was to remain unlocked to enable immediate access to emergency drugs. An emergency anaesthetic drug kit was located in the fridge, with information to direct staff to other medications if needed. The box had a tamper evident seal in place.
- We also found the fridge contained nutritional supplements. Two of these had been open for more than a week, which did not adhere to the product guidance, which stated that they should be discarded after five days of being opened. This meant that there was a risk of expired nutritional supplements being used for patients. This was highlighted to the nurse in charge of the ITU and the supplements were immediately disposed. In response, the ITU devised a daily checking procedure for patients prescribed supplements that are stored in the fridge. The nurse in charge was to audit this twice weekly.
- Controlled drugs (CDs) were managed in line with legislation and NHS regulations. The drugs, 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.
- The nurse who held the keys for the medication cupboard was named on the large wipe communication board on ITU. There was an assessment completed exploring the risks of all the keys being held together including the CD keys.
- High-risk medicines such as potassium on ITU were handled safely. Potassium ampoules were stored and recorded as a controlled drug, which meant that there were two checks made on the prescription and administration of the potassium. This helped reduce the risk of any medicine errors.
- There was no dedicated pharmacist for ITU, which did not meet the core standards for intensive care units. We

were told that a business case had been written to address this. A pharmacy technician topped up the medications twice a week and a pharmacist was available for advice and visits Monday to Friday afternoons.

Records

- The ITU 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 six observational charts we reviewed were completed as required and timed, dated, legible and clear.
- 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 author did not always print their name as stated in generic medical record keeping standards (2015). Out of fourteen entries by allied health professionals and medical staff, only five printed names were documented. This meant it might have been difficult to identify the person who had reviewed the patient.
- All multidisciplinary team (MDT) documented care and interventions in the same part of the healthcare records; facilitating a cohesive approach. However, physiotherapists documented reviews in a separate document kept in the case notes.
- The nursing documents were well completed. We saw completed entries for example, for bedrail management, malnutrition screening, falls risk, stool assessment, patient manual handling assessment wound and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.

Safeguarding

- Overall ITU staff were aware of their responsibilities to report abuse and how to find any information they needed to make a referral. We spoke with a range of doctors and nurses who were able to describe those things they would see or hear to prompt them to consider there being some abuse of the patient or another vulnerable person. Most were aware of the teams within the hospital to contact, and that the information could be found on the trust intranet.
- Staff were trained to recognise and appropriately respond in order to safeguard a vulnerable patient, although a number had not updated their mandatory training by the trust deadline. Safeguarding training was mandatory and covered vulnerable adults and children. Results from data supplied by the trust (as below) were against a trust target of 90% of staff having completed this by the end of 2015.
  - 66% of registered nurses had completed level one adult safeguarding training, although clinical support staff were not up to date with this (29%).
  - 77% of registered nurses had completed level two safeguarding children training, whereas 100% of clinical support staff had completed their level one safeguarding children training.
  - 100% of ITU administration staff had completed level one training for safeguarding adults and children.
- Evidence that adult safeguarding referrals had been made appropriately were seen during the inspection. However, a patient that developed pressure damage and therefore warranted an adult safeguarding referral; this did not occur for 36 hours following the detection. The reason for the delay was unclear.

Mandatory training

- Staff were not meeting the trust target (90%) with the latest mandatory training refresher courses. Staff were trained on induction and were expected to update this training at certain intervals set by the trust. Some of this training was accessed electronically online. There were seven mandatory training courses for all staff ranging from health and safety subjects, equality and diversity, to care of people living with dementia. Data supplied by the trust for September 2015 showed an overall completion level of 78%. The target was met for all groups of staff regarding, health and safety and equality and diversity. Compliance with information governance (61% overall) and fire safety (67% overall) did not meet the trust target.
- Mandatory training records were held locally and centrally. We were told that local mandatory training rates for ITU were between 70 and 80% up to date, which matched with the compliance level provided by the trust (above).

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to patient risk through regular review.

Ward rounds in the ITU took place twice daily in the morning and evening. The morning ward round was led by the consultant on duty and an evening review was carried out by a senior doctor covering ITU. This did not meet core standard for critical care units, which state that a consultant must undertake twice-daily ward rounds. This was not on the risk register. There was input to the ward rounds from unit-based staff including at all times the doctors and the nurses caring for the patient. The supernumerary nurse in charge of the ITU would attend the whole ward round.

- Patients were closely monitored at all times so staff could respond to any deterioration. Patients were nursed by recommended levels of nursing staff. Patients who were classified as needing intensive care (level three) were nursed by one nurse for each patient. Patients who needed high dependency care (level two) were nursed by one nurse for two patients. During the inspection there were six patients on the ITU including three needing level two care and one waiting to be transferred to a ward. An indication of something starting to change for the patient may then be picked up faster as patient care and response was closely supervised by a nurse at all times.
- 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, had been used by the trust since 2013. If a ward-based patient triggered a high risk score from one of a combination of indicators, a number of appropriate routes would be followed by staff. One of the triggers would include a review of the patient by the critical care outreach team (CCOT). 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 ITU consultants for support, advice and review. The CCOT consisted of experienced critical care nurses. Many of these nurses rotated out from the ITU to work shifts in outreach. They provided cover for the hospital 7.30am to 8pm, seven days a week. This had improved from 10 hours per day following the inspection in 2014. However, the CCOT did not provide 24-hour cover for the hospital as recommended in the Guidelines for the Provision of Intensive Care Services 2015 (Faculty of Intensive Care Medicine, Intensive Care Society, and others). This may increase the risk of deteriorating patients not receiving timely access to appropriate care and treatment overnight.
- CCOT support patients that have non-invasive ventilation, tracheostomies and patients that have central venous access devices throughout the hospital. All hospital nurses were to complete NEWS on line training, including ITU staff. Locally held data showed us during the inspection that just under 80% of ITU staff were up to date with the training.
- The NEWS was seen in use on the ITU with a patient waiting for a bed on the ward and when visiting a ward area with the CCOT nurse. Healthcare records of a patient that had been admitted to ITU from a ward at Hereford Hospital appeared to have not been seen by the CCOT despite NEWS score being triggered on and off for five days prior to ITU admission. However, the rising NEWS (between five and nine) did prompt escalation to various medical staff, including medical registrar and ITU doctor review. CCOT helped design the fluid management pack that was being trialled in the hospital, which included acute kidney injury awareness, fluid balance and fluid prescription, charts. This was seen in use on the wards when accompanied CCOT on visit.
- We were told and we observed the CCOT attend the medical staff handover from night doctors to day doctors. This was attended by staff including consultants, a doctor from each hospital team and a pharmacist. Doctors that had been covering overnight night handed over specific patients of concern. At 8pm, CCOT informed the ITU doctor and nurse in charge of the hospital of any at risk patient out on the wards that needed to be kept under close observation. The ITU consultant, we were told, worked closely with the CCOT and they discuss any patients they are concerned about.
- Staffing rotas were checked for August 2015, which showed that a CCOT band six nurse was rostered to cover outreach every day, including at weekends. Staff told us that when the ITU got busy the band six nurse who was covering the CCOT role may get called to look after patients on ITU, leaving the wards without CCOT support. The trust stated that in the six months ending September 2015, the CCOT spent 18 hours caring for patients (which they have identified required admission) on ITU.

Critical care

- The CCOT and lead senior nurse from ITU were on the faculty of a monthly study day called 'acute illness management' (AIM), internally delivered for trust staff which incorporated competencies which were assessed during the day.
- We were told that approximately seven children a year were admitted to the adult ITU. The actual figure for last year 1 September 2014 and 30 September 2015 was two and they did not remain on the unit. They were stabilised and retrieved by a specialist paediatric team and time critically transferred to Birmingham Children's Hospital. All band six and above nursing staff had completed the paediatric immediate life support (PILS) and the stabilising critically ill children courses. There were no paediatric trained nurses based on ITU but could access advice from children's ward nurses on site. Details of training to care for critically ill children undertaken by medical staff was requested but not provided by the trust.
- There was no onsite ear, nose and throat (ENT) surgeons so anaesthetist/ITU doctors would be called to patients with airway problems. Airway simulation days have been held to provide additional training to doctors regarding emergency airway management. Evidence of 18 staff attending this training January 2015 was provided.
- Sepsis six pathway (a bundle of medical therapies designed to reduce the mortality of patients with sepsis) was displayed on the ITU for staff information.

Nursing staffing

- There were safe nurse staffing levels in ITU meeting the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. A band eight senior nurse manager for the unit had been in post since April 2015. This was an improvement from the previous inspection where the lack of a band eight nurse meant the unit did not meet the ICU core standard. We were told that the nurse in charge of the unit was always supernumerary (does not have a patient allocated to care for) leaving them free to co-ordinate the shift. This was reflected in staffing rotas. The nurse in charge also wore a badge, which alerted visitors to the ITU who was managing the shift.
- The actual and planned staffing levels were on display in the ITU. Actual staffing levels were checked. In August 2015, six out of 28 shifts had one nurse less than planned level. However agency/bank nurse use was low (3.4% for twelve month ending May 2015).
- The rotas were generated and managed via an electronic system. The vacancy rate for trained nursing staff was 5% at the end of May 2015. We were told that 10 staff nurses had been recruited to the unit in the last 12 months. Lack of permanent nurses and use of agency staff had been identified as a potential patient safety risk in 2014. This was documented on the risk register and that there had been a successful business case to secure funding to increase the staffing establishment on the unit.
- Trained nurses worked a 12-hour shift pattern and rotated on to night duty. A health care assistant was also available on each shift.
- The CCOT provided seven days a week, 12 and half hours service per day.
- There was good handover among nurses. Nurses handed the patients over to the new shift and included updates regarding communication, hygiene, malnutrition, fluid balance, pain, elimination, sleep or ability to rest, and individual needs. It was attended by all the oncoming team including the band eight nurse for the ITU and the CCOT nurse. Then nurses had a more detailed handover at the bedside for the patient /s they had been allocated.
- We spoke with a new member of staff on the unit working as a ward clerk for the ITU. We were informed that this role had been reinstated recently. This would positively impact the day to day running of the unit.

Medical staffing

- The level of cover provided by medical staffing on the ITU did not meet all professional standards and recommendations. 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 an absolute maximum of six beds. This was significantly better than the core standards recommended ratio of one consultant for a maximum of 15 beds.
  - Consultants provided a good level of continuity. A consultant would spend four full, and a half-day working on the unit.
  - There was a designated clinical lead consultant for ITU.

- The use of locum medical staff was rare (19 occasions in the six-month period ending September 2015) and there was an induction pack developed, to be used for any locum doctor was employed.
- On weekdays, there was a specialist registrar doctor on duty. This met the recommendation of the core standards for there to be a trainee doctor for no more than eight patients.

- Areas which did not meet professional standards and recommendations were;
  - There was not always an anaesthetist that specialises in intensive care covering the ITU because the rota was split between critical care and anaesthetics. Four out of five consultants had fellowship faculty of intensive care.
  - Staff told us and we saw evidence in patients' health records that a consultant conducts a ward round each day including at the weekend. However, this did not meet the core standard for intensive care units, which states 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 core standard states that a consultant in intensive care medicine must be immediately available 24 hours a day/seven days a week for ITU. Staff from a variety of disciplines told us the consultant was easily contactable and available out of hours. Not all on-call consultants specialised in intensive care.
  - Out of hours cover (weekends and nights) for the ITU was provided by a registrar or associate specialist level doctor. They also provided cover for maternity, the emergency department and sometimes assisted to cover theatre. A member of the medical staff told us that it was common to be called to maternity when on call. The frequency on the being on call for the registrar doctors was one in every eight nights. A trainee doctor told us that they were initially concerned with on-call arrangements but found that most of the time it was quiet.
- There was an entry to the risk register detailing issues regarding anaesthetic cover (including critical care) for the elective care division and senior ITU staff acknowledged that more consultants were required. A gap analysis had been carried out and stated that seven consultant posts were unfilled to cover critical care and anaesthetics. The clinical lead consultant for ITU maintained that despite not meeting core standards the medical cover for the unit was safe. There were no reported incidents related to medical staffing between 6 March and 29 June 2015.
- Shifts have been covered by locum medical staff, on 19 occasions in the six month period ending September 2015, and often by a locum who worked for the trust on a long term basis.

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 ITU 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.
- Evacuation routes were kept clear on the unit and there was a fire evacuation plan for the ITU, a copy of which has been requested but not provided by the trust. However mandatory training rates for fire safety overall were below trust target at 67%.

Are critical care services effective?

Good

Critical care services provided effective care and treatment that met patient's needs. Staff could access information that they needed to assess plan and deliver care effectively.

Consent to care and treatment was obtained in line with legislation and evidence of appropriate use of mental capacity assessments and deprivation of liberty safeguards were seen.

Critical care services had been considered an outlier for patient mortality (in other words there were more deaths than expected) in the year 2013/2014. It was acknowledged that the data showed improvements and they were no longer considered an outlier for patient mortality.

Critical care

While the ITU were contributing to the national ICNARC and potential donor audit, there were no planned local audits to evaluate policies or effectiveness of treatment interventions and care provided.

The unit had strong links with the critical care networks' educational group. National competencies for critical care nurses were used. However, we were told that study leave for completing courses such as the critical care post registration award was limited. There were gaps in support arrangements for staff highlighted by low appraisal rates for nursing staff (50% of were up to date at August 2015).

Evidence-based care and treatment

- The ITU had an operational policy that detailed admission criteria and access. However, it was past its review date of October 2014 and required review as it included access to the interim HDU beds that were no longer used.
- Patients' care and treatment was assessed during their stay and delivered mostly along national and best-practice guidelines. For example, National Institute of 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 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). However, the physiotherapists showed us new documentation they were piloting for ITU patients that incorporated outcome measures. 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.
- There was a daily audit review of patient care and treatment. There was a daily audit tool to support the daily 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'. This meant each aspect of care was reviewed and a record made to check everything that should be done for a patient had been completed appropriately.
- Patients' length of stay was submitted to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients). The mean average length of stay for all admissions in the ITU in the 12 months from to April 2014 to March 2015 was 3.8 days. The national mean average of around five days.
- Patients were safely ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.
- The ITU 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. During the inspection, there was also evidence of delirium (temporary acute confusion state) screening on admission documented in the healthcare records of the patients.
- Patients were assessed for risks of developing venous thromboembolism (VTE) such as, deep vein thrombosis from spending long periods immobile. There was a daily review of patients for risks of developing VTE and patients were provided with preventative care including compression stockings and sequential compressions devices in line with NICE83 statement 5.
- The ITU met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. As is best practice, the ITU led on organ-donation work for the trust. In the NHS, there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. There was a specialist nurse for organ donation who was employed

by NHS Blood and Transplant 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 ITU team were meeting core standards relating to engaging, and participating in a critical care operational delivery network. They belong to the Birmingham and Black Country network and we were told that the senior nurse and lead consultant were involved in quarterly professional meetings.
- While the ITU were contributing to the national ICNARC and potential donor audit, there were no planned local audits specifically pertaining to critical care to evaluate policies or effectiveness of treatment interventions and care provided.

Pain relief

- Patients were given effective pain relief and strategies were based upon best practice. We checked a patient's record, to assess whether they had been provided with pain relief prior to physiotherapy and found that it had been given to the patient for seven out of eight treatment sessions.
- The unit had carried out a local initial ITU patient survey (13 patients) and results for August 2015 showed that 90% of patients strongly agreed or agreed that their pain had been effectively managed during their stay.

Nutrition and hydration

- Patient nutrition and hydration needs were assessed and effectively responded to. The patient records we reviewed were well completed, and safe protocols followed. Fluid intake and output was measured hourly, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. Any feeding through tubes or intravenous lines was evaluated, prescribed and recorded.
- The ITU had guidance, protocols and some support for specialist feeding plans. A dietitian attended the ITU every weekday to support patients with naso-gastric tubes, total parenteral nutrition (nutrients supplied intravenously through a central venous access devices), and percutaneous endoscopic gastronomy (PEG) feeds. The dietitian service was not dedicated for ITU; however, we were informed they take part in the critical care network for dietitians to keep up to date with best practice. There were approved protocols for nursing staff to commence enteral feeding on ITU, including clear flowcharts and information regarding testing for confirmation of correct nasogastric tube placement.
- Specialist dietary requirements were available on request including gluten free, low allergen, soft diet and religious needs. Although, not all staff seemed confident about getting special diets for patients with religious needs.
- Patients on ITU 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.
- Evidence was seen in healthcare records that the Malnutrition Universal Screening Tool (MUST) was used to assess a patient's risk of malnutrition.
- Data supplied by trust showed 73% of nursing staff on ITU were up to date with training and competencies to administer intravenous fluids and medication by September 2015.

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in ICNARC the national clinical audit for adult critical care; the case mix programme (CMP). Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. Mortality indicators are integral to the ICNARC audit. Previously ICNARC indicators deemed the ITU to have worse rates than other comparable services related to death rates. The standardized mortality ratio (SMR, the observed number of deaths per year against the expected number of deaths per year) had been worse than the predicted range for 2013/2014, so the ITU was considered a 'statistical outlier'. Following this, the clinical lead consultant provided reports to the trust board. In January 2015, the report concluded that more recent data (for the first six months of 2014) had indicated further falls in SMR, demonstrating a consistent

improvement and was no longer considered an outlier. The data was also discussed in monthly morbidity and mortality meetings, however the minutes were incomplete.

- The ITU was performing as expected (compared to other similar services) in all seven CMP indicators used in the ICNARC Annual Quality Report (2013/2014) and these areas were:
  - Out of hours discharges to the ward
  - Non clinical transfers (out)
  - Unit acquired MRSA
  - Hospital mortality
  - Out of hours discharges (not delayed)
  - Delayed discharges (12 hour delay)
  - Unplanned readmission within 48 hours
- There was an administration clerk specifically employed to input data for ICNARC. ICNARC reports were discussed at mortality and morbidity meetings and ITU staff meetings. Data was collected by the bedside nursing staff using a paper-based system. Data was not included when patients were critically ill outside of ITU (level two or three care) therefore when the interim HDU beds were used; the patient outcomes will not have been included. The data showed that the interim HDU was used for 25 patient admissions in a 12-month period ending in August 2015. There had been no deaths recorded for the interim HDU, which was last used by one patient in the month of August 2015.

Competent staff

- Staff were required to be assessed each year for their competency, skills and development. Half of the nursing staff had been given an annual review of their competence and performance. All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and due an appraisal. The nurses were divided into teams each led by a band six to facilitate team working and organise appraisal completion. Half of ITU nursing staff (including two staff described as additional clinical services) were up to date (at August 2015) with annual appraisals which was below the target of 90%. We were told that there was also a rolling six week programme for clinical supervision of nursing staff.
- Medical appraisal rates were 100% and revalidations were completed with no non-engagement notifications.
- There was good support to trainee doctors. Those we met said they felt valued members of the team. One of the senior trainee doctors told us that they had been very impressed with the leadership on the unit and had received a good induction and allocated an education supervisor for support.
- A band seven clinical lead experience critical care nurse role focused on professional development and staff competencies, in line with core standards, which states that each unit will have a dedicated clinical nurse educator responsible for coordinating the education, training framework for nursing staff and pre-registration student allocation. Assessments of practice assessments completed by staff were seen, including skills such as; arterial blood gas sampling, echocardiograph (ECG), recording and assembling ventilators.
- Two trained nursing staff could access a post registration award course in critical care, provided by Wolverhampton University each year. However, we were told study leave for completing the course was limited; with one nurse stating they had not wished to commence the course because of this. The amount of paid study leave provision was requested but not supplied by the trust. Post registration award should be held by at least 50% of trained staff according to core standards and we were told the figure was 76%. The actual percentage provided for October 2015 was 53%.
- 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. Staff told us which competency programme level they were working through and we saw evidence that these were reviewed and updated. The senior nurse for ITU described taking an active part in critical care networks educational group, looking at national competencies for critical care.
- The band six nurses working with CCOT were all working through CCOT competency booklets based on the National Outreach Forum (NORF).
- Five healthcare assistants (HCA) were employed by ITU and they were involved in aspects patient care under the supervision of the trained bedside nursing staff. Additional skills included recording a 12-lead ECG, setting up ventilators to be used and putting arterial blood samples through the analyser machine.

Competency documents were completed regarding these skills and we saw evidence of completion and certificates provided. Checklists were used to support the induction of new HCAs and we saw evidence of these completed, dated and signed. There was a HCA available on the ITU 24 hours a day. The HCAs also worked closely with the housekeeper, maintaining a clean environment on the ITU.

- We were told, and we saw evidence, that new nursing staff to the ITU had a period of time where they were supernumerary (extra to the clinical numbers) in line with core standards. Generally, it was between two and six weeks, although the length of time varied dependent on the individual's needs. Clear induction processes were described and supported by documentation, which we saw during the inspection, including a checklist that was completed in this period.

Multidisciplinary (MDT) working

- The ITU had input into patient care and treatment from the physiotherapists, pharmacists, dietitians, speech and language therapists, microbiologist (a healthcare scientist concerned with the detection, isolation and identification of micro-organisms 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 MDT working for the benefit of the patient, including the ability to respectfully challenge aspects of treatment plans if necessary. All the members of the MDT did not routinely attend the ward rounds on the unit; however, the nurse in charge of the ward did and would collate advice and help to communicate effectively plans made by other disciplines.
- A physiotherapist was available on the unit twice daily (Monday to Friday). We spoke with a physiotherapist who was seconded to work on ITU for a year. Overall, they had found they worked as a team with the nursing staff, saving specific tasks, such as patient mobilisation and moving and handling, to be done together. We saw physiotherapists working well with the MDT.
- Evidence of frequent dietitian reviews were observed in patient's healthcare records and a dietitian visiting the unit told us that their advice was valued on the ITU by the MDT.
- Patients discharged from the ITU were reviewed by the CCOT. Patients would then be visited once they had settled into the new ward. There was no limit to the reviews and these would be done as often or as little as required. The data from the follow up visits were captured on the CCOT trust internally developed database started in April 2015. This showed that the CCOT reviewed 124 patients on average per month which (including referrals) in the 12 months period ending June 2015.

Seven-day services

- Staff told us that at the weekend, the consultant tended to come in on a morning and we saw evidence in patient records of consultant led ward rounds once a day documented. This does not meet core standards for critical care units which state this should be 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.
- Physiotherapists were available for ITU patients including at the weekends and overnight, via an on call system. Frequent physiotherapy reviews were seen documented in health care records; including daily reviews of patients at the weekend
- A pharmacist was available Monday to Friday. This was not a not a dedicated service for ITU, therefore had been subject to a business case to apply for funding to create a dedicated ITU pharmacy post.
- The dietitian provision was again not a dedicated service for ITU, but available Monday to Friday.
- Speech and language therapists were available on request, Monday to Friday.

Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their ITU stay. Healthcare records at the trust were paper based and were available at the patient's bedside. Some information including results from patient tests and guidance was available via the trusts intranet. For example, during the consultant-led ward round, a portable computer on wheels accompanied the staff. This allowed patients diagnostic results to be accessed, as well as guidance and policies. During the ward round, a patient needed antibiotics prescribing. Staff accessed the relevant trust policy at the bedside and were able to look at prescribing guidance, drug interactions and alternatives for patients with allergies. This reduced delays and improved effectiveness and efficiency of ward rounds.

- We met a ward clerk on ITU who was new in post. This role had recently been reinstated to support effective communication throughout the unit.
- 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. They appeared to be completed fully; however sheets may be lost and relied on staff remembering to complete them and does not enjoy the security or flexibility of electronic systems.
- The trust intranet was open and available to all substantive staff. The staff had good levels of access to their own information. We were told that all nursing staff had a general password to access information on the computer and all band six and above staff, have access to a shared drive to store management documentation and information. Critical care has its own generic email address for all ITU staff so that they can access emails, although not all staff had a trust email address.

Consent and Mental Capacity Act (MCA)

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the Mental Capacity Act 2005 when treating an unconscious patient, or in an emergency. A review of consent forms in patient notes showed they had been correctly completed by an appropriate member of the medical team.
- MCA awareness and understanding varied among the ITU team. During the inspection a patient who had a mental capacity assessment carried out, was on the unit. This was regarding the patients' ability to consent to care and treatment while in hospital and had been carried out without delay (on admission). The appropriate paperwork had been completed and documented in healthcare records. The outcome of the assessment found that the patient did not have capacity, so a Deprivation of Liberty Safeguards (DoLS) authorisation form had been sent to the local authority as per policy. The patient had also had to undergo emergency surgery and a specific consent form had been completed, specifically for adults who are unable to consent to treatment, noting lack of capacity and best interest decision making.
- Locally held data on ITU showed that 79% of trained nursing staff were up to date with DoLS training and 74% were up to date with MCA training in September 2015.
- Physiotherapists routinely documented whether patients had capacity to consent to therapy or treatment best interests, every time they attended to a patient.

Are critical care services caring?

Good

Critical care services were providing good, compassionate care.

Patients were unanimously positive about the care they had received and this had been captured in a recent ITU patient survey. Many kind and caring interactions were seen by inspectors, whilst maintaining the highest regard for patient's dignity and privacy.

Relatives expressed that they had been kept up to date with their loved ones progress and supported by the staff at the bedside. Not all relatives were happy with the level of communication; one family had raised issues with the nursing team. This this was not a consistent finding amongst all relatives and visitors, as the majority were happy with the level of emotional care and treatment they and their loved ones had received.

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care, we could not talk to as many patients as we might in other settings. However, patients we were able to speak with said they had found the staff caring and compassionate. Patients said they felt safe and supported. One patient said 'the care is fantastic…" and staff really look after me. All patients said their privacy and dignity was maintained. They said curtains were drawn around them for intimate care or procedures. Relatives of patients on ITU told us that the care their loved ones had received was good. Another relative described the ITU nurses as "wonderful". One family told us that they had experienced other units and in comparison said that this was "a brilliant ITU".
- A patient was observed being assisted to eat their meal in an appropriate dignified and caring manner. Plenty of time was given and the nurse was attentive, at the same level as the patient and made the interaction appear discreet.

Critical care

- There was a calm atmosphere on the unit and the staff were seen to introduce themselves to patients and relatives, offer explanations and provide opportunity to ask any questions.
- The NHS Friends and Family Tests (FFT) were questions asking patients if they would recommend the unit to their family and friends. These questions were usually asked when the patient was discharged from the hospital. As very few of the patients were discharged from ITU (they usually went to a ward before ultimate discharge) they were not participating in the test.
- The unit carried out an initial local ITU patient survey and results showed that patients agreed with the following statements 'my privacy was always maintained' (92%); and 'I was always treated with respect' (100%).
- We observed good attention from all staff to protect patient privacy and dignity. Curtains were drawn around patients and doors closed when necessary. Voices were lowered to avoid confidential or private information being overheard. The nature of most critical care units meant there was often limited opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. The ITU were very aware of this issue demonstrated by reporting when patient's transfers to the ward were delayed. Mixed sex occupancy instances were reported by ITU on 17 occasions between 6 March and 29 June 2015.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. They told us communication was good, and this had extended to talking with their families. We observed staff, both doctors and nurses talking inclusively with patients and their relatives.
- The views of relatives and carers were listened to and respected. However, one patient's relatives told us that they had encountered communication issues, especially not being able to speak to medical staff. This this was not a consistent finding amongst all relatives and visitors, who reported positive interaction with medical staff. In contrast, another family told us that they had been spoken to by a surgical consultant that day and they were very much kept informed by the staff at the bedside. They said they can speak to a doctor any time and have found the medical staff honest and upfront in discussions. The lead doctor for critical care told us that he felt proud of the ITU especially how well the team communicate with patients and their relatives. We reviewed patient healthcare records and found that documentation regarding communication between ITU team and relatives and visitors, was minimal in detail.

Emotional support

- The ITU team demonstrated that they appreciated the emotional turmoil that patients and relatives experienced due to critical illness and ITU admission may cause. They provided a supportive, kind and unrushed approach. They incorporated questions into a recent ITU patient survey to ensure that patients and relatives were kept well informed; acknowledging lack of communication could be a cause of emotional stress. 91% of relatives agreed that they were kept up to date with any changes in the patients' condition and were never given conflicting information by staff members. Patients agreed (84%) with the statement that they were kept updated on their progress.
- We were informed that psychiatric assessment and support can be accessed for ITU patients from the nearby mental health trust.
- There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant and was based at the hospital, to directly support the organ donation programme and work alongside the clinical team.

Are critical care services responsive?

Requires improvement

Overall, critical care services were found not to be always responsive to the needs of patients.

There were occasions when patients were delayed in transferring to a ward bed when they no longer required critical care. Sometimes when a bed became available patients were relocated during the night.

Critical care

It was unclear whether patients could always access an ITU bed when required. The trust stated that information about occasions when level two (HDU) patients cared for outside of ITU was not collected.

There were no toilet or shower facilities for patients within the ITU. This was particularly relevant for patients that were improving from critical illness and waiting transfer to ward areas.

There was no follow-up clinic for patients that have been discharged home from after an ITU admission.

However, there was evidence that improvements had been made to ensure that patients could access services despite external pressures on flow within the rest of the hospital. There had been a clear focus to reduce cancellations of patient surgery due to lack of ITU beds and they had achieved this through rationalising elective booking procedures and being proactive especially at a senior nursing level.

There was one formal complaint in last 12 months ending August 2015. Staff took complaints and concerns seriously and made adjustments to improve communication between MDT and patients relatives.

Service planning and delivery to meet the needs of local people

- There was no follow-up clinic for patients that have been discharged home from after an ITU admission, which was recommended in NICE guidance. The lack of the clinic was not entered on the risk register.
- There were no patient facilities to shower or bathe 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. During the inspection, a patient waiting for a ward bed was delayed by more than three days. Warmed, specially developed bed bath wipes were used to wash patients rather than bowls of soap and water; the senior nurse told us that this had on occasion led patients to believe that they have not been washed while they were on ITU. This was to be further explored in future monthly patient/relatives surveys.
- Visiting times could be flexible to meet the needs of the patient and their loved ones. They were described as 'open,' however visiting was not allowed during the hours of 2pm and 3pm as this was the patients rest period. The policy was for only two visitors per bed space unless the patient was extremely poorly. There was limited space in the units and visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in critical care. Visiting times prioritised the needs of the patient, while being supportive to relatives. Visitors agreed with this overall, however one family found the policy of two visitors per bed space restrictive.

Meeting people's individual needs

- Every day a core care plan for patients were completed by nursing staff. These were individualised meet patient's needs. A patient in side room was seen to have access to a clock, television set and a notice board for patient, relatives and staff use to communicate messages.
- Patients that were living with learning disabilities 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 ITU 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 they could access for support. Information was supplied by the trust regarding patients living with learning disabilities including supportive advice to assist with communication and a hospital passport system to be completed; however, these were not seen in use.
- Relatives and visitors of patients being cared for on the ITU had access to two waiting rooms that had recently been decorated with comfortable large chairs. There were also free hot drinks available. We were told that there were up to four rooms available for relatives to stay overnight if required. We met some relatives during that were staying at the hospital whist their relative was a patient on ITU; they said that they had been treated very well and had no complaints. A transfer folder on the ITU had information on how to get to other hospitals from Hereford. Staff could give this to relatives.
- However the relative's toilet facilities smelled musty and the shower had a sign stating it was unusable. Updated information provided by the trust explained that following high counts of legionella found over two years ago from the shower; the water incident group decided

to disconnect the shower from the mains to eliminate the risk. The plans were for the shower to be removed and the drain covered. No timescales were provided for this work.
- Information leaflets about what to expect on intensive care for patients and relatives were available on the unit printed in English.
- Translation services were obtainable and staff were aware of this but they had not recently had any experience of using it. They also had access to 'no verbal' cards which could be used to assist with communication.

Access and flow

- The ITU had six beds all of which were funded to provide level three care (ITU patients); however could mix and match according to patient's level of care (level two being HDU patients). There was a standard operating policy describing the admission process to the ITU; however, it was past its review date of October 2014 and required review as it included access to the interim HDU beds that were no longer used.
- The ITU had approximately 400 admissions per year and a third of those were ventilated (level three) on admission. The critical care adult occupancy fluctuated between 50% and 100% however predominantly it had been around the national average of 80% (NHS England data from May 2013 and March 2015).
- Many (66%) patient transfers out of ITU were delayed due to a bed elsewhere in the hospital being unavailable (according to annual data for 2014/2015). The delays were mostly 24 hours or less (95%) although some were longer. Three per cent of patients waited between five and nine days for discharge from the unit. The ITU was performing as expected (compared to other similar services) regarding delayed discharges (12 hour delay) in the ICNARC Annual Quality Report (2013/2014). Although patients remained well cared for on ITU, when they were medically fit to be discharged elsewhere, the unit was not the best place for them. It also delayed access for patients who needed to be admitted.
- Due to the delays experience in accessing ward beds when required, the clinical lead consultant for ITU told us that there were patients that were transferred out overnight. The core standards for intensive care units stated, discharge from should occur between 7am and 10pm. Seven patients who were transferred to the wards out of hours were reported as incidents electronically between 6 March and 29 June 2015. There was also noted to be three patients in July 2015 who had been transferred out to a ward between the hours of 10.30pm and 00.20am documented in the ITU's admission sheets. These issues were felt to be outside of the ITU team's control. Delayed ITU or out of hours discharges did not feature on the risk register for ITU.
- Despite the pressure of transferring patients out of the unit when ready for the ward, there were few transfers due to non-clinical reasons and patients were rarely cared for in theatre recovery awaiting on ITU. However, there were two occasions reported electronically between 6 March and 29 June 2015, when patients were cared for in theatre or the recovery room until a bed was available on ITU. This is in contrast to data provided during the last inspection in 2014 when 92 patients required level two care outside of ITU (10 July 2013 and 26 March 2014). The number of occasions that patients required level two (HDU) care outside of the ITU/HDU facilities in the last 12 months to August 2015 had been requested, however the trust has stated this information was not collected. Therefore, no assurance could be provided regarding this issue.
- Three 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. There was a standard operating policy describing the admission process to the ITU; however, it was past its review date of October 2014 and required review as it included access to the interim HDU beds that were no longer used.
- We were told by senior nurse that after a patient has been deemed ready for step down transfer to a ward for more than 24 hours, a mixed sex occupancy breach would be declared and reported electronically as an incident. 17 instances of mixed sex occupancy were reported by ITU occurring between 6 March and 29 June 2015.
- The trust advised us that for the 12 month period ending March 2015, there were six occasions when patients had their surgery cancelled on the day, due to lack of bed availability on ITU. This was for patients who needed level two or three care post operatively. The three senior lead nurses from ITU, theatres and surgery respectively, worked closely together and met twice daily in theatres with key staff to discuss patient flow. They feel they have been able to make a positive impact on patient flow and have demonstrated this by reducing

patient surgery cancellations. Evidence to support this claim has been provided demonstrating reduction in cancellations for the elective care division. Staff told us that if a patient was deemed to require an ITU bed after their surgical procedure this was requested using a 'planned ITU/HDU request' form. There was only one elective ITU/HDU bed that could be booked each day. We noted that the form also had the option for extended enhanced recovery time while in theatres. This was a planned extra length of stay in recovery after surgery rather than being transferred to ITU. We were told this option had also reduced cancellations when ITU beds were not available. We were told that CCOT reviewed any extended enhanced recovery patients and then visited them when they have been transferred to a ward. Patient's feedback regarding this specific option was not collected by the trust.

Learning from complaints and concerns

- In the last 12 months the unit had received one formal complaint in August 2015. This complaint was regarding another service but had an ITU component and was in process of being investigated. The clinical lead consultant planned to meet with the family.
- ITU patients informally raised concerns complained about noise levels on the ITU on occasion, due to monitors, alarms and staff and interventions. In response to this, earplugs had been made available.
- Staff told us that relatives often complained informally about the cost of car parking at the hospital site, which was £15 for 24 hours. Concessions against the cost of car parking were available. Relatives told us they asked for and received the concessions for the car parking.
- One family told us they had not had a speedy response from staff when issues were raised. In response, the ITU team had begun weekly MDT meetings, including family members, to improve communication.

Are critical care services well-led?

Requires improvement

The governance of critical care services did not always support the delivery of high quality person centred care. Arrangements for governance and performance management did not always operate effectively.

Incident reporting was predominately done by the nurse in charge of ITU. There was a risk this could act as a barrier to raising concerns by more junior staff, who described limited experience of reporting incidents.

There was a limited approach to obtaining the views of people using the services and did not meet NICE guidance for rehabilitation after critical illness regarding provision of a follow-up reviews for patients following discharge.

Where changes or improvements were made, the impact on the quality of care was not adequately monitored or reported. Innovation within the ITU team and may well have been taking place but not formally captured.

Vision and strategy for this service

- Critical care was managed under the umbrella of the elective care division. The vision and strategy for the unit was clear and shared by the senior staff, clinical lead consultant, lead nurse and elective divisional manger that we spoke with. This vision included a larger ITU/HDU in the future with 10 critical care beds, increasing CCOT cover to 24 hours a day and increasing the number of consultant anaesthetist posts.
- Two interim HDU beds that were in use during the inspection in 2014 were located away from the main unit on coronary care unit and staffed by ITU. During this inspection, we visited the coronary care unit and were informed that the interim HDU beds were officially closed but staff on the unit could not provide information to why this had happened. The announcement regarding the closure was made the week prior to our inspection.

Governance, risk management and quality measurement

- There was a risk register for the elective care directorate and it contained four appropriate entries for ITU. There was evidence of regular review and discussion of the risks. A copy of this was on display on the unit. The risk register also matched with most of the senior staff concerns.
- The ITU participated in a national database for adult critical care as recommended by the FICM Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. Mortality and morbidity monthly meetings to discuss patient outcomes and ICNARC data were not

sufficiently captured in minutes to provide assurance. A member of staff told us that they had attended some of the mortality and morbidity meetings but did not feel that issues that were discussed were feedback widely. Outside of ICNARC there was lack of local audit activity to evaluate effectiveness of care and treatment provided on ITU.

- Risk assessments and policies provided by the unit were often beyond review dates; for example the standard operating policy describing the admission process to the ITU, was past its review date of October 2014. The ITU 'business' meeting minutes provided did not to address governance issues. Local governance such as incident reporting was however discussed at ITU nurse meetings. There did not appear to be a MDT approach to governance.
- We were told a saw that senior staff and the nurse in charge usually completed the incident reports for ITU. As the nurse in charge was always supernumerary, this might mean they were able to complete these on behalf of staff. However, this may be a barrier for staff to freely report concerns.

Leadership of service

- The bedside nurses were supported by the supernumerary experienced critical care nurses in charge of each clinical shift. The unit was also supported by senior critical care nurses, one whose role was to focus on nurse education and one a new temporary post, was to focus on quality and finance. The lead nurse was extremely knowledgeable and had worked at the trust for a significant period. There was a risk of overreliance on this person, as during the inspection almost all nursing staff stated that they would refer to them for advice for all types of concern. The responsibility of management could be shared more amongst the senior nursing team.
- The lead nurse was seen to effectively manage and escalate issues when staff arriving on duty at 7.30am, were unable to find appropriate car parking spaces.
- The unit was led by a clinical lead consultant, lead nurse who were visible, accessible and approachable. They were dedicated, knowledgeable experienced clinicians and managers.
- We met a trainee doctor on ITU who told us that they had found the leadership, morale and culture on the unit very impressive and had received a very good induction.

Culture within the service

- The team working culture was evident on the unit and clearly a culture of mutual respect for different members of the MDT. A HCA told us that the allied healthcare professionals that attended the unit were very approachable. The culture between the medical and nursing staff was described as 'healthy' as nurses felt able to challenge consultants for explanations if required. Staff told us that this ability to challenge extended to all the members of the MDT.
- The morale seemed good and many staff expressed that it was a lovely team and a nice place to work and they clearly enjoyed providing treatment and care to their patients.

Public engagement

- There was limited evidence of public opinion being sought within the ITU. August 2015 ITU patient survey did ask for feedback from patients' relatives and there was an action plan showing some consideration for changing services as a response to public feedback. Opportunities regarding follow up services for patients following critical illness were not developed outside of initial visits by the CCOT.

Staff engagement

- There was a structured approach to team meetings within ITU to encourage staff attendance. Senior nurse (band six and above) meetings were alternated with general ITU meetings held monthly. We saw that the minutes included feedback regarding incidents were included and information about ITU meetings were on display on the communication board in the coffee room.
- While trained staff agreed that local ITU management was good they felt that they did not see much of the managers in the elective division generally. A band five staff nurse said that they had attended trust briefings led by the chief executive officer.

Innovation, improvement and sustainability

- Following the June 2014 inspection there were areas that still required improvement, such as:

Critical care

- increasing medical staff cover out of hours to meet core standards
- local audits to evaluate care and treatment, and changes to clinical practice
- there was limited evidence of innovation within the ITU team and may well be taking place but not formally captured
- a culture of continuous improvement needed to be fostered and changes and learning from incidents, complaints, claims and concerns, feedback needed to be clearly demonstrated and evident. Pressure ulcers developed by patients on ITU were classed as unavoidable, however there were improvements to pressure ulcer prevention strategies identified during the inspection, including the lack of tissue viability team involvement in the subsequent RCAs
- patients requiring level two care outside of the ITU whilst waiting for admission was not captured
- intravenous fluids storage remained unsecured
- lack of ITU follow-up service (NICE guidance for rehabilitation after critical illness).

- Areas that had improved included since the June 2014 inspection**:**
  - the presence of a band eight lead nurse role (meeting core standards)
  - extra investment in nursing staff numbers
  - increasing CCOT service cover by 2.5 hours a day
  - reinstating a ward clerk role
  - renovation and improvement in some of the ITU facilities
  - closing the HDU beds which were difficult to staff and were not located near the ITU
  - senior nursing structure within the elective care division were working together and reported to be making improvements to patient flow within, theatres, ITU and elective surgery
  - reduced cancellations of surgery due to lack of ITU bed availability.

Maternity and gynaecology

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

Information about the service

The Wye Valley NHS Trust provides maternity and gynaecology services at Hereford Hospital. This report focusses on the maternity services; review of gynaecology pathways are included in this report.

The maternity services at Wye Valley NHS Trust are part of the Integrated Family Health Service (IFHS). The IFHS provides women's health and paediatric services in the hospital and child health, sexual health and school nursing in the community. The IFHS' 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. Between January and December 2014, 1,761 babies were born at Hereford Hospital.

The maternity service at Hereford Hospital offer: 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. 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 the services. For the maternity services we spoke with four patients, 20 midwives and support workers individually, and 12 midwives in two focus groups. For the gynaecology services we spoke with three patients and four nurses. We also spoke with four medical staff who worked across the maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

We saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment. However, we also saw that the clinical governance system was not robust. Senior staff within the maternity unit did not manage incidents in a timely manner and in accordance with best practice.

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out policies in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Patients told us they had a named midwife. The ratio of clinical midwives to births was one midwife to 27 women which is similar to the national average of 1:28. Staff told us that they offered all women one to one care in labour but were not always able to provide this. Although this was recorded on the electronic system, staff could not show the percentage of women who actually received one to one care. Women told us they felt well informed and were able to ask staff if they were not sure about something.

Are maternity and gynaecology services safe?

Inadequate

Five serious incidents were reported for maternity to the Strategic Executive Information System (STEIS) between May 2014 and April 2015. We saw documentary evidence that demonstrated that the trust was consistent in its review and analysis of incidents. Senior staff did not assure us that investigations were monitored and action plans reviewed and closed.

We saw evidence of learning from incidents, but in some cases this was not evidence-based. For example we noted that cord blood analysis for all newborn babies was introduced following an incident, which is not recommended best practice.

Systems, processes and standard operating procedures in maternity were not always reliable or appropriate to keep patients safe. We saw that an anaesthetic room used as a second theatre on a delivery suite was not fit for purpose. The room was introduced following a serious incident. The trust had assessed the risk and considered that, on balance; the risk of the arrangements were less than the risk to patients being transferred to general theatres. We observed poor practice around swab counting and fresh eyes review of cardiotography (CTG) fetal heart rate recordings. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour.

The named midwife model was in place and women told us they had a named midwife. We were told by staff, but could not confirm, that women received one-to-one care in labour.

All areas of the maternity and gynaecology service we visited were visibly clean and well maintained with display boards detailing cleanliness and safety information. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that the equipment was safe for use. However, emergency equipment was not checked on a daily basis which meant that equipment was not ready use.

Maternity and gynaecology

The planned and actual staffing levels were displayed on all wards in the gynaecology and maternity units and were mostly in accordance with national requirements.

Incidents

- Staff told us that they were able to raise concerns and were confident that their concerns were listened to. Furthermore, staff told us that Datix™ reporting was not seen as a bad thing anymore and they had noticed a dramatic change in the amount of feedback they received from incidents.
- We were not assured that the trust approach to incident management was timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users. We saw that 175 maternity and 29 gynaecology incidents were reported between March and June 2015. The risk coordinator confirmed that across maternity and gynaecology there were 121 open incidents awaiting investigation with 106 of these overdue, there were 52 incidents on hold undergoing investigations, and 138 incidents waiting for final approval.
- Escalation of risk was identified through a computer based incident reporting system, Datix™. 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.
- 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.
- We saw that learning from seven obstetrics and gynaecology RCAs between September 2014 and April 2015 was published for staff to read. A brief case history, adverse outcomes and important learning highlighted by each RCA were contained within the report.
- We were not assured that the trust approached incident management in a consistent and robust manner.
- We saw from the maternity risk strategy policy that serious incidents were discussed with service unit leads, clinical director, patient safety lead and head of quality and safety and reported according to the Serious Incident Framework (NHS, March 2015). In addition a potential serious incident (SI) was discussed with the Clinical Commissioning Group (CCG).
- We saw that the trigger list contained incidents that needed to be considered as SIs. Such incidents had to be escalated to the trust quality and safety unit within 24 hours. A haemorrhage over 1000mls was included on the list. We saw that a blood loss of 4500mls had not been treated as a SI and had not been reported to the CCG. We saw documentary of evidence of the incident being categorised as no harm on the incident log and moderate harm for the mother in the RCA. We were told the CCG had not been informed because the incident was not considered an SI. This meant that trust policy was not being followed.
- It was the responsibility of the band 7 manager reviewing incidents to allocate the level of harm in line with National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS) definitions of harm. We saw that there was a variation in the assessment of harm. For example, the log of maternity incidents for March to June 2015 contained eight incidents relating to third or fourth degree tears. Four of these were classified as causing no harm, three were classified as causing low harm and one was classified as causing moderate harm. We raised this with management who were unaware of these discrepancies.
- Five serious incidents were reported to the NHS Strategic Executive Information System (STEIS) by maternity services between May 2014 and April 2015. There were two unexpected admissions to the neonatal unit (NNU), one infected health care worker, one incident relating to safeguarding a vulnerable adult and one unspecified incident relating to the maternity services.
- We saw documentary evidence that there were 20 unexpected admissions to the NNU between March 2015 and June 2015. It was not clear, and staff could not tell us, why these had not been reported to STEIS when two unexpected admissions to NNU had previously been reported.
- We were not assured of a robust approach to safety incident investigations. We were told that whether an incident met the criteira for a SI was decided on a case by case basis using the new SI framework and that following every reported SI, a full investigation was undertaken and a report developed in line with National

Patient Safety Agency (NPSA) good practice. However we saw documentary evidence that an incident that had occurred in June 2015 had not had a 72 hour review and the RCA had not been started at the time of our inspection. This had since been supplied to us but was not completed robustly. Omissions and errors included inconsistent and incomplete chronology; unexplained time lapses; risk factors consiederd to reach risk scoring and the deciosn making behind the scoring were missing; it was not clear what grade of staff were involved; the explanation for delay in consultant presence considering the concerns raised was not provided; a true root cause was not identified.

- We reviewed another RCA and were not assured that it met the standards of the Serious Incident Framework (NHS, March 2015). We saw little correlation between the lessons learned and the recommendations. We did see not how documents reviewed as a result of the RCA would be embedded. The root cause was not identified and the action plan was not monitored.
- 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 from a RCA that parents had been given a verbal apology and that a duty of candour letter had been sent offering them the opportunity to participate in the investigation.

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. The trust was not using the maternity safety thermometer and did not share plans for implementation. Outcomes for **perineal and/or abdominal trauma (caesarean section)** were recorded on the monthly quality report however other outcomes were not recorded in this way. This meant that the measurement of the proportion of patients that were kept 'harm free' from **post-partum haemorrhage, infection, separation from baby, psychological safety**, babies with an **Apgar score of less than seven at five minutes** and/or those who were **admitted to a NNU were kept under review through the maternity service governance processes.**

Safety Thermometer - Gynaecology

- The NHS Patient 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 for pressure ulcers, falls and MRSA bacterium for over 1000 days. There had not been a case of **Clostridium difficile** since 21 November 2014.
- However, a fall occurred on the women's health ward during our inspection. The alarm was raised by a staff member shouting for help. We were told that the incident had been reported verbally to the manager and the member of staff involved would be expected to complete an incident report before the end of the day.

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. We saw environmental audits for all areas provided to us by the trust. The delivery suite achieved 72% compliance and the maternity ward achieved 66% in the audit conducted in September 2014. The gynaecology

ward scored 88% compliance. We saw action plans in place to address any identified shortfalls however these did not have a date by which actions should be completed.

- We saw documentary evidence that there were 14 days in September 2015, six of which were consecutive, when the obstetric theatre was not cleaned. The labour ward coordinator could not tell us why this cleaning had not taken place and was not aware of this shortfall or ongoing monitoring or actions to ensure compliance. This meant that women and babies were potentially at risk of infection.
- 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.

Environment and equipment

- We found equipment was clean and fit for purpose. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- Resuscitation equipment was not checked daily to ensure equipment and supplies were complete and within date. The resuscitation trolley on the maternity ward was checked fortnightly. When asked why it was not checked more frequently and staff told us that it was due to a lack of staffing capacity. Furthermore, we observed that one of the resuscitation trolleys had two checklists which could cause confusion; staff on duty were unable to account for this. The neonatal rescusitaire on delivery suite were inconsistently checked with a number of days omitted. The coordinator was unaware of this when it was brought to her attention and staff acknowledged that on occasion the workload can impact on the checking of equipment.
- The equipment check log showed that the obstetric emergency trolley on the delivery suite had not been checked weekly as required for three consecutive weeks between the 22 July and 14 August 2015. Some weekly checks were late. Staff told us that in the event of a check being missed, the equipment was checked at the next available opportunity, which could be on the following shift.
- An intercom and buzzer system was used to gain entry to the delivery suite and the maternity ward to identify visitors and staff to ensure that women and their babies were kept safe.
- There was a patient information board on the maternity ward with patient information that was visible to visitors.
- 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. 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 saw a booklet on the delivery suite that contained photographs demonstrating evacuation of the pool.
- We saw that there was one main waiting area in the antenatal clinic and another in the corridor leading to the delivery suite and maternity ward. There was also a curtained off area used for gynaecological treatments. During our June 2014 inspection, we found that the antenatal clinic was also used as a gynaecological clinic. We were told that this was no longer the case, however we observed both maternity and gynaecology patients in the waiting room awaiting appointments at the same time. Whilst quiet areas were available for consultations, privacy could be compromised.

Medicines

- 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 daily. This ensured that medicines were maintained at the recommended temperature. We saw that the drugs fridge on the maternity ward had not been checked on 14 occasions in six months. It had also

exceeded the required range of 8°c on 17 occasions in six months without any action taken. Pharmacy had been informed of one occasion on 14 September 2015 but had not replaced the drugs until 21 September. Staff had not reported the fault on the fridge and when they did so, pharmacy failed to respond in a timely manner. This meant that medicines were not stored correctly putting women and babies at risk of the administration of ineffective medicines.

- We saw that ampules of sterile water and sodium chloride were located next to each other in the unsecured emergency trolley on the maternity ward. There was a risk that the similarity of these ampules may lead to confusion on administration. The substances were also not stored correctly.
- We spoke with one antenatal patient who had been waiting for an injection for an hour; she was otherwise happy with her care.
- 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 good practice and ensured the medicines had been checked for safe administration.
- 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 September 2015 the VTE score for delivery suite was 86% and the score for the maternity ward was 45%. Treatment to prevent blood clots was prescribed and administered in accordance with the trust policy.

Records

- The maternity service had moved to a paper-light records management system. Women did not carry handheld notes and did not have access to their records on line at the time of our visit.
- Community midwives carried i-Pads which contained patient records. These were protected by three separate log-in sessions. Midwives reported lost or stolen devices to security who could disable them. This meant that patient's information was protected.
- Due to connectivity problem, community midwives had to download information for use in women's homes. This added to their workload and resulted in risk when they could not access records in a timely manner.
- 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.
- We reviewed a set of records on the maternity information system to gain understanding of the system. Hard copies were not available for us to review.
- We saw that patient records on the gynaecology were stored in the main corridor of the ward. At the time of our visit the trolley was open. On subsequent visits to the ward, the trolley was closed but not locked. This meant that patient records were not always stored securely.

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.
- There was a child and baby abduction policy in place to ensure the safety of 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 we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- Safeguarding training compliance at level three was recorded at 75% compared to the trust target of 90%.
- Staff mostly reported good support from the safeguarding midwife who visited wards regularly to review safeguarding issues, and was available by telephone during working hours. Midwives on the preceptorship programme told us they would like more support with safeguarding in the community.
- A flag showed on the maternity service information system for any woman who had a safeguarding concern to help alert staff to the concern. Any safeguarding plans were also uploaded to the information system.
- We found that staff in the emergency department could not access the maternity information system and therefore were not able to identify safeguarding concerns if women attended the department.
- If a woman presented herself for treatment who was not known to the service, staff informed the local safeguarding board who then made enquiries with the

social services department in the woman's home locality. We saw that staff responded appropriately when a woman was admitted with unidentified safeguarding concerns.
- Training was ongoing to safeguard patients at risk of and treat those affected by female genital mutilation (FGM). The trust was unable to provide evidence to demonstrate how many staff had been trained.
- We saw that all women were asked about domestic abuse in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded. Staff knew how to make referrals to other agencies in cases of disclosure.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010). A safeguarding case supervision policy was in date and community midwives undertook safeguarding supervision in line with trust policy.
- The CQC Review of health services for Children Looked After and Safeguarding in

Herefordshire was published September 2015. We saw that recommendations relating to the IFHS had been identified and an action plan had been developed to address these.

Safeguarding adults level 1 training required by midwives had a 75% compliance compared to the target of 90%.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health.
- Maternity specific mandatory training and other learning and development was managed by the practice development midwife, who was also responsible for infant feeding. We saw that 92% of midwifery staff and 100% of medical staff had completed mandatory training. This met the target set by the trust of 90%.
- Not all aspects of training met the trust target compliance of 90%. For example, midwives were only 81% compliant with information governance; 67% compliant with moving and handling for people handlers; and 73% compliant with infection control level 2 yearly training.
- Specific maternity mandatory training covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breach presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.
- 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 was unable to provide evidence to demonstrate CTG training compliance.

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. In September 2015, 92.5% of women were booked by 10 weeks and two days gestation of pregnancy. We saw that an on-going risk assessment was carried out at subsequent antenatal visits and referral to the obstetric team made if risk factors were detected.
- Women that had problems in pregnancy were reviewed on the DAU. From here they could be admitted to the ward for short periods of time to be reviewed regularly 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.
- There was only one consultant trained to perform Middle Cerebral Artery (MCA) Doppler assessments. MCA 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 however we could not see evidence of an action plan to address this situation.

- Women were offered vaccinations against influenza and whooping cough.
- 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 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 (ITU).
- There was not a dedicated high dependency area within delivery suite. We were told that plans for a high dependency area were in development and would be supported by guidelines that were in preparation.
- Women with complex needs were cared for in room 5, which was adjacent to the anaesthetic room. This was the largest treatment 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.
- The anaesthetic room was also used as the second theatre when the obstetric theatre was in use. Whilst it had only been used three times since this was identified during our June 2014 inspection, the risk that the lack of a second theatre could prevent timely emergency intervention. The room was introduced following a serious incident. The trust had assessed the risk and considered that, on balance; the risk of the arrangements were less than the risk to patients being transferred to general theatres. This was on the risk register. The trust recognised that the room was unsuitable 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 possible prosecution by Health and Safety Executive over not meeting Health Technical Memorandum (HTM) and Mechanical and Electrical compliant standards.
- The recovery area was in a curtained bay, off the corridor adjacent to the theatre. This did not have an emergency bell which meant that help could not be summoned in an emergency. Furthermore, the corridor location of the bay did not afford adequate privacy and dignity for newly delivered women.
- 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 that all the stages were completed correctly and that checklists showed that this was usual practice.
- 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. We saw from an audit of information entered into the maternity information system that swab counts were incomplete for August 2015. Compliance with swab counting was 51% after delivery of the baby and 72% after a woman had perineal sutures. This meant that women were potentially at risk from a retained swab, which is a Never Event. 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.
- 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. A review of the data entered onto the maternity information system showed that in September 2015, 61.5% of CTGs were reviewed hourly and 'fresh eyes' review took place in 60% of cases. We did not see evidence of a trust target for this activity.
- Midwifery hand over took place at the change of each shift. Handover included a review of all women on the wards and allocation of work. We observed that the midwifery handover on the delivery suite was organised

and systematic. We also observed that hand over on the post-natal ward which, although not as comprehensive, demonstrated the passion and caring attitude of the midwifery staff.

- 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' 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 (Situation, Background, Action, and Recommendation) 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 had not used Birthrate Plus®. A local tool had been used to analyse their maternity workforce aligned with their service's individual care pathways.
- It was not clear to us that the trust was using an acuity tool to assess workload and capacity in the maternity unit. We were told that capacity was assessed four hourly by the coordinator on the delivery suite and entered onto the maternity information system and that the escalation policy was used when one to one care in labour was not achievable. Staff told us that they offered all women one to one care in labour but were not always able to provide this. Although this was recorded on the electronic system, staff could not show the percentage of women who actually received one to one care. The obstetric quality indicators from 12 October 2015 did not show that one to one care in labour on it was monitored.
- Midwifery staff rotated between the hospital and community. This model of providing care meant that all midwives could respond to times of full capacity when the escalation process was put in place because they could confidently and competently work across all areas of midwifery.
- Staff told us of concerns about the skill mix in maternity because the trust had recruited 25 band 5 midwives. These midwives required additional support during their preceptorship programme which put pressure on the service. This was not on the risk register. After the inspection, the trust clarified that there were 15 band 5 midwives on the preceptorship programme.
- 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 planned and actual staffing levels were displayed at the entrance to each maternity ward. The delivery suite required four midwives and one maternity support worker (MSW) on each shift. We saw that required and actual staffing was not met on the late shift on 23 September 2015 as there were only three midwives on duty.
- Staffing requirements for the maternity ward was two midwives and two MSWs on the day shift and two midwives and one MSW on the night shift. We saw that required and actual staffing were met on this ward during our inspection.
- We were told that there was an absence factor of 8.1 WTE. The vacancy rate was 1.8 WTE; the sickness rate was 3.3 WTE and maternity leave 3 WTE in addition 3 midwives were either supernumerary, under supervised programmes or contributing towards administrative duties. In addition, three midwives were working in non-clinical roles pending investigations.
- The maternity unit did not use agency staff and had its own bank of temporary staff. This was made up of permanent staff who undertook extra work to cover shortfalls. We visited delivery suite during the evening and found that the head of midwifery was working clinically and that the community midwife on call had been called into support delivery suite.

- In June 2015, the midwife-to-birth ratio was 1:27 (one midwife to 27 births). This was around the national average of 1:28. We saw that in the preceding year the ratio had been 1:30. Midwives told us, and we saw, that staff were unable to provide one to one care in labour. During our observation of handover, we saw that women in active labour had one to one care but three other patients with complex needs were allocated to one midwife.
- Each full time community midwife had a caseload of 60-70 patients which is better than the recommendations by the Royal College of Midwives of 1:96. The establishment of midwives in the community had been reduced from 22 WTE to 17 WTE in order to support the hospital based service. Staff we spoke with felt that this had increased their workload and felt pressurised. They told us they felt there was 'lots of take and no give', that visits were replaced by phone calls due to capacity and that they worked over their contracted hours daily. We observed that the on call community midwives were called in to the unit to support delivery suite.
- We found that there was 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. Senior management told us that they would 'never' expect band 5 midwives to have responsibility for caseloads with a high level of safeguarding concerns. We saw that a junior midwife had a complex caseload with a high percentage of safeguarding concerns whilst a more senior midwife had a low risk caseload and was supported by a junior midwife. We were told that band 6 midwives did not rotate as much as junior midwives in order to provide continuity of care to women.
- Staff told us that there was an inconsistent approach to the risk assessment of mobile phone connectivity in the community which put them at risk. They were required to inform delivery suite when going out on call and on their return. It was not always possible to this in areas of low connectivity which meant that at times their whereabouts was unknown. This issue was not on the risk register.
- Antenatal clinic staff said they required at least three members of staff every day. A lack of administrative staff meant that midwives undertook non midwifery duties including booking appointments and scans. Not all midwives had access to the systems for booking scans. We were told that this was because there are not enough system licenses.
- We noted a disparity in the allocation of staff. For example, the community establishment had been reduced to support the main unit but midwives were placed in roles that could be carried out by support workers in the clinics and nurses in the Early Pregnancy Assessment Unit (EPAU).
- Obstetric support workers (OSWs) supported the obstetrician in theatre. We were told that posts had been transferred to the medical budget which meant that the delivery suite was not always supported by support workers. A business case for 5.4 WTE support workers was needed to resolve this, however this had not been submitted to the board for approval at the time of our inspection. We saw that the shortage of OSWs, particularly at night, was rated red on the risk register. Contingency was that managers were attempting to cover night shifts with permanent staff to reduce risk as more staff were available in the day to assist in theatre.

Nursing staffing

- The gynaecology ward had eight beds which consisted of a four-bedded bay and four side rooms.
- We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift.
- The trust recognised that there was a risk of harm to patients due to there being only one rostered RN on the women's health ward to lead, manage and co-ordinate the assessment, planning and implementation of care for the eight bedded ward. This breached the trust's recommended two RN requirement when there was a need to implement systems and processes within the ward and when there was reduced RN specialty knowledge within the ward setting.
- The trust recorded on the risk register that it had difficulty in retaining and appointing permanent RNs which had meant the frequent use of bank, agency and redeployed RN's. The trust had agreed to the recruitment of 1 WTE RN which was ongoing.
- Nurses rotated to the gynaecology outpatient clinic and were supported by health care support workers.
- The ward had a part-time ward clerk who worked 19 hours per week (Monday, Wednesday and Friday). The ward clerk had been working on the unit for four to five

months and had not yet completed introductory training. We were also told that there are several new health care assistants (HCAs) on the ward who had not completed their training. Staff we spoke with told us that this meant nurses had to complete administrative tasks which detracted from direct patient care.

Medical staffing

- The trust employed 17 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 36% which is similar the national average of 35%. The percentage of registrars 24% which is fewer than the national average of 50%. The percentage of middle grade doctors was 34% which is greater than the national average of 8%. There were 6% junior grade doctors which is 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 the consultant staff stayed on the delivery suite every day from 8.30am until 8.30pm, Monday to Friday and for three hours on Saturdays and Sundays. Out of hours cover was provided by the 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. This caused challenges if the consultant had a clinic on Mondays and had been called out the preceding night. Delay in consultant presence due to not being on site was on the risk register and discussions were ongoing with the surgical team to provide increased consultant cover. Whilst this was a feasible solution for gynaecology, it could put obstetric patients at risk.
- We were told that staffing middle grade doctors had improved and the trust was not as reliant on locums as it had been. For example in obstetrics and gynaecology, the locum usage had reduced from 4.1% between December 2013 and December 2014, to 0.3% between January and May 2015. The absence of junior doctor cover after 8.30pm 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.
- 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.
- The gynaecology service was covered by a junior trainee and a registrar from 8.30am to 5.00pm 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.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.

Are maternity and gynaecology services effective?

Requires improvement

Care and treatment did not always reflect current evidence-based guidance.

Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. However, some of these guidelines were out of date.

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. For example we saw little progress in the reduction of the caesarean section rate.

Compliance with three yearly Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 40% and 33%, respectively. This meant that staff who had not received the training many not have the appropriate skills to care for patients under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.

Maternity and gynaecology

Staff were mostly competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- We noted that on the June 2015 risk register provided to us by the trust 13 guidelines were out of date, with an additional 39 that would be out of date by August 2015. At the time of our inspection, we observed that guidelines were mostly in date; however several were up to one year beyond their review date, for example the trust major incident plan.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation 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 our discussions and from observations that care was being 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 being 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 were told that the unit had been historically medically led. Midwifery staff were working hard to drive normality. A virtual midwifery led unit (MLU) had been created to offer women a low risk environment.
- We saw a notice within the delivery suite reminding staff that all babies required cord blood to be taken for blood gas analysis following birth. Evidence indicates that delayed cord clamping provides babies with additional blood and nutrients that help them to adjust to their new surroundings. Fewer babies need transfusions for anaemia, the risk of bleeding in the brain (intraventricular haemorrhage) and the risk of necrotising enterocolitis (a severe infection in the bowel) are reduced. NICE Quality Standard 190 Intrapartum care states 'Do not clamp the cord earlier than 1minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60beats/minute that is not getting faster'.
- When asked, staff told us that they had not been involved in the decision to take cord blood samples on all babies and considered it a 'knee jerk' reaction to an incident. Although they questioned the practice of cutting the cord early to obtain cord blood samples on all babies, the practice had been mandated and they were complying with the decision
- 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 trust had adopted the Robson classification system for recording caesarean sections which has 10 categories that support the analysis of the caesarean section rate.
- We saw documentary evidence that the caesarean section rate for women who had a previous caesarean birth was above 60% between April and September 2014. Steps put in place to reduce this included improved counselling around the risks and benefits of caesarean birth; reviewing all emergency caesarean sections from the previous 24 hours; presenting personalised caesarean section rates for individual consultants were anonymised and rates to the unit; presenting audit results on a three monthly basis to maternity; and obstetric unit staff and a "pan-unit" multi-disciplinary study day on normality was held.
- 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.
- A vaginal birth after caesarean section (VBAC) clinic was held by the supervisors of midwives aimed at reducing the caesarean section rate. The results of the Robson audit for August 2015 showed that although the rate for first time mothers had reduced overall those having a repeat caesarean section was 81%.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure. Women we spoke with told us they had received good care and they had been informed about their discharge home.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4. We found that the completion of the documentation followed a robust process.

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 pregnancy, 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.
- The trust actively participated in national audits including the National Screening Committee antenatal and new born screening audit and the National Diabetes in Pregnancy Audit.
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that the trust had monitored its performance against the recommendations of the report. We saw that there were plans actions to address any shortfalls identified by creating a formal action plan which would be monitored through the service unit improvement plan.

Pain relief

- Women we spoke with in maternity felt that their pain and administration of pain relieving medicines had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens 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 hour a day.
- A birth pool was available on the delivery suite so women could use water immersion for pain relief in labour. However staff preferred to use an inflatable pool because of concerns around emergency access. Staff told us that training had been provided in response to an incident with regular 'skills drills' on pool evacuation.

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.

Maternity and gynaecology

- The trust had been awarded and maintained UNICEF Baby Friendly Initiative stage one accreditation. 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.
- We observed handover on the maternity ward and saw that staff had challenged a paediatrician who had requested that a breast fed baby was given a complimentary bottle feed and spoke passionately about their support of women to initiate breastfeeding
- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 71% in June 2015 which was worse than the national average of 75%.
- In relation to meeting their nutritional needs women were able to choose from a varied menu, which also met their cultural requirements
- Women told us that food was available outside of set meal times if they did not feel like eating at set meal times.

Patient outcomes: Maternity

- 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.
- A maternity dashboard was not used for recording activity and outcomes. Quality data obtained from the information management system was available to illustrate delivery rates but was not matched against other indices such as staffing number of incidents and complaints. This meant that the trust could not effectively monitor issues such as clinical outcomes in times of shortage of staff.
- August 2015 quality data demonstrated that:
  - The normal delivery rate was 60%, which is the same as the RCOG recommendation of 60%. The homebirth rate was 3.6% which was higher than the national average of 2.3%.
  - The caesarean section rate was 26.6%, worse than the national average of 25%. Of these, 15.8% were elective, which was worse than the national average of 10.7% and 10.8% were emergency which was better than the national average of 14.7%. The induction of labour rate was 20%, which was less than the national average of 22%
  - The Ventouse delivery rate was 3% which was better than the national average of 7% (2014) and the forceps delivery rate was 7% which was worse than the national average of 5.8% (2014).
  - There were three third or fourth degree tears recorded which equated to 2.2% of patients.
- Other clinical data normally recorded on a maternity dashboard for example postpartum haemorrhage, admission to the intensive therapy unit following complications after the birth and unexpected term admissions to the neonatal unit were not recorded.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. A team of professional 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.
- The trust provided activity data for 2014 that demonstrated the following:
  - 4185 referrals to the gynaecology service
  - 193 elective split-spell discharges
  - 434 day case split spell discharges
  - 186 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. 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 delivery suite that had been produced to support staff.

Midwives had been trained in new born and Infant Physical Examination (NIPE) and carried out this examination within 72 hours of birth. This enabled women to be discharged home without waiting to see a paediatrician.

- 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. Appraisal rates for staff were provided for us and these demonstrated that 95% of midwives had been appraised.
- Student midwives spoke highly of their mentors and felt well supported.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:11 (LSA Report 2014) which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- Junior doctors reported having little access to education. A meeting was planned with a consultant to discuss this situation.

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.
- Staff were expected to sign an attendance sheet at handover. We saw that this had missed signatures from all grades of staff and were not assured that all the staff who should attend handover did so.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- 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. We were told that this was problematic if the woman was from Wales due to differences in cross country communication systems.

Seven-day services

- Access to medical support was available seven days a week. The early pregnancy the service ran weekday mornings but if necessary early pregnancy scans could be done at weekends by the on call consultant or a radiologist could be called in by the on call consultant.
- Community midwives were on call over a 24 hour period to facilitate home births.
- Women could attend the DAU 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.

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.

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.

Maternity and gynaecology

- Staff within the IFHS within the maternity ward and delivery suite who were required to complete the three yearly Mental Capacity Act 2005 training were 40% compliant. Staff were 33% compliant with the required three yearly Deprivation of Liberty Safeguards training. Compliance did not meet the trust target of 90% and meant that staff who had not received the training many not have the appropriate skills to care for patients under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

Are maternity and gynaecology services caring?

Good

Feedback from patients and those close to them was positive. Patients told us that they felt safe. Staff treated patients with dignity, respect and kindness during all interactions and patient-staff relationships were positive.

Patients were involved and encouraged to be partners in their care and were supported in making decisions. Women told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Staff responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. The February 2015 FFT achieved the following results:
- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? The trust achieved a score of 100% for this question which was better than the national average of 95%.
- How likely are you to recommend our delivery suite/ birthing unit to friends and family if they needed similar care or treatment? A score of 94% was achieved which was similar to the national average of 96%.
- How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? A score of 87% was achieved worse than the national average of 93%.
- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? A score of 98% was achieved compared to the national average of 97%.
- We observed caring and compassionate interactions between staff and women. The women's forum reported that feedback from the postnatal group was really positive about the care they had received
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. Partners of pregnant women told us that they felt included and well informed.
- One woman we spoke with told us that the unit was short staffed and busy. Her partner was involved in the care, felt well-informed and was allowed to stay over twice.

Emotional support

- Midwives observed women for anxiety and depression levels.
- Bereavement support was offered by midwives. Memory boxes were provided to parents who had suffered a pregnancy loss. Chaplaincy support was available.
- Counselling for termination of pregnancy was not provided at the trust. Staff referred women to their GPs if they requested support. One patient we spoke with told us of a breach of confidentiality that occurred when a member of staff commented that all women in the bay were pregnant.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

The gynaecology ward had outliers that impacted on the care provided to women with gynaecological conditions because beds were occupied with patients with medical conditions.

Patients' individual needs and preferences were considered when planning and delivering services. The maternity service was flexible and provided choice and continuity of care.

The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support patients with particular needs.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

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 pathway.

Access and flow: Maternity

- The maternity unit had not closed between June 2014 and May 2015.
- Women could access the maternity service via their GP or by direct referral. We saw that 85% of women were seen by a midwife by 12 weeks and six days of pregnancy. 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.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place to give birth. This decision was made when they were 34 weeks pregnant and information was provided to assist in making their choice. 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.
- Elective caesarean section lists ran twice a week. There were three operations on each list. There was one obstetric theatre and the anaesthetic room was used as a second theatre if required. We were told that this had been used on three occasions since October 2014.
- The DAU provided an assessment service to women between 8.30am and 6.00pm Monday to Friday on an appointment basis. Women could be referred to the DAU by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as reduced fetal. 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 where women with urgent complaints could be reviewed and assessed. Women were provided with the telephone number for the unit and could access it directly if they had any concerns. Staff worked on delivery suite if required and carried the triage phone so that they could take calls.
- A side room on the triage unit was available for intimate examinations. This room was also used for the paediatrician to examine babies. This meant that the room was not always available.
- We noted that bed occupancy for maternity was worse than the England average for both 2013/14 and 2014/15. We saw that bed occupancy between January and March 2015 was 73% compared to the England average of 57%. This indicated that women had longer stays in hospital in comparison to the other trusts.

Access and flow: Gynaecology

- A midwifery-led 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.

- We saw that there were three gynaecology patients and two outliers (patients who are not being nursed in a specialist area for their particular condition) on the ward on one occasion during our visit. Staff told us that this increased during winter pressure and could affect care provided to women with gynaecological conditions.
- There were 5.5 theatre lists per week for gynaecology operations. The trust provided us with information that showed 14 operations were cancelled on the day of surgery between April and August 2015. However, staff told us that on average two operations per week were cancelled on the day.
- We saw that the waiting time for gynaecological surgery was 10 weeks which was within the referral to treatment target (RTT) of 18 weeks.
- Colposcopy and hysteroscopy was offered on an outpatient basis. There were plans to move this to a nurse-led service.
- Women attending the clinic for both maternity and gynaecology appointments reported long waiting times. There was a board that informed patients of the waiting time but this was visible to all areas of the waiting area.

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 and a plan was then developed.
- We saw that women made birth plans and that, on the whole, these were adhered to.
- The trust ran a diabetic clinic to support women throughout pregnancy.
- Specialist midwives for screening and safeguarding who, having successfully completed additional training, gave advice and support to women and midwives. Midwives with special interest led on maternity projects, bereavement support and care of women with diabetes as part of their substantive role which meant that they were not always available if activity was high.
- 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.
- Partners could visit between 10am and 10pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies. Partners were not encouraged to stay overnight because it was identified as a security risk. We were told that women had been asked and the response was that they did not want partners staying with them. 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.
- Information leaflets were available for women suffering pregnancy loss outlining the choice of expectant (awaiting events) or surgical management.
- We saw that there was an interpreter service available face to face or by telephone.
- A 'virtual' MLU had been set up in one of the rooms on delivery suite. We were told that this room offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. A portable birth pool was located in this room for women who wished to use water immersion for pain relief in labour.
- Privacy and dignity was enabled by the use of privacy screens around beds and on the entrance to rooms on delivery suite.
- We found that women who had experienced 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 was working with a local bereavement charity to improve the bereavement service and we were told of plans to create a dedicated room situated away from the main delivery suite so that women and their partners could remain private and avoid areas where women had just given birth.
- 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 proposal for a band 7 bereavement lead had not been approved. The HOM told us that a business case would be submitted for a dedicated bereavement team.
- 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 NNU.

- 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 made sure that the care received met women's needs.

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 forwarded to the service unit's inbox and distributed to responsible officers for investigation and response within 25 days.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint
- Information from the trust indicated that there had been six formal complaints between September 2014 and September 2015. We were told that there were two maternity and two gynaecology formal complaints open at the time of our inspection.

Are maternity and gynaecology services well-led?

Requires improvement

There was a statement of vision and strategy. However, staff we spoke with did not demonstrate awareness or understanding of it.

There were fragmented governance structures. The trust did not use a maternity dashboard. Quality data was recorded on the management information system and reviewed to identify trends and aid forward planning.

However, we were not assured that robust analysis was taking place. Not all risks were identified on the risk register and we could not always see evidence of an action plan to address the issues.

The trust was monitoring its progress against our last report. There were 63 items on the patient care improvement plan (PCIP); we saw the numbers were not concurrent and that 37 actions were complete and 17 were incomplete.

There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.

There was an active women's forum that met regularly.

Vision and strategy for this service

- We that the Women's Health Services Vision and Strategy 2014 had been developed with staff and that the vision was to have 'High quality, safe, value services for women, babies and their families by reliable, confident and informed staff'. This was not supported by an action plan.
- We were told by senior management that the 'core is the woman and the nurture and development our work force' and that the strategy was to have 'everyone working together, a good skill mix well trained, to be a value for money hospital'.
- Although the staff told us that 'the structure is now there' they were confused about the vision and strategy for the service. They told us that there had been a big drive to improve following the CQC visit in June 2014 and that they were 'still on a journey'.
- Senior managers cited the development of the MLU as the main priority for the maternity service. It was hoped this would be open in spring 2016 but managers were not confident that this would be the case. However, staff told us that they would prefer the second theatre on delivery suite to be the priority for the maternity services and expressed their concerns about this ongoing safety issue.

Governance and risk management

- We saw that fragmented clinical governance and risk management arrangements were in place. A risk coordinator was in post for the IFHS. The manager also supported audit and complaint activities. The risk coordinator assumed responsibility for paediatrics,

NNU, community and gynaecological services in 2014; previously this role was solely for maternity risk. There had been recent changes concerning administrative support which meant that the risk coordinator did not have the support they required to fulfil all aspects of their role.

- The Obstetrics and Gynaecology Weekly Risk Review Meeting fed into the monthly Obstetrics and Gynaecology Governance Group which in turn reported to the monthly Integrated Family Health Service Unit Overarching Governance Group who reported to the board. All meetings were minuted.
- An Obstetrics and Gynaecology Clinical Excellence Group met monthly to discuss new and emerging clinical practice guidelines and national recommendations.
- The quarterly Perinatal Mortality and Morbidity Meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence.
- A Labour Ward Forum met 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. Staff told us that this was developed because the Labour Ward Forum had only met five times in the previous year.
- 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 forwarded to the Quality and Safety Unit who decided whether the threshold for reporting to STEIS and to commissioner was met. We saw that an incident involving a 4500ml haemorrhage necessitating admission to ITU was not considered a SI and therefore not reported appropriately.
- We reviewed the minutes of the Obstetrics and Gynaecology Governance group for March 2015 to June 2015 and saw that the meeting followed a standing agenda. Issues were identified, actions planed along with start dates. However deadlines for completion of actions were not set.
- The trust did not use a maternity dashboard. Quality data was recorded on the management information system and reviewed to identify trends and to aid forward planning. However, such data was not correlated with items normally found on a dashboard such as staffing and we were not assured that robust analysis was taking place.
- The maternity and gynaecology risk register contained eight risks related to maternity, one risk related to gynaecology and one risk related to both areas. We saw that progress was noted for mosts risks and that the risk register was discussed at the monthly women and children's directorate meeting. However, we could not see evidence of an action plan to address the issue that only one consultant trained to perform Middle Cerebral Artery (MCA) Doppler assessments and the impact this could have on patient care. Not all risks were identified on the risk register, for example, concerns about the skill mix in maternity and inconsistent mobile phone connectivity in the community.
- 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.
- Band 7 midwives were fully aware of governance issues and trends of key performance indicators (KPIs) such as induction of labour and caesarian section rates but they were not sure that the band 5 and 6 midwives would be aware of the KPIs or have an understanding of their significance.

Leadership of service

- The matrons had acted up in the absence of the HOM for six months and found this experience valuable. Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level.
- The HOM as professionally accountable to the director of nursing and quality and was line managed by the business manager of the service unit. This meant that two appraisals were undertaken. Staff were positive about the HOM telling us that 'they help out when we are busy, they're always there'. We observed that the HOM was providing clinical support to delivery suite at the time of our evening visit to observe handover on delivery suite.

- The clinical director (CD) reported a good working relationship with the HOM and the medical director. The medical director 'was very approachable'. The CD could also go directly to the chief executive officer CEO and felt able to access him as necessary.
- We were told that the HoM did not have direct access to the trust board. Midwifery issues were taken to the board by the director of nursing and quality. Staff felt there was a potential risk that maternity related issues and 'nuances' may not be fully understood at board level if they were not communicated by a midwife.
- Staff said that senior managers were visible and that an 'open door' policy was in operation. However, the HOM was not located in the unit. We were told by the CD that the HOM had moved offices because 'everyone was knocking on the door'.
- Members of the trust board were visible. There was a nominated non-executive director with the responsibility of maternity services. The director of nursing and quality was the lead executive for midwifery and any risks relating to midwifery care. We saw that their photograph was displayed on the delivery suite with a space to record when they had last visited the ward. This was annotated as 21 August 2015; although staff thought they had seen them the week of our visit.

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 resilience and a determination to do the best they could under the constant pressure they were facing.
- Staff told us that the service was 'reliant on goodwill' and that 'everyone was tired'.

Public and staff engagement

- An active women's forum was in place. We saw minutes of meetings held in May, July and September 2015. 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. The group had commented on plans for the MLU, asking that a separate entrance be considered.

Innovation, improvement and sustainability

- We saw that a maternity patient care improvement plan (PCIP) had been developed in response to our last report. There were 63 items on the PCIP; we saw the numbers were not concurrent and that 37 actions were complete and 17 were incomplete.
- We saw that the trust challenged some of the findings in our report. And provided evidence to support their views. For example, the trust disagreed that there were no bereavement facilities stating that there was a plan for development of this service which would be implemented after the MLU was completed. Interim plans were to use room 4 on Delivery suite as a bereavement room. We did not see this in use at the time of our visit.
- We saw that the trust had completed actions to reduce the caesarean section rates. However, caesarean section rates were above the national average at the time of our inspection with levels of 30% in April 2015 and 34% in July 2015.
- There was a lack of innovation and sustained, continual improvement across the service.
- We saw a lack of awareness and learning from the experiences and outcomes from other maternity units.

Services for children and young people

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

Information about the service

The services for children and young people at Hereford Hospital consist of a special care baby unit (SCBU) and a children's ward which catered for young children and adolescents.

The SCBU has 12 cots. One cot is for babies who need intensive care and two cots are for babies with high-dependency needs. The unit does not routinely care for babies born under 30 weeks gestation and where this does happen it is for periods of less than 24 hours. Babies who are expected to require intensive care for more than 24 hours are transferred to other hospitals in the West Midlands.

The children's ward has 16 beds incorporating day surgery patients. The ward also had a paediatric assessment consisting of four beds, which is open from 8am to 8pm.There is one bed for children with high-dependency needs and four cubicles that can be used for isolation. The beds are in bays of four or in single cubicles.

There are parents' facilities on the children's ward and SCBU as well as play areas on the children's ward.

During our inspection we visited the SCBU and the children's ward. We spoke with a number of staff including 16 nurses, nine doctors and three support assistants. We also spoke with 15 patients and seven relatives.

We observed interactions between staff, patients and parents. We read care records, policies and procedures and other documentation as necessary. We reviewed data provided by the hospital.

Summary of findings

Services provided to children and young people were not safe or effective and the directorate was not responsive or well-led. However, we found the services to be caring to patients' needs.

Staff did not always support incidents with by taking appropriate action or recording appropriate action taken or share lessons learned.

Patient records contained good detail. However, the members of staff who completed the records did not always sign and date them. Staff did not securely store patient records.

The level of care provided to patients with mental health needs was not adequate. Arrangements were in place for reporting safeguarding concerns. However, safeguarding referrals were not always made for children who require a referral. Although most staff had completed some form of safeguarding training, there was a lack of knowledge amongst trust staff with whom we spoke about when safeguarding referrals should be made. This meant that service users were not always protected from abuse in accordance with regulatory requirements.

Some equipment was not locked away securely, including sharp objects.

The trust set minimum staffing levels for each shift. However, a staffing needs analysis for nursing staff on the paediatric ward determined that the minimum

Services for children and young people

levels did not meet Royal College of Nursing guidance. A staffing needs analysis had not been undertaken for the SCBU. The staff we spoke with told us that staff shortages did not impact on patient care and that all members of the team worked hard to ensure patients were cared for safely.

Compliance with completion of mandatory training and completion of appraisals for nursing and medical staff was poor and did not meet the trust's target.

Existing policies were not dated, out of date and/or not always appropriately referenced.

Audits were not always undertaken in line with agreed plans and learning was not implemented or evidenced.

Service plans for the year ahead lacked detail and risks were not always identified and recorded.

Governance arrangements were not effective. The trust failed to demonstrate that areas of concern were sufficiently discussed or that agreed actions were carried forward.

Patients were generally very satisfied with the level of care they received and made few complaints made about their care and treatment.

Are services for children and young people safe?

Inadequate

Services for children and young people at Hereford Hospital were judged to be inadequate for safety.

Incidents were mostly investigated on a timely basis, although there were some examples where this was not the case. Some investigations were closed without any form of review or investigation. We noted that actions recorded did not always address the issues raised and there was a lack of shared learning. The one serious incident reported in the previous year had been investigated, however the actions from the investigation did not legally address the issues raised.

The trust held internal perinatal mortality and morbidity meetings which could be attended by paediatric and obstetric medical staff as well as nurses and midwives. Review of the minutes confirmed they lacked detail and action points were not always recorded. For example, the July 2015 minutes reported on four separate cases.One case listed the death with details of discussion points and agreed actions. For the other three cases, there were no details recorded as to why the case had been brought to the meeting and although learning/discussion points were recorded, there were no agreed actions for the other three cases presented.

Arrangements were in place for reporting safeguarding concerns. However, safeguarding referrals were not always made for children who require a referral. Although most staff had completed some form of safeguarding training, there was a lack of knowledge amongst trust staff with whom we spoke about when safeguarding referrals should be made. This meant that service users were not always protected from abuse in accordance with regulatory requirements.

Completion of mandatory training within the service was poor and not compliant with the trust's target of 90%, particularly for basic life support.

The environment was visibly clean during our inspection and staff followed correct protocols with regards to personal protective equipment. However, the cleaning

schedule for the SCBU was not completed for a number of dates in September 2015. The staff we spoke with told us that the unit had been too busy to undertake all required cleaning regimes.

Night staff checked resuscitation equipment once every 24 hours. However, they did not record what they checked and who undertook the checks beyond a set of initials. Nursing staff on day shifts did not make equivalent checks, which may have made them less familiar with the equipment available.

Treatment rooms that contained sharp items were not sufficiently secure to prevent unauthorised access. We requested that this issue be addressed and a keypad lock was fixed on both doors during our inspection.

There was an insufficient number of points for high-flow oxygen on the paediatric ward. Some pieces of equipment were not portable appliance tested (PAT).

Records were not stored suitably to ensure they could not be accessed by other patients or visitors. Records contained adequate detail but were not always signed and dated by the members of staff who completed the notes.

Physical security arrangements were not suitable. Although the entrance to both wards required staff to answer a buzzer to monitor who entered the department, there were no security guards for the paediatric department or SCBU to contact in the event of an incident. Staff were instead required to contact a porter or the police.

There was good use of tools to detect deterioration in paediatric patients' medical conditions. However, this was not the case for neonatal patients and reliance was placed on the expertise and experience of the nurse caring for the patient.

Staffing arrangements were not sufficient because minimum staffing levels did not meet Royal College of Nursing guidance. There was a medical staffing vacancy rate of 13% for medical staff, primarily among middle-grade doctors.

Incidents

- There were 146 incidents reported within the children and young people's acute services between the period March and August 2015, with no incidents categorised as serious.
- 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, with six incidents taking between eight and 38 days to be reported and five incidents taking between 30 and 50 days to be reviewed and closed. The trust's incident reporting policy states that incidents must be reported at the earliest opportunity.
- Most incidents were routine occurrences which required reporting, for example, babies unexpectedly admitted to SCBU or child and adolescent mental health patients admitted to the ward.
- Review of the incident summaries and actions taken indicated that action did not always address the issues raised. For example, one incident identified poor staff management of a parent who became aggressive; action taken was to discuss the incident with the staff members involved. Staff were not offered training to improve their conflict resolution skills.
- We saw that incidents were sometimes closed before the investigation had been completed. For example, one incident related to an appointment letter being sent to a patient after the appointment had taken place. The outcome of the investigation was for a further investigation to take place, the incident was then closed.
- We were told that the most recent serious incident reported was in August 2014. We reviewed the investigation report, the report failed to identify weaknesses in the trusts management and care for a patient. Weaknesses identified by the trust related only to the patient's carer and new procedures were introduced to place more onus on the patient's parents or carers who are not legally responsible for the patient once admitted to hospital.
- We spoke with staff about learning lessons from incidents. All of the staff we spoke with told us that they now received feedback relating to any incidents they had reported or been involved with but that there was no wider / shared learning from incidents reported by others.

- We asked staff about their understanding of duty of candour which requires staff to be open and honest with patients and their relatives when an incident has occurred. The majority of staff we spoke with were unable to explain what this meant.
- We were told that paediatric deaths were discussed at the monthly Hereford and West Midlands Children and Young People Death Review but that there had been no inpatient deaths in the last 12 months. There was no internal meeting process for paediatrics.
- The trust held internal perinatal mortality and morbidity meetings which could be attended by paediatric and obstetric medical staff as well as nurses and midwives. Review of the minutes confirmed they lacked detail and action points were not always recorded. For example, the July 2015 minutes reported on four separate cases. None of the discussions detailed when the death had occurred, or who was involved to ensure effective mapping of the cases and possible underlying themes. One case listed the death with details of discussion points and agreed actions. For the other three cases, there were no details recorded as to the 'type' of death, and although learning / discussion points were recorded there were no agreed actions. For example, case three made reference to the need to develop an ITU infusion chart in the discussion amongst other things, but the action summary was recorded as, 'no required action'

Cleanliness, infection control and hygiene

- We observed the paediatric ward, outpatients department and SCBU to be visibly clean during our inspection. However, we noted that the cleaning schedule for SCBU had not been completed for total of 12 days during September with a further four dates only partially completed. We spoke with staff about this who told us that they had been too busy to undertake the cleaning on these days because the department had been busy and the ward clerk was on holiday. On two of these days this had been documented on the checklist, other days were left blank.
- Concerns around the capacity of the department and inability for staff to undertake cleaning had not been escalated.
- There was a sticker system in place which indicated equipment had been cleaned and we observed that stickers had been placed on equipment.
- Staff wore personal protective clothing as required and this was available throughout the ward areas. Although we observed one member of staff on the paediatric department not wearing appropriate clothing whilst preparing to serve food. We raised this with the ward manager and our concerns were addressed immediately.
- Hand gel was available at each doorway on the wards.
- Isolation facilities were available on both the children's ward and SCBU. Signs to inform staff of the need for isolation procedures were visible.
- During the previous inspection the outside play area on the children's ward had a drainage ditch around it that contained stagnant water and debris such as tissue paper. This had been repaired and the play area was suitable for children and free from stagnant water.
- There had been no reported cases of MRSA or Clostridium difficile in the preceding 12 months.

Environment and equipment

- The resuscitation equipment contained varied sizes of apparatus to cater for the potential range in ages and sizes of the children. Whilst there were appropriate sized disposable laryngoscopes, a second set was stored in a locked room.
- There were records that daily checks had been carried out on the resuscitation equipment. Although we noted checks were only carried out once each day by night staff with no clear documentation of what checks were undertaken and who had undertaken them (beyond a set of initials.
- We observed that some equipment had not been PAT tested annually both on the paediatric ward as well as SCBU.
- There were two treatment rooms in the paediatric ward which were not locked and had sharp items amongst other things which could be accessed by children or teenagers. We requested this be addressed immediately and a keypad lock was fitted on the treatment rooms the next day.
- The children's outpatients department was not a safe environment for children. We saw that the cords used for the blinds were too long and presented a ligature risk. We also observed that sharps were placed at a level above 'head height' which presented a risk to staff and patients and we reported this to the trust.

- We observed on the paediatric ward that there were two patients with the same first name in side-rooms directly next to each other which increased the risk that treatment for these patients could easily be mistaken.
- We also noted 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 this, they would need to be transferred to another hospital immediately. This had been identified by the trust as a risk and plans were in place to install additional piped units. This had been on the risk register since the previous financial year.

Medicines

- Medicines were securely stored in both the children's ward and SCBU.
- A medicine administration record specific for children was used and we saw that this was completed appropriately for most patients; however, we noted that the prescription for one patient was recorded in millilitres instead of milligrams or micrograms which increased the risk of the patient being given an incorrect dose of their medication. This potential risk had not been picked up by the ward pharmacist.
- There was no specific policy available for parents to administer medicines to their children. 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. We spoke with one family who gave their child their medicines. They were happy to do this and ensured that their child was given their medicines. We noted that a code for 'self-administration' was documented onto the prescription chart however this code was following the trust policy for adult self-administration of medicines and not for a parent giving a child their medicine.

Records

- We saw that records were not always stored securely on the wards; patient notes were stored in trolleys at the nurses stations and were not locked away. We observed occasions on both wards when the station was left unmanned for short periods. We also observed that and some patient notes were placed next to the patient's beds or outside their room in open trays. This have could compromised security of the notes as well as patients' confidentiality.
- From review of a sample of patient records we found that they contained detailed information, although it was noted that not all entries had the individual member of staff's name, position, signature and date recorded.
- We reviewed advance care plans for a sample of patients and saw that these had been completed and reviewed. DNACPR (do not attempt cardio pulmonary resuscitation) sections of the plan which had been completed and signed by all appropriate parties.
- We requested copies of the patient record audit and action plan, however, an audit on patient records was not provided. We did receive a presentation from an audit specifically relating to new paediatric admissions. This related to records audited from 2013 and identified weaknesses in the completion of records but there was no supporting action plan. A second audit, a re-audit on completion of paediatric national early warning scores in 2015 was also provided this demonstrated some improvement since the previous audit with more work to be done.

Safeguarding

- We requested data from the trust regarding the number of safeguarding referrals made. The trust provided information supplied from the local authority as this was not routinely collated. We were told that 17 referrals had been made during two quarters in the previous year although were not provided with the exact timeframe and data for the current year was not provided.
- The staff we spoke with were confident in talking about the types of concerns that would prompt them to make a safeguarding referral, not all staff were confident in understanding the referral process but told us they would seek advice as required.
- None of the nursing staff we spoke with had made a safeguarding referral, one of the medical staff reported that they had recently made a safeguarding referral. We were told that this was because most of the children who may have required one were already known to social services or that the emergency department (ED) would have made the referral before the child was admitted to the ward. Patients admitted to the paediatric ward via ED only accounted for 6% of all admissions, which meant that only a small percentage of patients were admitted to the children's ward via ED.

- There was an alert field in patient notes to alert staff that there may be safeguarding concerns relating to the child, as applicable.
- We were not assured that safeguarding referrals were always made when required. We reviewed a sample of files where it would have been appropriate to make a referral; staff had not made a safeguarding referral in seven of the eight cases.
- When we spoke with staff they had not previously considered it necessary to refer the other two children, referrals were subsequently made by the trust.
- Review of training data confirmed that the trust had not achieved compliance with its target of 90% for all staff groups having completed the required level of safeguarding training. There are four levels of safeguarding training, level 1, 2, 3 and 4 staff members must complete the required level depending on their role, for example medical and nursing staff must complete all levels to level three.
- Level 3 safeguarding training had been completed by 91% of nursing staff on the paediatric ward and 84% of nursing staff on SCBU. All medical staff had completed level 3 safeguarding training and the named consultants had received level 4 safeguarding training
- The trust had a chaperone policy which made specific reference to chaperone arrangements for children under the age of 16.

Mandatory training

- There were 10 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, resuscitation, dementia awareness, infection control.
- 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 staff were expected to 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. A percentage of 94% had been achieved for neonatal life support by both medical and nursing staff who worked on SCBU.
- The department had not met its trust for other mandatory training courses, for example, attendance for information governance was 72% for all staff within paediatrics. safeguarding adults compliance was 70% for all staff, 59% of staff had completed basic life support, data for basic life support was not provided for SCBU nursing staff who worked on the unit.
- Nursing and medical staff were also expected to complete European Paediatric Life Support (EPLS), although this was once every four years, which meant that basic life support which was completed annually was necessary to ensure staff that also have advanced training are kept up to date with their basic skills.
- The majority of nursing and medical staff were listed as not required to undertake EPLS training, 36% of nursing staff had completed EPLS training and 22% of medical staff had completed EPLS training.
- We were told that there was always at least one member of staff per shift working who was trained in EPLS, however, this was based on the shift co-ordinators knowledge of who had completed the training and if changes were made to the shift, this may not be possible. Therefore, there was a risk that there was no one working a shift who had completed the EPLS training, which placed patients at risk.

Assessing and responding to patient risk

- The paediatric ward were commissioned to provide one high dependency bed for children, SCBU had one intensive care unit (ITU) cot and two high dependency unit (HDU) cots.
- Staff used a paediatric early warning (PEWS) tool to monitor and manage deteriorating patients on the children's ward. Staff used a separate tool according to the child's age and we saw examples that staff had completed with scores accurately calculated. Although we noted that staff had not completed the tool for one patient on admission, subsequent recordings were completed in line with requirements.
- An audit on the use of PEWS was included as part of the 2015/16 audit plan and we were provided with evidence that a follow-up audit had taken place. Recommendations had been made and an action plan developed, although the committee had not yet agreed timescales for completion.

- The neonatal unit did not have an early warning tool available and although a specific national tool had not been developed for neonates, there was a risk that warning signs of a neonate's deterioration may not have been detected promptly.
- Children who were admitted because of mental health reasons were admitted to a side room. A nurse completed an initial assessment to determine whether the patient required one to one care from a mental health nurse. The department did not employ mental health nurses directly and they were sourced from a local agency. Whilst waiting for a mental health nurse to arrive, the ward required the child's parent or carer to provide one to one care until the nurse reported for duty. Parents and / or carers were required to sign a disclaimer to agree to provide one to one care and we saw evidence of these on a sample of patient files. Such arrangements are not legal as it is the trusts responsibility to care for all patients admitted to the ward. There was an increased risk that patients were not receiving the required level of care and may pose a risk to themselves and others. We raised this with members of the trust board who were unaware that the disclaimer was in place and stopped the practice immediately.

Nursing staffing

- There were an agreed number of nurses working each shift (three during the day and two at night on paediatric ward with two nurses during the day and at night on SCBU). The paediatric ward had one additional nurse during the day to support winter pressures. However, the trust did not use an acuity tool to assess whether additional resources were required depending on the acuity and age of patients present on the ward.
- Review of the staff rotas for a two-week period in August 2015 confirmed that all shifts had the minimum number of staff based on current staffing numbers. However, the paediatric ward had undertaken a staffing needs analysis against the recommendations of the Royal College of Nursing guidance and found that it did not meet the standards expected when the ward was full to capacity and that the deficit was greater when the ward was fully populated by children under the age of two years. There were no plans in place to increase staffing based on the findings. A staffing needs analysis had not been completed for SCBU.
- The vacancy rate in August 2015 for the paediatric ward was 6% and 8% for SCBU. The trust did not provide us with data for paediatric outpatients.
- Sickness rates in August 2015 for paediatric-nursing staff was 12% for ward nursing staff and zero for outpatient nursing staff.
- The staff we spoke with told us that they could be understaffed at times and that even when they were fully staffed the ward could be very demanding depending on the acuity of patients. But that all staff worked together to ensure patients were cared for safely. It was the perception of staff that care provided was safe.
- Nurses on the paediatric ward were all qualified children's nurses and we were told that there was always one nurse on SCBU who had a post registration qualification in caring for neonates. Evidence provided by the trust demonstrated that 68% of SCBU nurses had completed their post registration qualification.
- Handovers took place at each shift change.
- During the period July to August 2015 we noted that there had only been two incidents reported where the shift was short staffed, other than where one to one care was required for Children and Adolescent Mental Health (CAMH) patients.

Medical staffing

- The vacancy rate for August 2015 was 13% for medical staffing with sickness at 0.33% for the same period.
- There was 24-hour consultant cover for the SCBU and the paediatric ward.
- There were 10 consultants employed for children and young people services, the trust had recently renegotiated working to employ two additional consultants and ensure adequate cover was provided. This was in part to address the middle grade issue. Each consultant was on a rota for 'consultant of the week' when they were responsible for the paediatric ward and SCBU with a colleague taking over from 5pm. It was very apparent that the paediatric consultant body worked very well and cohesively with each other. During the inspection, the overnight paediatric consultant called the daytime paediatric consultant overnight when there were two emergencies, since overnight, there would only be one paediatric consultant and a junior doctor. The middle grade doctors did not undertake night shifts.

Services for children and young people

- There were three middle grade posts (with currently only one full-time middle grade). The trust were finding it difficult to recruit to these positions and regular locum staff were used to fill the rota.
- Eight junior doctors worked across paediatrics and SCBU, the deanery had recently reduced the number of junior doctors they would supply to the trust, which left vacant posts also covered by locums.
- We were told that recruitment arrangements were in place and that the trust had plans to recruit from India.
- There was a 'consultant of the week' who provided seven days cover by working 8.30am to 6pm from Monday to Sunday to ensure consistency of care and support.
- The junior doctors' rota also provided consistency. One doctor was responsible for an area such as the SCBU for three or four days consecutively.
- Handovers took place twice each day and we observed this happening and found it to be effective.

Major incident awareness and training

- The trust's Quality and Performance Board had reviewed and approved the major incident plan in October 2013; the plan was due for review in October 2014. 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.

Security

- 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.
- The trust had developed and approved 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.
- The trust had a policy on physical intervention, which covered approved methods of restraint of children. The trust also provided a statement that that staff could make reference to guidelines published by the Royal College of Nursing (RCN) on restraining/holding and could access these directly from the RCN website. Staff we spoke with told us they had not received training on restraint and that they had not ever needed to restrain a patient. Staff also told us they would try talk to a patient to calm them down and call the police if necessary. However, there was a risk situations may have arisen which would require a patient to be restrained or held and staff were not suitably prepared to deal with such an incident.
- 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.
- A member of staff reported an incident where a parent had become aggressive and a porter had been called to attend the situation. The porters contracted by the trust had not all received training in restraint.
- Trust staff had not completed restraint training and not all staff had completed conflict resolution training. In accordance with NICE guidance, in any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act1998, the Mental Capacity Act2005 and the Mental Health Act1983.

Are services for children and young people effective?

Requires improvement

Services for children and young people were not effective.

A clinical audit plan had been developed for 2014/15 and 2015/16. However, some audits had not been completed and agreed actions and recommendations did not always address the issues identified.

Policies and care pathways relating to paediatrics and neonates were not always up to date, did not have review dates recorded and/or were not always appropriately referenced.

Pain assessment tools for babies and children were available but not always completed when they were supposed to be.

Nutrition arrangements were suitable and patients were offered a choice of food in accordance with their dietary requirements and/or religious preferences.

The service used a dashboard to monitor performance, although this was difficult to read 'at a glance', narrative was included. It was not always clear which department the data related to and not all relevant data was included, for example emergency readmission figures.

There were arrangements for referring patients to mental health colleagues, although these arrangements did not always work quickly and efficiently.

Multidisciplinary arrangements worked well to ensure patients' needs were met. We saw that consent to treatment was gained from patients or their parents.

There was a revalidation process in place to ensure all medical and nursing staff had up-to-date registration with the relevant professional bodies. Appraisal arrangements were in place, although the appraisal rate was below the trust's target of 90% for medical and nursing staff.

Nursing staff were not suitably trained to care for patients on the paediatric (high dependency unit) HDU bed or patients who required temporary care for mental health needs.

Evidence-based care and treatment

- There were a range of trust wide policies as well as those specific to neonates and paediatrics. Trust wide policies followed a formal approval process, although this was not always the case for local policies and procedures. For example a pain management protocol had been developed for babies which was being followed, however, it was unclear whether this had been formally approved or not; there was no pain management protocol or policy for children.
- We also noted that a number of policies and care pathway protocols were either out of date or not dated and whilst from review the guidelines were well written and informative, there was a risk that policies may not be updated or reviewed based on the latest national guidance. For example, the care pathway for anaphylaxis, paediatric sedation guidance, cystic fibrosis admission proforma and Tricyclic antidepressant poisoning, did not reference the appropriate current evidence base, and there were no appropriate references recorded. Some of the guidelines and policies did not have any information on who wrote them, when it was written and/or when it needed to be reviewed, along with no referencing of the appropriate evidence base. 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 very well referenced and written.
- Staff on 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 showed participation in local groups and sharing of knowledge and learning.
- We were provided with copies of the children's health services clinical audit plans for 2014/15 and 2015/16. 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 2014/15 listed 32 audits planned for the year, of which 12 had been completed; the remaining 24 either did not report on the status or had been deferred for 2015/16.
- The 2015/16 plan listed 21 audits for the year, the plan did not record proposed start and completion dates and three did not have an identified lead. If leads are not identified and proposed start and end dates specified there was an increased risk that planned audits would not take place as demonstrated with the 2014/15 plan.
- We reviewed a sample of recent audits and found that the audits had clear aims and objectives, findings were detailed and supported by recommendations and action plans. However, we noted that not all recommendations and action plans addressed the issues identified. For example; the neonatal jaundice presentation identified a low level of compliance with all babies having had all required investigations (45%) as well as (0%) of primary care providers being updated with awaited results. Recommendations and supporting action plan aimed to address the issue around completing all investigation by revising the proforma used but failed to address the issue regarding updating primary care providers with awaited results; this was not listed as a required action.

Pain relief

- There was a pain protocol for babies which outlined how to identify, assess and manage pain experienced by babies. Guidance had not been developed for pain in children.
- 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 were not completed consistently. 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

- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs.
- Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- We observed a meal time and found that choice was supported and that children and young people got their preferred meal when they wanted it.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided.
- Staff who worked on SCBU promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- Snacks were available on the children's 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.
- 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.
- Special diets such as gluten-free and diabetic and multiple faiths were catered for. 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.
- On both units patients were weighed and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support.
- Hot and cold drinks were available on the children's ward at any time.
- Patients on the children's ward told us the food was good and they could choose what they wanted.
- Parents could make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- The paediatric department monitored the monthly ward activity including length of stay, primary diagnosis, speciality and source of referral.
- A dashboard was in place for Integrated Health Services, which included acute and community paediatrics as well as maternity and gynaecology. Some information within the dashboard included a narrative as to which speciality it related to, but not all. For example, complaints and incidents were not broken down by specialty. A narrative was provided by exception for referral to treatment which was being met by paediatric, although it was noted they were a number of cases down for elective and day case admissions.
- The dashboard did not report on the number of emergency re-admissions. We noted from externally sourced data that the trust's rate of emergency readmission for both elective and non-elective procedures was worse than the national average.

Competent staff

- Staff completed an annual appraisal as part of their personal development review. The staff we spoke with told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Review of data at the time of inspection, confirmed that overall 67% of staff had received an appraisal which did not meet the trust target of 90%. Nursing staff in outpatients and SCBU had the highest rates of between 80 and 100%, with nursing staff on paediatrics and medical staff achieving a rate of 64% and 62% respectively. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.
- 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.

Services for children and young people

- Staff did not always have additional skills required to meet the needs of patients in their care. For example, staff were not trained in caring for patients with mental health needs.
- Each shift on SCBU had at least one member of who had a post registration qualification in neonatal care, 68% of SCBU nurses had completed their post registration qualification.
- The paediatric ward had one HDU bed. During the period April to August 2015 a total of 37 HDU patients had been admitted with an average of 2.6 days length of stay. However, we noted that only one nurse had received training in caring for HDU patients. This meant that most of the time, patients were care for by nursing staff who did not have the required skills.

Multidisciplinary working

- The staff we spoke with told us that there was good support 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.
- Multidisciplinary team involvement in care was documented in children's notes.
- Play therapists were available on the ward, Monday to 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.
- The department did not hold psychosocial meetings to discuss children who had attended the ward for mental health needs and 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

- The consultants provided 24-hours–a-day, seven-days-a-week cover. This meant there was a specialist consultant available at all times.
- Pharmacy support was available each day with out of hours arrangements in place.
- Radiology services were provided on an on-call basis, which meant there could be a delay in accessing the service.
- Physiotherapy was available on weekdays, as well as out-of-hours, but 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.
- Access to psychiatric services was available Monday to Friday from the local Child and Adolescent Mental Health team. A service was not available at weekends, therefore if a child with mental health needs was admitted over the weekend, they would need to wait until Monday morning for a comprehensive assessment. Agency nurses were employed to care for patients with mental health needs as required, there could be a delay in appointing a mental health nurse, during which time care was provided by another member of staff or the child's parent or carer.

Access to information

- A copy of the patient's discharge summary was given to the patient as well as sent to the patient's GP. There were no recently reported incidents of staff not having patient notes available as required.

Consent

- We spoke to medical staff who had a good understanding of gaining consent from children and the guidance around this with regard to a child's capacity to consent.
- Consent could be obtained by the child and / or their parents depending on the outcome of their assessment and we saw examples of these.

Are services for children and young people caring?

Good

Care provided to patients at Hereford Hospital was good.

Services for children and young people

All patients and relatives we spoke with told us they were satisfied with their care. They felt staff listened to them and were compassionate, and our observations supported these assessments.

The staff we spoke with demonstrated an appropriate understanding of the needs of children and young people. They ensured that patients and their families were involved in decisions about patient care.

There were play specialists available six days per week. These specialists empowered children and young people to ensure they were involved in their care.

We found evidence of multidisciplinary support being facilitated throughout children's services.

Compassionate care

- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- The parent of one patient told us, "The staff here are brilliant, I've been very happy with the service and everything has been explained to us".
- We observed staff supporting and treating patients in a kind and caring manner.
- The '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, although has only recently started being used within paediatrics. Friends and family data was reported on as part of the Integrated Health Service Governance meeting, however, data was at directorate level and information specifically for paediatrics was not reported on.
- We requested additional information regarding the friends and family test, paediatrics achieved scores of 100%, 96% and 100% for June, July and August, respectively with a response rate of 30%, 39% and 85% for the same period.

Understanding and involvement of patients and those close to them

- 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.
- Patients and parents said they could be involved in their own care and treatment if they wished
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child.
- Staff discussed treatment with patients in a way that children could understand.
- Staff had requested to learn sign language as well as Makaton, to promote effective communication between staff and patients. Makaton is a communication tool used by people with learning disabilities to enable their independence and communication.

Emotional support

- There was no professional psychologist or counselling care available to provide emotional support for patients or parents. The psychological support for patients or families, who may be distressed, was provided by the medical and nursing team, not specially-trained professionals. There was psychology support for patients with diabetes; but not for other children who attended the department.
- There was a chaplain with special interest in maternity and children's services although this service had recently been reduced.

Are services for children and young people responsive?

Requires improvement

Services for children and young people required improvement for responsiveness.

The department's business plan lacked detail and there was no clear plan in place to meet the needs of local people. However, access to and flow through the service worked well. This was because there were short lengths of stay within the department and a low level of demand. Flow did not work as well for patients admitted with mental health needs. This was because patients could face long waits for assessment by the mental health team, particularly for weekend admissions.

A document had been developed to provide personal care assessments for patients who were expected to remain in the department for longer periods or attend the department regularly. However, this document was not completed for most patients.

Services for children and young people

A passport document had been developed to record care and communication needs for patients with learning disabilities. We noted that the document was not user friendly and lacked pictures or other tools that may have helped to support these patients. The department did not use any other communication tools.

Translation services were used as required and worked well when needed. There were no leaflets readily available in other languages, however the Patient Advice and Liaison Service could provide assistance if required.

There were suitable entertainment arrangements to cater for children and teenagers. There was a separate playroom for younger children as well as a room specifically for teenagers. There were also suitable arrangements in place for parents to stay with their children overnight.

There was a small number of complaints received about the service. These complaints were not always responded to in a timely manner.

The department was small and not able to provide separate bays for teenagers and young children or single-sex accommodation. Patients could be accommodated in side rooms if these were available.

Service planning and delivery to meet the needs of local people

- We requested a copy of the departments business plan, we were provided with a presentation document for integrated family health as well as a plan for SCBU.
- The integrated family health presentation provided an overview of objectives as well as achievements and challenges for the previous year, although this lacked detail. For example, one of the challenges was listed as, 'increase in patients not attending', there was no indication as to what type of appointment this related to or how significant the increase was. Another challenge was listed as 'cancelled operations', a narrative explanation was not included.
- The objectives for 2015/16 were listed although it was noted that these were not directly linked to the trust's strategic objectives and were not explicit in their content nor clear if they related to acute or community objectives. For example, one objective was, 'to recruit, develop and retain workforce to meet service needs'. The objectives were not time specific and had not been assigned to a lead person to ensure implementation.
- The business plan for SCBU was more refined and specific to the department needs, it had considered the wards strengths and weaknesses as well as specific objectives. However, there were no clear targets or milestones linked to objectives and ownership of objectives had not been defined.
- We were told that staffing levels on the paediatric ward were increased during winter months to help cope with additional pressures with an increase in demand. We were told that a plan had not been formally documented but was in the process of being drafted.
- The trust provided a statement that staffing on SCBU was the same all year round with no alterations made for winter. This was because the pressures on the Unit remained the same year round.

Access and flow

- The children's ward had 16 inpatient beds with an additional four in the paediatric assessment unit which operated from 8am to 8pm. 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 average length of stay between the period April to August 2015 was just over half a day.
- The SCBU had 12 cots, including one intensive care bed and two high dependency beds. We requested details of bed occupancy and length of stay but this was not provided. 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.
- 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.
- 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 local CAMH team did not provide a service out of hours which meant patients had to be admitted until a formal

mental health assessment had been completed. Data on the frequency and length of stay of patients with specific mental health needs was requested but not provided.

Meeting people's individual needs

- The paediatric consultant body had experience in general paediatrics and neonates, and they all had their own specialist interests, running specialist clinics, sometimes jointly with a tertiary specialist from the surrounding area. They had been instrumental in setting up specialist services for patients with paediatric diabetes, cystic fibrosis and oncology. There was strong evidence to reflect how cohesively the paediatric consultant body worked and helped each other, as well as with members of the paediatric and neonatal MDT. In view of the chronic shortages of junior and middle-grade medical staff, the paediatric consultant body had incorporated novel working patterns to provide 24/7 consultant led and delivered paediatric and neonatal services.
- 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 but these were not on file.
- A 'patient passport' was completed for patients with learning difficulties 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. There were no communication aids in place to support patients with learning disabilities. We saw from a recent staff meeting that some staff had requested to attend training to learn how to use specific communication tools and better support patients with learning disabilities, we were told that this was being supported although had not been progressed.
- 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 unavailable or another language required interpretation, Language Line was used and worked sufficiently well although this was not the preferred option.
- Leaflets could be accessed in other languages. The PALs team could produce leaflets in other languages if requested, although 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 and a computer gaming system was available if requested. The room used for adolescents.
- The paediatric ward had four bedded bays which were not separated by age or gender. 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 paediatrics and SCBU to accommodate parents in a more comfortable setting if required.

Learning from complaints and concerns

- During 2015 two complaints had been received about the paediatric department. Both complaints were 'ongoing' and as yet had not received a formal response. One complaint dated back to March 2015 and it had been documented that regular meetings had been held with the child and their parents. The second complaint date back to August 2015 with an agreed formal response to be sent at the end of September. Therefore it was not possible to consider the outcome and lessons learned from complaints received.
- 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. Staff told us there was no mechanism for sharing learning from complaints made in any other part of the organisation. This meant opportunities to improve practice as a result of investigations into complaints were not shared with the paediatric department.

Are services for children and young people well-led?

Services for children and young people

Requires improvement

Services for children and young people required improvement for well led. Two business plans had been developed for the service. The first was for Integrated Family Health Services (IFHS), covering acute and community paediatrics as well as obstetrics and gynaecology. The second was for the SCBU. Both business plans lacked detail and did not always specify the specialities that they related to.

There was an overarching governance meeting for IFHS as well as a paediatric business meeting. The paediatric business meeting reported to the IFHS meeting. Terms of reference had been developed for the IFHS meeting and the paediatric business meeting. Action notes and minutes for both meetings lacked detail and did not always specify which specialities had been discussed when a summary had been recorded.

The performance dashboard did not always clearly stipulate which specialities its information related to, although a narrative was provided for most areas.

The risk register was not used to ensure all risks had been identified.

We were told that local leadership worked well. Staff reported that they felt well supported by managers and that managers were approachable.

Patients and staff were given opportunities to provide feedback about the service. It was not clear how feedback from staff was acted on.

Vision and strategy for this service

- The staff we spoke with did not know what the vision and values were and they were not evident in the departments business plans did not make reference to them.
- The IFHS business plan, 2015 listed key operational objectives for the year. These were mostly generic for example, meeting targets and recruiting staff, it was not clear which specific vision or goals there were for acute paediatrics.
- The business plan for SCBU listed five key issues as continuing to provide a quality and safe service for sick and preterm infants to ensure best outcomes; to facilitate increased number of qualified in speciality nurses; to facilitate growth of leadership and management of senior neonatal nurses; to reach agreement with commissioners on funding of transitional care; and to explore if there was a case to strive for level 2 service.

Governance, risk management and quality measurement

- The main committee for paediatrics and SCBU to discuss governance issues was the paediatric business meeting. Any exceptions were reported to the integrated family health service governance meeting (IFHSGM). The IFHSGM attendees were responsible for reviewing and managing risk, quality, performance, human resources, finance and service improvement. The committee met monthly.
- Review of the July and August 2015 action notes confirmed the risk register was regularly reviewed. Overall there was minimal discussion recorded from the meetings, for example, the 'dashboard' was listed as 'discussed', discussion around incidents was recorded as, 'in the dashboard'. It was therefore unclear whether this information had been reviewed and discussed or not. We noted that the dashboard reported on outstanding complaints and incidents, and a summary report was embedded in the document. The dashboard was presented for integrated health services as a whole and for some elements it was not clear whether the delays related to acute paediatrics and / or community paediatrics, obstetrics and gynaecology.
- Performance for community paediatrics was discussed, but there was no evidence that performance for the acute service was considered other than local targets for sending out paediatric outpatient letters. Safeguarding issues were noted as well as progress with the clinical audit plan.
- The paediatric business meeting had a similar agenda and discussion was focussed on paediatric issues, terms of reference had been agreed. Minutes recorded brief discussion and actions to carry forward, although discussion recorded in the minutes was minimal; for example, under the heading, 'Quality Measures', it simply recorded the need to audit performance with sending outpatient letters.

- We were provided with a copy of the risk register dated 1 July 2015. The risk register had three risks relating to paediatrics and none for SCBU. We noted that some additional risks had been discussed for inclusion at the August IFSHUG.
- 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 one of the risks related to the risk of CAMH patients self-harming or absconding, the mitigating control was recorded as arranging one to one cover from a mental health nurse and there were no further gaps in controls identified therefore this risk was identified as unlikely. It failed to consider arrangements in place until a mental health nurse had been appointed and was on site caring for the patient.
- Risks which the department had failed to consider included, the treatment rooms not being locked, the blind cords in the paediatric department presenting a ligature risk as well as the cleaning schedule in SCBU not being completed.

Leadership of service

- The clinical management for medical and nursing was well established and the staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable expressing their views to more senior management if they needed to.
- It was the perception of some staff, that although management were supportive that sometimes directives were given without explanation or rationale for the changes being made and that staff were not always consulted on changes.

Culture within the service

- The staff we spoke with in paediatrics and SCBU told us that it was a wonderful place to work and that they felt supported by their peers and managers. We observed positive interaction between all staff groups. Nursing staff and support workers told us that they felt comfortable in raising serious issues directly with consultants if they needed to and always felt listened to.
- There was an area for staff to rest and / or have private conversations if they needed to. Staff told us they were confident in sharing information with their manager if they needed to.

Public engagement

- 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 recently introduced a 'Saturday club'. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.
- Patients were given the opportunity to provide feedback as part of the National Children'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.
- Patients also had the opportunity to provide feedback via the Friends and Family Test although monitoring of data was provided at directorate level.

Staff engagement

- 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. However, the action plan provided was trust wide and therefore we were unable to link this directly to the satisfaction of staff working within the paediatric and SCBU.
- 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.

Innovation, improvement and sustainability

- We were told that staff had the opportunity to generate ideas and develop them via team meetings. We were told about a recent example where staff had requested to learn sign language as well as Makaton. Makaton is a communication tool used by people with learning disabilities to enable their independence and communication.

End of life care

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

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. The hospital reported there had been 704 deaths at Hereford Hospital between April 2014 and May 2015. 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 April 2014 and May 2015, its specialist palliative care team (SPCT) saw 450 patients. The majority of all patients the team saw in 2014/2015 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. This meets the National Institute of Clinical Excellence (NICE) recommended guidance for staffing. There are 2.3 WTE clinical nurse specialists in palliative care based at the hospital. This is made up of three clinical nurse specialists and a lead nurse.

This team also provides training to staff on the wards on various aspects of palliative care.

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 work Monday to Friday, from 8am to 4.30pm. They provide a 24-hour on-call rota. We found staff who worked in the mortuary maintained patients' dignity after death.

During our inspection, we spoke with one patient and three relatives. We also spoke with 18 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 36 Do Not Attempt Cardio-Pulmonary Resuscitation forms (DNACPR). We received comments from our listening event and we reviewed the trust's performance data.

End of life care

Summary of findings

We found that staff providing end of life services were caring. End of life services required improvement across the safe, effective, responsive and well-led domains.

During our inspection we found there to be maintenance issues with the mortuary body storage units (fridges), resulting in one bank of fridges reaching temperatures above the guidelines. The staff in the department had not escalated this risk or instigated alternative storage arrangements.

We found two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) policies on the trust's intranet with differences, which could confuse staff.

We saw evidence that the trust had a replacement for the Liverpool Care Pathway (LCP) and was this is use on all wards. The resulting Multidisciplinary Care Record for adults for the last days of life (MCR) ensured that patients had a clear care plan that specified their wishes regarding end of life care.

The SPCT had recently begun a process to monitor the quality of the service effectively. For example, we saw an audit looking at whether there were any obstacles to patients' discharge, and to monitor whether patients died in their preferred location. Information from these audits was fed back to the team and we saw evidence of changes to practice. We saw that they had introduced a new document for anticipatory medication. This was written in hospital before a patient's discharge for use by district nurses when the patient returned home to prevent delayed medication. We also noted the SPCT worked proactively with local providers of end of life care and tried to influence how services were delivered to the local population.

The SPCT members were competent and knowledgeable. We saw examples of good multidisciplinary team working. The palliative care team was visible on all wards and nursing staff knew how to contact them. The team regularly attended other specialty multidisciplinary meetings such as respiratory, gynaecology and haematology to provide support and guidance.

The SPCT team had a person-centred culture, and staff we observed were respectful and maintained patients' dignity. We saw staff responding to patients' wishes. The SPCT members felt supported in their work and they worked well as a team. Staff were clear about their roles and their involvement in decision-making. The patients we spoke with said they had the right pain relief and told us they were happy with the food and drink offered. They said staff were caring and compassionate.

Feedback from ward staff, medical staff, patients and relatives suggested that the SPCT and chaplaincy team staff supported families effectively and with compassion.

The trust gave us the statistics for the time between a patient's referral and the SPCT's first response, covering the period between 1 April 2015 and 30 September 2015. We saw there were 233 referrals during this time. The average number of days to first response was 0.36. The SPCT saw 73% of patients on the same day as the referral, 23% were seen the day after the referral was made.

Ward-based staff, medical staff and relatives we spoke with reported a timely turnaround from referral to response.

The SPCT planned to develop the service providing more support to non-malignant illnesses such as renal and respiratory diseases and were writing a business case to support the increased staffing that this would require.

All SPCT staff we spoke with were doing further training in areas such as advanced symptom control, counselling and Master's level clinical assessment. All these demonstrated evidence of further skills and competency development.

At the time of inspection, the trust did not have an on-executive director who could provide representation of end of life care at board level.

End of life care

Are end of life care services safe?

Requires improvement

End of life services required improvement in order to be safe.

We found there to be maintenance issues with the mortuary fridge resulting in one bank of fridges reaching temperatures above the guidelines. The staff in the department had not escalated this risk or arranged alternative storage arrangements.

We found two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) policies on the internal intranet. Having two policies on the intranet, with differences could result in confusion for staff. We informed the trust about this issue during our inspection. There were appropriate numbers of trained clinical and nursing staff to ensure that patients receiving end of life care were well cared for on the wards. Each ward had at least one palliative care link nurse who acted as the connection to the SPCT. They had quarterly 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.

Incidents

- During our inspection, 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. We saw from the fridge temperature recording documents and talking with mortuary staff that there had been an intermittent problem with one bank of fridges not staying at the required temperature since May 2015. We saw documented service records that showed external engineers had visited to make repairs. However, we were told by the mortuary manager that due to the intermittent nature of the problem the fault had not been repaired. The issue with the bank of fridges had not been entered on to the mortuary risk register. We saw documented evidence that the mortuary manager had raised a concern, following the trust reporting procedure, on 16 September 2015, as the fridge had not maintained necessary fridge temperature on three consecutive days. The external engineers had been contacted to request that they visit to make necessary repairs. When we visited the mortuary on 23 September 2015 the fridge registered 9°C. We were assured that alternative arrangements were being made to ensure correct storage procedures were followed. On our return to the mortuary on 24 September 2015, the fridge registered 11.5°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. Risks associated with anticipated events were not fully recognised, assessed or managed. Since our inspection, we have been informed that the fridge has been repaired and the fridges are maintaining temperatures within recommended guidelines.
- There had been no end of life care related never events reported in the previous 12 months (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).
- Staff we spoke with knew how to report an incident or raise concerns. Staff told us they were encouraged to report incidents using the electronic reporting system. They were able to show us evidence of how they changed practice following an incident, demonstrating that they learnt from it. We saw an end-of-life discharge guideline that had been developed in response to a previous incident. A patient had been discharged out of hours with incorrect medication leading to the district nurse being unable to administer medication in a timely manner, causing distress to the patient and their family. The SPCT team wanted to raise the profile of the importance of proactive management and forward planning for care at the end of life. They devised and implemented the end of life discharge guideline, specifically for patients who had little time left and who wanted to go home for their end of life care. It included a community drug chart to be completed by the discharging doctor. This meant that the medication could be given promptly.

Cleanliness, infection control and hygiene

- The mortuary and viewing areas were visibly clean, well maintained and well ventilated. The mortuary staff

informed us that all areas were cleaned by a designated member of staff. The mortuary had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage.

- The SPCT and mortuary staff wore clean uniforms with arms 'bare below the elbow'. We saw staff in the mortuary area wearing the correct personal protection equipment (PPE) such as gloves, aprons and over shoe protectors as per trust protocol and we observed PPE to be accessible throughout the department. Porters we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access the necessary equipment.
- When we visited wards, we saw staff in clean uniforms with arms 'bare below the elbow' and that hand gel was available at the entrances for visitors and staff to use. We observed staff and visitors using these.
- Although there was a standard of practice document for the receipt of bodies (suspected infection) on the internal intranet staff we spoke with were not able to direct us to a specific document relating to handling bodies with infectious diseases. Mortuary staff and porters told us about the procedures they follow and equipment they use, but without a specific knowledge of the document, there was a danger that risks would not be not fully recognised, assessed or managed.

Environment and equipment

- The mortuary had been licenced by the Human Tissue Authority to allow post mortem examinations and storage of bodies. The trust informed us that the licence is renewed annually, following a self-assessment audit. The next site inspection visit is due in 2019. Post mortems were carried out on the premises five days per week in the morning.
- The mortuary was equipped to store 40 deceased patients, 36 in fridges and four in long term storage. Staff told us these facilities were sufficient to meet the needs of the hospital and local population.
- There were four spaces for bariatric patients; there were specific storage trolleys and large fridges to accommodate them.
- Equipment in the mortuary was maintained through the service level agreement (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. 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. On inspection, we found the trolley to be in a poor state of repair, with parts such as a rubber stopper missing from a hydraulic foot peddle. The cover was worn and looked dirty and there was no documented cleaning schedule for this cover.
- People reaching the end of their life were nursed on the general wards in the hospital. Staff told us, whenever possible, patients were to be cared for in side rooms in order to offer quiet and private surroundings for the patient and their families. 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.
- 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 (NPSA).
- Following National Patient Safety Agency (NPSA) guidance in 2011that recommended all Graseby syringe drivers should be withdrawn by 2015. The trust had replaced Graseby Syringe Driver MS26 with McKinley syringe drivers The trust had provided a comprehensive education programme for all nursing staff in March 2015. 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 told us they felt confident in using this equipment and that they had received adequate training to be able to do so.

Medicines

- Following a recommendation by NPSA the trust had replaced syringe drivers used across Wye Valley NHS Trust. The implementation was supported by a comprehensive education programme in March 2015. All new qualified 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.
- Medicines were prescribed following the Wye Valley formulary and a web accessible West Midlands palliative

care formulary. The hospital used a comprehensive prescription and medication administration record chart for patients, which facilitated the safe administration of medicines. Specialised prescription charts supported prescribers to follow the agreed protocols for people who had medicines administered via syringe pumps. Medicines delivered via syringe pumps were prescribed appropriately.

- 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.
- Medication required for discharge such as pain relief was identified and written up as part of the discharge process so that medication could be provided by district nurses on discharge. We saw a prescription chart for use with the syringe pump, which had been designed for continued use once the patient went home. This ensured continuity of care.

Records

- We saw that patients' records were stored securely in all ward areas in order to ensure they could not be accessed by people who did not have the authority to do so.
- In the mortuary, we saw a policy and procedure in use for identifying bodies with the same name, which reduced the risks of misidentification. There was a policy for the management of unidentified bodies. Staff were able tell us in detail about these processes.
- We found two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) policies on the internal intranet. One was called 'Do not attempt cardio-pulmonary resuscitation (DNACPR) policy' with a review date November 2015. The second was called 'DNRCPR policy' with a review date of September 2016. The information in both was similar but the newer one had more detail, for example, in the 'responsibilities for medical staff' and definitions in the cardio-pulmonary resuscitation (CPR) section. The newer version included a decision-making framework. The example of the DNACPR form in the appendix was different. We were informed by the resuscitation officer we spoke with that the second document was the most current. We were concerned that having two policies on the intranet could result in confusion for staff. We informed the trust about this issue during our inspection.

Safeguarding

- The SPCT, mortuary staff and chaplain were aware of their responsibilities and how to report concerns. At the time of inspection, the trust training database showed that 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%. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.
- There had been no reported safeguarding concerns relating to end of life care.
- Portering staff were provided via a service level agreement (SLA) with a facilities management company. The SLA did not ensure that there was an expectation that the porters received safeguarding training.

Mandatory training

- The SPCT members said that they had completed mandatory training, which included safeguarding, dementia awareness, equality and diversity and manual handling.
- At the time of inspection, the trust training database showed that 53% of the SPCT attended mandatory training or had a date booked to complete their mandatory training to date. This did not meet the trust target of 90%. The SPCT manager was aware of the teams' training needs and was working towards ensuring training targets were reached. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.
- The trust training database showed that none of the mortuary staff had completed their mandatory training or had a date booked to complete their mandatory training to date. This did not meet the trust target of 90%.

Assessing and responding to patient risk

- The results of the National Care of the Dying Audit published in May 2014 showed that 64% of patients had been recognised as dying at the end of their life, this was better than the England average of 61%. 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 national average for those patients who had been assessed within their last 24 hours, with 92% compared to the England average of 82%, being assessed.
- The trust used the national early warning score (NEWS) system for monitoring acutely ill patients. This system alerted staff of patients clinically deteriorating. The tool allowed staff to monitor patient functions, such as their heart rate, blood pressure, temperature and oxygen levels at the bedside and staff calculated a NEWS for each patient. It was used appropriately to alert the appropriate clinician to patients who may be deteriorating.
- Staff had received training in basic life support. There was standard emergency equipment available to support patients in an emergency throughout the hospital.

Nursing staffing

- The SPCT, which covered both acute and community, was up to full establishment. There were 2.3 WTE clinical nurse specialists in palliative care based at the hospital. This was made up of three clinical nurse specialists and a lead nurse. They are available from 9am to 5pm Monday to Friday. The team covered leave amongst themselves. The SPCT felt that they were able to meet the demand with their current establishment.
- Each ward had at least one palliative care link nurse who acted as the link with the SPCT appointed lead in the clinical areas. They were provided with quarterly training sessions and network meetings which assisted in maintaining competency for their role. They were expected to share new knowledge, processes and skills to their ward teams relating to end of life care.

Medical staffing

- The SPC team was led by the lead palliative care consultant who was hospital based two and half days per week (0.5 WTE) The team had support one day a week from a speciality doctor, who also worked at the local hospice. The team told us they were up to full medical establishment. The medical staffing model met the medical staffing recommended National Institute of Clinical Excellence (NICE) guidelines.
- Out of hours, a telephone on-call service was available, provided on an on-call rota system by consultants based at the local hospice, which included the SPCT consultant. Support could also be sought from the community based palliative care clinical nurse specialists from 9am until 5pm Saturday, Sunday and bank holidays.
- Medical staff we spoke with on the wards were aware of the guidance for care during end of life and how to access the SPCT for advice should they need it.

Security

- Access to the mortuary was controlled by the mortuary staff, security team and porters office.

Major incident awareness and training

- We looked at the mortuary's storage contingency plans. The mortuary had the capacity to store 40 deceased patients. There was 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?

Requires improvement

DNACPR forms were not always completed accurately. The 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms were stored at the front of the patients' notes. They were easily identifiable, allowing easy access in an emergency. We could see that forms followed patients into the community and back into hospital. Not all the forms we looked at had been completed in line with trust policy. We looked at 36 DNACPR forms across all ward areas. Nine had not been reviewed and endorsed by a consultant/ or most senior health professional. We found one form that contained the date and patient's details but no other information had been completed.

21 of the 36 DNACPR forms we looked at stated that that the patient did not have capacity to make decisions in relation to cardio-pulmonary resuscitation (CPR). There was no evidence that an assessment had been used in the decision making process or any information concerning capacity documented in progress notes.

End of life care

We saw evidence that the trust had instigated and embedded a replacement for the LCP. This was called the MCR. This ensured that patients had a clear care plan that specified their wishes regarding end of life care.

Staff on the wards were aware of the approach the trust was using for patients receiving end-of-life care. For example, all staff we spoke with were aware of how to contact the SPCT. We saw that palliative care link nurses had been identified on each ward. These staff were the appointed lead in the clinical areas to share any new information relating to end of life care with ward staff and to attend network meetings where any updates were provided.

Staff were appropriately trained and supported and there were regular multidisciplinary meetings. Care and treatment was delivered in line with current evidence-based standards. Patients had appropriate access to pain relief. Palliative care and end of life team members were competent and knowledgeable and there were good examples of multidisciplinary team working.

Evidence-based care and treatment

- The SPCT delivered care in line with evidence-based guidance such as the West Midlands Palliative Care Symptom Control Guidelines. The guidance was available on the hospital intranet.
- The trust had taken action in response to the 2013 review of the LCP. We saw that the MCR 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).
- The SPCT also said that they had sought trust staffs' engagement on designing the MCR document. We saw evidence across all the wards we visited, that the SPCT supported and provided evidence-based advice and training to other health professionals such as complex symptom control and managing difficult conversations.
- Representatives from the SPCT attended professional networks to support and inform their practice. Professional groups attended included the West Midlands Palliative Care Expert Advisory Group, Three Counties Palliative Medicine Clinicians Group and West Midlands Palliative Care Physicians Group.
- The National Care of the Dying Audit - Hospitals (NCDAH) 2013/14 for the organisational indicators, demonstrated that the trust had not achieved 4 out of 7 measures and found to be worse than the national average for 4 out of 10 measures for the clinical indicators. Since this was identified, we saw evidence that the areas identified for improvement had been addressed through the development of the MCR document. We saw sections of the document included assessment of nutritional and hydration requirements, patients spiritual beliefs and preferences, and care after death.
- The data for the National Care of the Dying Audit for 2014/2015 had been submitted and the SPCT were awaiting the results.
- 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. A small internal audit had been carried out on the multidisciplinary care record for adults in the MCR documents that had been returned to the SPCT. 84 MCR documents had been returned. Of these, 20 (24%) achieved preferred place of death, 48 (57%) preferred place of death was unspecified/unknown, 16 (19%) had not achieved their preferred place of death.
- The trust's most recent DNR CPR 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; they were usually carried out by junior doctors as part of their research projects. Action plans were produced and this information was feedback to the staff teams via their line managers.
- We saw the standards of practice for the mortuary, which were reviewed annually and 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.

Pain relief

- Patients under the care of the SPCT had their pain control reviewed daily and ensured that PRN (when required medication) medication was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, scheduled pain relief.

End of life care

- There were tools in place to assess and monitor pain, and pain control was a priority for staff involved in end of life care.
- The patient we spoke with told us that they had received appropriate access to pain relief.

Equipment

- We were told that by staff that patients had access to appropriate equipment to keep them safe and comfortable.
- Staff told us that they had access to necessary equipment within a few hours for patients at the end of life whose discharge was being fast tracked.

Nutrition and hydration

- The National Care of the Dying Audit (2013/2014) found that only 38% of patients had received a review of their nutritional requirements, this was worse than the England average of 41%. The national care of the dying audit, also identified that only 44% of patient's hydration requirements had been reviewed, which was worse that the England average of 50%.
- The trust has taken action to address this issue. Nutrition and hydration needs at the end of life were highlighted and assessed using the MCR. Assessments incorporated patient choice, wishes and comfort and we saw ongoing nursing assessments included nutrition, hydration and mouth care needs. We observed that nutritional assessments were completed. Patients were routinely assessed using the Malnutrition Universal Screening Tool (MUST) this was used to identify nutritional risks. The nursing records such as nutrition and fluid charts were thorough and summarised accurately.
- We saw that menus catered for cultural preferences.

Patient outcomes

- The National Care of the Dying Audit published in May 2014 showed that 64% of patients had documented recognition that they were in the last hours or days of life. This is better than the England average 61%. This meant that most of the time 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. We saw evidence that through the development of the MCR document that the trust was trying to improve this practice.
- The SPCT had started to evaluate the MCR we were shown a local audit of the MCR carried out by the SPCT. The audit focused on identifying that conversations had been documented. The audit reviewed the information for 84 patients where the MCR had been used. We saw that discussions with patients and family, about the patient being in the last days of life, were recorded in 80% of audited documents. 71% of the 84 patients care plans they looked at, included recorded discussions around nutrition and fluids, and that 70% recorded the patient and family preferences. The results of the National Care of the Dying Audit published in May 2014 showed that the trust scored better than the national average for those patients who had been assessed within their last 24 hours, with 92% compared to the England average of 82%, being assessed.
- The trust had put itself forward for repeating the National Care of the Dying Audit later in 2015.
- 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 and the trust were awaiting results at the time of our inspection.

Competent staff

- The SPCT provided education on a formal and informal basis.
- The SPCT had developed a number of training courses to support the ward staff working with patients at the end of life. They provided three, two day 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 advance communication skills training for consultants.
- The MCR, the replacement for the LCP was introduced in September 2014. The SPCT provided a training programme on using this document, which was available to all acute staff between September 2014 and December 2014. This programme was attended by 117 staff. The SPCT also presented the new care plan to the trust board and at medical forums.
- The mortuary manager provided training to porters in the trust's procedures for transporting bodies to the

mortuary and the use of equipment. 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.

- The SPCT were competent and knowledgeable. They were aware of recent developments within their specialities including changes in national guidance. They attended regular team meetings and were offered group and individual supervision regularly, where there were opportunities to reflect on their practice.
- The trust target for annual appraisals was 90%. At the time of inspection, 69% SPCT nurses had been appraised in the last 12 months. The chaplain had been appraised in the last 12 months. None of the mortuary staff had been appraised in the last 12 months. However, after the inspection the trust told us that there were updated figures available that showed increased levels of appraisals but were unable to provide evidence to support this on our request

Multidisciplinary working

- The SPCT regularly attended the specialist teams' multidisciplinary team (MDT) meetings such as respiratory care, gynaecology, haematology and neurology to provide support and guidance.
- The team had established close links with other providers 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 move across care settings.
- Portering services were provided through a SLA by a facilities management company. The operations manager informed us that in the past they would have regular meeting with the site manager. This allowed them to monitor the services provided, discuss any concerns and address any practical issues. These meetings were not been running due to changes to the management structure, but they felt these should be reinstated.

Seven-day services

- The hospital SPCT was available from 9am to 5pm, Monday to Friday. Outside of these hours, specialist palliative care advice was available to Herefordshire and Mid Powys via St Michael's Hospice. A consultant based at St Michael's Hospice provided a telephone on-call service. Support could also be sought from the community based palliative care clinical nurse specialists. There were two full time mortuary staff one mortuary manager and one mortuary technician. The two staff worked Monday to Friday 8am to 4:30 pm. 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.

Access to information

- 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.
- The SPCT told us that currently there was no countywide information technology system between Wye Valley NHS Trust, mental health services, GPs and primary care teams, which resulted in some information not being shared effectively. The MCR followed them from hospital to the community. This ensured that the patient's care plan, which specified their wishes regarding end of life care, was passed on in a timely way.
- The MCR were accessible by all staff and ensured that patients had a clear care plan which specified their wishes regarding end of life care
- 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.
- Staff provided patients with information on how to contact the palliative care team and how to obtain additional support and information if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients DNACPR forms were not always completed accurately. We looked at 36 completed DNACPR forms across all ward areas. We saw that all decisions were recorded on two types of forms. We saw forms with a red border and forms that were completely red. The DNACPR form was at the front of the notes, allowing easy access in an emergency. Some of the forms we looked at had been completed in line with trust policy. From the 36 forms we looked at, nine had not been reviewed and endorsed by a consultant/ most senior health professional. We found one form that contained the date and patient's details but no other information.

End of life care

- 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 progress or that this information was documented in the patients notes. This was not line with trust policy or the Mental Capacity Act 2005 (MCA).

Are end of life care services caring?

Good

We received positive feedback about the SPCT from a patient and some relatives. They told us that they were treated with dignity, respect and kindness during interactions with staff, and relationships with staff were positive. They told us, and we saw that the palliative care team members performed patient reviews in a sensitive, caring and professional manner, engaging well with patients. We observed staff being respectful and maintaining patients' dignity, there was a strong person-centred culture.

We saw evidence that people were involved in making decision about their care. We saw the SPCT spending time talking to patients and their relatives. They were communicated with and received necessary information in a way that they could understand.

We saw evidence of patients and people and staff working together to plan care, and patients being involved in their care and treatment.

Compassionate care

- We observed that staff demonstrated a positive and proactive attitude towards caring for people at the end of life.
- The MCRs 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 were completed sensitively and detailed discussions with patients and their relatives. Records we saw on the wards, indicated that the preferred place of care/ preferred place of death. The wishes and preferences of patients and their families were documented.
- Relatives that we spoke with told us that the care provided was excellent, and that the team was very supportive. They said that that they were involved in their relatives care and informed at every stage.
- The SPCT staff we spoke with were very clear about their role in ensuring people received appropriate support. They described how important end of life care was and how their work affected the overall service.
- The SPCT had recently had recently submitted data for patients known to them from June to August 2015 to the FAMCARE 2 project a post bereavement survey of relatives about the care and support they and their relatives had received. They were awaiting those results.
- We observed that staff handled bodies in a professional and respectful way. The mortuary staff and porters told us that patients that arrived at the mortuary were cared for appropriately by the nursing staff shortly after death. Nursing staff were provided with training regarding how to perform procedures respectfully.

Understanding and involvement of patients and those close to them

- Patients' notes we looked at indicated they were kept actively involved in their own care and relatives were kept involved.
- We received positive feedback from two of the relatives we met. They spoke of excellent care, saying the team was very supportive. They said they were involved in their relative's care and staff kept them informed at every stage.
- We had one negative report from a relative who stated that they had been concerned that no one was checking on their relative. They had been unsure of how much food or fluid the patient had received. They had not raised these concerns with any of the ward team at the time. The relative informed us that they were considering putting in a formal complaint. We asked permission to speak to the ward manager about the concerns raised; they agreed that this issue could be raised. The ward manager was unaware of the relative's concerns, they told us that the family had not raised any concerns with them.

Emotional support

- The SPCT told us that care and support of patients and their carers/families including bereavement support were important components of the service. They felt they had the time to spend with patients and provide

End of life care

the emotional and psychological support to meet their needs. They provided a support and information service for patients and their carers, for example, they provided advice on symptom control, sickness and poor appetite.

- A counselling service was provided by the SPCT with the support of a clinical psychologist.
- There were four relatives' rooms with washing facilities available to enable relatives to stay on site if required. These rooms were used by relatives of patients nearing the end of their life.
- A Church of England chaplain was employed 15 hours a week supported by a number of volunteers covering all Christian denominations. There was cover in the hospital six days a week. The hospital did not provide a service on a Saturdays but a local vicar responded to emergencies by phone. The chaplaincy service had contacts with other religious leaders. This had not been necessary historically, due the limited diverse mix of the population. The chaplain told us that they had noticed an increase in diversity in both the employees and population and that they would continue to access support on an 'as and when' basis. An on-site chapel was open and accessible to all, 24 hours a day, seven days a week. The hospital also had a multi faith room. Recently the multi-faith room had been used to full capacity particularly by the Muslim community for Friday prayers. As a result, to increase capacity, the chapel was being made available for Friday prayers. The chaplaincy service could be accessed by patients, relatives and staff. Patients could refer themselves. The service was usually contacted by patients during their regular walk around the wards. Staff also alerted the chaplaincy team if a patient had requested to see them. We saw a process chart for obtaining a Church of England minister on the wards, which provided contact details. The chaplaincy held regular ecumenical memorial services for both adults and children who died in the hospital. A group of volunteers working with the chaplaincy team offered spiritual support to patients of all or no faiths. Chaplaincy volunteers also provided company and support to patients who had limited social support.
- The bereavement office provided bereavement support to families/carers after death.

Are end of life care services responsive?

Requires improvement

The organisation did not have the all the processes and information to manage current and future performance. The trust did not collect effective information on the percentage of patients who achieved dying in their preferred location. The trust did not collect information on the percentage of patients who achieved discharge to their preferred place within 24 hours. Without this information, we were unable to monitor if the trust was able to honour patients' wishes. Without collecting this information, the trust was unable to assess if they needed to improve on this.

The SPCT worked across the hospital and in community settings. They worked in partnership with a local hospice to provide patients with a streamlined service when they were in the hospital and after discharge. The SPCT was committed to ensuring patients receiving end of life care had a positive experience.

The MCR ensured that patients had a clear care plan that specified their wishes regarding end of life care. Staff were able to explain to us how they met the complex needs of patients on the wards. The treatment records we looked at provided detailed information and set out how to meet patients' needs effectively. These records had been developed to support patients' care needs and to enable them to die in their preferred place.

Service planning and delivery to meet the needs of local people

- Patients who were identified as requiring end of life care were referred to the SPCT by individual consultants or ward staff.
- The SPCT told us that they had received 450 inpatient hospital referrals between April 2014 and May 2015.
- 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. The SPCT had carried out a small internal audit on the MCR for adults in the last days of life documents that had been returned to the SPCT.
- The SPCT had started to collect data in order to audit the effectiveness of the MCR. Between October 2014 and August 2015 84 care records had been returned to the

SPCT. They were able to see that 20 (24%) patients had achieved preferred place of death. In 48 (57%) cases the patient's preferred place of death was unspecified/ unknown. 16 (19%) patients had not achieved their preferred place of death. Staff told us that patients were referred and transferred appropriately. Discharge or transition planning was a multidisciplinary team process. This process included input of hospital and community staff, as well as support agencies who were involved in providing care at home. Delays in discharging a patient home could occur because of the lack of available community care packages.

Meeting people's individual needs

- There were a range of locally and nationally produced information leaflets available for patients. These contained information on diagnosis and the type of treatments offered. There was also information available on what to do in the event of complications. The leaflets were available in different languages.
- We did not see any patients who did not speak English, but staff told us that translation services were available. The trust employs two translators and can access others via a phone line.
- Ward staff provided families with a bereavement booklet and contact numbers to call for support.
- Ward visiting times were flexible for those visiting patients at the end of their life.
- Staff told us that if a patient died when the family were not present, the staff ensured that they offered the family the opportunity to come to the ward before the deceased person was moved to the mortuary. Staff told us equipment such as commodes, bedpans and urinals, pressure-relieving equipment, including mattresses, were available for patients requiring them. The SPCT had recognised the needs of patients in vulnerable circumstances in relation to the future development of the service. In particular, we saw evidence of there being plans in place to improve support for patients with dementia at the end of life.
- Care and treatment records provided detailed information and set out how to meet those patients' needs effectively.
- 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 trust did not have a specific trolley used for transporting bariatric patients. Deceased bariatric patients were transported to the mortuary on their hospital bed covered with an appropriate 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.

Access and flow

- Where possible, side rooms on the wards were prioritised for patients at their end of life.
- We saw evidence of the protocol for rapid discharge being used, this included a local guideline and checklist for discharging a patient home whose anticipated prognosis is days to a short number of weeks. We saw a patient discharged to their chosen place in one day. The SPCT and ward staff told us that occasionally rapid discharge was not achieved because of delays in obtaining community packages.
- Data on how quickly rapid discharge was achieved was not collected. Therefore, the trust was unable to demonstrate if rapid discharge plans in place were effective and met patient needs.
- The porters told us that they were able to respond to calls made requesting decease patient transfer promptly. This was usually within 25 minutes and they were able to prioritise accordingly. Ward staff did not have concerns about these response times.

Learning from complaints and concerns

- There were no formal complaints relating to end of life specifically in the last six months. However, we were informed that when the trust's Patient Advice and Liaison Service (PALS) received a complaint or compliment that mentioned end of life care, the information was shared with the end of life team. (PALS support anybody having NHS treatment or partners, friends, family and carers. PALS staff will listen to questions or concerns and try to resolve them directly or will talk to NHS staff to get the answers needed.
- We saw letters and cards of thanks from relatives/carers addressed to the SPCT in their team office.

End of life care

- We saw letters and cards of thanks from relatives/carers of the recently deceased that had been cared for in the mortuary on the noticeboard of the mortuary office.

Are end of life care services well-led?

Requires improvement

Overall, we saw that leadership, especially at senior management level required improvement.

The trust did not have a non-executive director who could provide representation of end of life care at board level, which is a recommendation of the national care of the dying audit.

Patients DNR CPR forms were not always completed accurately, which was highlighted during our June 2014 inspection and had not been addressed. This meant that the trust was not doing all that was reasonably practicable to mitigate the risk of providing non-treatment to patients without their consent.

Trust management did not ensure that service level agreements were managed effectively to ensure patients were protected. Portering staff were provided via a service level agreement (SLA) with a facilities management company. The SLA did not ensure that there was an expectation that the porters received safeguarding training.

Issues were not always dealt with in an appropriate or timely way. Ongoing maintenance issues with the mortuary fridge had not been escalated, and no alternative storage arrangements had been instigated. The issue had not been placed on the mortuary or trust risk register.

We saw that the service had a replacement for the LCP, which was embedded across the wards.

We saw that the SPCT had governance arrangements in place to ensure that quality was monitored effectively and that there was learning from incidents, complaints and concerns.

The SPCT were passionate about its work in supporting and caring for patients and their families.

We could not evidence that governance arrangements were embedded in the mortuary.

Vision and strategy for this service

- The SPCT had an annual general meeting where they discussed and agreed their operational policy and work plans and priorities for the following year. We saw a copy of the meeting held in December 2014.
- We were also given a copy of the annual report produced by the team for the year end 2014.
- We saw a copy of the team's work plan for end of life care and priorities for 2015. The main priorities were listed as service development, education and audits/ surveys/guidelines.
- The trust had no non-executive director to provide representation of end of life care at board level. During the inspection, the trust informed us that they had identified a non-executive director with an interest in end of life care to provide this support for the future.

Governance, risk management and quality measurement

- Porters transported the deceased from the hospital wards to the mortuary and provided out-of-hours access to it. 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. Without this training, there was a risk that portering staff did not understand their responsibilities in identifying safeguarding concerns and would not feel confident in carrying out the appropriate actions if they had any concerns.
- We did not see any evidence of team meetings, supervision or appraisals within the mortuary team. When this issue was raised with the team, it was established that this was because there were only two staff within the team, performance issues, concerns, complaints and general communications were discussed informally.
- We looked at 36 Do Not Attempt Cardio-Pulmonary Resuscitation forms (DNACPR) across all ward areas. Nine had not been reviewed and endorsed by a consultant/ most senior health professional. We found one form that contained the date and patient's details but no other information had been completed. 21 of the 36 DNACPR forms, we looked at stated that that the patient did not have capacity to make decisions in relation to cardio-pulmonary resuscitation (CPR). But there was no evidence that an assessment had been used in the decision making process or any information documented relating the patient's capacity in progress notes.

End of life care

- We found two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) policies on the internal intranet, which could result in confusion for staff. A CPR policy was introduced in September 2015 which was an updated version of the Do not attempt cardio-pulmonary resuscitation (DNACPR) policy with review date November 2015. The older policy had not been removed from the intranet when the new policy had been introduced as a result, staff could access both.
- There had been intermittent maintenance issues with the mortuary fridges resulting 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.
- The SPCT held regular (six weekly) minuted team meetings in which performance issues, concerns, complaints and general communications were discussed.
- An operational policy was in place that set out the aims and objectives of the SPCT. We saw this was updated annually.
- Within the SPCT, multidisciplinary team meetings took place weekly. Complaints, concerns or issues were raised, discussed and planned for.
- We saw evidence of regular supervision, appraisals and professional development within the SPCT. Group supervision was provided supported by a clinical psychologist approximately six weekly.

Leadership of service

- There was good leadership of the SPCT. The team was led by the palliative care consultant and the specialist palliative care nurse team leader.
- All of the ward staff we spoke with knew who the leads were for end of life care.
- Staff spoke highly of the team and felt they were supportive and visible in the ward areas.
- We saw that the trust had an established replacement for the LCP called MCR, which we saw being used across the hospital.

Culture within the service

- All SPCT staff spoke positively about the service they provided for patients. Patient centred care was seen as a priority and everyone's responsibility.
- The SPCT were committed to delivering good care through training and support to ward staff. They had a proactive approach to ensuring the training of staff fitted the changing needs of the patients. For example, they delivered short training sessions on the ward at the same time as reviewing their patients' care.
- Across the wards we visited, we saw that the team worked well together with nursing and medical staff and there was good communication between not only the specialities but across disciplines.
- The SPCT and Macmillan Cancer Support and information services based at the Macmillan Renton Unit worked closely and supported each other in ways to improve the patient's experience. This teamwork was also supported by staff in the bereavement office, mortuary and chaplaincy.

Public engagement

- We were told that there was an active patient user group, held every three months for patients with cancer

Staff engagement

- Staff who attended courses provided by the SPCT were asked for feedback on their training and this feedback was used to develop future training. Staff we spoke with felt that the training they had attended had provided them with the necessary skills and gave them confidence.

Innovation, improvement and sustainability

- The SPCT had plans to develop the service providing more support to non-malignant illnesses such as renal and respiratory diseases and were in the process of writing up a business case to support the increased staff that this would require.

Outpatients and diagnostic imaging

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

Information about the service

Wye Valley NHS Trust runs outpatient, diagnostic and imaging services from Hereford Hospital.

The outpatient clinics are located throughout the hospital with reception desks and waiting areas in each outpatient area. The trust provides outpatient services across a wide range of specialities including cardiology, ophthalmology, urology, orthopaedics and radiology.

The trust provides hospital care to a population of over 180,000 people in Herefordshire and mid-Powys. Total outpatient attendances were approximately 323,244 between April 2014 and March 2015.

We visited the outpatient area that includes radiology, cardiology, ophthalmology, dermatology, ear, nose and throat (ENT), maxillofacial and orthopaedics. We spoke with 17 patients and their relatives and 66 staff including consultants, medical staff, radiographers, radiologists, assistant practitioners, nurses, healthcare assistants and reception staff.

We observed care and treatment and looked at 25 patient records. We also reviewed performance information from and about the hospital.

Summary of findings

We found outpatient and diagnostic imaging services to be inadequate.

We found the hospital was struggling to meet the demand for outpatient appointments. There were long waiting lists for appointments across most clinics. There were not effective systems in place to monitor and manage the risk to these patients. The lack of systems meant that patients were waiting longer than appropriate to be seen. The hospital failed to assess, monitor and mitigate risks relating to the health, safety and welfare of patients on the waiting list.

Patient appointments were often cancelled by the trust and patients experienced delays when waiting for follow up appointments. The trust did not meet the national referral to treatment target time for 95% of patients 18 weeks for outpatient services. The trust was unable to mitigate risks regarding referral to treatment times (RTT) as it did not have effective oversight of these risks across all specialities.

Outpatient and diagnostic staff showed a good understanding about reporting incidents. However, staff were inconsistent in reporting incidents and incidents were not always reported in line with trust policy. These issues meant the trust did not have an oversight of all incidents that occurred within outpatient and

Outpatients and diagnostic imaging

diagnostic imaging services. We saw that learning from incidents was inconsistent across the specialities and incidents were not always shared across the outpatient department as a whole.

Patients' personal identifiable information was not always kept confidential or stored securely. We saw patient records left in open plastic boxes and on top of trolleys in some clinics unobserved by staff. This meant there was a risk of patient records and personal details being seen or removed by unauthorised people.

The facilities in the Arkwright (temporary) Suite were inappropriate. The suite was cramped with insufficient soundproofing to protect patient privacy. However, there was a risk assessment and action plan to mitigate risk until the service relocated.

Some equipment had not been checked and maintained in line with manufacturers' recommendations. For example, we found risk assessments were not completed and radiology staff did not follow infection control processes.

Risk management and quality measurement systems were reactive and not proactive. Outpatient and diagnostic imaging services did not identify all risks to patients or effectively manage risks that had been identified.

Patients in radiology were routinely given contrast agent without prescriptions or a patient group directive. A contrast agent is a substance used to enhance the contrast of fluids within the body in medical imaging. All the radiology staff we spoke with were unaware that prescriptions were needed.

Patients received a caring service. Patients were treated with dignity and staff were kind, respectful and supportive. Staff gave clear explanations of treatments and most patients were positive about the care they received.

Managers of outpatient departments were accessible and respected by staff. Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of, policies and procedures.

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated outpatient and diagnostic imaging services as inadequate.

Incidents were not always reported in line with trust policy and staff were not clear about what should be reported as an incident. There was a system for reporting incidents but it was not always used. We saw that the learning from incidents was inconsistent across the specialities and incidents were not shared across the outpatient department as a whole.

There was not effective systems to monitor and manage risk to patients on outpatient waiting lists. This meant that the hospital failed to assess, monitor and mitigate risks relating to the health, safety and welfare of patients on the waiting list.

Patients in radiology were routinely given contrast agent without prescriptions or a patient group directive. All the radiology staff we spoke with were unaware that prescriptions were needed. This meant there was a risk that patients were not treated correctly due to incorrect prescribed dosages of medicine. However, medicines within the outpatient service were well managed and stored appropriately.

We saw practices that could compromise the health and safety of staff and patients in some areas. For example, we saw clinical waste stored inappropriately in the cardiac catheterisation suite and radiology protective equipment taped around the edges.

Records were not always stored securely. Rooms that stored records were unlocked and patient notes were kept on the floor in some areas and on open shelves and boxes in others. Staff in all outpatient clinics we visited reported that there were daily occurrences in which patient records were unavailable.

Staff compliance with safeguarding training did not meet the trust's target of 90%. Not all staff had the required level

of training as recommended by the Royal College of Paediatrics and Child Health. This meant that these staff were not adequately trained in their responsibilities for safeguarding children.

Most equipment was clean and checked as safe to use. However, we saw the use of damaged radiology equipment that had not been checked for damage since October 2010 despite recommended annual checks.

Incidents

- Between May 2014 and April 2015 outpatients and diagnostic imaging services reported six serious incidents requiring investigation for example; incorrect data in patient records. We saw these had been reviewed with identified actions taken.
- Incidents were not always reported in line with trust policy. For example, staff raised concerns that records were often unavailable for clinics and patients told us they had to wait longer to be seen as a result. It was accepted as common practice that not all of the patient care records would be delivered from the records department when required. Staff told us there were a number of reasons which included records being with the administration team waiting for letters to be typed up. Staff said they did not always report this as an incident.
- Staff were familiar with the electronic incident reporting system. They said they had not received formal training in its use. This meant staff were unclear what constituted an incident and what category they should use. We saw senior staff had recognised this issue and were in the process of adding a relevant category to the incident form.
- There was insufficient evidence to confirm that learning from incidents was trust wide. Feedback was generally kept within each care group service. Some staff told us that they did get feedback about incidents but it could take a couple of months.
- All staff we spoke with understood their responsibilities with regard to the duty of candour legislation. The duty of candour legislation requires an organisation to disclose and investigate mistakes and offer an apology.

Cleanliness, infection control and hygiene

- 85% of nursing staff had completed level 2 infection control training. This was below the target set by the trust of 90%.
- In the cardiac catheter lab we found clinical waste was stored in bags on top of the cleaning equipment within the cleaner's cupboard. This meant the catheter lab was not compliant with the clinical waste and handling procedures Environmental Protection Act (1990) which states that waste must be managed safely whilst ensuring the environment remains free from harm.
- Staff within the outpatient and radiology departments told us they regularly undertook infection control inspections, although we did not see evidence of these. We found damaged gonad shields with taped edges in radiology that were used for patient care. A gonad shield protects the pelvic area from radiation. This meant they could not be cleaned effectively. We reported this to the trust who responded by removing the damaged gonad shields. The trust confirmed they would be ordering replacement shields.
- There were systems in place for the segregation of waste materials such as x- ray solutions and sharp items. Sharps containers were available in each clinical area. We saw these were dated and not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of a needle stick injury.
- We observed that staff complied with the trusts infection control policy, for example; bare below the elbow.
- There were personal protective equipment available and hand-washing facilities in each clinical room. Staff across the outpatient services were seen to be using the personal protective equipment appropriately.
- Hand gel was available in all clinical areas. We saw posters in waiting areas and other communal areas advising patients to use hand gels. However, in the Arkwright unit the hand gel dispenser in the waiting area was behind a seat and could not be accessed if a patient was sitting in front of it.
- The trust commissioned an outside provider to manage its cleaning schedules within the hospital. Clinical areas appeared clean but we found no checks in place to monitor cleanliness.

Environment and equipment

- In the radiology department we observed staff used personal protective equipment (PPE). For example, lead gowns, which protect staff from the effects of radiation. We observed that 80 of the 100 lead gowns had not been checked for damage since October 2010 instead of

the recommended annual checks. The radiology manager confirmed this had been an oversight. We reported this to the trust who took immediate action on the day and checked all lead gowns.

- Equipment records in the cardiac angiography suite stated there was a fault with the piped oxygen supply and this had not been working since August 2014. However, staff were using portable oxygen cylinders instead. They said they were unclear as to why this matter had not been resolved.
- We saw evidence of maintenance checks of some equipment. For example, laser equipment in ophthalmology department.
- Equipment we looked at was visibly clean and stored appropriately.
- The trust's electrical maintenance engineering department were responsible for annual portable appliance testing (PAT). The equipment we looked at were in date, and the equipment appeared in good condition. A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use.
- Resuscitation trolleys in outpatients were centrally located and checked on a daily basis.
- There was an efficient 'air tube' transportation system in place to deliver samples and requests to other departments in the hospital. This meant patient samples, for example blood samples could be sent directly to the relevant hospital department.

Medicines

- Hereford Hospital had a pharmacy on site. They checked and replenished stock medicines in all departments and provided an outpatient dispensing service.
- We saw audits of medicines management had been completed and where actions were needed, they had been taken.
- FP10 prescription pads were securely locked away.
- We saw that room and fridge temperatures were checked to ensure medicines were stored at correct temperatures.

Radiology

- The radiology department used patient group direction (PGD) policies to allow staff who were not trained to give one or two specific medicines for certain procedures. For example, contrast agents. PGDs are documents permitting the supply of prescription-only medicines (POMs) to groups of patients, without individual prescriptions. Healthcare workers using PGDs should be sufficiently trained to be able to supply and administer POMs.
- We looked at these policies and saw there were no authorising signatures on any of the PGD documents. This meant that the documents were invalid and therefore staff were administering medicines without authorisation. This was contrary to the guidance provided by the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE).
- The radiology department for nuclear medicine had two PGDs in place. We saw these had been authorised and signed appropriately.
- Radiology and diagnostic staff were regularly administering different contrast agents for example, Niopam prior to treatment with no prescriptions. Five radiographers told us they did not have prescriptions for the different contrast agents they were giving patients. When asked what dose they were giving patients one radiographer responded "a standard amount for everyone". Radiographers were unaware that the dose should be determined by the patient's weight and that a prescription was needed. This meant there was a risk that patients were not treated correctly due to the incorrect prescribed dosage of medicine.
- Protocols were in place for radiographers which outlined how contrast agents should be used. However, these did not specify dose or type of contrast to use. Staff confirmed they took patients' medical history and checked to establish any contraindications when they completed the pre examination questionnaire before administering the contrast agent.
- We observed a robust and safe process for accessing "Dotarem "(a contrast agent) from a locked store room. Staff checked the date and content before it was administered.
- In radiology medicines were stored in locked cupboards. Lockable medicines fridges were in place, with daily temperature checks. This meant that the department were following the Department of Health (2003) Controls Assurance Standard: Medicines Management (Safe and Secure Handling of Medicines).

Records

- There were inconsistencies in the storage of records. In the fracture clinic and ophthalmology outpatient department's we saw records were not stored securely. For example, we observed patients' notes on trolleys and in open plastic boxes outside consulting rooms. This meant there was a risk these records were vulnerable to theft and unauthorised access and that patient's personal details were not kept confidential.
- Staff told us they placed the records backward facing so patients could not see names. Senior staff told us they felt this was the best option to protect confidential information, as clinics were very busy and using small lockable trolleys would take up too much space.
- Senior staff in ophthalmology told us that in September 2015 they had completed a risk assessment regarding patients seated in the waiting area who were looking at patient's records stored in the open plastic boxes to see where they were on the waiting list. Staff said they had not completed an incident form when this happened as they "felt that they would risk assess it and monitor". Staff said that senior staff were aware of the issue and had tried different lockable solutions but none had been satisfactory. This meant that there was a risk of patient records and personal details being seen or removed by unauthorised people in the department. Concerns about storage during clinics of patient's records were not on the risk register.
- Staff told us doctors in ophthalmology regularly left notes on their desk in clinic rooms overnight. There were no facilities in clinic rooms to lock notes away. Rooms were locked by nursing staff when clinics finished.
- In the ENT and maxillofacial unit we saw 28 plastic crates on open shelves in an unlocked room with no one present. There was a risk patient records could be removed or viewed by unauthorised persons and staff would not be aware.
- Administration staff told us there were delays of approximately a month in typing patient and GP letters. There were no facilities to securely store patient records within the administration environment due to the increased workload.
- Administration staff said there had been no additional increase in facilities within their office. They said they had no option but to store records in the unlocked room until they were finished with. We saw crates containing records waiting to be typed and filed were dated back to August 2015. This meant some records had been there for almost a month.
- In the main outpatient reception area we saw open plastic crates with patient records stored in a corner of the reception office. They were waiting to be collected by the records department. Staff told us they were collected twice a week and in the meantime they were stored in open crates. There were not enough crates to store all of the records therefore some were stacked on the floor. This meant records and personal information were not stored securely.
- Record storage was not identified as a risk on the trust risk register. Staff told us it had been but had been taken off.
- The hospital did not collect data on unavailable notes in clinics. Nursing staff told us there would be at least three or four sets of patient notes unavailable out of 13 patients booked at each clinic. In these instances, staff would create a temporary set of notes for patients. The hospital was aware that the use of temporary notes meant that there were duplicate notes for some patients. There was no process in place to ensure that all temporary notes were later filed within the patients original notes. 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, in instances where notes were unavailable or where temporary notes were not filed within the patient's original notes. This meant that the hospital was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of outpatients.
- We saw a team brief which reminded staff that all entries into patient notes must be legible, signed and dated as per the Standards of Clinical Record Keeping Policy. Some staff told us they were unable to access the computer to see the team briefs. One manager told us they printed information from the trust and pinned a copy on the staff notice board to ensure staff could access information.

Safeguarding

- Staff were aware of their role and responsibilities and how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children. We saw there were safeguarding policies in place and clear

procedures to follow if staff had concerns. Information about how to report any safeguarding concerns and safeguarding adult's information was displayed in outpatient clinics.

- The trust target for staff to complete safeguarding children level 2 was 90%. The records showed that 55% of additional clinical services, 75% of additional professional and technical staff and no administrative and clerical staff had completed this. 61% of nursing staff were compliant which did not meet the standards set by the Royal College of Paediatrics and Child Health (Intercollegiate document 2014). This meant that staff were not adequately trained in their responsibilities for safeguarding children.
- Administrative and clerical staff required safeguarding children's level 1 training. We saw that 67% of staff were compliant which did not meet the trust target of 90%.
- Safeguarding adults level 1 training was included as part of the mandatory training package. The trust target for staff for safeguarding adult's level 1 was 90%; however compliance had not reached this target for all staff. 72% of nursing staff and 75% of additional clinical services had completed level one. All professional and technical staff and administrative staff had completed this level.
- We saw safeguarding minutes dated March 2015 that said "Adult Safeguarding basic awareness was no longer part of the trust induction and staff raised concerns about the effect this might have on the training figures". However, staff said they had to book separately for their safeguarding adult mandatory training session. We spoke with one new member of staff who told us they had not completed safeguarding adult mandatory training.
- Staff raised concerns that they did not know which training they should be doing in relation to safeguarding children. In May 2015 the safeguarding and children's group meeting noted that the compliance rates for level 1 and 2 safeguarding children's training were highlighted as a risk for the trust as they had not reached their target. This meant the trust had recognised they had not reached their target level for some staff and plans were in place to ensure those staff still to complete training would be targeted.

Mandatory training

- All staff within the outpatient and diagnostic imaging service were aware of the need to attend mandatory training in issues such as moving and handling, and safeguarding. As part of the trust strategic objectives, they had identified the training and development needs of staff. There was a plan in place to enable staff to access training, which was noted on the October 2015 trust board meeting minutes.
- Information governance training compliance was 88% for professional scientific and technical staff; 76% for additional clinical services; 79% of nursing and midwifery and 100% for administration and clerical staff.
- Health and safety training compliance met the 90% trust target for all staff groups.
- Staff were given a choice of how they completed their annual mandatory training, whether by e-learning, face-to-face or ad-hoc sessions for practical work.
- There was an induction programme for all new staff.
- The trust had an electronic E-learning service. However, this was not accessible to all staff as they did not have a smartcard. Staff told us the trust was looking at introducing this service to all staff.

Assessing and responding to patient risk

- Several clinicians expressed concern to us about patient waiting times. There was no system in place to monitor and manage the risk to patients on the waiting list. This meant that the hospital was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- There were systems to triage and prioritise urgent and routine new referrals and send appointments as required to patients.
- The annual report and accounts for 2014/15 identified that the trust struggled to deliver cancer access target sustainability during the year as a result of the increase in dement. In March 2015, performance reported compliance with five of the six national cancer access standards. For example; the trust scored 97% for cancer 62 day screening against a target of 90% and 91% for cancer two week wait against a target of 93%. The trust failed to reach the two week wait (breast symptomatic) this is where the GP or other relevant health professional referred patient for breast symptoms but did not suspect cancer. The trust scored 83% against a target of 93%.
- We observed radiographers following the (IRMER) regulations that require radiographers to routinely check previous images before continuing with a scan or x-ray.

Outpatients and diagnostic imaging

- There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body whilst a CT scan uses X-rays and a computer to create detailed images of the inside of the body.
- The Ionising Radiation (Medical Exposure) Regulation (IR(ME)R 2000) require doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data have been collected and analysed for examinations performed with a view to establishing Local Diagnostic Reference Levels (LDRLs) and comparing against National Diagnostic Reference Levels (NDRLs) where available. We reviewed the patient dosimetry report for January to June 2015 which identified no issues or concerns with Hereford Hospital.
- We saw the new outpatient attendances and follow up outpatient attendances data between April and August 2015. We saw that both new and follow up appointments were 1% below trust target. This equated to 8% and 13% respectively. This was despite planned activity levels being lower for August than the preceding and subsequent two months. Both continue to be down on plan year to date. This meant there was a risk of some patients not receiving timely appointments to meet their needs.
- We saw the diagnostic performance from April to August 2015. We saw the service had not reached the trust target of 99% with the exception of August 2015. The trust board meetings minutes for October 2015 identified that the number of patients on the waiting list had reduced. MRI, CT and non-obstetric ultrasound had no patients waiting over six weeks. There were seven breaches in adult audiology and 12 in paediatric audiology due to on-going staffing and capacity issues. There were four breaches in Urodynamic due to consultant emergency leave.
- Processes were in place within outpatients to manage patients who deteriorated or became unwell within the department. There was an emergency response team within the hospital who could be summoned rapidly.

Nursing staffing

- In the outpatient departments the manager had developed a staffing calculator tool to ensure there were sufficient staff on duty. However, this was unused throughout all outpatient departments. The outpatient manager told us they used this to decide if they had enough staff to cover additional clinics and to inform senior managers of numbers of nursing staff that would be needed to deal with the increased demands for outpatient clinics.
- Recruitment of staff was in process through a variety of methods such as overseas recruitment. Another method was to encourage substantive nurses to complete additional hours (up to the maximum allowed by the European directive) for the next six months whilst the recruitment progressed. Bank staff were used to cover known absences through sickness or holidays.
- Most nursing staff told us that although they were busy, they felt they provided good and safe patient care in outpatients.
- Extra clinics were required to meet the needs of the local area and this was often covered by permanent staff who volunteered to work over and above their contracted hours.
- Administration staff said managers were aware that staff worked over their contracted hours to try to manage the backlog of clinical letters that needed typing, if staff were off sick or on holiday there was no backfill and the backlogs became longer. Staff said that managers were writing a business case to recruit more administration staff but this had not yet gone to the trust board for approval.
- Trust wide data showed that there was a vacancy rate of 3% for administrative and clerical staff.
- The trust had a revalidation plan in place for those nurses who needed to register in 2016.

Medical staffing

- The individual specialties arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Consultants were supported by junior colleagues in some clinics where this was appropriate.
- Staff told us there were gaps in recruiting dermatology because of the varying specialisms.
- The trust had a rolling programme to recruit suitably qualified staff. It had recognised that recruitment was difficult and was actively promoting the hospital to recruit staff.

Outpatients and diagnostic imaging

- We saw the medical staffing levels which showed that the trust was on par with their staffing levels. The exceptions were nuclear medicine whereby they were one staff short and the imaging services which showed a short fall of nearly three staff members.
- A validation plan was in place for all doctors requiring validation. We saw the action plan with the outcome of revalidation recommendations between 1 September 2014 and 23 September 2015. All 87 recommendations had been completed on time.

Major incident awareness and training

- The trust had a major incident policy which staff were aware of. It identified key contact details and a process for staff to follow.
- There were business continuity plans in place to ensure the delivery of the service was maintained in the event of a major incident.
- Staff said they knew about the trusts lone working policy and adhered to it. No concerns were raised by staff regarding this.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients were at risk of not receiving effective care or treatment in accordance with best practice guidance.

Staff did not always have the complete information they needed before providing care and treatment because records were not always available in time for clinics.

There were inconsistencies with staff annual appraisals, with variances ranging from 62% in cardiology to 87% in radiology.

Outcomes of patient care and treatment were not always monitored regularly or robustly. For example, outpatient staff often had to source critical information about a patient's care and treatment before the patient could be seen.

Staff gained consent for treatment.

Facilities were available for patients to access drinks in outpatient departments.

There was good multidisciplinary working to provide integrated patient care. Staff worked well together in a multidisciplinary environment to meet patients' needs.

Evidence-based care and treatment

- Protocols were in place that followed national guidance for radiology examinations such as stent insertion and orthopaedic x-rays.
- We spoke with nine staff including senior radiographers and managers. None were aware that best practice was for radiation dose levels to be routinely displayed in rooms. This meant that the department was not compliant with IRMER regulations. The manager immediately rectified the situation after we highlighted the issue.
- Staff told us they had no way of digitally archiving patient's coronary angiography images. These were stored on a compact disk (CD). Surgery or angioplasty for these patients was carried out at Worcestershire Royal Hospital. This meant clinicians had to ensure the CD's were available to be viewed at the operating hospital for patient procedures. Clinicians told us that whilst it had not happened yet there was a risk they could be lost and they had been occasionally unavailable when required. If this happened it meant that patients would not be able to have their procedure until new images had been acquired. This meant the service was not compliant with the National Imaging Board recommendations for coronary angiography and British Cardiovascular Intervention Society (BCIS) 2015 best practice guidance.
- Protocols were in place to ensure fast tracking for significant imaging findings such as cancer diagnoses and severe abnormalities relating to benign or malignant growths. Radiographers told us these findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action.
- We compared the radiology x-ray practice we saw with the Society and College of Radiographer's recommendations (IRMER) and saw that the department's practice was in line with professional guidance.
- Polices were in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.

- Each year members of the public undertake unannounced visits to assess how the environment supports, patient's privacy and dignity, cleanliness and general building maintenance. The Patient Led Assessment of the Care Environment (PLACE) inspection results showed the trust had scored 90% for the environment and 80% for patient privacy and dignity.

Pain relief

- Pain relief could be prescribed within the outpatient's department and subsequently dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing this by their consultant.
- We found examples of good multidisciplinary working both within and across teams. The notes of several patients undergoing investigation for chest pain were reviewed. These revealed evidence of compliance with the latest NICE guidance on chest pain management."

Patient outcomes

- Clinicians in ophthalmology had agreed to double book patients to ensure patient waiting times were not breached but no plan was put in place to ensure there were enough nursing staff to cover the demand across outpatient services. Staff told us the focus was on ensuring patient waiting times were not breached. This meant that there was no joined up MDT approach in the planning of services.
- The percentage of patent clinics cancelled, was 24% per month for February to May 2015. This was worse than the national average.
- Audit results as of 17th September 2015 showed the average waiting time for clinics was 34 minutes. The shortest waiting time was 0 minutes and the longest was 125 minutes.
- If patient records were unavailable, the trust said a consultant or registrar made the clinical decision as to whether or not they would see the patient. If the patient was unable to be seen an apology was given along with a new appointment date and details of the patient experience team should they wish to raise a concern. If the patient was seen, a temporary set of medical notes were created.

Competent staff

- The trust appraisal policy stated that all staff were required to have annual appraisal using the job description and person specification for their post. Staff that had received an annual appraisal told us it was a useful process for identifying any training and development needs. Trust data showed completed appraisal rates were different across departments. Some specialities were not meeting this requirement. For example; in cardiology 62% of staff had received an appraisal, 80% of nursing staff and 87% of radiology staff had completed an appraisal. Medical staff in urology and orthopaedics were 75% compliant with appraisals. However, in cardiology appraisal data was not recorded effectively and some staff names were duplicated. For example, one member of staff was recorded six times. Therefore, it was difficult to establish from the data how many staff had received an appraisal at a glance.
- There was evidence that staff training and skills competency were checked on recruitment.
- There was evidence that staff had opportunities for further training. For example: some band three health care assistants (HCA's) were supported to extend their role and complete additional training to become a band four. However this had not yet been rolled out to all HCA's. The trust was in the process of implementing a timeline for this to start.
- Managers confirmed that most nursing staff did not have any formal one to one supervision. The trust planned to set up a process but this would not be compulsory. One sister told us they had set up their own clinical supervision with another colleague as they felt it was important.
- There were no role-specific training standards set by the trust to state what staff had to complete as a minimum for their designated area of work. One manager told us they were developing what they considered a minimum level of training and expected staff would work towards this.
- In the echocardiography department, there were a high number of British Society Echocardiography (BSE) accredited physiologists. This meant the trust was following good practice guidance and ensuring patients received their care from appropriately trained staff.
- Managers told us there was good availability of training opportunities and staff were encouraged to take responsibility for organising their own training dates

Outpatients and diagnostic imaging

- All staff felt confident about looking after a patient with dementia or a learning disability. The learning disability specialist nurse and her team were widely known throughout the hospital. They were able to offer nurses and other clinicians' information as required.

Multidisciplinary working.

- We saw some good multidisciplinary working across some departments. For example, in the emergency department patients requiring urgent scans were seen by the MDT who quickly assessed and progressed any interventions quickly. We observed staff following the NICE stroke pathway guidelines which ensured patients received a prompt and comprehensive assessment from experienced clinical staff.

Seven-day services

- Radiology services were available 8am to 8pm, Monday to Friday. Staff told us they often worked until 10pm to manage patients waiting.
- The CT service worked seven days a week with variable opening times dependent on staffing availability. Usually averaging eight or nine hours per day.
- Outpatient clinics available on Saturdays if sufficient staff and consultation rooms were available. For example, in cardiology, as part of their waiting list reduction initiative. Outpatient clinics were occasionally available on Sundays. Managers told us there were plans to extend clinics to seven-day working, but significant work and additional medical and nursing staffing was required before this could be implemented.

Access to information

- Staff did not always have sufficient information about patients during clinic due to records not always being present.
- The administration staff told us that there were not enough administration staff to manage the workload. Staff confirmed this meant patient records were not updated or returned to records department when they should be. There was backlog of patient records across all specialties waiting for secretaries to type letters to inform patients and their GPs of their consultation. This meant that patient letters to GPs were not completed in a timely manner after clinics. For example, in cardiology, dermatology and ENT, there were approximately a one month delay in patient's reports and clinic information being typed up and sent on to their GP. This meant that GPs did not have the most up to date information on the patient's condition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw records that showed staff received training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff said they were confident about seeking consent from patients.
- We observed radiographers following the trust policy on consent. They ensured consent was gained for each scan or procedure.
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would be obtained in the outpatient clinic. Staff showed us consent forms the trust used. There were four different versions for staff to use. We saw they were clearly written and staff told us they were easy to understand.
- Patients were consented appropriately where they had capacity to make decisions.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good.

Staff treated patients with dignity and respect.

We observed staff listening and responding appropriately to patients' requests in a kind and caring manner.

Patients and relatives told us they found the staff to be kind and understanding. Both groups spoke highly of the care and support provided.

Compassionate care

- From July 2014 to May 2015 the response to ensuring inpatients had a positive experience of care averaged 70%. Specific data in relation to outpatient clinics was unavailable as the trust did not separate data into specialities.
- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and

diagnostic imaging departments, staff were friendly, warm and professional, putting patients and their relatives at ease. Patients were treated with dignity and respect.

- In all clinical areas, there was adequate provision to protect a patient's privacy and dignity. In diagnostic imaging, there were areas for patients to change into gowns and to remain there until their appointment.
- Outpatients departments had suitable rooms for private consultations. Chaperones were available if required.
- Patients said staff were professional, polite, kind and helpful.

Understanding and involvement of patients and those close to them

- We observed staff did not always inform patients of waiting times. Patients said they were not told of any delays and how long they may have to wait.
- Most patients felt well informed and involved in the decision making about their care and treatment from start to finish. However, we saw the trust was one of the worst performing trusts on the Care Quality Commission (CQC) inpatient survey about patient involvement in decisions during treatment.
- Patients told us they had received information about their conditions and medicines.
- We observed staff supporting two patients and their relatives to understand their care and treatment in the radiology department.
- One patient said "I feel involved in the consultation" and another said "they could not fault them" and "were well looked after".

Emotional support

- We observed staff supporting patients in a compassionate manner. Making sure they had a drink and understood what was happening.
- Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviour during their visit to outpatients. We observed staff supporting a patient who was anxious and helped them to manage their anxiety while they waited to be seen.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated responsive as inadequate.

The trust struggled to meet demand for outpatient appointments. Patients were consistently unable to access services in a timely way for initial assessments, diagnoses and/or treatment. Referral to treatment waiting times did not meet the national target in some clinics including respiratory medicine, gastroenterology and dermatology.

Patients were not always followed up with in a timely manner. Patients and GPs were not informed when patients would not be seen within the recommended follow up times. This meant that the hospital failed to assess, monitor and mitigate risks relating to the health, safety and welfare of these patients.

Services were not planned, organised or delivered in a way that met patients' needs. Waiting times for patients varied on arrival in the outpatient clinics. Some patients could wait several hours to be seen and were not warned of this possibility. Appointments for clinics were often cancelled at short notice and rescheduled several times.

Outpatients' care pathways were adversely affected by the limited availability of beds and theatre time. Patients who required admission could face delays in starting treatment.

Service planning and delivery to meet the needs of local people

- We observed that patients attending the ophthalmology clinic were kept informed if the clinic was running late. They displayed waiting times on small whiteboards on each clinic room door. However, patients could not see the boards unless they were standing directly in front of the clinic room door as clinic room doors were off a long narrow corridor.
- We asked the ophthalmology staff whether patients would be able to see the board as the lettering was small and all patients at the clinic had problems with their vision. They said most patients came with a relative and they would be able to read it. We asked three patients if they had been informed about waiting times and if they knew there was a board with clinic

waiting times. Two patients and their relatives told us they were unaware and had not seen the board on the clinic room doors. This meant that patients were not always informed about waiting times.

- In the main outpatient area we did not see any information about how long patients might have to wait. We asked three patients if they had been told how long they might have to wait. They told us they did not know but commented that sometimes they went into clinic on time and other times they waited longer.
- The manager of ophthalmology told us the clinic area was going to be extended as the volume of patients was high, they did not have enough clinical space, and space was cramped. The trust was providing a "mobile clinical area outside the building". This was planned to open in October or November 2015. We observed staff making the best use of space they had.
- Some outpatient nurses felt that staffing was generally sufficient but more clinics were needed because of the amount of patients on waiting lists. And they would need more permanent staff to manage the additional workload.
- Managers and staff told us there were capacity issues which meant that there were an insufficient number of clinics to deal with demand.
- During our June 2014 inspection the Arkwright Suite, temporary accommodation used for outpatient services, was found to be cramped with insufficient soundproofing to protect patients' privacy. We were informed this suite would be used for a six-month period. However, during our announced inspection we found this was building was still in use and soundproofing issues remain.
- The annual reports and accounts for 2014/15 identified that the trust board had approved the purchase of a second CT scanner. The board meetings minutes for October 2015 identified that the CT scanner was due to be installed by the end of the year. This means that the trust would be able to increase their workload and decrease patient waiting list.

Access and Flow

- Some specialities used the NHS Choose and Book national electronic appointment system whereby patients were sent letters to inform them how to make an appointment at the time of their choice. However, staff told us patients were often cancelled after they booked so they could release appointments for patients about to breach the 18 week referral to treat (RTT) or urgent patients who needed to be seen.
- Some patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult. One patient said," it's very hard to get through and if you do no one answers and a message says "ring back, and you can't leave a message".
- A quarter of all outpatient clinics had been cancelled each month between February 2015 and May 2105. However the trust advised that many had been back filled by junior medical staff. We were unable to confirm details of how many had been backfilled as this information was unavailable.
- We spoke with six patients waiting to attend clinics in the outpatient waiting room. Three out of the seven patients had their appointments cancelled more than once. One patient said they had had their appointment three times. Two patients were happy with the time they waited for their appointments and were seen on time in clinic.
- Senior staff within the ophthalmology clinic told us doctors had "agreed to have clinics overbooked" to manage the volume of work. Staff in ophthalmology told us doctors would rather "see patients and save patients eyes." For example; we saw one consultant list which should have had a maximum of 13 patients but had 19 patients booked. Patients we spoke with told us they knew they would have to wait and were happy that they were seen. This meant that the trust could not assess and monitor clinic schedules.
- Audit results as of 17th September 2015 showed the average waiting time from arrival to being seen in clinic was 34 minutes. The shortest waiting time was 0 minutes and the longest was 125 minutes.
- The trust had been performing worse than the national average for the percentage of patients seen by a specialist within two weeks of an urgent GP referral apart from those for cancer waits. For example, there was a 15 week wait for urgent dermatology referrals and a 25 week wait for routine appointments.
- The trust were performing worse than the national average for the percentage of patients waiting less than 62 days from urgent GP referral to first definitive

treatment for cancer waits. They had been performing better than the national average for percentage of patients waiting less than 31 days from diagnosis to first definitive treatment for cancer waits.

- The trust was performing worse than the national average for the percentage of patients waiting six or more weeks for diagnostic treatment.
- We asked the trust for RTT figures for all outpatient clinics at Hereford Hospital. The trust told us they had not collected this information since April 2015. This was in agreement with NHS England. However, this meant the trust were unaware how long patients were waiting for follow up appointments.
- We spoke with administration, secretarial, nursing and medical staff and the referral management team directly who gave us information on waiting times from their information technology (IT) systems. This showed that there were long waiting lists for a number of specialties. For example, first cardiology appointments were averaging 15 to 20 weeks. Staff said "many would have breached before their first routine appointment". Staff told us that earliest non urgent follow up appointments for cardiology were March 2016.
- ENT was averaging 22 to 26 weeks and gastroenterology 26 weeks for routine appointments. Dermatology had a 15 week wait for urgent and 25 weeks wait for routine appointments. Staff told us this was because they were short of consultants.
- Urology routine appointments were seen within the 18 week RTT.
- We saw the August 2015 strategic objective report that looked at improving the responsiveness of our services for the benefit of our patients and their families. The trust had identified regarding their continued failure in reaching 18 week RTT and two week waits. The report identified the impact and consequence to these breaches and the actions to be taken such as managing the change process to alter patterns of working hours for nurses and doctors.
- We were unable to gather waiting time information for all clinics from staff as some specialities kept their own waiting list information and they were spread out across the hospital. This meant that there was no central location that collected, assessed and monitored waiting times.
- We were not assured patients were always followed up in a timely manner. For example, in dermatology we saw a paper waiting list for follow up appointments. Patients had been seen by a locum consultant who left the trust in April 2015. The locum consultant had requested follow up appointments for between eight weeks and three months. None of the patients had been followed up within the timescale. Staff said the patients GP's had not been informed and patients would not be seen within the recommended follow up time.
- In cardiology outpatient records, several patients follow up appointments had been cancelled by the trust. One patient's follow up had been cancelled several times and their planned follow up had been delayed by 12 months.
- We were not assured that any staff member would take responsibility for dealing with these patients and there was a potential for patients to be at risk of harm and that their condition would deteriorate whilst waiting. There was no system in place to monitor the risk to patients on the waiting list. This meant that the trust was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Meeting people's individual needs

- We saw that staff had the radio on in the Arkwright Suite to limit the risk of other patients overhearing, but this was not entirely successful. After the June 2014 inspection, a clinic room nearest the patient waiting area had been decommissioned. This had reduced the likelihood of patients in the waiting area nearest the room overhearing consultations. However, we found there was still insufficient soundproofing and conversations could be overheard. The manager told us a plan had been approved for a replacement facility and staff were aiming to move by December 2015. They said the trust had completed a risk assessment of the services provided within the suite and decided to continue with clinics, as cancelling clinics would be more detrimental for patients than continuing the service in a suboptimal environment. Patients we spoke with in the unit were positive about the service and raised no concerns about privacy with us.
- We saw there was a variety of seating arrangements available for patients in all outpatient waiting areas. For example raised chairs to enable patients to get up independently.

Outpatients and diagnostic imaging

- Information leaflets and notices were displayed to remind patients of the importance of notifying the radiologist of any associated risks. For example: if patients were pregnant?
- A translation service was available to enable staff to communicate with patients where English was not their first language. Written information was available in several languages and large print.
- The outpatients and diagnostics services in the main building were all accessible and patients could access on foot or use the lift.
- There was adequate seating and equipment available in all of the outpatient areas.
- Some vending machines and a coffee shop were available to patients.

Learning from complaints and concerns

- The percentage of complaints responded to trust wide was within 25 days was 72% themes included complaints about poor communication, appointment waiting times and cancellation of appointments. The response rate had improved but remained worse than the trust 90% target. To ensure improvement continued the trust had implemented weekly meetings between the complaints team, service unit links and the head of quality & safety to discuss the current position of all complaints. The meeting introduced a timeline of three days from the date the complaint was received to review the complaint and establish whether the complexity of the case would require an extended deadline.
- Cancellation of appointments was highlighted by two patients as an issue. One said they had been cancelled more than once for different clinics.
- The outpatient manager dealt with initial complaints that had not been able to be resolved by individual managers in each clinic department. If staff were unable to deal with a patient's concerns satisfactorily, they would be directed to the patient advice and liaison service (PALS).
- In most of the areas we visited information on how to make a complaint was displayed. There were some leaflets available in outpatients departments including comment cards, which patients could complete and post. The complaints process was detailed in the leaflets, but this did not inform patients of the timescales in which they could expect a response.
- Staff confirmed that they were aware of complaints and had received feedback via the staff meetings.
- The trust policy stated that there was no mandatory complaints training provided to staff, but it was provided on an ad hoc basis. The principles of good complaints handling were included in the policy. Where PALS received complaints that required investigation by managers there was an electronic system to delegate responsibilities and track progress of the complaint.
- Managers told us that analysis of complaints was completed by PALS and that feedback on any trends or themes would be provided if it was relevant to each department.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate.

We found the governance arrangements to be ineffective. Risks were not always identified, and when identified were not managed effectively or in a timely manner. The trust did not recognise the issue regarding the unavailability of patient records and they were unable to quantify the scale of the problem. Risks regarding the storage of records and equipment had been identified but not managed. This meant the trust was unable to deal with the impact of this adequately.

There were no effective systems for identifying and managing the risks associated with outpatient appointments at the team, directorate or organisation levels. For example, information was not consistently collected on waiting times, number of clinic cancellations, or how long patients waited for follow up appointments compared to recommended follow up times.

Significant issues that threatened the delivery of safe and effective care were not identified or adequately actioned, and actions to manage these issues were not always taken. For example, arrangements for managing medicines in radiology.

Staff told us it was difficult to get concerns discussed and actions taken when they highlighted issues that impacted patients and staff. Staff felt that trust leaders were out of touch with what was happening on the frontlines. There

was a lack of clarity about authority to make decisions and how individuals were held to account. However, managers in outpatient departments were accessible and well regarded by staff.

Vision and strategy for this service

- Staff told us the trust vision and values were changing. Some staff were able to describe the previous trust vision and how they incorporated that in their work.
- Outpatient managers told us of recent changes and recruitment that was taking place to develop the service. This included environmental changes and changes to staff structures**.**

Governance, risk management and quality measurement

- There were no regular audits undertaken to monitor the availability of records. Some outpatient departments recorded unavailable records as an incident, but other areas did not. This meant the trust was unaware of the extent of the problem and there was no effective audit process in place to check.
- Risks identified by staff and known to the trust were not all on the risk register. There was a difference in what staff raised as concerns and what were recorded as risks such as: the ophthalmology clinic's concern with the confidentiality and storage of patient's notes. There was no effective plan in place to manage these risks and this was not on the trust risk register. The manager told us they had not considered the risk to be high enough and it was their intention to monitor the situation locally.
- In August 2014 the risk register identified concerns raised by staff which stated there was "a clinical risk to patients due to increased clinic activity" leading to "typing and filing backlogs within cardiology, gastroenterology, geriatric medicine and respiratory specialties". This led to "delayed interventions and diagnostic procedures, non-achievement of 18 week RTT and five day turnaround of patient appointment outcome. The risk had been reviewed in October 2014 with an action plan detailing the need to "write a business case" for more administration staff, desks, computers and office space. However, we found that during our inspection staff told us the situation was the same.
- In August 2014 the medicine risk register identified "risk of harm to staff due to health and safety breaches within rheumatology, cardiology and ENT secretaries and consultants offices as the offices were small/confined, overcrowded and had an array of old furniture within". Other risks identified included corridors and fire exits partially blocked with patient notes on the floors, store rooms brimming with combustible materials, fire doors unable to be closed and workstations that would not conform to display screen equipment (DSE) regulations. We found during our inspection that doors were left open and unwanted visitors could gain access to offices where patient notes lying on floors.
- Administration and secretarial staff we spoke with across all specialities told us little had changed within the service. For example they were still waiting for more staff to be recruited and did not have enough storage space to store records. For example; in the ENT administration office every space was occupied. We saw records were kept on open shelves and the room was not locked at night. We did not see any escalation to the "executive committee" recorded on trust minutes.

This meant whilst the trust had been aware of problems and put a plan in place it was not effective. The action plan was not followed and no one was effectively monitoring the outcome. This meant that the trust could be in breach of the Health and Safety at Work Act 1974 and The Regulatory Reform (Fire Safety) Order 2005.

- Incident reporting was inconsistent and there were no governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and risk associated to patients waiting longer than the national standards. This meant the impact and risk to patients was unknown. The trust were aware RTT performance information they were gathering was inaccurate. In April 2015 the trust board requested suspension of national reporting for non-admitted and incomplete pathways as a result of concerns over quality data. From April 2015 onwards, the admitted RTT performance was the only measure reported. However, no effective governance measures had been put in place to ensure the trust were aware of the risk to patients regarding the length of time they may have to wait to be seen for clinical appointments.
- There were some structures in place to maintain clinical governance and risk management. For example quality and safety meetings. They reviewed trust key performance indicators (KPI's) for example complaints and Friends and Family Test feedback.

Outpatients and diagnostic imaging

- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and they felt able to report incidents and raise concerns through these processes.

Leadership of service

- Staff told us that local leadership within outpatients were good. Managers were approachable, caring and enthusiastic. Staff felt involved and keen to improve systems and processes to ensure patients received the best care. All outpatient managers told us they had an open door policy.
- Staff felt communication with the board and senior managers had improved and things were beginning to happen. However, some managers and clinicians were concerned about the time it took to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff. For example; in outpatients managers and staff did not know who had overall responsibility for monitoring waiting lists across outpatients and ensuring patients were seen within the18 week RTT.
- Specialities had their own systems and booking practices. This meant that leaders were out of touch with what was happening on the front line. There was a lack of clarity about authority to make decisions and how individuals were held to account.
- Staff in outpatients worked together to resolve any conflict and everyone shared the responsibility to deliver good quality care. Radiology staff said they had good leadership and they felt well supported.
- The trust had polices in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.

Culture within the service

- Staff did not receive supervision. The trust staff guide for supervision described it as a formal process, but there was no implementation of the process although there was a plan in place to roll out group supervision for band 6 nursing staff. This was due to start in the next couple of months.
- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatient departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us.
- Staff in outpatients departments spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.
- Most staff said they were proud of their service and felt a strong sense of loyalty within the teams. However, some staff said they were unhappy as they did not feel the service they gave to patients was good enough and they had no control over what happened.
- The "unlocking our Potential" programme linked to changing the culture within the trust. Actions already underway included; increasing staff engagement through increasing visible leadership and giving managers greater confidence to manage difficult issues through the People Leadership Programme.

Public engagement

- The trust gained patients views about services in a number of ways. They requested feedback from Friends and Family Test and we saw posters on notice boards throughout outpatients. The trust did not separate its responses into specialities so we were unable to determine how many responses were specifically about outpatient services.

Staff engagement

- Staff told us that they were emailed a trust newsletter. Most said they did read it regularly and found it useful.
- Throughout the inspection, staff were welcoming and willing to speak with us. Staff described their role and most showed obvious pride in their department. They were very warm and complimentary about their peers and the hospital environment.
- The staff survey for 2014/15 showed that 43% of staff had responded. The most improved areas were; giving feedback about reported errors or incidents and that they had adequate materials, supplies and equipment to do their job. Areas which were in the bottom 20% of the trust included; ensuring staff received an annual appraisal and staff agreeing their role made a difference to patients/people who used the service.

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- We saw information that the hospital had an Expert Patients Programme (EPP). This course is for anyone who had a long-term health condition and who would like to find ways of managing their illness more positively in order to improve their quality of life. The course is free and consists of six weekly sessions. It is led by two volunteer tutors who themselves have long term conditions and have attended an EPP course. This meant they understood the challenges patients faced in having health problems. Topics covered included managing symptoms, relaxation techniques, diet, exercise and communication skills.

Outstanding practice and areas for improvement

Outstanding practice

- 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 recently introduced a 'Saturday club' and had been involved in the ED Patient-Led Assessment of the Care Environment audit (PLACE) aiding the redesign of the children's waiting area. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must ensure safeguarding referrals are made as appropriate.
- The trust must ensure all staff have the appropriate level of safeguarding training.
- 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 and appraisal to meet the appraisal target of 90% compliance.
- The trust must ensure there are enough suitably qualified staff on duty within all services, in accordance with the agreed numbers set by the trust and taking into account national recommendations.
- The trust must ensure there are the appropriate number of qualified paediatric staff in the ED to meet standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing.
- The trust must ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum.
- The trust must ensure processes in place are adhered to for the induction of all agency staff.
- The trust must ensure ligature points are identified and associated risks are mitigated to protect patients from harm.
- The trust must ensure risk registers reflect the risks within the trust.
- The trust must ensure all incidents are reported, including those associated with medicines.
- The trust must ensure effective and timely governance oversight of incident reporting management, including categorisation of risk and harm, particularly in maternity services.
- The trust must review the governance structure for all services at the hospital to have systems in place to report, monitor and investigate incidents and to share learning from incidents.
- The trust must ensure that all trust policies and standard operating procedures are up to date and that they are consistently followed by staff.
- The trust must ensure all medicines are prescribed and stored in accordance with trust procedures.
- The trust must ensure patient records are stored appropriately to protect confidential data.
- The trust must ensure patient records are accurate, complete and fit for purpose, including 'do not attempt cardio-pulmonary resuscitation' forms and prescription charts.

Outstanding practice and areas for improvement

- The trust must ensure risk assessments are completed in a timely manner and used effectively to prevent avoidable harm, such as the development of pressure ulcers within ED and pain assessments for children.
- The trust must ensure that mortality reviews are effective with the impact of reducing the overall (SHMI) for the service.
- The trust must ensure there are robust systems are in place to collect, monitor and meet national referral to treatment times within surgery and outpatient services.
- The trust must ensure there are systems in place to monitor, manage and mitigate the risk to patients on surgical and outpatient waiting lists.
- The trust must ensure staff check the "site" of the operation to ensure this is appropriately marked, prior to the operation; and ensure that the "site" of the operation is documented on the 5 Steps to Safer Surgery checklist.
- The trust must ensure all incidents of pressure damage are fully investigated, particularly within ITU.
- The trust must ensure there is a policy available to ensure safe and consistent practice for parents to administer medicines to their children.
- The trust must ensure there is a system in place to recognise, assess and manage risks associated with the temperature of mortuary fridges.
- The trust must ensure clinicians have access to all essential patient information, such as patients' medical notes, to make informed judgements on the planned care and treatment of patients.
- The trust must ensure outpatients patients are followed up within the time period recommended by clinicians.

Action the hospital SHOULD take to improve

- The trust should ensure all vacancies are recruited to.
- The trust should ensure that complaints are responded to within the trust target of 25 days and lessons learnt shared.
- 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.
- The trust should ensure all equipment is portable appliance tested annually.
- The trust should ensure there is an effective audit program and the required audits are undertaken by the services.
- 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 EDs.
- 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 ED to be admitted, discharged or transferred within four hours.
- The trust should ensure re-attendance rates within ED are reduced to meet the target set by the Department of Health.
- The trust should ensure the changes to manage overcrowding and patient safety in ED are sustainable.
- The trust should ensure infection controls risks, associated with environmental damage within ED, are mitigated.
- The trust should ensure changes continue to achieve adequate patient flow and capacity to accommodate emergency admissions in a timely way, ensure surgery cancellations are reduced and enable patients to be discharged from ITU in a timely way.
- The trust should ensure patients privacy and dignity is maintained when cared for the in the ED corridor.
- The trust should ensure the improvement of mental health service provisions within ED to prevent delays in specialist care.

Outstanding practice and areas for improvement

- The trust should ensure that the ED Escalation Management System (EMS) is used accurately and effectively to help the hospital identify the pressure within the ED and appropriate steps taken to reduce pressure as required.
- The trust should ensure that appropriate plans in place regarding all patients being assessed and treated as requiring a deprivation of their liberty safeguard.
- The trust should ensure unnecessary patient moves are minimised at night.
- The trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.
- Action should be taken to ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.
- The trust should ensure on the day surgical cancellations met the standard target.
- The trust should consider a follow-up clinic for patients discharged home from after an ITU admission, as recommended in NICE guidance.
- The trust should ensure the frequency of ward rounds on critical care meet core standards for critical care units.
- The trust should consider the critical care outreach team providing 24-hour cover for the hospital as recommended in the Guidelines for the Provision of Intensive Care Services 2015.
- The trust should ensure nutritional supplements are disposed of as per product guidance.
- The trust should implement the use of the NHS Maternity Safety Thermometer, and ensure robust analysis.
- The trust should ensure measures are in place to reduce the caesarean section rate.
- The trust should consider developing an early warning tool for neonates.
- The trust should ensure that all appropriate equipment is cleaned in line with trust policy to prevent the spread of infection.
- The trust should ensure appropriate staff are adequately trained in
- The trust should ensure that there is a system in acute paediatric services to check competencies of permanent staff.
- The trust should ensure there are a suitable number of points for high flow oxygen on the paediatric ward to meet patient need.
- The trust should ensure the trolley used for transporting bodies to the mortuary is fit for purpose.
- The trust should ensure cancellation of outpatient appointments are reviewed and necessary steps taken to ensure that issues identified are addressed and cancellations are kept to a minimum.
- The trust should ensure a suitable digital archiving system for cardiology department is provided.

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.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...