Wye Valley NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Inadequate
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Wye Valley NHS Trust 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's catchment area is characterised by its rural nature and remoteness, with more than 80% of service users living five miles or more from Hereford city or a market town. The trust has 387 beds and provides a full range of district general hospital services.

We inspected the trust in June 2014 and gave an overall rating of 'Inadequate', with particular concerns about the provision of services in both urgent and emergency services and medical care services. The inspection led to the trust being placed in special measures by the Trust Development Authority in October 2014. The trust developed a patient care improvement plan in order to implement improvements. An improvement director was appointed by the Trust Development Authority and commenced work in February 2015 to assist the trust to progress.

We undertook an announced inspection of Hereford Hospital, Bromyard, Leominster and Ross Community Hospitals between 22 and 24 September 2015. We undertook unannounced inspections on 25 September 2015 at Leominster Community Hospital and 1 October 2015 at Hereford Hospital.

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.

There were some areas of improvement from the previous inspection particularly within community services and urgent and emergency service. However, there were areas where significant improvement was required.

Overall, we rated Wye Valley NHS Trust 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.

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.

All community services were rated as good, with the exception of community inpatient services and community end of life care which were rated as requires improvement.

Overall we have judged the services at the trust as good for caring. Patients were treated with dignity and respect and were provided with appropriate emotional support. We found caring in community adult services to be outstanding.

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.
- Equipment was not always appropriately checked and maintained.
- Recruitment was a significant risk for the trust.
- The trust had high vacancy levels across both nursing and medical staff. With some areas having vacancy levels in excess of 40% for nursing staff at the time of the inspection.
- Temporary staff usage was high and temporary staff did not always receive an effective induction.
- Staff did not always have the appropriate training.
- A recruitment programme was ongoing and changes had been made to speed up the recruitment process. Oversees recruitment had taken place.
- 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.

Summary of findings

- Monitoring by the Care Quality Commission had identified mortality was above the expected range of 100 with a value of 114. The trust were implemented a series of actions to address this concern.
- The trust were not consistently meeting the national targets set regarding patients access to treatment and there was lack of oversight of the risk this presented to patients.
- The trust were not meeting the standard for patients admitted, referred or discharged from the emergency department within four hours.
- The trust did not have effective governance oversight of incident reporting and management, including categorisation of risk and harm. Incident management was not effective as to allow for the timely mitigation of the risks relating to the health, safety and welfare of service users.
- There was a lack of knowledge amongst trust staff with whom we spoke about when to make safeguarding referrals.
- Staff generally felt they were well supported at their ward or department level.
- Visibility of the executive directors had improved since the last inspection.

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 are; and had been involved in interviewing new staff in community services for children and young people. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.
- Compassionate care and emotional support provided by community adult service teams was excellent. Staff had a clear focus for providing best possible care and improving the well-being of patients they saw.
- Community services for children and young people had submitted a proposal for a group project incorporating local health visiting teams, children's centres, the local community and various members of the multi-agency team. The aims of the project were to: provide support and information to families on how to achieve healthy lifestyles; promote and support and encourage sensible weight management; enhance families ability to cook health nutritious meals; increase families social networks and therefore their social capital, leading to increased self-esteem and self-confidence; enhance links within the community by incorporating volunteers from within the community to help within practicalities of running groups on a regular basis; encourage links to other services within the community that promote lifestyle change, such as local gyms and swimming pool.
- Health visitors in Leominster supported children in need at Christmas with a Christmas hampers project by utilising local community charities and food bank services to donate food hampers for families in need.
- Health visitors at Ross Community Hospital had an allotment project to improve community engagement and encourage healthy eating. HVS had worked with a local charity to access allotments, for use by local communities to grow their own produce and share with families who had food and nutritional needs.
- A member of the Leominster SNS team had won a prize from a national professional journal for producing a domestic abuse peer support programme.
- The development of 'Fresh Eyes Peer Review', for complaints, which is an excellent example of a non-threatening, transparent, open and supportive initiative in organisational learning.
- The education team had effective plans in place and appropriate clinical direction. The team had been well embedded for some years and that the team was a beacon of good practice within the trust.

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.

Summary of findings

- The trust must ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust must ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- The trust must ensure staff receive 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.
- 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.
- The trust must ensure that the categorisation of incidents is completed accurately and full investigations are carried out as appropriate, including the identification of themes to ensure relevant actions are implemented.

Summary of findings

- The trust must ensure that governance systems in place are effective. This includes ensuring practices are consistent, in line with hospital policies, and documents are approved through the clinical governance structure.

Following the inspection we issued Hereford Hospital with a warning notice under section 29a of the Health and Social Care Act 2008. On the basis of this inspection, we are recommending the trust remains in special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Wye Valley NHS Trust

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's catchment area is characterised by its rural nature and remoteness, with more than 80% of service users living five miles or more from Hereford city or a market town.

The trust has 387 beds and provides a full range of district general hospital services. There are 312 beds within Hereford Hospital of which 289 are general and acute, 17 are maternity and six are critical care.

There are 98 community inpatient beds across four community hospitals. These are Bromyard Community Hospital, Hillside Intermediate Care Centre, Leominster Community Hospital and Ross Community Hospital. The inpatient services provided are predominately rehabilitation, with patients transferred from Hereford Hospital.

The trust has been in special measures since October 2014. An improvement director was appointed part time by the Trust Development Authority in February 2015, whose role has been to support the trust's improvement plan.

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.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included 18 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, a health visitor, a looked after children's nurse, a specialist dental adviser, a district 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 of 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.

Summary of findings

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 unannounced inspections on 25 September at Leominster Community Hospital minor injuries unit and 1 October 2015 at Hereford Hospital, including attending the trust board meeting.

During our announced inspection 22 to 24 September 2015 we visited Hereford Hospital, Bromyard, Leominster and Ross Community Hospitals, Hillside Intermediate Care Centre; and visited two dental access centres, Dishley Street Dental Clinic and Gaol Street Clinic.

We also visited the largest community children and young person's service at 1 Ledbury Road where there was a health visiting team community paediatric nursing team, community paediatric occupational therapists and community paediatric physiotherapists. 1 Ledbury Road housed a nine bedded respite centre for children and young people with learning disabilities, sensory impairment, and physical disabilities. The centre was scheduled to close in March 2016.

We held focus groups with a range of staff in both the Hereford Hospital and Bromyard Hospital. The focus groups included including nurses, junior doctors, consultants, health care assistants, midwives, allied health professionals, ancillary staff and clerical staff. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient 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

What people who use the trust's services say

During and post inspection we talked to patients across the trust. Most of the responses we received were positive about the services they had received with praise mainly relating to the level of care and compassion staff had shown them. Examples of comments included:

- "Help and support has been wonderful."
- "Absolutely would recommend."
- "Cannot fault treatment or staff, all excellent, first class all round."
- "The staff go above and beyond."
- "Everyone involved has been professional, helpful and caring."
- "Treatment and staff are superb."
- "I feel involved in the consultation"
- One patient said regarding outpatients, "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"".

Facts and data about this trust

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.

The trust employs 2482 whole time equivalent (WTE) staff, of whom 266 WTE are medical, 808 WTE are nursing and 1408 WTE are other staff including allied health professionals, ancillary and administration staff.

Summary of findings

In 2014/15 the trust's revenue was £182.6m. In September 2015 there was a forecast deficit of £19.9m for the 2015/16 financial year.

The health of people in Herefordshire is generally better than the England average. Deprivation is lower than average, however about 4,700 children live in poverty. Life expectancy for both men and women is higher than the England average. However, life expectancy is 4.8 years lower for men and 4.1 years lower for women in the most deprived areas of the county than in the least deprived areas.

Over the last 10 years, mortality rates have fallen. The early death rate from heart disease and stroke has fallen. Levels of teenage pregnancy among those under 18 years is worse than the England average, but breast feeding initiation rates are better than the England average. Estimated levels of adult smoking and physical activity are better than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average. About 18% of year 6 children (aged 10 and 11) are classified as obese.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust was inadequate with regards to safety. We found that five of the 13 services in the trust required improvement and five services were rated inadequate for safety. For September 2015, across the trust there was 69% compliance with adults level 1 and a 70% children level 1 safeguarding training, against a trust target of 90%. Arrangements were in place for reporting safeguarding concerns. However, staff did not always follow these arrangements and were not all confident in the reporting procedures. This meant that service users were not always protected from abuse in accordance with regulatory requirements. There had been 13.7 incidents per 100 admissions between May 2014 and May 2015, which is higher than the national average. There had been two never events during the same period. Incidents in some areas were not investigated in a timely manner and were closed before investigations were completed. This meant that an effective system was not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients in this department. Medicine incidents, such as missed doses were not always incident reported. The self-medication policy was not followed, so patients were unable to take their own medicines when they needed to. In radiology, medicines were administered by radiographers without a prescription or a patient group directive in place. In the emergency and the paediatric department, we identified equipment and environments that posed a ligature point and therefore was a risk to patient safety. We observed that preoperative safety checklists were not always completed properly. There was a high vacancy rate and an above the national average use of staff from agencies. Not all agency staff had undergone an induction. There was no clinical supervision in place for nurses in surgery, the outpatient department and acute paediatric services, or for junior doctors in community inpatient services.	**Inadequate** 

Summary of findings

The emergency department did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all emergency departments for 16 hours a day, 7 days a week.

The trust had developed a 'Fresh Eyes Peer Review', for complaints.

Duty of Candour

- Most of the staff we spoke with were aware Duty of Candour, in that they knew that if there was an incident or a complaint that the trust would be open with the patient. The trust had developed an excellent leaflet to support the staff's knowledge. However, it was acknowledged that the process was not fully embedded with all staff.
- The trust had developed a 'Fresh Eyes Peer Review' for complaints, which was an excellent example of a non-threatening, transparent, open and supportive initiative in organisational learning.

Safeguarding

- For September 2015, across the trust there was 69% compliance with adults level 1 and a 70% children level 1 safeguarding training, against a trust target of 90%.
- The trust employed a safeguarding lead for children, who had overall responsibility for compliance with Section 11 of the Children's Act 2004. They were also responsible for quality, with regards to children's safeguarding, policy development and training.
- The adult safeguarding lead had similar responsibilities with regards to training and policy development. There was a plan to employ an additional band 5 nurse, as it had been recognised that the number of concerns and referrals had risen as a result of The Care Act 2014 and increased awareness of staff with regards to reporting concerns.
- Both leads were trained to safeguarding level 4. Both delivered a range of training to all staff, which was a combination of e-learning, and face to face.
- There were two lead doctors for safeguarding.
- There had been 212 safeguarding alerts raised by the trust since 1 April 2015.
- In the paediatric ward we reviewed six patient notes and found that there had been no safeguarding referrals for five children who required a referral. These were patients who had been admitted with overdose/self-harm. We also observed three additional patients who presented during our inspection. All three required a safeguarding referral in line with the trusts

'Safeguarding and promoting children health and welfare policy'. However, trust staff had only referred one of these three patients and CQC staff prompted trust staff to consider patient referrals for the other two patients. 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.

Incidents

- Most staff told us that they were familiar with the incident reporting process and that they received feedback when they reported concerns.
- There had been 156 serious incidents and 5,317 incidents reported to the National Reporting and learning System (NRLS) between May 2014 and May 2015, which equates to 13.7 incidents per 100 admissions which is higher than the national average. Of these 95% caused no, or were graded as causing low harm.
- There had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), 20 cases of **Clostridium difficile** and five of Methicillin Sensitive Staphylococcus Aureus (MSSA) for 2015/16.
- During the past year, the trust had recorded 95 pressure ulcers, grade two, three or four, 44 falls and 33 catheter urinary tract infections.
- 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. One never event was where a guidewire was left in place, which should have been removed following the procedure. The other was where the wrong sized component was implanted during a joint replacement.
- 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. We saw another patient's notes in critical care, where the "site" of the operation had not been documented on the 5 Steps to Safer Surgery checklist. This meant there was a risk of the operation being performed on patients at the wrong site amounting to occasioning avoidable harm.
- We saw that that the trust approach to incident management was slow and did not enable timely assessment of the risks

relating to the health, safety and welfare of patients. We saw that across maternity and gynaecology there 121 open incidents awaiting investigation with 106 of these overdue. In addition, there were 52 incidents on hold undergoing investigations and 138 incidents waiting for final approval.

- We saw in children's and young people's services that incidents were sometimes closed before the investigation had been completed. In children's and young people's services we looked at 23 incidents that were reported and closed in August 2015. Seven incident summaries indicated that the actions taken did not address the issues raised. One incident regarding a staff member about to use non-sterile scissors for a dressing change had no actions taken or lessons learnt documented. This meant that the hospital was failing to assess, monitor and mitigate risks relating to the health, safety and welfare of patients using children's and young people's services.
- The trust used the electronic reporting system's home page to highlight individualised issues to ward sisters about their areas. This meant the senior staff were immediately aware of any incidents that had happened in their department as soon as they logged onto the system.

Medicines

- Medicine incidents were not always reported. Staff knew that medicine incidents should be reported. However, they said that they often did not have time to complete the online reporting form.
- Despite the availability of learning from medicine incidents on the trust's intranet we found a lack of consistent arrangements in place to share and discuss good practice at ward level. The Medicine Safety Officer (MSO) explained that learning from reported medicine incidents was undertaken, however agreed that governance arrangements within each directorate to cascade learning to all staff could be improved. It was a particular challenge to ensure agency nurses were involved in shared learning. This meant that the trust did not have an accurate overview of incidents surrounding medicines.
- Although arrangements were in place to enable inpatients to self-medicate during their stay in hospital the hospital policy was not followed.
- There was no policy available for parents to administer medicines to their children.
- In the imaging department we found that radiographers were administering intravenous medicines, without a signed prescription or a patent group directive (PGD) in place. A PGD is used when prescription only medicines are administered to

groups of patients without individual prescriptions. They are commonly used when medicine is used as a routine, for example, contrast media. Healthcare workers, such as nurses and radiographers should be trained to administer PGDs. The pharmacy department were supplying these routine medicines, but had assumed they were prescribed for individual patients by a doctor. We raised this with the trust at the time of inspection who took action to address this.

Assessing and responding to patient risk

- We were assured that there was an appropriate level of corporate attention and senior leadership provided for infection prevention and control. In particular, we were assured that there was positive non-executive director challenge and support for these activities and that external relationships, for example with commissioners, were positive and focused on patient pathways rather than rigid boundaries.
- The hospital did not collect data on unavailable notes in clinics. There was not a consistent process in place to manage the use of temporary notes this 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.
- The Escalation Management System (EMS) scoring in the emergency department did not always reflect the pressure in department seen on inspection. This meant that other services in the hospital did not respond to the risk in a timely way staff told us this was a frequent occurrence.

Staffing

- The trust recognised that there were challenges recruiting and retaining staff in all areas. We saw the trust's recruitment and retention strategy document dated July 2015 that had been approved by the board in July 2014, covered the period 2014 to 2019. The objectives were set into short medium and long term goals: Initiatives to reduce workforce bill, initiatives to become employer of choice and initiatives to improve workforce planning.
- The medical staff human resources recruitment policy was reviewed. It was up to date and described all the appropriate areas. It had been properly ratified and gave assurance that the policy was fit for purpose.
- 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.
- Staffing gaps were not always adequately covered and there was an overreliance on unregistered staff to replace registered nurses in some areas.
- On medical wards we found agency staff were not always inducted and found evidence of this impacting on patient care. For example, we saw an incident reported relating to agency staff where a patient's medicine doses had been missed.
- 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.
- 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.
- Up to six consultants were available in the emergency 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. This did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all emergency departments for 16 hours a day, 7 days a week as a minimum.
- The trust had a governance system in place which gave assurance that all doctors and nurses were registered whilst at work.
- The mix of medical staff was similar to the national average with slightly more consultant and junior doctor positions.

Summary of findings

- There was no clinical supervision in place for nurses in surgery, the outpatient department and acute paediatric services, or for junior doctors in community inpatient services.
- There was no system in acute paediatric services to check competencies of staff. This meant that we were not assured staff received appropriate supervision necessary to enable them to carry out the duties they were employed for.

Equipment and Environment

- The facilities and premises were not all appropriate for the services they provided. 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.
- In the emergency and the paediatric department, we identified equipment and environments, such as blind cords and a false ceiling, which posed a ligature points and therefore was a risk to patient safety. These had not been identified or risk assessed by the trust and we highlighted these risks to them.
- Equipment was not always stored in an appropriate way.
- Equipment was not always checked or maintained appropriately there were particular issues within the radiology department with the checking of protective radiology equipment for staff and patients. The trust addressed that at the time of inspection.
- Clinical waste was not always appropriately stored
- Areas were generally clean.

Are services at this trust effective?

Requires improvement

The trust required improvement with regards to effectiveness. We found that eight of the 12 services rated within the trust required improvement and four services were rated good for effectiveness.

The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated more patients were dying than would be expected for the period April 2014 to March 2015. This had been reported to the trust board and an action plan was in place to understand and improve results.

Mental Capacity Act 2005 assessments were not routinely carried out on patients who had been subjected to a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) assessment.

There was no Deprivation of Liberty Safeguards (DoLS) or MCA lead for the trust. There was a two month delay between applications

made by the trust and approval by the local authority. At the time of our inspection there were 22 DoLS applications outstanding. We found patients were, in effect, deprived of their liberty without a standard DoLS authorisation in place.

Policies and care bundles were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet. However, some policies were in need of a review and standard operating procedures were not always in place.

We saw some good examples of multi-disciplinary working across the trust. Staff appeared to know each other well and worked together as a team in most services.

Evidence based care and treatment

- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- 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 which needed review in October 2014.
- The trust had a series of care bundles in place, based on the appropriate 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.
- Standard operating procedures were not always in place. For example, for the use of the pain chart used in community inpatient settings.

Patient outcomes

- 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.
- Emergency department re-attendance rates was 7.3% within seven days between January 2013 and March 2015. This was worse than the standard of 5.5% set by the Department of Health.
- The trust was worse than the England average for elective readmission risks at 145 compared to the England ratio of 100 patients. The non-elective risks for readmission was better than the England average with the exception of ENT which was at 185 patients.

Multidisciplinary working

- We saw some good examples of multi-disciplinary working across the trust. Staff appeared to know each other well and worked together as a team in most services.
- A new medical director had been in post since March 2015. Prior to this many of the consultants were reported to be disengaged from the trust and how it worked. However, over the last year there had been new appointments, new services introduced, for example acute medicine and the consultant body were working through the medical director and were engaging with the executive team and the board.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was no Deprivation of Liberty Safeguards (DoLS) or Mental Capacity Act 2005 (MCA) lead for the trust. This had been identified on the trust's risk register since February 2015. However, we saw no evidence that progress had been made to mitigate the risk and appoint a dedicated trust lead. At the time of the inspection the adult safeguarding lead was undertaking this role.
- We were told that there had been 282 DoLS applications in 2014 and 210 for 2015 at the time of the inspection. There was a two month delay between applications made by the trust and

approval by the local authority. At the time of our inspection there were 22 DoLS applications outstanding. The trust had not undertaken any audits on the efficacy of MCA assessments or DoLS applications.

- 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. The service was not carrying out any DoLS audits.
- We looked at 38 DNACPR forms across all inpatients. In 23 cases we saw that decisions had been made about patient's capacity where there was no evidence of mental capacity assessments being completed or documented in the patients' notes. This meant that staff who obtained consent from people who use the service did not comply with the Mental Capacity Act 2005 and the Code of Practice. In addition, the trust were not doing all that is reasonably practicable to diminish any risks associated with the safe care and treatment of patients with DNACPR instructions in place.
- We examined 13 patients' case records within surgical wards and theatres. 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. There was no evidence of staff obtaining consent from people who use the service adhering to the Mental Capacity Act 2005 and the Code of Practice.

Summary of findings

Are services at this trust caring?

Good

We found community adults services were outstanding for caring. We rated all other trust services as good for caring. Staff were caring and compassionate to patient needs and treated patients with dignity and respect. Patients said they were kept informed about and felt involved in the treatment received.

Most patient's felt supported and would recommend the trust to their family and friends.

Patients, their families and carers were exceptionally positive about the care and treatment they received from adult community services which we rated as outstanding. We witnessed positive interactions throughout all community services, staff provided holistic care, focusing not only on improving patients' physical conditions but demonstrated a strong emphasis on wellbeing and emotional support.

Staff within community adult services took patients additional needs and current health conditions into account during assessments and treatment, altering communication to ensure patients were involved in decision making.

We observed staff demonstrating good communication skills during interactions with children, young people and families. Staff gave clear explanations and checked children, young people and their parents/carers understanding.

Compassionate care

- We witnessed patients treated with compassion, dignity and respect.
- We observed caring and compassionate interactions between staff and patients.
- Most patient's felt supported and well-cared. Patients, their families and carers were exceptionally positive about the care and treatment they received from adult community services.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Patient feedback from the NHS Friends and Family Test (FFT) showed that between August 2014 and February 2015, the trust performed better than the England average, in that between 96% would recommend the trust to their family and friends consistently that most patients would recommend adult community services to friend and family in all areas, with the exception of the emergency department.
- The emergency department had worse than the national average (88%) FFT scores for June and July 2015, 71% and 75%

respectively. 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

- Most patients felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that patients could understand and was appropriate and respectful.
- Staff within community adult services took patients additional needs and current health conditions into account during assessments and treatment, altering communication to ensure patients were involved in decision making. We observed this in a falls assessment clinic with physiotherapy staff providing a first assessment to a patient with dementia. Time was taken to communicate in a way the patient understood and allowed them to be part of the decision making process.
- We observed staff demonstrating good communication skills during interactions with children, young people and families. Staff gave clear explanations and checked children, young people and their parents/carers understanding.

Emotional support

- Patients received appropriate support to cope emotionally with their long term conditions. We witnessed positive interactions throughout all community services, staff provided holistic care, focusing not only on improving patients' physical conditions but demonstrated a strong emphasis on wellbeing and emotional support.
- During home visits with the district nursing team we saw an example of a patient who had struggled to engage with healthcare professionals previously and had self-neglected for a long period. Following involvement from the team the patient described a dramatic improvement in their wellbeing and social aspects of their life. The patient stated that the care provided from community nursing teams had not only improved their physical condition but given them a better quality of life from their emotional care.
- The Cancer Patient Experience Survey for 2014 showed that that the trust performed broadly in line with other trusts in England.

Summary of findings

- The CQC inpatient survey for 2014, again demonstrated that the trust performed in line with other trusts, except for the question, 'Were you involved as much as you wanted to be in decisions about your care and treatment?' This showed a worse performance compared to others.

Are services at this trust responsive?

Inadequate 

We rated the trust as inadequate with regards to being responsive. Surgery and outpatient and diagnostic services were rated inadequate for being responsive. We found that eight of the 13 services in the trust required improvement for being responsive.

The trust were not consistently meeting the national targets set regarding patients access to treatment and there was lack of oversight of the risk this presented to patients. The hospital was not effectively recording or reporting waiting times for surgery or outpatients. Evidence showed that there were long waiting lists for a number of specialties.

Patients within the emergency department waited longer that was acceptable. The trust was consistently failing to meet meeting the standard for patients admitted, referred or discharged from the emergency department within four hours and some patients waited longer than 12 hours.

Overcrowding was an issue in the emergency department with patients receiving care within the ambulance corridor. Although staff took measures to protect the patients privacy and dignity this was not always effective.

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 had some systems in place to meet individual patient needs, for example the Frailty unit had14 beds for patients living with a dementia, where care was provided by staff who had received dementia awareness training. However, mental health provisions did not always meet patient needs.

The trust had actions plans to improve the delivery of services to meet patient needs. Including a new purpose built 16 bedded Frailty unit, additional surgical slots and six hyper acute stroke beds

Summary of findings

Systems and processes were in place to advise patients and relatives how to make a complaint. A 'Fresh Eyes' review was undertaken on a sample of complaints, whereby a member of staff from another department would assess learning from complaints in another department.

Service planning and delivery to meet the needs of local people

- The patient care improvement plan (PCIP) outlined objectives to help tackle capacity issues. 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 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. However, given the trusts level of vacancies and recruitment challenges it was unlikely this would occur at that time.
- The service did not provide a hyper acute stroke service during our inspection, and services were provided by another local NHS trust. However, new commission meant that the service opened six hyper acute stroke beds in October 2015 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 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 facilities and premises were not all appropriate for the services they provided. 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 affected the delivery of national targets such as waiting times. This meant there was a risk of harm to staff and patients and the continued ability to provide inpatient care due to the age and condition of the hutted wards.

- 1 Ledbury Road, a children's respite service, was due to close in March 2016. The manager told us the decision to close the respite centre was due to a more individualised model of respite care with increased levels of integrated working being introduced by the local authority. The trust were working with the CCG and local authority to ensure children had new respite stay offers prior to any full service closure.

Meeting people's individual needs

- 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.
- The needs and wishes of patient's with a learning disability or of patients who lacked capacity were understood and taken into account. 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.
- Staff knew how to access interpreting services.
- During visits with district nursing teams we saw care of a patient with chronic mental health problems and they showed a full understanding of how these their conditions affected their compliance with self-care, giving advice to the patient accordingly.
- Mental health provisions did not always meet patient needs. For example, we were told that psychiatric care and support was difficult to access at the community hospitals. Also Child and Adolescent Mental Health Services covering the emergency department 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.

Dementia

- 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 not a formal designated lead currently driving the strategy forward so it had "stalled".
- 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.
- 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.
- 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.
- Community therapy and nursing teams had good knowledge of how to improve care for those living with dementia.

Access and flow

- 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.
- Overcrowding was an issue in the emergency department with patients receiving care within the ambulance corridor. Although staff took measures to protect the patients privacy and dignity this was not always effective.
- The trust was unable to mitigate the risks regarding referral to treatment times (RTT) because it was not fully aware of the scale of the problem. The trust was not able to evidence that they had oversight of the risk this presented across all specialities.The trust had not been effectively collecting and reviewing RTT for outpatient (admitted and non-admitted) pathways at Hereford Hospital. However, administration and secretarial staff provided evidence on waiting times from the information technology systems. We saw first appointment waiting times for ear, nose and throat (ENT) were between 22 and 26 weeks; gastroenterology had a 26 week wait for routine new appointments; dermatology had a 15 week wait for urgent referrals instead of two weeks and a 25 week wait for routine appointments. There was an increased risk of harm to patients due to the lack of clinical triage of the patients who were waiting, particularly of the patients who were waiting over 18

weeks for appointments. The trust's patient care improvement plan (PCIP) showed that the objective to improve outpatient response times was overdue. The initial deadline for completion had been set for the end of November 2014, and then extended to the end of March 2015; however the PCIP dated 21 September 2015 provided by the trust showed the objective remained overdue. Yet, the trust provided formally collected data showing the first appointment waits were 10, 11 and eight weeks, for ENT, gastroenterology and dermatology respectively. The data provided did not correlate to the waiting lists that we saw during the inspection. This meant that the trust's systems and processes that were established did not operate effectively to monitor the outpatient waiting time data and allow the trust to clinically prioritise patients.

- 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.
- We were not assured patients were always followed up in a timely manner. In dermatology outpatients we saw a waiting list for follow up appointments. Patients had been seen at an appointment by a locum consultant who left the hospital in April 2015. Twenty-five patients, including adults and children, required further dermatology appointments. The 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' GPs had not been informed that patients would not be seen within the recommended follow up time.
- In surgery 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.
- 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.

Learning from complaints and concerns

- Systems and processes were in place to advise patients and relatives how to make a complaint. Information was displayed within the department and leaflets were available to patients.
- The trust aspired to acknowledge receipt of a complaint within three days and provide a response to a formal complaint with 25 working days. In 2014/2015 the trust acknowledged 100% of formal complaints within three working days and 77% of complaints were responded to within the agreed deadline. This had improved compared to 2013/14 where the trust acknowledged 98% of formal complaints within three working days and 73% of complaints were responded to within the agreed deadline. We saw that over the last three years complaints had remained fairly static at an average of 250 per year. The top five themes were:
  - Admission/discharge/transfer arrangements
  - Clinical treatment
  - Appointment cancellation and delay
  - Attitude of staff
  - Communication
- Complaints could be raised in a variety of ways, in person, verbally, in writing and electronically.
- All staff who were involved in complaints management had undergone training, which had been facilitated by a solicitor who specialised in medical negligence.
- Early on in the investigation the complainants were telephoned to ascertain if they wanted a meeting. Staff were encouraged to apologise to complainants.
- Any upheld complaints required an action plan which was added to the particular service unit's improvement plan. One in ten of these were checked by the head of quality and safety, to ensure that learning had taken place.
- Partially held complaints were reviewed by the head of quality and safety to ascertain if there should have been any shared learning. If this was found to be the case, details of the compliant added to the monthly team brief, so that all staff were made aware.

Summary of findings

- All service units undertook monthly clinical governance meetings which were attended by a member of the patient experience team to discuss complaints and learning arising from them.
- A 'Fresh Eyes' review was undertaken on a sample of complaints, whereby a member of staff from another department would assess learning from complaints in another department. This was open to all staff. We asked how this was done in view of staff shortages in all departments, we were told and saw evidence that 100 staff gave up their own time to take part.

Are services at this trust well-led?

Requires improvement

We found that eight of the 13 services in the trust required improvement for being well led. Outpatient and diagnostic services were rated inadequate for well-led.

The trust had recently developed their vison, their mission and their values, which 10% of the staff had been involved in the development. These were not yet fully embedded or understood by staff at the time of the investigation.

Following the trust being placed into special measures in October 2014, a patient care improvement plan (PCIP) was developed. We found that there was limited consideration given to whether the actions taken had achieved the required objective and there was limited monitoring of outcomes.

The trust did not have effective governance oversight of incident reporting and management, including categorisation of risk and harm.

We were not assured that the organisation had a clear framework in place for ensuring that registered nurse to assistant practitioner delegation was appropriate. There was no medical workforce plan in place. However, there was a plan to produce one by March 2016.

There was a lack of policy development, workforce strategy or education for allied health professionals.

Both the Board Assurance Framework (BAF) and the corporate risk register were reviewed and although the majority of the organisation's key risks were represented there was not detailed reference to the risk of the organisation not having effective processes in place or oversite of the issues relating to RTT and the relevant mitigation required.

We were assured that appropriate steps had been taken to manage the 'Fit and Proper persons' legislation implementation.

Summary of findings

Recent appointments to the executive team were seen in a positive light by all staff we spoke with.

There had been improvements in the visibility of the executive team since the previous inspection in most areas

There was recognition that the organisation given its size and location needed to work differently to provide a sustainable model for delivery of sustainable services to its population. This was actively progressed by the chairman and chief executive officer.

Vision and strategy

- The trust had recently developed their vison, their mission and their values, 'Compassion, Accountability, Respect and Excellence'. The trust was proud that 10% of the workforce had been involved in developing their values.
- These were not fully understood or embedded at the time of the inspection having recently been developed.

Governance, risk management and quality measurement

- Both the Board Assurance Framework (BAF) and the corporate risk register were reviewed and although the majority of the organisation's key risks were represented there was not detailed reference to the risk of the organisation not having effective processes in place or having oversite of the issues relating to RTT and the relevant mitigation required.
- We saw that there was a risk management reporting structure. The individual service units governance, performance, quality audit and finance reported into the trust board. The trust board were responsible for reviewing any incidents that were rated above 12, which are incidents that have been assessed as major/have or could cause harm/have a high risk of reoccurring.
- The trust did not have effective governance oversight of incident reporting and management, including categorisation of risk and harm. Incident management was not effective as to allow for the timely mitigation of the risks relating to the health, safety and welfare of service users. Incident investigations and actions identified did not always address the issues identified.
- There was no evidence from the investigation reports of effective executive or senior review and sign off for completed investigations and learning was not always appropriately identified.

Leadership of the trust

Summary of findings

- Both the chairman and chief executive joined the trust in June 2014 and were passionate about wanting to see improvements within the organisation.
- The executive team had seen some recent changes with two new members joining the trust in the months preceding the inspection. Although both relatively new to the trust they demonstrated a good understanding of the issues and challenges along with the commitment to address them and were already taking action in some areas.
- Most of the divisional senior team and the non-executive directors had some longevity working within the trust. We found leadership of the outpatients services required strengthening.
- The trust had been in receipt of support from an improvement director allocated by the trust development authority.
- Following the trust being placed into special measures in October 2014, a patient care improvement plan (PCIP) had been developed. We were not assured there had been effective oversight of this. The actions did not always reflect the achievement of the outcome intended and there was limited consideration to monitoring of outcomes. Many of the actions were rated green, which indicated they had been completed, and on examination there was limited evidence that they had been effective in delivering the intended improvement.
- Most staff said most of the executive were visible. Most staff that we spoke with reported to us that they saw their immediate line manager regularly. This was an improvement from the previous inspection.
- At the time of our inspection, there was no medical workforce plan in place. However, there was a plan to produce one by March 2016.
- We were not assured the board had set standards and thresholds for poor staffing and were clear about how these linked to unsafe care. In particular the balance between agency and permanent staff and how this was managed on a daily basis.
- We were informed of the plan to open additional capacity in the next month utilising staff from existing areas were vacancies were high. When we questioned this the trust informed us they were now delaying this and would undertake a risk assessment before doing so.
- We found that key clinical executives did not have substantive deputies to support the key work streams that needed addressing.

Summary of findings

- We were assured that plans were in place to improve the organisation's state of readiness for nursing and midwifery revalidation.
- We were not assured that the organisation had a clear framework in place for confirming that registered nurse to health care assistant delegation was appropriate. However, we were assured that assistant practitioners were few in number and that therefore the risk was reduced.
- We were not provided with any assurance about practice frameworks for allied healthcare professionals (AHP) including engagement in strategy, policy development or education for AHP's. We were not assured that there was a workforce strategy for AHP's who are often key to the workforce in community services.
- We found that that there was an appropriate level of corporate attention and senior leadership provided for community nursing and that there was a good understanding of the challenges, particularly in retention and recruitment
- Overall, we were assured that there was good corporate understanding of the risks, issues and priorities in human resource management.
- The education team had effective plans in place and appropriate clinical direction. The team had been well embedded for some years and had excellent and well developed networks and demonstrated effective and consistent leadership.

Culture within the trust

- Most staff we spoke to were friendly and welcoming.
- There were appropriate mechanisms in place for the management of equality and diversity. There was a good corporate understanding of the issues locally both in relation to service users and carers. There was an acknowledgment that equality and diversity activity needed to be embedded and that data collection needed to be improved.
- All of the staff we spoke to were proud to work for the trust and felt they did the very best they could for patients. All the staff we spoke with said they would be happy for themselves or member of their family to be treated within the trust.
- Staff acknowledged difficulties with moral in some areas, with an element of fatigue among staff. All staff were aware of concern associated with the poor recruitment and retention.
- Some staff told us that they felt there were limited career opportunities as the middle and senior grades of staff hardly ever left the trust.

Fit and Proper Persons

- The Fit and Proper Person Test is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role.
- We were assured that appropriate steps had been taken to manage the 'Fit and Proper persons' legislation implementation. All the senior staff we spoke with were aware of this legislation.
- We checked board members personnel files and found them all to be compliant.

Public engagement

- There were over 100 volunteers who undertook various tasks in all the hospitals, including meeting and greeting patients, chatting with patients on the wards. There were chaplaincy volunteers and volunteers making tea and coffee in the Macmillan Renton Unit.
- Volunteers ran a charity on behalf of the trust, Wye Valley NHS Trust Umbrella Charity, to raise funds to buy equipment for all the hospitals in the trust.
- The trust also had a patient forum which was made up of ex or current patients. The group was led by the director of nursing and quality and met bi-monthly. Discussions were held with the group about their experience of their care and how care could be improved.
- In addition, the trust had 2400, people who were seen as 'members' and was keen to encourage local residents, patients, service users, carers, and staff to become members to help develop the way local healthcare services were provided. However, engagement with this group had been reduced since the trust had been placed into special measures.
- Members also attended some trust committees, such as the Good Corporate Citizen Committee, and often attended the trust public board and annual general meeting.
- Members were also invited to participate in the yearly Patient Led Assessments of the Care Environment (PLACE), which assessed the cleanliness, food, privacy and dignity of the patient environment. 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%.

Staff engagement

Summary of findings

- The trust took part in the 2014 national staff survey, the response rate was in line with the England average. The trust returned eight negative findings and seven positive findings, an improvement overall on the 2013 survey.
- The areas where the trust results were better than the England average in 2014 related to:
  - Effective team working
  - Percentage of staff who had received health and safety training in the past year
  - Percentage of staff reporting errors, incidents or near misses in the past month
  - Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell
  - Percentage of staff able to contribute towards improvements at work %
  - Staff motivation at work
  - Percentage believing that trust provides equal opportunities for career progression or promotion
- The areas where the trust results were worse than the England average in 2014 related to:
  - Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
  - Percentage of staff working extra hours
  - Percentage of staff appraised in last 12 months
  - Percentage of staff suffering work related stress in last 12 months
  - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
  - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
  - Percentage of staff reporting good communication between senior management and staff
  - Percentage of staff having equality and diversity training in the last 12 months
- There was a staff engagement plan in place which was created following the 2014 staff survey to tackle the main elements of staff engagement. This was monitored by the remuneration and workforce committee. The predicted date for the action plan to be completed was January 2016.
- The trust's whistleblowing policy was reviewed. It covered all the expected areas, roles and responsibilities and set out the trusts approach to whistleblowing. Although there were people in the trust with specific roles, staff could approach any

manager under the whistleblowing policy. Evidence was not seen of how this policy was disseminated (other than posting on the intranet). There was no evidence that managers had been trained in its implementation.

- We were informed that there had been four cases of whistleblowing, in the last 12 months two were closed and two were still under investigation. The case files were requested. However, only one was made available. We found that the file was incomplete, there was insufficient evidence to give assurance that the whistleblowing policy was being followed.
- Some staff felt that there was a disconnect between community and acute services within the trust. They felt that the trust focus was on improving acute care and there was minimal recognition for the work that had been completed in community services.

Innovation, improvement and sustainability

- There was a focus on understanding and reducing the trust mortality this was being led by the medical director, who had been in post since March 2015 was seen by all staff we spoke with as really positive appointment and had been instrumental in implementing mortality and morbidity meetings, commencing an acute medicine service, assisting the director of nursing and quality to engage senior nurses and appointing several new consultants, who had a similar vison.
- Recruitment was a significant challenge for the trust and there were a number of actions being taken to address this including recruitment of oversea nursing staff. However, the trust felt they were disadvantaged by their geographical location and were considering what other actions could be taken to provide a sustainable recruitment and workforce solution.
- 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 are; and had been involved in interviewing new staff in community services for children and young people. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.

Summary of findings

- The trust encouraged staff to be innovative. For example, theatre staff had contributed to the re-designing of recovery paperwork, including altering sections for pain management and arterial lines.
- There was recognition that the organisation given its size and location needed to work differently to provide a sustainable model for delivery of sustainable services to its population. There was work on going to link with partner organisations which was being actively progressed by the chairman and chief executive officer.

Overview of ratings

Our ratings for Hereford Hospital

	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	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate

Our ratings for Wye Valley NHS Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	☆ Outstanding	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community health inpatient services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community End of Life Care services	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Community health urgent care services (MIU)						
Community heath dental services	Good	Good	Good	Requires improvement	Good	Good
Special care dental services						
Other specialist services						
Overall Community	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement

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 are; and had been involved in interviewing new staff in community services for children and young people. We spoke with some representatives from the group who were very passionate about their role and welcomed the opportunity to make a difference.
- Compassionate care and emotional support provided by community adult service teams was excellent. Staff had a clear focus for providing best possible care and improving the well-being of patients they saw.
- Community services for children and young people had submitted a proposal for a group project incorporating local health visiting teams, children's centres, the local community and various members of the multi-agency team. The aims of the project were to: provide support and information to families on how to achieve healthy lifestyles; promote and support and encourage sensible weight management; enhance families ability to cook health nutritious meals; increase families social networks and therefore their social capital, leading to increased self-esteem and self-confidence; enhance links within the community by incorporating volunteers from within the community to help within practicalities of running groups on a regular basis; encourage links to other services within the community that promote lifestyle change, such as local gyms and swimming pool.
- Health visitors in Leominster supported children in need at Christmas with a Christmas hampers project by utilising local community charities and food bank services to donate food hampers for families in need.
- 24 HVS had worked with a local charity to access allotments, for use by local communities to grow their own produce and share with families who had food and nutritional needs.
- A member of the Leominster SNS team had won a prize from a national professional journal for producing a domestic abuse peer support programme.
- The development of 'Fresh Eyes Peer Review', for complaints, which is an excellent example of a non-threatening, transparent, open and supportive initiative in organisational learning.
- The education team had effective plans in place and appropriate clinical direction. The team had been well embedded for some years and had excellent and well developed networks and demonstrated effective and consistent leadership.

Areas for improvement

Action the trust MUST take to improve

Action the trust 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.

Outstanding practice and areas for improvement

- 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.
- 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.
- The trust must ensure that the categorisation of incidents is completed accurately and full investigations are carried out as appropriate, including the identification of themes to ensure relevant actions are implemented.
- The trust must ensure that governance systems in place are effective. This includes ensuring practices are consistent, in line with hospital policies, and documents are approved through the clinical governance structure.

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Please refer to the location reports for details of areas where the trust SHOULD make improvements.

Following the inspection we issued Hereford Hospital with a warning notice under section 29a of the Health and Social Care Act 2008. On the basis of this inspection, we are recommending the trust remains in special measures.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity The regulation was not being met because risks were not always identified and all mitigating actions taken in community inpatient services. The governance structure in place did not always practice in line with trust policy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 **Staffing** 2. Persons employed by the service provider in the provision of a regulated activity must—

This section is primarily information for the provider

Requirement notices

a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

The regulation was not being met because not all staff in community inpatient services had had mandatory training, supervision and appraisals as required by the trust's policies.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) (2) (3) HSCA 2008 (Regulated Activities) Regulations 2014 **Need for consent** 1. Care and treatment of service users must only be provided with the consent of the relevant person. 2. Paragraph (1) is subject to paragraphs (3) and (4). 3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. * Mental Capacity Act 2005 The regulation was not being met because staff in community settings completing DNA CPR forms did not comply with the Mental Capacity Act 2005 and the Code of Practice; and that systems were not in place to assess, monitor and mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Four out of eleven DNACPR forms we reviewed stated that the patients did not have mental capacity. However there was no evidence of mental capacity assessments being completed.