Herefordshire Council

AGENDA

Health & Social Care Overview and Scrutiny Committee

Date: **Wednesday 3 December 2014**

Time: **2.30 pm**

Place: **The Committee Room, Shire Hall, Hereford**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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If you would like help to understand this document, or would like it in another format, please call David Penrose, Governance Services on 01432 383690 or e-mail dpenrose@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health & Social Care Overview and Scrutiny Committee

Membership

Chairman	**Councillor CNH Attwood**
Vice-Chairman	**Councillor MD Lloyd-Hayes**
	Councillor PA Andrews
	Councillor JM Bartlett
	Councillor PL Bettington
	Councillor KS Guthrie
	Councillor Brig P Jones CBE
	Councillor JLV Kenyon
	Councillor NP Nenadich
	Councillor CA North
	Councillor SJ Robertson
	Councillor J Stone
	Councillor GA Vaughan-Powell
	Councillor DB Wilcox

Non Voting

AGENDA

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any Members nominated to attend the meeting in place of a Member of the Committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on the Agenda.

4. MINUTES (TO FOLLOW)

To approve and sign the Minutes of the meeting held on 24 November 2014.

5. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

To consider suggestions from members of the public on issues the Committee could scrutinise in the future.

(There will be no discussion of the issue at the time when the matter is raised. Consideration will be given to whether it should form part of the Committee's work programme when compared with other competing priorities.)

6. QUESTIONS FROM THE PUBLIC

To note questions received from the public and the items to which they relate.

(Questions are welcomed for consideration at a Scrutiny Committee meeting so long as the question is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it ***no later than two working days before the meeting*** *to the Committee Officer. This will help to ensure that an answer can be provided at the meeting).*

7. PRESENTATION ON THE DEMENTIA WORK UNDERTAKEN BY THE COURTYARD, HEREFORD

Presentation on the Dementia work undertaken by the Courtyard, Hereford

8. WYE VALLEY NHS TRUST 9 - 140

To receive a report from the Chief Executive of the Wye Valley NHS Trust on the recent CQC Inspection and report.

9. HEALTHWATCH UPDATE

To receive a verbal report on any issues of concern to Healthwatch.

10. ADULT SOCIAL CARE LOCAL ACCOUNT 141 - 168

To note a report on the Adult Social Care Local Account.

11. ADULT SOCIAL CARE PEER CHALLENGE 169 - 200

To note the outcome of the Adult Social Care Peer Challenge undertaken in June 2014 and to consider the council's response to the areas for improvement identified.

12. WORK PROGRAMME 201 - 204

To note the Committee's Work Programme.

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

You can contact Councillors and Officers at any time about Scrutiny Committee matters and issues which you would like the Scrutiny Committee to investigate.

There are also two other ways in which you can directly contribute at Herefordshire Council's Scrutiny Committee meetings.

1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

2. Questions from Members of the Public for Consideration at Scrutiny Committee Meetings and Participation at Meetings

You can submit a question for consideration at a Scrutiny Committee meeting so long as the question you are asking is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting. Contact details for the Committee Officer can be found on the front page of this agenda.

Generally, members of the public will also be able to contribute to the discussion at the meeting. This will be at the Chairman's discretion.

(Please note that the Scrutiny Committee is not able to discuss questions relating to personal or confidential issues.)

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YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.

- Inspect agenda and public reports at least five clear days before the date of the meeting.

- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.

- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.

- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.

- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.

- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.

- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).

- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

HEREFORDSHIRE COUNCIL

SHIRE HALL, ST PETER'S SQUARE, HEREFORD.

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Herefordshire Council

MEETING:	**HEALTH AND SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE**
MEETING DATE:	**3 December 2014**
TITLE OF REPORT:	**WYE VALLEY NHS TRUST CARE QUALITY COMMISSION INSPECTION**
REPORT BY:	**Chief Executive, Wye Valley NHS Trust**

1. Classification

Open

2. Key Decision

This is not an executive decision

3. Wards Affected

County-wide

4. Purpose

4.1 To receive a presentation on the recent Care Quality Commission Inspection of the County Hospital

5. Recommendation

THAT: The Committee considers and discusses the Patient Care Improvement Plan.

6. Alternative Options

There are no relevant alternative options.

7. Financial Implications

7.1 There are no financial implications to this report.

8. Legal Implications

8.1 There are no legal implications to this report.

9 Appendixes

Appendix 1 – Presentation

Appendix 2 – CQC Wye Valley NHS Trust Quality Report

Appendix 3 – Wye Valley NHS Trust Patient Care Improvement Plan

10 Background Papers

10.1 None identified.

The Patient Care Improvement Plan
Progress as at November 2014

Richard Beeken
Chief Executive

Herefordshire's health service provider

Themes

Patient Flow & Urgent Care demands

Internal

- Ambulatory emergency care – averaging 11/day
- Emergency Physician of the Day (EPOD)(8:00 a.m. – 8:00 p.m.) – reducing Length of Stay
- Acute medicine – 2 new consultants February 2015
- Discharge bundle and process improvement

External

- System Resilience Plan – capacity and demand schemes
- Vanguard Unit 2014/15. Bed capacity increases planned thereafter
- 2nd wave resilience monies – weekend discharge team

Herefordshire's health service provider

Themes

Wye Valley NHS Trust

Leadership – A&E

- Service Unit Director (SUD) appointment (Urgent Care) made and commenced on 1st October 2014
- SUD and Clinical Director – Warwick University Medical Leadership Programme
- New, senior A&E Consultant appointment – 1st September 2014
- Consultant presence later in the day – meeting demand pattern
- Strategic workforce plan – middle grade and RGN recruitment
- Retention of A&E operational manager role
- Minors stream breaches meeting trajectory

Themes

Wye Valley NHS Trust

Stroke Services

- Investment by CCG and Powys agreed – September 2014
- Joint commissioner / provider stroke board oversight
- New model of care agreed, recruitment underway
- Risk – securing specialist nursing staff

Herefordshire's health service provider

Themes

Wye Valley NHS Trust

Quality Governance and learning

- Team Brief process audit and changes
- Quality Committee – formal review of implemented learning from incidents
- Mortality Reviews – wider consultant engagement, health economy oversight group, tracker system from January 2015
- Care Bundles re-launched – greater consistency

Themes

Wye Valley NHS Trust

Organisational development

- Board reviewing vision, mission, strategic objectives and developing organisational values with staff – January 2015
- "Top 100" leaders development programme being prepared
- Nursing, midwifery and clinical professionals strategy launched
- Medical engagement scale approach
- Trust Executive Management as decision making vehicle with clinical involvement
- Patient Care Improvement Plan progress in extensive staff engagement sessions – January 2015 and beyond

Themes

Wye Valley NHS
NHS Trust

Professional development and training

- Clinical supervision effectiveness review
- Pay progression linked to training and appraisal progress
- Clinical champions and specific Deprivation of Liberty (DOLS), Mental Capacity Act (MCA) and safeguarding training by Service Delivery Unit
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) audit and feedback improvements

Themes

Wye Valley NHS
NHS Trust

Estates issues

- A&E majors area expansion – April 2015
- A&E children's waiting area – March 2015
- Security input improvements to A&E
- Midwifery Led Unit (MLU) development – charitable funds - Autumn 2015
- Clinical waste issues at community hospitals resolved
- Roll out Trust Development Authority Infection, Prevention and Control (TDA IPC) recommendations

Herefordshire's health service provider

Themes

Wye Valley NHS Trust

Outpatients

- Improved capacity planning through annual planning process – reduced overbooking from 2015/16
- Outpatient footprint expansion – Fred Bulmer Unit – Autumn 2015

Herefordshire's health service provider

Buddying arrangement with University Hospitals Birmingham NHS FT

Wye Valley NHS Trust

LEADERSHIP

- Leadership/management development (especially clinical mentorship)
- Recruitment challenges – New ways of working, new clinical roles

GOVERNANCE

- Mortality review and learning
- Incident, complaint processes and learning
- Risk management
- Clinical information development

CAPACITY

- IT/EPR development
- Business case development

Herefordshire's health service provider

How will we know when we have improved?

- Exec team to develop 12 key outcomes of success – for Board and TDA agreement. Possible outcomes include:-
  - Elimination of avoidable harm in urgent care pathway
  - NHS Constitutional standards safely met
  - Staff turnover and vacancy improvement
  - Improved staff and patient survey results
  - Meeting NHS England 7/7 working standards
  - Mortality indicator improvements
  - Incident reporting in national upper quartile
  - Improved “patients charter” times in outpatients

Herefordshire’s health service provider

Questions?

Herefordshire’s health service provider

Wye Valley NHS Trust

Hereford County Hospital

Quality Report

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

Date of inspection visit: 3, 4, 5 and 19 June 2014
Date of publication: 14/10/2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	**Inadequate**
Urgent and emergency services	**Inadequate**
Medical care	**Inadequate**
Surgery	**Requires improvement**
Critical care	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Services for children and young people	**Requires improvement**
End of life care	**Requires improvement**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Hereford County Hospital as part of the Wye Valley NHS Trust inspection on 4 and 5 June 2014. The trust was placed in band 2 in our Intelligent Monitoring, and therefore recognised as a high priority for inspection (band 1 being highest and band 6 lowest). We were aware of a rapid response review conducted by NHS England at the end of 2013.

The hospital serves a population of around 220,000 patients from England and Wales. There are approximately 240 beds and 2,700 staff. The hospital provides a full range of DGH services to its local population, with some links to larger hospitals in Gloucestershire, Worcestershire and Birmingham.

We found that services provided at the hospital were inadequate, with particular concerns about the provision of services in both A&E and medical care services.

We found that caring was largely good across the trust, with only A&E falling short of the level of caring that would be expected.

We saw that the inability to manage patient flow was a major issue for the trust, which caused pressure on A&E services, medical patients to be located on inappropriate wards and cancelled surgical operations. This also caused pressure in the community. We found services had long waits for patients to be seen. We saw waits in A&E regularly exceeded the national target of four hours. We found that overbooking in outpatient clinics was common. Pressures on bed availability meant that patients were cared for on wards that they should not have been on. We saw that this resulted in some patients missing their medical review, and some patients being delayed for discharge. Bed occupancy was routinely over 95% (the national average is less than 86%) and at times exceeded 100%. Surgical operations were regularly cancelled, some on the day of surgery.

We found poor systems for medicines management. We saw that cleanliness and hygiene was below standard and that some equipment had not been cleaned for some time.

Many staff talked about the sustained pressure, and in some areas this had become a normal part of working practices. Increased pressure had reduced the time for staff appraisals and staff training. As a result the development of staff was not prioritised. Staff were proud to work for the trust, but many were weary with the continued pressure and could see no end to this.

We saw a poor culture of incident reporting that resulted from a lack of feedback of actions arising from previous incidents. Some staff felt that reporting was pointless and lack of reporting of (mainly) non-harm incidents was endemic. As a result of this, the trust was unable to learn and improve services and protect patients in the future.

In summary we found that

In A&E we found that overall services were inadequate.

We saw that the flow of patients through the service was poor and long delays were common. The service regularly breached the national four-hour wait. There were insufficient rooms to accommodate all patients appropriately. Patients did not have sufficient assessment or oversight from nursing staff during their time in the service.

We found poor systems for medicines management. We saw that cleanliness and hygiene was below standard and that some equipment had not been cleaned for some time.

We saw that medical staff in A&E did not take adequate responsibility for the assessment and prioritisation of patients. Provision of staffing (especially medical staff) was insufficient. There was no reliable system to escalate concerns or to prioritise patients for treatment.

Summary of findings

We saw a poor culture of incident reporting resulting from a lack of feedback of actions arising from previous incidents.

We saw poor leadership and little engagement of staff in decision making. Many staff talked about the sustained pressure and described their role as 'firefighting'.

We saw that medical staff did not take an adequate management responsibility for the assessment of patients, which had led to poor care. Team working in A&E services was poor and effective clinical challenge was not evident. The culture to support this was not evident.

We saw lack of emphasis on reporting and learning from incidents. Staff and management were aware of this, but we saw little drive to improve this.

In medical care services we found that services overall were inadequate.

We saw lack of leadership in resolving the issue of bed management and patient flow. Pressures on bed availability meant that patients were cared for on wards that they should not have been on. We saw that this resulted in some patients missing their medical review, and some patients being delayed for discharge. Bed occupancy was routinely over 95% (the national average is less than 86%) and at times it exceeded 100%.

We saw that the service had higher mortality rates than expected.

The stroke pathway required improvement and we saw lack of drive from clinical and senior managers to take this forward. Not all patients were getting appropriate stroke care with lack of access to, and training in thrombolysis.

We saw inappropriate re-use of equipment designed for single use, and lack of awareness of the risks of this. We saw out of date food products on one ward.

We saw a poor culture of incident reporting resulting from a lack of feedback of actions arising from previous incidents. Staff felt that reporting was pointless; and lack of reporting of (mainly) non-harm incidents was endemic. As a result of this the trust was unable to learn and improve services and protect patients in the future.

Many staff talked about the sustained pressure; and in some areas, this had become a normal part of working practices. Over 50% of staff in a recent staff survey believed they worked in crisis mode too often.

We found that overall, staff were caring towards patients and people who used services.

In surgical services we found that services required improvement.

We found that bed pressures were causing cancellations of operations. This was sometimes happening on the same day as surgery. Patients were not always rebooked for their surgery with 28 days as the standard expects.

We saw previous problems with use of the WHO safer surgery checklist. The service indicated that this had been improved through monitoring. We noted that consultant staff were not yet able to report incidents through the new IT system (DATIX). We heard of decisions taken contrary to national guidance and with little clinical engagement.

We noted that data showed the trust had higher mortality in musculoskeletal conditions than would have been expected.

We saw that the day surgery unit was used for patients staying up to five days. The facilities for these patients were inappropriate. There was no planned daily ward round for these patients.

We saw a poor correlation between the risks discussed by staff and the service and trust risk register.

Some staff reported little knowledge of executive leads and they felt that this may have improved in recent weeks only as a result of the CQC inspection visit.

We found that overall, the service was caring towards patients and people who used services.

Summary of findings

In critical care services we found that services required improvement.
We saw higher than expected mortality from the recent ICNARC audit data. We saw the trust had taken some steps to improve this (e.g. matching Michigan initiative).

We saw that at times there were insufficient medical staff to manage this service. We saw that bed occupancy was higher than national averages. Operations had been cancelled due to lack of critical care beds. We also noted that some patients were treated in the theatre recovery area when critical care beds were not available.

The service also managed the HDU beds, which were not located in critical care. This stretched the nursing resource in managing two separate areas.

We saw poor compliance with mandatory training. There was a poor culture of incident reporting, which was as a result of lack of feedback of actions arising from previous incidents.

We found that overall, the service was caring towards patients and people who used the service.

In maternity services we found that services required improvement.
We found that rates for caesarean section along with those of instrument delivery (e.g. forceps) in maternity were higher than the national average.

We saw that maternity services were not always making changes quickly following reported incidents. Lack of access to a second theatre had been identified from a previous incident. No contingency plan was currently in place.

We saw that the service was cluttered and cramped; equipment was stored in corridors. One piece of equipment showed it was last serviced in 2011.

Plans to make changes to the service had not engaged staff. They believed the plans would result in less space and greater problems. The worries remained unresolved. Staff felt unable to influence decision making. Staff felt health record systems did not allow them to see all the records they required to deliver effective care.

Incident reporting and learning required improvement. We saw a poor correlation between the risks discussed by staff and the service and trust risk register.

We found that overall, the service was caring towards people who used the service.

In children's services we found that services required improvement.
We saw the service had taken actions as a result of previous incidents. However, we did not see that children's services shared learning with or from other services.

Systems for safeguarding were poor; they did not always alert staff to risks, and medical staff had no training in safeguarding. Systems for managing the training and development of staff required improvement.

Lack of psychiatric assessment was a significant challenge for the service.

The children's play area was a potential health risk. Little action had been taken. In other areas cleaning schedules for play equipment required improvement.

Increased pressure had reduced the time for staff appraisals and staff training; as a result the development of staff was not prioritised.

We saw a poor correlation between the risks discussed by staff and the service and trust risk register. There was a lack of leadership to progress.

We found that overall, the service was caring towards patients and people who used the service.

Summary of findings

In end of life care services we found that services required improvement.
We saw a poor approach to and completion of DNACPR (do not attempt cardio-pulmonary resuscitation) documentation.

We saw that a change from the Liverpool Care Pathway had begun without a clear replacement for this pathway. The result was uncertainty over the pathway to follow.

Lack of feedback from clinical incidents meant that staff were unable to improve practice.

Patients were able to be discharged to their preferred place of death in a very timely way. Over 80% of patients died where they chose to.

We found that overall, the service was caring towards patients and people who used the service.

In outpatients services we found that services required improvement.
Overbooking of outpatient systems was common. Clinics ran late. The outpatient service did not monitor the frequency of this and were unable to show its impact. There were no facilities for refreshments for patients. Staff were unable to take a break between the end of one clinic and the start of the next.

We were told it was a regular occurrence not to have the full set of notes in clinic. Instead staff made a temporary set from information available. This is poor practice when it happens regularly. The trust was unable to produce data to show how often this occurred as it had not undertaken audits to identify the impact of this.

Incident reporting was inconsistent.

Staff did not have the knowledge to undertake mental capacity assessments in line with the Mental Capacity Act 2005.

The Arkwright suite was introduced as a temporary facility to support outpatients. However, it had inappropriate soundproofing to hold clinical consultations. It was not fit for use in this way.

The service did not have a system for understanding patients' feedback; although complaints had recently risen by 12%.

We found that overall, the service was caring towards patients and people who used the service.

Overall, we have rated this hospital as inadequate.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	During our visit, the service had been on a high state of escalation (level 4) in responding to the workload coming in to both A&E and the follow-on impact to the rest of the trust. This had been the case for many weeks before our visit. During the week we were there, the trust had considered declaring the situation as a major incident, but the influx of patients reduced slightly. The service provided by A&E was not always safe. There were not enough medical staff to provide safe care, particularly at weekends. Maintaining the flow through the department was not always possible because of the lack of available beds in the trust. There was insufficient space to assess and treat patients. This meant that patients were cared for in non-clinical areas where they did not have access to a call bell, and their privacy and dignity were not always maintained. Staff did not routinely check patients for pressure area care, nutrition and hydration, or if the patients required support using the toilet. Management of medicines (controlled drugs) and record keeping of medicines was poor. The environment for children was particularly poor. The children's waiting area was inadequate and the cubicles set aside for children were used for adults. The system to check whether a child was on the child protection register was unreliable. Staff trained in paediatric care were not always available in A&E. Prioritisation or escalation of patients based on their clinical need was not fully responded to or dealt with appropriately. Patients had long waits to be seen. A&E did not have systems to meet the needs of patients living with dementia or a learning disability. Some patients received care without having a name band on to identify them. The use of care bundles or care pathways was sporadic. Where care pathways were used the pathway guidelines were not always followed. Not all of the care bundles had been updated to reflect

Summary of findings

evidence-based care. We saw equipment that was not clean and we saw uncertainty over who was responsible for cleaning some areas, which meant that these were not regularly cleaned.
Staff did not always report incidents or receive feedback or learning from incidents. There was no security in A&E.
There was no clear leadership in A&E. The senior medical and nursing staff did not work closely in a coordinated way to lead the team and this led to poor patient care. Medical staff did not take adequate management responsibility for the assessment of patients, which led to poor care.

Medical care

Inadequate

Patients received compassionate care and we saw that most patients were treated with dignity and respect. We found good examples of multidisciplinary team working in the acute trust and joint working across community services.
Safety in medicine was compromised. We found a sub-optimal stroke service that could place patients at risk because the trust did not have hyperacute stroke facilities or staff with relevant competencies to support patients eligible for thrombolysis treatment; prescription medicines on that were not appropriately stored; shortfalls in staffing numbers for patients requiring non-invasive ventilation; and medical outliers (medical patients on none medical wards) that missed medical reviews.
There were high bed occupancy levels and poor patient flow in the trust, which had a negative effect on the quality of patient care. There was a lack of senior medical staff at night and at weekends, and delayed discharge due to untimely medical reviews. There was a lack of urgency from the trust to resolve and improve these medical speciality issues.

Surgery

Requires improvement

Staff in the elective care service unit were passionate and committed to their roles, and we saw that senior staff had ownership of the areas they held responsibility for. Staff were keen to develop and improve the service. Learning from mistakes and incidents had been embraced and procedures had been reviewed when needed. Further training had been identified to reduce the risk of repeat events.

Summary of findings

However, the flow and effectiveness in surgical wards and operating theatres was severely impeded by the difficulties the trust had with bed flow and medical outliers (a patient admitted to one ward but placed in another department's ward). Inappropriate use of the day surgery unit (for inpatients) and the operating theatre recovery area (to hold patients until beds became available) increased patient dissatisfaction and generated a risk to patients' safety and wellbeing. In December 2013 we had been concerned whether the day surgery unit was safe to support patients' wellbeing and safety. The use of the day surgery ward for patients staying longer than 23 hours remains a concern.

Safety protocols and national safety guidelines to keep surgery safe were being ignored and overruled by senior managers trying to mitigate the trust-wide bed flow problem. The impact on surgical areas was not taken into account.

Medical staff were not able to report incidents on the trust incident reporting system; staff did not always get feedback on incidents they had reported and a culture of doubt on the value of reporting incidents existed.

The trust had higher than expected mortality from musculoskeletal conditions.

Critical care **Requires improvement**

Critical care services required improvement in safe, effective and responsive areas. Overall, we found caring and leadership in the critical care services to be good.

The critical care bed capacity presents significant challenges for the hospital to ensure patients receive safe and appropriate care. The limited availability of the critical care outreach team needs further review to ensure that very ill and deteriorating patients receive appropriate care and treatment.

Staff were encouraged to report incidents, but did not receive feedback about when changes would be made. The lack of feedback does not convince staff to continue reporting incidents. The environment was clean and hygienic. Arrangements for medicines were generally appropriate, but improvements were needed.

Summary of findings

The unit had a clinical audit programme to monitor adherence to guidance. There was good multidisciplinary working by critical care staff and mutual respect for all staff in the department. There was a need to ensure that suitably experienced doctors and nurses are available to provide care out of hours during weekends and evenings.
Patients and relatives told us that staff were caring and compassionate, and we also observed this during our inspection. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the unit.

Maternity and gynaecology

Requires improvement

While staff were found to be caring, we also found that the maternity and family planning services required improvement to be safe, effective and responsive to the needs of local people.
Staff provided kind and compassionate care. However, there were risks that were not reported or monitored through the governance processes. The risk register did not reflect the concerns described to us. Changes following recent incidents had not been implemented.
The facilities were small for the number of births. There was not an effective second theatre. Lack of staff was causing a delayed response. There appeared to be a plan for addressing some of this, but staff told us they didn't think it was the right location, and had no opportunity to influence the decision making.
The service did not have a midwife-led unit, although a plan was in place. There was a birthing pool.
There was a high induction, instrumental delivery and caesarean section rate, not all of which was being reviewed to address. There was no bereavement facilities and little vision or innovation. Outcomes were monitored, but there were few actions to address outcomes that fell outside the national average.

Services for children and young people

Requires improvement

Staff in the special care baby unit and the children's ward were polite, caring and kind. Patients and parents said the care was "very good" and described staff as "helpful" and said they were kept well informed. All areas of the departments were clean and tidy. The children's ward offered a

child-friendly environment, with play areas for various ages. There was 24-hour consultant cover seven days a week. The development of the paediatric assessment unit had led to rapid access for children. Staff were supported by their managers.
However, we saw the service required improvement for being safe, effective and well-led.
Senior staff members said they were not integrated with the other departments in the hospital and worked in isolation of them. Records seen at inspection showed that staff were not up to date with mandatory training, which included the safeguarding of children for medical staff. Records did not demonstrate that staff were having their competency assessed. Following the inspection, the trust provided information which stated that the compliance rate for mandatory training for clinical refresher updates and health and safety on the children's ward was 82%, and that this had been updated on the trust's training department records.
There were no policies and procedures for the care and safety of patients.
There was a lack of personal and environmental risk assessments, and actions to reduce risks had not been taken. We noted that the edges of the children's play area required cleaning, but this had not been done. Some systems had failed in practice, such as those to monitor that correct procedures had been followed for consent to treatment. There was a lack of provision for the emotional support of patients. The number of nursing staff was meeting the needs of the service by relying on the goodwill of the staff to work overtime, which was not sustainable.

End of life care — **Requires improvement**

We found end of life care was caring and responsive of patients' needs.
'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not always completed in line with trust policy. In one case, a patient who wanted to be resuscitated had a completed DNACPR form.
The rapid discharge pathway enabled patients to leave the hospital within four hours.

Summary of findings

All of the patients we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment.
Following the removal of the Liverpool Care Pathway (LCP), there was no clear pathway for staff to follow when delivering end of life care. The trust had developed its own end of life care records that had replaced the Liverpool Care Pathway. This had yet to be implemented because it was going through an assessment process before sign-off by the trust board.
Improvements were needed to make sure all patients' records in relation to 'do not attempt to resuscitate' decisions were completed in line with trust policy. The forms were not filled in to clearly demonstrate how decisions had been arrived at.
Nursing and medical notes lacked detail of conversations with patients and families about their wishes regarding resuscitation.
We found the deceased were cared for by a team of dedicated staff who maintained a patient's dignity after death. Bereavement staff supported families effectively.

Outpatients and diagnostic imaging

Requires improvement

We observed patients were cared for in a clean and hygienic environment. There was a system for reporting incidents, but this was not always being used in a consistent manner.
In some areas we saw practices that could compromise the safety of staff and patients.
Patients' care pathways were adversely affected by the limited availability of beds. This meant when outpatients needed to be admitted there were delays in starting treatment.
There were systems to triage referrals and send appointments to patients.
The trust was struggling to meet the demand for outpatient appointments so overbooking of clinics was commonplace, causing delays for patients. The impact of this was not being monitored.
Patients were treated with dignity and respect. Staff were well regarded by patients, who were overwhelmingly positive about the care they received.

Summary of findings

The managers of outpatients departments were accessible and respected by staff. Steps were being taken by managers to improve the service offered to patients.
The facilities in the Arkwright (temporary) Suite were inappropriate.
Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of policies and procedures.

Inadequate

Hereford County Hospital

Detailed findings

Services we looked at

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

Contents

Detailed findings

Background to Hereford County Hospital

Hereford County hospital is a small hospital with 239 beds. It is part of Wye Valley NHS Trust formed in April 2011 by the merger of acute, community health and adult social services in Herefordshire. In September 2013 adult social services became the responsibility of Herefordshire Council.

The trust provides services to 180,000 people in Herefordshire and to 40,000 people in Powys, Mid Wales. The catchment area is rural and remote. More than 80% of the people using the services live five miles or more from Hereford city or a market town.

The hospital provides services that include: A&E; elective surgical procedures; critical care (level 1, 2 and 3); medical care (including care to older people); maternity; services to children and young people; end of life care; and outpatient services.

We carried out a comprehensive inspection because Wye Valley NHS Trust had been flagged as high risk on CQC's Intelligent Monitoring system (which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations). The announced inspections took place on 3, 4, 5, June with an unannounced inspection on 19 June 2014.

Our inspection team

Our inspection team was led by:

Chair: Dr Andrea Gordon, Deputy Chief Inspector, Care Quality Commission

Inspections Lead: Tim Cooper, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists, which included: medical directors; a director of nursing; consultants and junior doctors; a midwife; senior and junior nurses; a student nurse; and three experts by experience.

How we carried out this inspection

We visited the hospital and spoke with people who used services, relatives and staff.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 4 and 5 June 2014 and an unannounced visit on 19 June 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We interviewed key members of senior staff. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Detailed findings

Facts and data about Hereford County Hospital

Overall, Wye Valley NHS Trust has approximately 300 beds and employs around 2,700 staff who provide acute and community services to the people of Herefordshire and Powys in Mid Wales, a combined total of approximately 220,000 residents.

In 2012/13 the acute hospital saw 14,273 day cases, 67,441 new outpatient attendances and 149,682 follow up attendances. There were 5,791attendances at the minor injuries units and 48,118 attendances to A&E.

The trust had a financial surplus in 2012/2013 of £294,000 on a turnover of £175 million. This includes financial support of £9.5 million, which was made available to the trust following agreements reached within the local health economy.

Between October and December 2013, bed occupancy for the trust was 94.5%. This was well above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

There had been a number of recent changes at board level. The chair and chief executive of the trust both started on 2 June 2014, the day prior to the inspection.

The chief operating officer had been in post since May 2013, the human resources director since January 2014 and the medical director was an interim post at the time of the inspection.

CQC inspection history:

The trust has been inspected six times since registration, across three of its locations. The most recent inspection was at Hereford County Hospital in October 2013.

Hereford Hospital was inspected four times between April 2011 and October 2013. At the most recent inspection, it was found to be non-compliant for all four of the outcomes inspected. These were respecting and involving people; care and welfare of people using services; supporting workers and assessing and monitoring the quality of service provision. We took enforcement action as a result of our concerns on this last outcome.

Leominster Community Hospital was inspected once in July 2012. It was compliant with all six outcomes that were inspected. The Hillside location was inspected once in June 2011. It was found compliant with the single outcome that was inspected.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

From April 2013 to April 2014 Hereford County Hospital A&E department saw 49,311 patients, of which 4,084 patients required treatment for a major illness or injury. The A&E department has been awarded trauma status, which means it supports the regional trauma centre at Queen Elizabeth Hospital in Birmingham. Its role is to assess and stabilise trauma patients before transfer to the trauma centre, and rehabilitate local patients once they are fit for transfer back to Herefordshire.

A&E has four main areas: minors with two cubicles; two 'see and treat' rooms; majors with eight cubicles and four beds in an overspill area; a resuscitation area with three beds, one of which was set up for paediatric emergencies.

During our announced inspection we visited A&E on two consecutive weekdays. We followed this up two weeks later with an unannounced visit on a Thursday night. We met with over 50 patients and their relatives. We spoke with over 30 members of staff including: nurses; healthcare assistants' consultants; doctors; support staff; and senior managers. We observed care and treatment and looked at care records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust's A&E service.

Summary of findings

During our visit, the service had been on a high state of escalation (level 4) in responding to the workload coming in to both A&E and the follow-on impact to the rest of the trust. This had been the case for many weeks before our visit. During the week we were there, the trust had considered declaring the situation as a major incident, but the influx of patients reduced slightly.

The service provided by A&E was not always safe. There were not enough medical staff to provide safe care, particularly at weekends. Maintaining the flow through the department was not always possible because of the lack of available beds in the trust. There was insufficient space to assess and treat patients. This meant that patients were cared for in non-clinical areas where they did not have access to a call bell, and their privacy and dignity were not always maintained. Staff did not routinely check patients for pressure area care, nutrition and hydration, or if the patients required support using the toilet. Management of medicines (controlled drugs) and record keeping of medicines was poor.

The environment for children was particularly poor. The children's waiting area was inadequate and the cubicles set aside for children were used for adults. The system to check whether a child was on the child protection register was unreliable. Staff trained in paediatric care were not always available in A&E.

Prioritisation or escalation of patients based on clinical need was not fully responded to or dealt with

Urgent and emergency services

appropriately. Patients had long waits to be seen. A&E did not have systems to meet the needs of patients living with dementia or a learning disability. Some patients received care without having a name band on to identify them. The use of care bundles or care pathways was sporadic. Where care pathways were used the pathway guidelines were not always followed. Not all of the care bundles had been updated to reflect evidence-based care. We saw equipment that was not clean and we saw uncertainty over who was responsible for cleaning some areas which meant that these were not regular cleaned.

Staff did not always report incidents or receive feedback or learning from incidents. There was no security in A&E.

There was no clear leadership in A&E. The senior medical and nursing staff did not work closely in a coordinated way to lead the team and this led to poor patient care. Medical staff did not take adequate management responsibility for the assessment of patients which led to poor care.

Are urgent and emergency services safe?

Inadequate

The service provided by A&E was not always safe. There were not enough medical staff to provide safe care, particularly at weekends. The nursing staff had not received all of their mandatory training, in particular safeguarding and life support training. There was not enough space to assess and treat patients that meant that patients were being cared for in corridors, relatives' rooms, the procedure room and the plaster room. Patients in these areas did not have access to a call bell. Patients who could eat and drink were not always given water and were at risk of dehydration.

Staff recognised when patients were deteriorating and escalated care. Escalation was not always effective. The A&E electronic patient records were mostly effective.

The environment for children was particularly poor because we found that there was an inadequate waiting area and the cubicles set aside for children were used for adults. The system to check whether a child was on the child protection register was unreliable.

Initial assessments relied on patients giving the A&E receptionist reliable information and two separate nurses sending patients to the required treatment area. There was no doctor overseeing the initial assessments and patients were not seen in order of medical priority. Some patients received care without a name band on to identify them. The use of care bundles or care pathways was sporadic and where care pathways were in use the guidelines were not always followed.

Staff did not always report incidents. There was poor practice in recording controlled drugs used in the resuscitation area. Staff did not receive feedback or learning from incidents. There was no security in the A&E department.

Cleanliness, Infection control and hygiene

- The A&E department employed one housekeeper responsible for cleanliness in the department. There was a weekly cleaning schedule that covered equipment, the trolleys, cubicles, resuscitation room and 'see and treat' rooms. Staff signed when cleaning had been completed. We found that this demonstrated

most of the schedule had been achieved most weeks. There were cleaners employed to wash floors, empty bins and clean high and hard-to-reach places, which we saw appeared clean.

- Staff had not carried out daily cleaning in the resuscitation room. We saw the housekeeper's weekly cleaning schedule for the resuscitation room shelves, but found that they had been last cleaned five days prior to our inspection. The A&E manager told us that the nurse in charge of the resuscitation room was responsible for the daily cleaning of shelves. However, the nurse in the resuscitation room was unaware that they were responsible for daily cleaning. This meant that that there was an infection risk because the daily cleaning regime had not become an established routine.
- Equipment in the department was not always clean and decontaminated between patients. This included the blood gas analyser, the IV fluid warmer pump, syringe driver pumps and the non-invasive positive pressure ventilation (NIPPV). For example:
  - The blood gas analyser in the resuscitation room had blood spatters on it that increased with each use during our inspection. Although the weekly cleaning schedule included the blood gas analyser, on our visit it had not been cleaned for two weeks and was an infection risk.
  - The equipment used for non-invasive positive pressure ventilation (NIPPV) appeared dusty, and its sticker showed that it had last been cleaned 47 days before our inspection.
- The cubicle areas had disposable curtains that had been installed immediately before our inspection. The manager told us that they would be replaced every six months or as and when they had been contaminated. However, the hospital did not have a supply of disposable curtains to use in the event of contamination. The manager told us that they would revert to the old fabric curtains in the event of contamination. This indicated that there were no robust procedures to help prevent cross-contamination infection.
- We saw staff regularly wash their hands between patients. Gloves and aprons were available in allocated clinical areas. However, staff looking after patients in non-clinical areas such as the corridor or quiet room did not have easy access to hand-washing facilities and we saw that gloves or aprons were not available within those areas during our inspection. Staff adhered to the 'bare below the elbow' policy.

Nursing staffing

- Nursing staff were allocated to specific areas of the department. There was a band 6 nurse who coordinated all admissions to 'majors' in A&E. The manager told us that there should be a middle grade doctor working alongside the band 6 nurse, but there were not enough medical staff to do this.
- Not all patients had an allocated nurse at night. We saw that a male agency nurse allocated to the procedure room at night, but he had been told not care for the lone female patient due to sensitive issues. We asked who was caring for her, and no member of staff could tell us. In another example a patient receiving treatment in the quiet room had no allocated nurse.
- During the day emergency nurse practitioners (ENP) were allocated to the A&E 'see and treat' area to assess and treat walk-in patients for minor illnesses and injury. There were two rooms allocated. However, there was only one ENP available on 29 of the 31 days in May 2014. The manager told us that the other 'see and treat' room would be staffed by a doctor. There was no evidence that there was a doctor allocated on any day.
- The trust had increased their number of ENPs from three to six in March 2014. This had improved the amount of time the A&E 'see and treat' service was available from 8am to 8pm.
- At night there were four agency nursing staff regularly employed to work night shifts. The agency staff we spoke with told us that they often found themselves working with a large number of other agency staff in A&E at night.
- During the night of the unannounced inspection we observed that staff were 'borrowed' from wards. One nurse from each ward were asked to work for an hour at a time caring for patients in the majors overspill area. However, there were too few nursing staff to care for the needs of patients in the majors overspill area.
- The trust spent 15% of their nursing staff budget on agency or bank (staff who work overtime in the trust) staff in March 2014. Overall the trust spent more on the agency staff than other trusts in the same region (2%).

- Not all nursing staff knew where the A&E resuscitation trolleys were, even though all agency nurses had appropriate induction on arrival for their shift. This meant that there was a risk that staff would not promptly locate equipment during an emergency.

Medical staffing

- The trust had identified that they needed 16 shifts of medical staff every day. But, only 11 shifts were allocated to medical staff every 24-hour period on weekdays and seven shifts at weekends. Therefore, there were too few medical staff available to assess and treat patients during weekdays and significantly fewer staff at weekends. This put patient care at risk.
- The trust had identified that they needed five full-time consultants in A&E. We found two consultants in the unit who were in their first consultant post. There was also an associate specialist in emergency medicine was also regularly used on the consultant rota. There were two vacancies. The trust told us that one consultant had been recruited and was due to start in September 2014. However, there would still be too few experienced consultants in A&E to meet patient needs.
- Consultant cover was provided during 9am-5pm, Monday to Friday and 9am to 1pm at weekends. Consultants were on-call and available by phone over the 24 hour period. When a consultant had been called in during the night they were unable to attend their booked shift the next day. This meant that there were not enough consultants to provide cover for the department.
- There were four middle grade doctors employed and four vacancies. The shifts allocated to them were filled with a locum doctor or a senior house officer (SHO) when one was available. In the last three weeks of May 2014 there were 10 shifts a week that had no middle grade cover on weekdays and no locums available. The rota showed permanent staff were doing extra shifts at weekends. The manager told us that it was difficult to find reliable and dependable medical staff.
- At night there were not enough doctors to meet patients' needs. The three doctors that staggered shifts throughout the night were all locums. We observed patients who had arrived in A&E at night who waited for over four hours to be seen by a doctor.
- Between midnight and 8am there were two locum doctors on shift. We found that one doctor was covering the resuscitation room and majors, while the other covered minors and the 'see and treat' patients. The department was full and non-clinical areas were being used to treat patients. Patients waited for over four hours to be seen by a doctor. Patients were continuously arriving by ambulance. There were too few doctors to see patients, which meant that patients did not receive timely treatment.
- There were six senior house officers (SHOs) allocated to A&E. They rotated through all shifts over 24-hours and covered seven days a week. The duty rota showed that some SHOs were regularly working six days a week because they took on extra shifts.
- There were no doctors specifically allocated to the 'see and treat' area for minor injuries and illnesses, which operated from 8am to 8pm. During the two days of our inspection we saw that the ENP would ask the consultant to provide assistance from the senior house officers (SHO) in the medical team. However, we found that there were not always enough medical staff to assist the 'see and treat' area.
- The trust spent 15% of their medical staff budget on agency or bank staff in March 2014. The overall trust agency spend was higher than other trusts in the same region (2%).

Initial assessment of patients

- We found that patients were not safe for the following reasons:
  - Walk-in patients booked into A&E with the receptionist. Patients gave a brief account of why they were there and the receptionist would record this. Receptionist staff were not medically trained, yet the hospital relied on their skills and knowledge to establish the reason why the patient was at A&E. Although receptionists followed guidelines to refer urgent cases to 'majors' in A&E, we saw that when they tried to do this there was no reliable system to escalate care compounded by a lack of available doctors. There was not a robust system in place that ensured that patients were reviewed and prioritised by clinical staff in a timely way.
  - The receptionist could bleep the stroke team for a suspected stroke. We saw the receptionist bleep the stroke team at 10.30pm at night, but the bleep was not answered because there was no on-call stroke team. Fortunately this patient eventually was diagnosed as not having a stroke.

- All patients' details were entered on a computer system that could be accessed by all A&E staff. The computer system listed all of the minor and major patients in one long list, which meant that the patient list was very long. Also, it was not immediately clear how many patients needed to be seen in the minor or major side of A&E.
- The computer system did not display enough information for doctors to decide which patients needed priority. For example, the comments were very general such as 'chest pain' or 'unwell adult'. The doctor or ENP would have to scroll through the patient list and look at each individual's medical details to decide who to treat first. There was no alert to tell medical staff that a patient might have other health conditions such as pregnancy or mental health issues. Nurses would prompt doctors to look at patients who had additional needs.
- During the day the ENP would use what the receptionist had written about a patient's condition to decide who would be seen in the 'see and treat' rooms.
- Patients who did not fit the criteria for 'see and treat' were assessed by the triage nurse, who would also use what the receptionist had written about a patient's condition to decide who they would triage. There was no discussion or working closely with the ENP to ensure that no patients were missed.
- During the night one of the doctors would see walk-in and minors' patients, which included children. The decision on who to treat first was again based on what the receptionist had entered on the computer system. However, in practice patients were seen in the order that they arrived at A&E. This meant that we saw children in the A&E waiting area at 2.30 in the morning after they had already waited for more than four hours for treatment.
- Doctors did not have a safe system to prioritise patients for treatment. We asked the two night doctors which patients they would be seeing next and both answered that they did not know. They told us they would probably see the person who had been there the longest.
- Doctors did not work with the nurse coordinator to ensure that the assessment of expected ambulance or walk-in patient admissions were seen in order of priority. The nurses told us that they had to manage patients by carrying out as many investigations and observations as they could to try and pre-empt any treatment delay caused by the lack of doctors.
- Nurses would prompt the doctors to see patients who were either deteriorating or had extenuating conditions. We observed that the doctors took no notice of the nurses' prompts and saw the next person in the queue. The nurses described the doctors' behaviour as "stubborn" and "the more they prompted the slower they would be". This meant that patients were not seen in order of medical priority.
- During the night we observed that doctors did not take into account any extenuating factors when they decided who to treat next. For example, we saw a full-term pregnant woman, a child with special needs and a baby and none were prioritised by the doctors. When we asked the doctors what they would make a priority, one doctor said "a major event, such as a heart attack".
- Children were triaged or seen and treated in the same way as an adult. We saw that the receptionist had to prompt the 'see and treat' practitioner or doctor to see children who had been in the waiting room for more than one hour, including one child who was febrile (a high fever that may lead to a fit or convulsion).
- Children would wait for long periods without any assessment during the night. We saw the receptionist prompt the doctor to see three children because they had been in A&E for over an hour without being seen. One child with a head injury was seen only after they started to vomit, and another child with a limb injury was still waiting after three and a half hours. The doctor did not respond to any prompts from the receptionist or nursing staff. We concluded that children at risk because there was no effective system to assess them in a timely way.
- Children with special needs were also assessed the same way as adults. During the night we saw that one child with special needs became distressed and the receptionist had to prompt the doctor to see the child. However, this did not happen for a further 90 minutes prolonging the child's distress.
- Children did not get referred to the paediatric team in a timely way. Children waited for over two hours to see a doctor at night because there was no effective system from triage to the doctor. For example, we

saw that one baby had been triaged by a nurse after one hour, but had to wait a further 2 hours 50 minutes for a doctor to review the case. The child had ingested a chemical and been in A&E for three hours and 50 minutes before the doctor checked the online poisons information. The doctor contacted the paediatrician after the child had been in A&E for four hours and was then referred to the paediatric team and admitted to hospital. We observed that the child was at risk of harm because they did not receive medical attention in the first four hours following the injury, or referral to the paediatrician until four hours after admission. We found that there was no reliable system to review the medical condition of children, particularly at night.

- Nursing or medical staff could consult the paediatric team for support, which would either ask for a child to be transferred to the paediatric assessment unit or send a paediatrician to A&E. Some children were admitted to the paediatric assessment unit.
- Triage was not always safe or effective. For example:
  - The triage nurse had assessed one patient for urgent treatment and then sent them to the waiting room. The doctor was unaware the patient required urgent treatment and did see them for another three hours. When had seen the patient they found that they did not require urgent treatment. Not only had the triage nurse failed to escalate the patient's care but had also possibly made an inaccurate initial triage assessment.

- During the night we saw the triage nurse assess one elderly lady one hour after they had arrived by ambulance. The triage nurse concluded that the patient required urgent treatment for sepsis. However, the treatment was not prescribed by a doctor for another two hours and the treatment not given until half-an-hour later. Sepsis treatment must be started within one hour of admission, and this patient was only treated after a wait of three and a half hours. We found that the patient was at risk of sepsis because there was no safe system to refer patients who needed urgent treatment to the doctors.
- The trust's clinical quality indicators showed that most patients who arrived by ambulance were initially assessed in 10 minutes of arrival. There was a system to ensure that patients were booked into A&E promptly on arrival.
- A&E was often full, and patients arriving by ambulance were assessed in non-clinical areas such as the corridor. When the corridor had more than four patients the ambulance crew waited with the patient until a member of staff was available and space for the patient. The trust's quality indicators showed that patients waited for 50 minutes or more when the ambulance crew could not book them into A&E because it was full. The longest single wait recorded was six hours.
- There was a direct computer link between West Midlands Ambulance Service NHS Foundation Trust (WMAS) and A&E. This meant that A&E staff knew which patients were being admitted and could allocate appropriate areas for assessment.
- There was no direct link between the Welsh Ambulance Service NHS Trust and A&E, so patients arrived at the department without notice and could not be allocated an assessment area.
- Ambulance crews contacted the A&E department when they recognised a patient was having a stroke, and the patient would be immediately placed on the trust's stroke thrombolysis pathway on admission to A&E. We saw that two patients admitted with a suspected stroke in a couple of hours of each other. However, they received different treatment because the medical team had not been made aware of one patient and the CT scanning team were not expecting them. We found that this caused a delay in their diagnosis and treatment. The staff did not report this as an incident.
- The two 'see and treat' rooms were not suitably equipped to treat patients that needed to lie down for assessment or treatment. This meant that some patients who could have received prompt minor treatment had to wait for a long time for an available room in another part of A&E.
- During our inspection we found that only one of the 'see and treat' rooms was in use because there were too few staff to run both. Only one member of staff was allocated to the 'see and treat' area and this resulted in long waiting times.
- Patients who had underlying conditions such as asthma or epilepsy did not have their routine medication prescribed or administered. We saw that patients who had waited in A&E for many hours (including overnight) could potentially miss doses of their medication and become unwell.

Urgent and emergency services

Management of the deteriorating patient

- The unit used a recognised early warning tool to help staff assess whether patients' observations indicated that they were deteriorating medically. When staff input the observations onto the electronic observation charts the computer system automatically provided the national early warning score (NEWS).
- NEWS was displayed on the computer list of patients so that all staff could see immediately when a patient's NEWS indicated that their condition required urgent action.
- Two-thirds (66%) of staff had received training in how to use the NEWS tool and recognised when to escalate care.
- Patients who had a high NEWS had their observations recorded more often. We observed that patients with a high NEWS had their care escalated to a doctor promptly because staff recognised when patients' observations indicated they were deteriorating.
- Staff also took other observations to measure patients' levels of consciousness where necessary. Although these were recorded in the electronic records they were not displayed on the computer list. This meant that it was not immediately obvious to medical and nursing staff if a patient had an altered level of consciousness.
- Only 26% of staff nurses had undergone training in anaphylaxis (a severe, potentially life-threatening allergic reaction) treatment. This training was provided on the Intermediate Life Support (ILS) training. This placed patients at risk of not receiving prompt treatment.
- We were told that if patients were to be kept in the department for over four hours, efforts would be made to try and ensure the patient was transferred to a proper bed with a pressure relieving mattress if appropriate. We found that all of the 16 patients who had been in the department over four hours were on trolleys. Nine of these patients were over 80 years old and five of them had been in the department for over 12 hours. There had been no assessment of patients' risks of pressure ulcers and there was no system to move patients' position regularly on the trolleys. We saw that older patients admitted to A&E were not protected from the risk of pressure ulcers.
- We witnessed inadequate escalation of care from A&E when stroke consultants were not informed about patients who were due to be admitted with suspected strokes. We were told that poor escalation was common practice for this pathway, and one consultant commented: "Staff don't understand that patients need to be referred."
- In May 2014 four out of 45 confirmed stroke patients were thrombolysed. Stroke consultants were concerned about the adequacy of thrombolysis training and understanding among A&E staff. They thought that this lack of understanding reduced the numbers of patients that were thrombolysed. We could not find an A&E doctor that administered thrombolysis to ask about their training.
- We witnessed poor monitoring of a patient following the administration of thrombolysis by trained medical A&E staff rather than British Association of Stroke Physicians (BASP) accredited stroke specialists. This occurred because the patient's care had not been escalated in line with the stroke thrombolysis pathway.

Nursing and Medical Handover

- The receptionists ensured that they provided a complete handover between shifts. Waiting times were reviewed and shared with all staff.
- The nursing staff shifts were so varied that the cross-over times resulted in limited time for handover. Nursing staff handed over their areas of care to the nurse taking over and nurse coordinators would handover to each other.
- Doctors handed over patients to the doctors coming on duty in the resuscitation room.
- No A&E team handover took place because the medical and nursing staff worked separately and resulted in no patient flow planning or coordination.

Incidents

- There had been 11 reported serious incidents between August 2013 and June 2014, nine were attributable to the trust. We looked at the root cause analysis investigation carried out on three of them. The investigations had concluded with a series of actions and learning to be shared with trust staff.
- Outcomes from the incidents recommended that staff ensure call bells were available to patients and were staff reminded to report adverse incidents. The learning and recommendations from these incidents were shared in the regular staff newsletter. However, during our inspection we observed that patients did not have access to call bells, which meant that learning from incidents had not been embedded.

- We observed an incident where a patient was admitted with a suspected stroke and did not receive the care detailed in the stroke pathway. The incident was not reported by staff.
- Outcomes from reported incidents recommended that staff report all incidents. Staff gave us examples where they had witnessed aggression and verbal abuse in from patients or visitors, where they had not reported the incident. Although the trust had received 32 incident reports relating to aggression and verbal abuse between August 2013 and June 2014, staff told us they had not reported all incidents of this nature...
- Staff told us that they did not receive feedback from incidents. In the January 2014 trust staff safety culture survey nearly 30% of staff said that they either never or rarely got feedback about changes that resulted from incident reports.

Environment and Equipment

- The environment on A&E was unsafe for the number of patients attending the department. There was space to see 14 patients in 10 cubicles for adult patients plus four overspill beds. However, during our inspection we found that 23 adult patients were receiving treatment in the resuscitation room, cubicles, overspill beds, plaster room, procedures room, two children's rooms, relatives/ quiet room and in the corridor.
- Patients were also cared for in the plaster and procedure rooms on a daily basis, which could not be used for the purpose they were designed for. For example, on the day of our inspection we found that one patient was cared for in each of the plaster and procedure rooms. Staff told us that these rooms usually had two patients each, with a screen between patients. There were no call bells in these rooms to summon assistance.
- The children's waiting area was very small. Children were observed waiting in a mixed reception during periods when some adult patients were intoxicated, visibly injured, aggressive and threatening self-harm. This meant that children were not safeguarded against witnessing inappropriate adult behaviour.
- Staff told us that the quiet room was a multi-purpose room which was at times allocated to patients who were at risk of suicide, displayed aggression or had a psychiatric condition and needed a quieter spacer. However, the room had fixings on one of the doors that could have been used as a ligature point. Although we received assurances from the trust that patients who were at risk of suicide would not be left unattended, we found that the room was unsuitable and unsafe, and patients who posed a self-harm risk were not adequately protected.
- The two cubicles allocated to children were often used for treating adults. Doors in the cubicles led to the children's waiting area, which could mean that children were at risk of harm from an unwell adult leaving the cubicle.
- Staff were providing treatment in the quiet room such as taking blood and cannulating patients. There were hand-washing facilities in the room. At night we saw that one patient receiving treatment for over six hours while they waited for psychiatric assessment. The patient did not have access to a call bell and their intravenous infusion was hooked up onto furniture.
- There were two 'see and treat' rooms, but they did not have a trolley or treatment couch. We observed patients who should have been treated in the 'see and treat' area receiving care in the 'minors' or 'majors' cubicles. Patients who needed to lie down for minor treatment could not be treated in the 'minors' area. The lack of appropriate facilities resulted in longer patients-wait times.
- There were no wheelchairs available in A&E. We observed one patient struggling to move through A&E for treatment. The ENP who was going to treat the patient in an adult 'majors' cubicle told us that there were no wheelchairs in A&E during the day because they were used throughout the hospital. We observed that over two days there were no wheelchairs for A&E patients and patients with reduced mobility had no safe way to get to the treatment cubicles from the waiting room.
- The fluid warming equipment did not have a portable appliance testing (PAT) sticker to demonstrate that it had been checked for safe use.
- The blood glucose monitoring machine appeared clean and there was a system to check the machine daily. However, the records showed that the monitoring machine had been only been tested 9 out of 31 days in May 2014 and had not had a daily test for accuracy and reliability. There was a risk that the equipment would not be reliable in the event of an emergency.

Urgent and emergency services

Medicines

- Medicines and controlled drugs (CDs) were prescribed electronically and administered correctly in the 'majors' areas of A&E.
- CDs were administered in the resuscitation (resus) room without a prescription or record on two occasions in the last two months. The CD register in the resus room showed that nine vials of alfentanil injection 1mg/2ml had been removed from the CD cupboard for administration on the morning of our inspection, but there was no record. We looked at a previous record in the CD register and found that five vials of fentanyl injection 500mcg/10ml had been removed for a patient in April 2014. We looked at the paper and electronic notes for that patient and found no record of the CDs being prescribed or administered. The hospital policy states that all medicines must be prescribed. This meant that CDs were being administered without a prescription, a record of the date, time, dose or the person who administered them.
- Staff had not completed the CD register because entries were missing for the time and dose of two different medicines that that had been removed from the CDs cupboard.
- Staff did not correctly complete the dose of the CDs being removed from the cupboard. One entry for a CD used "mls" not "mgs" for dosage, where the medicine was 1mg in 2mls.
- Staff did not correct omissions or make corrections in line with trust policy. We brought the incorrect dosage in the register to the nurse's attention, and they crossed out 'mls' and replaced with 'mgs'. The CDs register was then inaccurate because only 3mg had been removed from the cupboard although it showed 6mg had been taken. We raised the omissions and corrections with the manager, who told us that they could see that the CDs register had been completed incorrectly.
- The pharmacy department carried out regular audits of the CDs register, and the last one had been in January 2014. A clause in the audit asks for: "Errors are bracketed in such a way that the original entry is still visible. These are signed, dated and witnessed (at the bottom of the page with an explanation)." A&E was compliant with this condition in the last audit.
- There was 95% compliance in the January 2014 audit, and an action had been implemented to rectify the area of non-compliance.
- The hospital's medicine policy states that two members of nursing staff are required to check, record and remove a CD from the CDs cupboard. We found that on one occasion during our inspection and on two occasions in April 2014 that only one person had signed to say that the CDs had been checked and made available for administration in contravention of the hospital's medicine policy.
- The hospital medicine policy states that where a medicine is supplied in micrograms that it should be recorded in 'micrograms' and not any abbreviated to 'mcg'. We found medicine on the CDs register that had been listed in mcg instead of micrograms. This illustrated that staff had not followed hospital policy and there was a potential risk of a medicine error.
- Medicines were stored correctly in locked cupboards or fridges where necessary and at the appropriate temperatures. We found that where intravenous fluids were stored in a warming cabinet, the temperatures of the cabinet were checked daily and their expiry dates changed accordingly. Where medicines were stored in a fridge the temperatures were checked daily.

Name bands

- One patient told us that their name band did not have the correct information on it. They told staff who replaced the name band with one that had the correct details.
- We found that not all patients who received treatment and medication had a name band. In these cases staff would not have been able to follow the trust medication policy when administering medication, which requires staff to check the bands before administering medicines.
- An alert in 2009 from the former National Patient Safety Agency (NPSA) requires all hospitals to produce printed patient name bands using a patient administration system (PAS) that records patient names, addresses, date of birth and all contact with hospital services. We saw staff that hand wrote patient details on blank name bands, and were not complying with the NPSA alert.
- Patients with an allergy were issued red name bands that met NPSA guidelines.

Hydration

- None of the patients who could eat and drink had access to water during the day. Most of the patients had been in the department for over four hours and six patients had waited for over 12 hours. They had been

offered a cup of tea when nursing staff had the time. Most of the patients in corridor, cubicles, procedure, plaster and the relatives' room had no access to a call bell. We heard patients calling out, but there were no staff to respond. We found that patients were at risk of dehydration because they could not summon assistance and fluids were not available.

- During our unannounced inspection at night the nursing staff had a jug of water and disposable cups available to give patients water. However, we found that not all patients who were able to drink had been offered it.

Records

- All patient A&E records were entered and stored on an A&E computer system. All healthcare staff in A&E used the system, which created a complete record of patients' attendance in A&E.
- When patients were admitted to a hospital ward their records were printed and formed the paper copy of their hospital notes.
- There was no link between the A&E Symphony system (a patient management system used to track patients during their visits to A&E) and the hospital PAS system. Staff had to access both systems to obtain information about alerts, previous pathology and x-ray results.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- There was no system in A&E for recording mental capacity assessments.
- Only 6% of nursing staff had completed training in using the Mental Capacity Act to assess patients' capacity to make decisions about their care or consent to treatment.

Mandatory training

- Mandatory training included annual life support skills, and in the last 12 months 61% of all nursing staff had received basic life support (BLS) training. Also, 20% of staff nurses had received intermediate life support training (ILS), and 14% had taken an advanced life support (ALS) course in the last 12 months. But, less than 30% had completed paediatric life support training, which meant that a significant number of nursing staff had not received any life support training in the last 12 months. We found that this put patients at risk because there were too few suitably skilled staff to provide care if they needed life support.
- Only 17% of nursing staff had received mandatory training in safeguarding of vulnerable adults, putting them at potential risk because so few staff could recognise the signs of abuse and how to report it.

Safeguarding Children

- The receptionist did not have access to the child protection register. All children attending A&E were checked against the hospital PAS system for an alert by the nurse and doctor providing their care. However, PAS does not specify what the nature of the alert is. An audit carried out between 1 January 2014 and 30 April 2014 showed discrepancies in the way staff recorded that they had checked if a child was on the child protection register. This meant that there was a risk that children were seen in A&E by staff who did not know if they were on the child protection register or not.
- Where an alert was displayed on the A&E computer system the medical notes were ordered.
- Mandatory trust training included safeguarding of children and young people, but only 29% of nursing staff had completed the course leaving the majority of nursing staff unable to recognise and report safeguarding issues. This meant that vulnerable children and young people who attended A&E were at potential risk of not being safeguarded against abuse.
- We asked nursing staff if they knew the procedures for children who were on the risk register. They all told us that they had not received children's training and were not aware of any special procedures.
- There was no system in place to ensure that all children were seen by a consultant where a child had visited A&E more than three times in one year, and staff were unaware of the procedures to follow if this had been the case.

Major incident awareness and training

- The trust had a major incident plan that had been updated in September 2013. The Wye Valley NHS Trust is represented on the West Mercia Local Resilience Forum (WMLRF) Risk Assessment Sub-Group and at the Herefordshire Multi-Agency Tactical Silver Group. This gives the trust an understanding of the local risks that may cause a major incident and the ability to work with other agencies on major incident planning.

Urgent and emergency services

- On the day of our inspection staff carried out a practice of the procedures to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT). This gave some staff practical experience in preparing equipment and planning for these incidents.
- During the unannounced inspection at night we asked staff if they knew where the equipment for a major incident was stored. None of the staff knew where the store was located.
- We found and looked at the equipment stored for a major incident and found that it was very cramped with equipment piled high. Some of the boxes were not clearly labelled and some had expiry dates of 2012. The trust informed us that some of the boxes contained training suits and although they had 2012 expiry dates, there had been an extension of three years on the expiry date for training suits. There was no leg room to access specific equipment because the floor space was taken up with equipment. We judged that in the event of a major incident the equipment could not be readily located or reached because of the cramped and disorganised storage.
- Although staff were able to prepare for the practical aspects of a HAZMAT incident, there was a lack of awareness about the business continuity and emergency planning disruptions that would require special measures to be implemented.
- On the first day of our inspection the implementation of a major incident declaration was discussed because of the number of patients arriving at the hospital and the lack of capacity. The capacity management process scored them at level 4 (the highest possible).

Security

- There was no security in A&E. Only 6% of staff had received training in conflict resolution, and in the event of any incidents staff told us that they would call the police. If an incident occurred that involved aggressive or violent behaviour, there was no security on site to protect patients and staff.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Staff used care pathways and bundles. However, not all of them been updated to reflect evidence-based care.

The trust had taken part in some of the College of Emergency Medicine (CEM) audits in the last four years, but the findings and recommendations from the audits had not been acted on.

There was a lack of referral to specialist nurses and allied health professionals, which meant that patients did not receive all the support they needed. There were no criteria for referring patients from A&E to speciality teams, which led to delays in patients receiving specialist care.

Although there was a good relationship and computer link with the West Midlands Ambulance Service, A&E had no relationship with the Welsh Ambulance Service. This meant staff were unaware of patient admissions from Wales and could not prepare for them.

Use of National Guidelines

- A&E used a combination of care bundles and pathways to provide care for patients with conditions such as sepsis, stroke, gastrointestinal bleed and asthma. There was a system to evaluate the use of the care bundles, which meant that patients could receive medical care that was evidence-based.
- The care bundles and pathways were paper documents that did not link to the electronic A&E Symphony system. This meant that not all information was documented in the same place and as a result staff might not be aware if a patient was on a care bundle or pathway.
- One of the key messages from the most recent mortality review in March 2014 included a reminder to clinical staff to use care bundles.
- The 2012 Stroke Thrombolysis Pathway and 2013 Stroke Integrated Pathway were based on Royal College of Physicians (RCP) and National Institute for Health and Care and Excellence (NICE) stroke guidelines. Therefore, staff had access to the latest evidence-based stroke pathway care.

- There were no care pathways or bundles available to staff to treat renal colic pain management, although these had been devised.
- The A&E department took advice and implemented suggestions from the emergency care intensive support team (ECIST) report (October 2013). We saw that the trust had implemented a 'see and treat' process as a direct result of the report. But, there was no process to evaluate whether the change in practice had benefited patients.
- Changes had followed the ECIST report, but the impact was not yet being seen.
- There were no criteria for referring patients from A&E to speciality teams. At times speciality teams would not accept referrals because A&E had not carried out enough diagnostic tests, which delayed the patient's treatment by the specialist team.

Outcomes for the department

- The unit contributed to the College of Emergency Medicine (CEM) audits, including consultant sign-off, renal colic, pain relief in children, vital signs in 'majors', fractured neck of femur, severe sepsis and septic shock.
- Wye Valley NHS Trust participated in all three audits for 2013/14 and has registered to participate in all three audits in 2014/15.
- The 2011 to 2012 CEM consultant sign-off audit showed there was no consultant activity at the weekends. During our inspection we found consultants provided cover from 9am to 12 noon on Saturday and Sunday and on-call at all other times. This led to very limited consultant cover in A&E at weekends. The trust had not taken part in the 2013 CEM audit due to the late timing of the audit, the trust had undertaken three CEM audits already in that same year. There were plans to employ more consultants, and one was due to start in September 2014.
- The CEM audit for feverish children 2012 to 2013 showed that in only 40% of cases staff had taken children's observations in 20 minutes of attendance in A&E. This was worse than in the previous 2010 CEM audit when it was at 60%. The trust had not taken steps to improve or monitor the observations of children in A&E despite the CEM audit results that showed poor performance. This meant that there was a risk that A&E would not identify a feverish child.
- The trust did not take part in the 2012 CEM renal colic audit.

Care Plans and Pathway

- All staff used a computer system to enter information about patients' vital signs, medication, diagnostic tests and treatment. There were no care plans or pathways on the system.
- A&E staff used Paediatric Assessment of Wheeze (PAW) guidelines from 2009. There was no review date and the guidelines were not in line with the British Thoracic Society's British Guideline on the Management of Asthma 2012. Children were therefore at risk of receiving care that was not up to date or evidence-based.
- There was information available within A&E regarding the diabetic ketoacidosis pathway and an acute urinary retention pathway for staff to follow and refer to specialist teams when required.
- Senior doctors used the A&E triage form to assess suicide risk. There was a referral path to mental health services from another provider, but it was unavailable most of the time because the service agreement was in a state of constant change.
- There was no provision for mental health support for patients who were not medically fit for discharge.
- Staff provided thrombolysis treatment to one patient who was experiencing a stroke. We observed that the thrombolysis treatment was given without 15 minute observations or close follow up of their oxygen saturation levels. This meant that staff did not follow the stroke thrombolysis pathway and provide evidence-based care.

Multidisciplinary team working and working with others

- There was no evidence of patients in A&E being referred to specialist nurses for conditions such as diabetes, cancer, stroke or palliative care.
- There were several student nurses working in the department who were observed working well together and with trained staff.
- Staff reported that they had limited support from the psychiatric team. We saw that patients were experiencing problems associated with their mental health conditions received no care from the psychiatric team. During the night we observed that one patient was referred to the psychiatric team, but they refused to see the patient because the patient had consumed alcohol.
- There was no physiotherapy or occupational therapy (OT) support for patients in A&E. We saw three patients

admitted to hospital after a minor injury. As a result of their long wait they were judged to have reduced mobility. But, their mobility and safety could have been assessed at an earlier stage to prevent hospital admission.
- There was pharmacy support to manage medicines and carry out medicines audits.
- On the day of our inspection we found that the hospital was in crisis. A&E was full, and more patients were expected to arrive in ambulances. We observed a bed manager's meeting that involved all management levels in the trust, the ambulance service, commissioners and social care services. The communication at the meeting was effective, and agencies and staff worked together to manage the crisis.
- There was no liaison officer to coordinate between the ambulance services and the hospital to manage admissions. A&E had a particularly good working relationship with the area station officer at West Midlands Ambulance Service. This meant staff could plan and manage patient admissions to the department effectively.
- The A&E department had no relationship with the Welsh Ambulance Service, which left staff unable to plan or prepare for admissions from Wales.

Equipment and facilities

- There was no printer in the resuscitation room and doctors would go to the main A&E area to pick up requests for x-rays, bloods and patient labels. We spoke with staff who told us that patient treatment time was wasted on administration tasks. We found that the A&E printer was unreliable and saw doctors using the printer in the 'see and treat' room. Medical staff in resus were not always available when patients needed emergency treatment because of the time taken on administration duties, and patients in the 'see and treat' rooms were interrupted by doctors collecting their printing. The problem with the printers had been escalated to the consultants, but staff had not received any feedback.

Seven-day services

- The A&E department provided assessment and treatment for patients seven days a week. The 'see and treat' service was also available from 8am to 9pm seven days a week.
- Radiology was available 24 hours a day. All radiographers had received training to provide CT scans of the head. During the night, an on-call system provided CT scans of any part of the body.
- There were pathology services available 24-hours a day.
- In addition to the daily pharmacy, there was a limited on-call pharmacy system at night and weekends.

Are urgent and emergency services caring?

Requires improvement

Staff did not routinely check patients for toileting, pressure area care, nutrition or hydration, particulary when the service was busy. Privacy and dignity were not always maintained in the corridor where patients were cared for due to lack of space. Patients did not always get food and drinks. Patients who could only eat pureed food or had special diets were not catered for.

The trust had improved its response rate in the Friends and Family Test and had scored above the England average.

Compassionate care

- The trust used a number of methods to capture patient experience in A&E. The results were reviewed regularly by the trust's quality committee, which compared results and discussed the effects of changes in service. The results for November 2013 to January 2014 showed that there was greater patient satisfaction following the opening of the new clinical assessment unit.
- Patients were provided with information on how to take part in the Friends and Family Test, and how to access the patient advice and liaison service (PALS). The results of the Friends and Family Test were displayed in the waiting area.
- Overall A&E Friends and Family Test results were above the national average. Over 19% and 25% of patients responded to the test in February 2014 and March 2014, which was above the England average (17.4%).
- We found that the receptionists were polite and helpful. We saw that the receptionists at night went out of their way to try and keep patients informed about the reasons for extended waiting times and prompted staff to see patients.
- Staff did not routinely check patients for toileting, pressure area care, nutrition or hydration. We observed

the chief operating officer during the bed management meeting request that all staff provide comfort rounds. We saw that some patients were calling out because they did not have access to their call bells. We saw that where staff were available they attended to patients' needs, but this meant that only patients that could ask for help received comfort care.

- In the 10 cubicles, eight of the patients did not have access to a nurse call bell. There was no call bell facility in the corridor, the procedure or the plaster room. Staff were not compensating for this by increasing the checks on patients.
- Patients who did not require surgery and could eat and drink did not have access to water. On the first day of our inspection 16 patients had been in the department for more than four hours, and five of these patients had been in A&E for over 12 hours. Where patients had been given a hot drink, this had been provided when the nursing staff had found the time. There was no system to ensure that patients had access to fluids.
- Staff had access to food for patients such as breakfast, but one patient we spoke with at 7pm had been in A&E for more than 14 hours and had not had any lunch. There was no facility to provide pureed meals or special diets for patients, and food provision was not always reliable.
- In the corridor we found women and men of all ages placed on trolleys so that they looked directly at each other. There were frail elderly people, some with dementia who were confused and without any family or carers. There were people who had mental health issues who were distressed. Ambulance crews waited in the corridor to hand over, and staff used the corridor to access the resus room. There was one privacy screen used to carry out personal care. However, we saw that the privacy screen was taken into resus, which meant that people's privacy and dignity was not maintained.
- By comparison when A&E was less busy we observed that patients were cared for and responded to with care and compassion. Patients commented that "when you get seen staff are very good".

Patient involvement in care

- Half (50%) of the patients we spoke with told us that they were kept informed of what was happening and knew their treatment plan. We observed that at night patients were not kept informed of the reasons for waiting in the 'majors' area of A&E. We saw that this caused distress to patients and their relatives.

Emotional support

- We saw no evidence of staff contacting specialist nurses for people with conditions such as cancer or who were receiving palliative care.
- There was 24 hour chaplaincy support available for the relatives of patients who died in A&E.

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

Inadequate

The trust regularly performed at less than the England average for national targets. For example, patient discharge times, admssions or transfers in four hours, and spending more than 12 hours in A&E after the decision to admit to the hospital had been taken. Patients had long waits in the service to be seen.

Maintaining the flow through the department was not always possible due to the lack of beds throughout the trust. The trust had a good system of booking ambulance patients in promptly, but once the department was full ambulance crews had to wait with patients in the corridor or in ambulances. The The arrival of ambulances from Wales was unplanned and increased the pressurein the service.

Staff trained in paediatric care were not always available. A&E did not have systems to meet the needs of patients living with dementia or a learning disability. Staff did not access the translation services. Staff could not provide access to follow up appointments for conditions such as transient ischaemic attack (TIA), abdominal pain, chronic obstructive airways disease (COPD) or asthma.

The number of complaints had reduced since the opening of a clinical assessment unit for GP-referred patients. Most complaints were dealt with in line with the trust's complaints policy.

Urgent and emergency services

Access

- Between April 2013 and February 2014 A&E had rarely met the national NHS Constitution target of admitting, discharging or transferring 95% of patients in four hours. The average for the year was 92%, but performance in September and December 2013 was very poor at less than 85% and less than 90% in February 2014. During the week of our announced inspection only 80% of patients were admitted, discharged or transferred in four hours. The trust was performing less well than the England average.
- During 2013 to 2014 2,500 patients waited between four and 12 hours to be admitted once the decision to admit had been made.
- During the week of our inspection 999 patients attended A&E and 198 were treated as a 'major', while 133 patients waited between four and 12 hours to be admitted to the hospital after the decision to admit them had been taken.
- Where the decision had been taken to admit a patient to the hospital from A&E the national target of no one waiting more than 12 hours on a hospital trolley was not always met. The trust had six cases that breached the target in the last two quarters of 2013 to 2014. During the week of our announced inspection two people breached the 12-hour target. The trust was performing less well than the England average.
- National targets do not measure how much time that patients spend in A&E. Trust data for 2014 showed that the longest time a patient had to wait in A&E was over 17 hours. We met six patients who had been in the department for over 12 hours. However, only one of them would have breached this target because the decision to admit them had not been made, or made many hours after they attended A&E.
- In April 2014 5.1% of patients left without being seen, which is around the national average of 5%.
- From January to March 2014 urgent pathology results met the trust's target of 90 minutes in over 95% of cases.

Maintaining flow through the department

- During our inspection we found that A&E was under severe pressure. All of the available space in the department was in use. There were ambulance crews arriving with patients continuously, and some brought in by Welsh ambulance crews were not expected.
- At 10.30am on the first day of our inspection 16 patients had been in the department for more than four hours. Nine of the patients were over 80-years-old and five of them had been in A&E for over 12 hours.
- At 11am on the first day of our inspection the trust recognised that they were overwhelmed by the influx of patients. They took steps to assess patients for discharge in the acute and community hospitals. They had cancelled operations and were caring for patients in day care beds and the discharge lounge.
- The bed management team met at regular intervals during the day and liaised with the commissioners, ambulance services and social care services to help discharge patients, release beds and improve the flow through A&E. By 8pm patients had started to be admitted to the hospital. This demonstrated that the trust took appropriate action to solve the flow problem in A&E.

Meeting the needs of all the people

- Any patient who attended A&E with an eye condition was booked in and sent immediately to the eye the needs department.
- We saw that up to four patients were cared for in the corridor on a daily basis. The number was verified in the staffing rota.
- Staff were unaware of the system introduced in the department to identify patients living with dementia. There was a dedicated room which had been decorated to meet the needs of patients with dementia. Within the room there were old pictures of Hereford and a memory box to make the room as comfortable as possible. The memory box of small items that patients living with dementia could look at and handle to occupy their time and prevent undue anxiety was found to be empty. Staff were unaware of the recently updated notice board with information about dementia. One of the junior sisters had been allocated as the A&E dementia lead. Only 31% of staff had ever received training in dementia care. We saw that patients living with dementia received the same care as other patients in A&E, and no allowance was made for their anxiety or confusion. We observed three patients living with dementia calling out and appearing anxious.
- Staff did not have a system to provide prompt support for people living with a learning disability and who had challenging behaviours to help prevent undue distress or anxiety. We saw two people with a learning disability

with challenging behaviours who had to wait for long periods. We observed that the longer they waited the more difficult it became for the patients' carers to manage their distress and anxiety.

- Translation services were available, but staff did not use them. Patients relied on family and friends to communicate with staff. There is a local growing Polish community, but we found no signs or information in Polish.
- Medical staff could refer patients for a follow up appointment at the Rapid Access Chest Pain Clinic. Patients would receive a telephone call to make their appointments once they were discharged, which would prevent re-admission to A&E.
- Patients had no access to other follow up appointments for conditions such as Transient Ischaemic Attack (TIA), abdominal pain, chronic obstructive airways disease (COPD) or asthma. This meant that some patients who were discharged from A&E did not have any planned follow up care, which meant there was a risk that they would return to A&E.
- Staff trained in paediatric care were not always available in A&E. The trust recognised that there were not enough staff in A&E with paediatric skills and knowledge. The manager told us that this had been placed on their risk register. We looked at the risk register but found no mention of the lack of paediatric-trained staff. The trust had not identified and taken action to rectify the issue.
- Children could not be assessed and treated in the cubicles designed for them because they were being used to treat adult patients.
- An automatic discharge summary was sent to the GP by email when a patient was discharged from A&E. The e-mail detailed the reason for admission and any investigation results and treatment undertaken.
- There was a television screen in the waiting area that gave patients the estimated waiting before they would be seen in the 'see and treat' area.
- The waiting area for children was very small and provided seating for two people. There were a small number of toys and books and a cabinet with empty draws. The area had recently been screened from view from the waiting room. The trust had identified that the children's waiting area was inadequate in 2007. The risk register shows that the trust is waiting costing from Estates and Facilities before a final submission of the business plan is made to the Charitable Trust Funds.
- There were two toilets in the 'major's' area, one for men and one for women. Both toilets were large enough for a wheelchair and provided handles to help with mobility.

Complaints handling (for this service) and learning from feedback

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make a complaint they were referred to the patient experience team. Complaints were acknowledged in writing and complainants were provided with a timescale for the formal reply.
- There were leaflets available in the department for patients to make a comment, compliment, concern or complaint, which included assurances that patients' care would not be adversely affected by raising a complaint. There was also information about how patients could escalate their concerns if the hospital has not been able to resolve their complaint.
- There had been a decrease in complaints since the hospital had opened a clinical assessment unit for patients referred to the hospital by their GP, which had reduced the number of patients attending A&E.
- Most of the complaints in A&E were about the quality of the care and treatment.

Are urgent and emergency services well-led?

Inadequate

There was no clear leadership in A&E. The senior medical and nursing staff did not work closely in a coordinated way to lead the team.

Medical staff did not take on any management responsibility for the assessment of patients, which had led directly to poor care.

A culture in the department had developed where staff did not want to upset each other. This was because staff at all levels were under great pressure due to staff shortages and poor patient flow through the department. This meant that medical and nursing staff failed to have vital discussions about improving the safety and responsiveness in A&E. Incodents were not always reported This led to both the trust and clinical staff not being fully arware of all the safety issues in the service that may require their response.

Urgent and emergency services

Nursing staff and junior medical staff were not encouraged to speak out or become involved in the improvement of the service.

There was no clear plan for the service. Plans to respond to individual issues were in place; but there was no overarching strategy to guide the service.

Vision and strategy for this service

- There were plans to change the layout of the department so that all patients who arrived by ambulance were in a clinical area. Plans for staffing this area included one nurse and one doctor. The manager of the unit told us that the plans for these changes had the support of the trust board. However, there was no timescale for the changes because the finance had not been approved.
- The manager told us that there would be a workforce review to increase the numbers of medical and nursing staff, including a housekeeper. We saw that a business plan had been drawn up for the year 2013 to 2014, but the dates had passed and there was no evidence of it being updated or implemented.
- Staff told us that they were aware that changes were planned but were unable to tell us what these were.

Governance, risk management and quality measurement

- Senior medical and band 7 or 8 nursing staff from A&E met monthly to discuss local issues, complaints, incidents, difficult cases and staffing morale. There was no planned feedback to the A&E staff about the issues and learning from incidents.
- The service unit manager, service unit head of nursing, finance and senior medical and nursing staff met monthly to discuss A&E's business performance. This included the risk register and future impacts on staffing. The service unit manager fed back directly to the service unit performance meetings, which fed back to the trust's quality committee.
- Appraisals had been completed for 80% of A&E staff.

Leadership of service

- The unit manager was a band 8 nurse who reported to the service delivery manager. One of the A&E consultants was the A&E clinical director. There was regular contact between the leadership, but the staff had no involvement in decision-making or discussion about the service.
- Daily leadership was directed by the band 6 nurse coordinating the shift. They described the difficulty in getting the doctors to work with them as a team to assess and treat patients in an organised way. One nurse said "there is no leadership in this department".
- There was no senior clinical lead on shift to take responsibility or challenge why patients had to wait so long.
- Staff told us that the chief operating officer visited the department three or four times a week.

Culture within the service

- There was no effective communication with other specialities. The clinical director and management had liaised with speciality teams to establish referral criteria from A&E. There had been no response. This had a direct impact on patient care because there were no referral criteria, which led to delays in patients receiving treatment from a specialist team.
- The two A&E consultants were under a great deal of pressure to cover for the two consultant vacancies. They described their role as firefighting and said they were not able to contribute effectively in the management of the department. The trust had appointed a consultant who was due to commence employment at the trust in September 2014.
- Nursing staff expressed disappointment with the level of medical support in the department.
- We were told that middle grade doctors did not always feel support by the Senior House Officer in their assessments or help them to make referrals to speciality teams in the hospital.
- All staff expressed concern about the sustained exposure to extreme operational pressures.
- Managers told us that monthly meetings between senior medical and nursing staff were very polite. However, the issues about the lack of medical support in the 'see and treat' areas and support for the nurse coordinator roles were not discussed. Managers told us that the relationships and politics between staff meant that issues were difficult to address.
- The middle grade doctors were described as 'worn out'. The managers described how the working practices in the department depended on which doctor was on duty. This meant that nursing staff were coordinating

the admissions to the 'majors' side of A&E without medical support. This had a direct impact on patient care. We saw an example of a patient who had been admitted for emergency treatment of a stroke:

- The treatment was time-sensitive and prompt action by the medical team would have a bearing on the patient's outcome. We saw that the nurse coordinator tried to facilitate the CT scan and medical treatment. However, because the medical team had not been involved in the admission, key referral and medical information was missing. This delayed the CT scan and subsequent treatment. It was a coincidence that the stroke team was in the A&E department at the time. They were made aware of the situation and ensured the patient received their treatment in the recommended time limit.
- There was an identical incident reported in December 2013.

- The trust told us there had been one meeting held for junior sisters in May 2014 and drop in sessions for other nursing staff throughout the year. However, staff told us that team meetings were on an ad hoc basis and information usually shared during these meetings was shared at handover. They said that team meetings could not be held because of the excessive workload.
- There were daily briefings either verbal or written from the nurse in charge to feedback any particular issues. However, this did not appear to work in both directions, and staff did not get an opportunity to discuss departmental issues.

Innovation, improvement and sustainability

- A&E consultants were periodically invited to present a topic of their choice to the trust board
- A workforce review was in progress that would include an increase in staff at all levels and include a paediatric ENP for a pilot.
- Junior staff told us that they were not actively encouraged to be involved in quality improvement projects, staff told us that they were continually under extreme operational pressures. The trust told us that staff had suggested and been involved in quality improvement projects including: the designation of a dementia friendly room; implementation of a reminiscence box and that a junior member of staff had developed a TIA patient leaflet.

Medical care (including older people's care)

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

Information about the service

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

We visited the following wards: acute assessment unit (AAU/Frome ward); the clinical assessment unit; respiratory and cardiac medicine ward (Arrow); gastroenterology and geriatric medicine ward (Lugg); diabetic care and stroke medicine ward (Wye/stroke unit); the coronary care unit (CCU) specialising in caring for people with cardiac conditions; the discharge lounge; and the endoscopy service.

We spoke with over 50 members of staff including: nurses; doctors; pharmacists; therapists; administrators; and housekeepers. We spoke with 20 patients and four relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Summary of findings

Patients received compassionate care and we saw most patients were treated with dignity and respect. We found good examples of multidisciplinary team working in the acute trust and joint working across community services.

Safety in medicine was compromised. We found a sub-optimal stroke service that could place patients at risk because the trust did not have hyperacute stroke facilities or staff with relevant competencies to support patients eligible for thrombolysis treatment; prescription medicines on that were not appropriately stored; shortfalls in staffing numbers for patients requiring non-invasive ventilation; and medical outliers (medical patients on none medical wards) that missed medical reviews.

There were high bed occupancy levels and poor patient flow in the trust that had a negative effect on the quality of patient care. There was a lack of senior medical staff at night and at weekends, and delayed discharge due to untimely medical reviews.

There was a lack of urgency from the trust to resolve and improve these medical speciality issues.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Safety in medicine was compromised.

On the ward we saw safeguarding alerts raised. However, we found prescription medicines on two wards that were not appropriately stored and out–of-date nutritional products. Staffing numbers were short of the British Thoracic Society guidance for patients requiring non-invasive ventilation (NIV).

Medical outliers (medical patients on none medical wards) missed medical reviews.

The quality of care and the escalation of patients on the stroke pathway were unsafe. There was a potential risk of providing a sub-optimal stroke service and harm to patient safety because the trust did not having hyperacute stroke facilities that were required due to the large geographical area the trust served, or staff with relevant competencies to support patients eligible for thrombolysis treatment.

Incidents

- Medical specialities reported one Never Event (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in October 2013. Where Methotrexate (a drug that can be used in rheumatic diseases) prescribed once a week, was given daily for three consecutive days. We found a full investigation had been completed with appropriate recommendations for improved practice and arrangements for shared learning.
- Medicine specialities had the highest number of incidents with 63 serious incidents between May 2013 and April 2014. This accounted for 35.8% of the trust total. Sixty of the incidents were classified with a moderate degree of harm, and one had resulted in death.
- In medical specialities 17 grade 3 pressure ulcers were reported as serious incidents that required investigation between April 2013 and February 2014. We saw local learning from these incidents on one ward (Arrow) where changes in documentation and audits had been implemented to reduce the number of pressure ulcers.
- There had been seven hypoglycaemic incidents reported in the acute trust between May 2013 and February 2014. The diabetes nurse told us that as a result of these incidents staff training was planned in 2014 to address improve knowledge of the prevention and management of hypoglycaemia.
- All the staff we spoke with said they were aware of how to report incidents. However, some staff told us that they did not receive feedback from incidents so did not always report all incidents. This opinion was mirrored in the January 2014 staff safety culture survey, which showed nearly 30% of staff said that they either never or rarely get feedback about changes that resulted from incident reports.
- We saw an example of learning on the respiratory ward (Arrow) following an incident with chest drains, which led to staff training and amendments made to the chest drain care plan.

Safety thermometer

- The trust-wide performance for new venous thromboembolism (VTE) was worse than the England average between March 2013 and February 2014. Data for March and April 2014 showed performance was also slightly worse than the England average. The trust performance between March 2013 and April 2014 was not consistent. Performance for new pressure ulcers was better than the England average, as was performance for catheters and new urinary tract infection and falls with harm for patients over 70-years-of-age.
- NHS Safety Thermometer information for a ward was clearly displayed on huddle boards (information boards) on each ward. This included information about falls and new pressure ulcers. These key safety measures were monitored regularly and made available to staff and patients.

Cleanliness, infection control and hygiene

- Staff followed the trust infection control policy. Staff were 'bare below the elbow', used hand gel between patients and used personal protect equipment.
- Infection rates for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) in the trust were in an acceptable range.
- We saw 11 patients in the acute assessment unit (AAU) side rooms being barrier-nursed to prevent the spread of infection.
- An infection control nurse told us that they completed monthly saving lives and mattress audits along with

spot check commode audits to ensure infection control policies were adhered to. The April 2014 commode and toileting audit showed 100% compliance for cleanliness across medical wards.
- In endoscopy we saw a system to decontaminate equipment appropriately that used a colour-coded classification of dirty equipment in the red end and clean equipment at the green end. We saw records to show that the decontamination and equipment checking system worked effectively.

Environment and equipment

- The wards were well lit, clean and tidy.
- Equipment was clean and functional. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- We found three open equipment store rooms on two wards (AAU and Lugg), which meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.
- Resuscitation trolleys were centrally located. We inspected four trolleys and saw that they were clean, the defibrillators had been serviced and that staff documented equipment testing each day to ensure equipment was fit-for-purpose.
- We saw a nurse about to use a single-use enteral syringe (a syringe used to administer nourishment and medication via a feeding tube) again a second time and which had been left on the patient's bedside cabinet. We intervened to prevent the use of the syringe. The nurse challenged our intervention and told us "we use these for 24 hours usually". The syringe was not reused.
- We saw three other patients with open single-use enteral syringes on their bedside cabinets. We reported this to the sister who told us that nursing staff had been told the equipment was for single-use only.

Medicines

- We saw staff wear red tabards when they gave out medication to prevent them from being interrupted and to allow them to concentrate on the task.
- We found one drug chart on AAU had not been signed when the patient had received the medication. We raised this with staff and it was amended.
- We found prescription medicines on two wards (AAU and CCU) were not appropriately stored in locked facilities.
- We found out-of-date nutritional products on two wards (AAU and CCU). We reported these to staff, who told us that there was no system to check the use-by dates for the nutritional products stored on the ward. We also found out-of-date food on one ward (Lugg), which meant that patients were at risk of eating out–of-date food. We reported this to staff, who told us that the housekeeper was responsible for checking food was in date, the out-of-date food was disposed.
- Ward fridge temperatures were checked regularly and adjusted if found to be outside the accepted range to ensure the efficacy of the medicines they contained.

Records

- Patient records were on paper so that all healthcare professionals could use the same documents to maintain a clear chronological record of patient care.
- During a nurse handover we witnessed nurses struggling to read medical notes because of illegible handwriting by the clinician.
- Nursing documentation covered risk assessments. We found two out of four patients had not had risk assessments completed four and five hours after transfer to the AAU. Nursing staff were aware of this, but they told us that they had been too busy to complete them despite being fully staffed.
- We looked at five observational assessment charts on Lugg ward. All charts had national early warning scores (NEWS) recorded. However, on seven occasions we found staff had not indicated what action had been taken for patients whose scores were raised. One patient had consistently raised NEWS recorded and therefore required escalation. We asked the nurse in charge about this and they told us that the patient was stable, but the assessments did not support this.
- Four out of five Malnutrition Universal Screening Tool (MUST) assessments we looked at on Lugg ward were either incomplete or incorrect.
- There was a delay in completing electronic discharge summaries. A medical team member told us that this was due to lack of staff. We saw a pile of patient notes on the AAU waiting for discharge summaries to be completed. This delayed patient discharges.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by nursing staff that where appropriate patients had dementia screening completed on admission. The abbreviated mental test score (AMTS) was used, but not all staff had been trained to complete this screening.

Medical care (including older people's care)

- The trust had a lead nurse for safeguarding and we were told that they would support the process of alerts.
- We saw information about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguard 2007 (DoLS) on notice boards for staff to refer to. We were told that there was a MCA and DoLS eLearning package on the intranet. We saw a nurse on AAU completing a mental capacity assessment who had not completed the training.
- A medical team we spoke with told us that they had received mental capacity assessment training during their initial medical training. They told us that they did not complete formal mental capacity assessments for all patients they considered should not be resuscitated. This meant that patients did not always receive an appropriate mental capacity assessment, and this was not in line with the trust Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy.

Safeguarding

- Trust data showed that only 28% of staff had received safeguarding training, but staff we spoke with knew how to raise safeguarding alerts.
- We saw one example in medical notes of a safeguarding incident, and the nurses could tell us about recent safeguarding incidents they had on their wards.

Mandatory training

- Data from the trust showed the compliance for mandatory training for care close to home and urgent care was 64%. However, the data for specialty medical staff showed that only 19% had undertaken mandatory training. All staff we spoke with, including medical staff, said they were up to date with their mandatory training.

Management of deteriorating patients

- The trust had an 'identification and intervention required for the deteriorating patient' policy.
- The medical wards used the national early warning score (NEWS) tool to escalate care for acutely ill patients. Staff we spoke with were aware of the appropriate action to be taken if a patient score was higher than expected. Patients who required close monitoring and action were identified and cared for appropriately.
- We saw an example of a junior doctor escalate care for a deteriorating patient. They told us: "Consultants are always available to ask for help."
- Nursing and medical handovers occurred at the start of each shift. Staffing for the shift was discussed as well as any high risk patients or other potential issues.
- The trust had a stroke integrated care pathway and a stroke thrombolysis pathway, but we found that these were not always followed. The quality of care and the escalation of care for patients on these pathways was not safe or effective. This was because of inadequate escalation from A&E and the lack of availability of stroke consultants to proactively identify stroke patients being admitted to the trust 24 hours a day.
- At night we witnessed a suspected stroke patient being admitted. Their care was escalated, but there was no stroke doctor on site to provide specialist advice.
- The risk register highlighted that the trust risked providing a sub-optimal stroke service and harming patient safety because it did not have hyperacute stroke facilities that were required due to the large geographical area the trust served, or staff with relevant competencies to provide thrombolysis treatment for patients.
- The trust accepted and treated patients for transient ischaemic attack (TIA) without the dedicated beds, equipment or staff competencies to support this patient group. The staff competency requirements are: 80% trained to 20% untrained for the number thrombolysis beds.
- We were given examples of three patients that had missed medical reviews that week and we saw medical notes to support this. One patient could have been discharged a day earlier if they had received a medical review.

Nursing staffing

- We saw that one trained nurse was looking after three patients who required non-invasive ventilation (NIV) and who were located in two different rooms in AAU. This did not meet British Thoracic Society staffing guidance and was highlighted on the risk register.
- Staff told us that 11 out of 17 staff on the respiratory ward (Arrow) were trained to care for patients who required NIV. If trained staff were not on duty patients were moved from the respiratory ward (Arrow) to AAU for treatment.

Medical care (including older people's care)

- Nursing staff told us they used their own staff rather than agency to cover shifts to increase continuity of care. This was reflected in the trust's agency expenditure that was below average for the NHS England (Midlands and East) area.
- For nursing staff the acuity and dependency tool was used daily to ensure staffing levels reflected patient needs. At night we found enough staff on duty. However, one qualified nurse was moved from a ward to cover staff shortages in the Hillside Immediate Care Centre. Staff told us that this had happened before.
- A sister told us that she had acquired another healthcare assistant to care for an increasing number of vulnerable patients on the ward. However, a qualified agency nurse had not turned up for their shift on the ward and this meant that the overall staff number had not increased.
- A sister told us that some European nurses required further training and supervision to practise safety.
- One nurse told us: "We're often short staffed." We were told by the AAU sister and the respiratory ward (Arrow) that their nursing establishment had recently been increased, but that they were still recruiting for the posts.

Medical staffing

- Wards had daily consultant-led rounds from Monday to Friday. The trust board papers demonstrated that they were committed to 24/7-working and were taking steps towards this.
- Three of the four registrars we spoke to told us that they did not have an induction to the trust.
- At night and weekends the trust had only one registrar and two junior doctors in the hospital, despite named medical consultants being on-call. We spoke to two doctors who told us that night cover did not increase when there was high medical bed occupancy and this meant that they could not complete all their tasks.
- There was no specialist stroke consultant cover at night or weekends. Stroke consultants were expected to care for all stroke patients and rotate with medicine consultants to provide the 'on take' medical service in AAU. This meant that they were unable to focus solely on the care of stroke patients. One consultant commented: "There is unsafe and inconsistent medical cover."
- Medical outliers (medical patients on none medical wards) were cared for by medical doctors. We spoke with a team of medicine doctors. They gave us examples of three patients that had missed medical reviews that week and we saw medical notes to support this. They told us that it was "unsafe care" and did not provide "continuity of care".
- Nursing staff on the respiratory ward (Arrow) told us that they sometimes found it difficult to get medical reviews during the night. On a surgical ward (Leadon) we found five medical patients all under different medicine consultants. Nursing staff told us that it was often difficult to get a medical review for these patients and that they had completed incident reports to highlight delays in urgent medical reviews.

Are medical care services effective?

Requires improvement

The trust participated in all the national clinical audits they were eligible for, except for the cardiac arrest audit. In 2012 the trust had scored below the national average for the Sentinel Stroke National Audit Programme (SSNAP) due to service provisions rated below the national standards, including staff shortages.

The trust had worse than expected mortality for the demography of patients admitted as measured by the Hospital Standardised Mortality Ratio (HSMR).

There were good examples of multidisciplinary team working in the acute trust and joint working across community services. Some medical support services did provide some weekend and on call cover, but there had been little progress in other areas such as the stroke pathway.

Evidence-based care and treatment

- The trust participated in all the national clinical audits they were eligible for, except for the cardiac arrest audit.
- In a patient's diabetic notes we saw a medical note entry quoting the National Institute for Health and Care Excellence (NICE) for Nutritional Support in Adults 2006 guidelines to justify patient treatment.
- We witnessed a chemotherapy patient presenting with potential neutropenic sepsis receive antibiotics in one hour, which met the National Chemotherapy Advisory Group 2009 guidelines.

- Endoscopy services had gained Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. This meant that endoscopy services had JAG quality assurance in all aspects of care. The unit's policies, practices and procedures were also safe and compliant with JAG and The British Society of Gastroenterologists (BSG) national guidelines for endoscopy.
- The trust used the Think Glucose clinical pathway to manage patients with diabetes as a secondary diagnosis. This is in the recommended guidance on the maladministration of insulin supported by NHS England in The Never Events List 2013/2014 update.

Care Pathway

- There were specific care pathways for certain conditions to standardise the care given. For example, suspected myocardial infarction (MI) patients would be transferred to Worcestershire Acute Hospitals NHS Trust as soon as possible. We were told by staff that this pathway worked well.

Patient outcomes

- The trust had greater than expected mortality for the demography of patients admitted as measured by the Hospital Standardised Mortality Ratio (HSMR). Excess mortality related to medical conditions such as acute and chronic renal failure, musculoskeletal and neurological conditions. There were monthly mortality review meetings and meetings with the Clinical Commissioning Group (CCG), and appropriate action plans were developed to reduce avoidable harm and mortality rates for the trust. However, there were no significant improvements in the outcomes.
- A dedicated staff member collated information to complete the Sentinel Stroke National Audit Programme (SSNAP). SSNAP is a national clinical audit programme that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. In 2012 the trust had a total organisation score that was below the national average. The trust lost points due to service provisions rated below the national standards, such as lower bed numbers and fewer staff including nurses and junior doctors.
- In May 2014 97.8% of stroke patients were admitted to the stroke ward directly from A&E, and received a computerised tomography (CT) scan in 24-hours of admission.

Competent staff

- All nursing staff, medics and therapists that we spoke with told us that they had annual appraisals and one-to-ones and supervision when required.
- The data showed 80% compliance with appraisals for staff in the care closer to home and urgent care specialty

Multidisciplinary working

- There were good ward links with specialist services and we saw patients being referred to services such as tissue viability, safeguarding and diabetes.
- There were two multidisciplinary team (MDT) stroke meetings per week to discuss patient care. We attended a meeting with input from medics, nursing, physiotherapy, occupational therapy, dietetics and stroke administration.
- There was MDT working in diabetes services, and we were told that there were joint clinics and meetings with community services.

Seven-day services

- Consultants we spoke with told us that endoscopy and stroke services were unable to provide a seven-day service due to a lack of consultants. The endoscopy service ran until 9pm to manage waiting lists and this resulted in a 97.5% utilisation rate.
- Radiographer services were available weekdays from 8am to 8pm. There was a 9am to 5pm service on Saturday and Sunday covered by staff working overtime. A business case was being developed to improve the service. There was an on-call out- of-hours service for urgent scans including head trauma and stroke.
- The diabetes service ran from Monday to Friday. There were diabetes management pathways on the intranet for staff to refer to and ward staff could tell us where to find them.
- Occupation therapy provided a service on Saturday and Sunday mornings until 12.30pm, in addition to their weekday service.
- Physiotherapy provided a weekend service for high risk patients and an on-call physiotherapist was available 24-hours a day.
- The pharmacy was open on Saturday and Sunday from 8.30am to 1.00pm. However, we spoke with a pharmacist who told us that they often worked over these hours to arrange medication so that patients could be discharged.

Medical care (including older people's care)

Are medical care services caring?

Good

Patients received compassionate care and we witnessed positive interactions between patients and staff. Most patients and relatives we spoke with said they felt involved in the care. The trust was ranked 35 out of 155 trusts in the National Cancer Patient Experience Survey 2013.

Privacy and dignity of inpatients in the clinical assessment (CAU) and endoscopy units was compromised.

Compassionate care

- The NHS Friends and Family Test response rate and score was improving for medical wards. In March 2014 there was one ward out of six with a score lower than the national average (Lugg).
- We witnessed positive interactions between patients and staff. Patients were treated with dignity and respect by all staff. Doctors and nurses introduced themselves appropriately and curtains were drawn to maintain patient privacy.
- Patients we spoke with were very positive about the care they had received. One patient told us: "Everyone is caring", and another said: "They've really looked after me."
- All patients appeared to be well cared for. For example, they looked comfortable and were washed and dressed in day clothes.
- 'You said, We did' reports were displayed on huddle boards (information boards) on every ward with examples of how the ward had responded to patients' feedback.
- We saw evidence of thank you cards throughout medical specialities.
- Patient's privacy and dignity was maintained in most medical wards and areas. However, in CAU inpatients had to walk across an outpatient waiting area to use bathroom facilities, and in the endoscopy waiting area inpatients wearing bed clothes shared the same waiting area as outpatients.

Patient understanding and involvement

- Most patients and relatives we spoke with said they felt involved in their care.
- We witnessed the stroke MDT (multidisciplinary team) meeting consider the requests of patient carers when planning patient discharge.
- One relative told us: "Staff are different all the time so you don't know who to ask." However, one stroke patient told us that they had been fully informed and understood their care and treatment.

Emotional support

- Patients told us staff were supportive, although they could be busy at times.
- The trust was ranked 35 out of 155 trusts from the 135 that responded to the National Cancer Patient Experience Survey 2013. Out of the 63 survey questions the trust came in the top 20% for answers to 20 questions, which included an example of a clinical nurse specialist that listened carefully to the patient, and in the bottom 20% on answers to11 questions.

Are medical care services responsive?

Inadequate

There were high levels of bed occupancy and poor patient flow in the trust. The increased number of medical patients was managed by using beds on the surgical wards, day surgery unit, CAU and discharge lounge for medical outliers (medical patients on none medical wards). We saw evidence that patients missed medical reviews which delayed discharge and the trust patient tracking system did not support doctors to track patients easily.

Access and flow

- There were high levels of bed occupancy and poor patient flow in the trust. During our inspection the bed occupancy rose to over 100%. This negatively impacted on medical patients' access to care.
- We were told by staff that there was a protocol to prevent bed moves between 11pm and 7am. However, we found evidence of patients being moved during the night to help manage bed capacity issues.
- Patients admitted from A&E or referred by their GP were sent to the AAU or CAU. We were told that direct GP referrals had been stopped temporarily due to the lack of bed capacity.
- Consultant ward rounds on AAU had increased to help manage bed pressures.

Medical care (including older people's care)

- After triage patients were referred to the care of an appropriate consultant and transferred to the designated specialist medical ward, if a bed was available. If a patient was medically fit they were discharged.
- There were more medical inpatients than medical beds. The trust managed this by using beds on surgical wards, the day surgery unit, CAU and discharge lounge for medical outliers (medical patients on none medical wards). The medical outliers were cared for by medical doctors and also by medical and surgical nursing staff.
- We found one patient admitted with respiratory problems had been transferred from the respiratory ward (Arrow) to a surgical ward (Monnow) and was then under the care of gastroenterologists. The nurse told us: "This was not ideal."
- We spoke with a medical team of doctors. They told us that they have to make time-consuming searches for medical outliers because the trust tracking system does not highlight patient transfers.
- There were more stroke patients than allocated stroke beds, therefore medical beds had to be used to accommodate them. We were told that there was an eight-week wait for a community rehabilitation bed. One consultant we spoke with was concerned about the lack of medical provision at the Hillside Immediate Care Centre that restricted discharges because they did not feel patients would receive adequate medical reviews. This resulted in a lack of flow for stroke patients, but readmission rates had improved.
- Nurses on the stroke ward told us that they were usually contacted when a stroke patient was admitted. However, there and been a recent incident where this had not happened and a patient had been left on a trolley in the ward until a bed became available.
- The discharge lounge was used for medical inpatient beds to manage capacity pressures. There were clear admission criteria for non-complex patients waiting for discharge, and the lounge aimed to meet guidance for single sex wards.
- The discharge lounge had good access to a patient garden and local parking. There was limited catering provision and no shower facilities for patients staying overnight. To organise medication to discharge a patient staff took the prescription to the pharmacy and returned later to collect the medicine, which they said was time-consuming. Staff reported that they had no problem obtaining medical reviews and treatment for patients in the lounge, even though it was some distance from other inpatient areas.
- The trust transport service ran from 9am to 10pm. Staff told us that they would stay after this time to ensure patients got home safely.
- Endoscopy services produced most patient reports on the same day for patients to take away and to give to GPs.
- Occupational therapy staff told us that they could get most equipment on the same day for urgent discharges.

Meeting people's individual needs

- The trust had a draft version of a dementia strategy and gap analysis report with an action plan. We saw initiatives used such as a 'nine important things about me' booklet and blue flower signs behind patient's beds to identify and meet the needs of patients living with dementia.
- We were told that relatives were encouraged to be involved in patient care and that patients living with dementia could be given one–to-one care. However, some of the healthcare assistants were not always trained in dementia care. We saw hospital standards for dementia displayed on wards.
- Staff told us that most wards had a dementia champion. Staff believed that a dementia specialist nurse and consultant had been appointed to provide leadership and expert advice across the trust. However, the trust reported that these staff members had special interest in dementia but were not appointed as dementia specialists. Staff did not know their names.
- Staff told us that there was a learning disabilities specialist nurse, but did not know the colleague's name. We found that both examples indicated that staff on wards were unaware of specialist posts.
- There were many patient leaflets available on the wards providing information about different clinical conditions. In endoscopy leaflets were in English and Polish.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display in the wards.
- Wards sisters could tell us about the recent complaints in their areas, what they had done to address them and how they had been disseminated to the team.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

All nursing staff spoke highly of the ward staff, managers and matron as leaders.

There was a lack of motivation from the trust to innovate and improve medical specialities such as delays in arranging specialist medical cover out-of-hours and acting on recommendations to ensure stroke services were safe. Risk registers did not identify the lack of bed capacity or management of patient flow.

Vision and strategy for this service

- There was a lack of urgency by the trust to improve the safety and vision of the stroke service. NHS England conducted a rapid response review in October 2013 and recommended the trust explore using telemedicine through a stroke network. This would provide an out-of-hours stroke physician decision-making service for thrombolysis treatment. A stroke consultant told us that although the service had received funding, the trust had failed to set it up. The delay could have a negative impact on patient care.
- The trust had attempted to create a stroke network with other NHS trusts, but it had not yet been successful. The recently formed stroke project board had developed a business plan to ask the clinical commissioning group (CCG) for extra funding.
- Most medical supportive services provided some weekend cover. Specialist medical cover had not achieved seven-day-working and we found no evidence of a strategy to resolve this.

Governance, risk management and quality measurement

- The urgent care closer to home directorate's risk register highlighted risks across medical specialities. Actions had been identified to address the concerns. However, medical bed capacity and patient flow was not highlighted on the risk register.
- The division had quality dashboards (indicators used to assess service quality) for each service that compared performance against quality and performance targets. Ward sisters told us that they had monthly meetings with the director of nursing to discuss performance.
- Endoscopy monthly staff meetings discussed governance, risk and policy. There were also weekly operational meetings to ensure targets were being met.
- Staff working on the discharge lounge were unable to provide data to show how long patients stayed there.

Leadership of service

- There was a lack of leadership to resolve the problem of poor patient flow caused by discharge delays and inadequate management of medical bed capacity.
- Nurses told us that their immediate managers were friendly, supportive and approachable.
- The band 7 nurses were supernumerary, which meant that they could focus on managing the ward.
- The nurse in charge was identified by a red badge. We were told by staff that band 5 nurses qualified in the past 12 months were the allocated nurse in charge on rotas. This was a high level of responsibility, particularly for AAU and CAU, and when there were few band 6 and 7 staff to provide cover and support at night and weekends.
- An infection control nurse we spoke with told us: "We feel supported by the trust board, they listen to us and change things if we advise it.

Culture within the service

- When we spoke with senior nurses they told us they were proud of staff working in medicine because of their commitment in such stressful and busy times.
- Most staff told us that lack of bed capacity in the trust had become the norm.
- The January 2014 staff safety culture survey showed that nearly 90% of staff either strongly agreed or agreed that they worked together as teams to get the work done quickly.
- The survey also showed that more than 60% of staff either strongly disagreed or disagreed that there were enough staff to cope with the workload. Over 50% of staff believed that they worked in crisis mode and tried to do too much too quickly.

Innovation, improvement and sustainability

- AAU had been awarded a "Going the extra mile" scheme certificate by the trust to acknowledge the work on the unit.
- We were told by nursing staff that there was a lack of practice development for them to improve their skills.
- A diabetes nurse, whose role included responsibility for education, was completing a Postgraduate Certificate in

Education. There were monthly diabetes training sessions, spot teaching sessions and e-learning for staff to improve their diabetes knowledge. The diabetes nurses had recently established a diabetes link nurse group to improve communication and share practice in the trust and community. They reported that community teams had embraced the group, but there were few diabetes link nurses in the trust.

- We were told that staff would like to complete a diabetes nurse prescriber course to improve their own skills and knowledge, but this had been refused because of restrictions on study leave.

Surgery

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

Information about the service

Surgical wards and operating theatres were managed in the elective care service unit. There were 38 general surgery beds provided in hutted wards. The eight-bed gynaecology ward was managed by the women's health directorate. There was a mixed admission unit with 35 beds. Trauma and orthopaedics had 38 beds across two wards. The day surgery ward had a mix of beds and trolleys, and could accommodate 16 trolleys or 12 beds.

There was a suite of seven operating theatres with a dedicated recovery suite. A pre-operative assessment unit was separate from the main hospital, but on the hospital site. We were able to visit all of these areas.

We spoke with 25 patients and 38 members of nursing staff across all grades. We spoke with three visiting relatives and five consultants. We also spoke with five FY1 (junior doctors), two medical students and five administrative staff. We observed handovers and protected meal times, reviewed records and nursing and medical notes.

Summary of findings

Staff in the elective care service unit were passionate and committed to their roles, and we saw that senior staff had ownership of the areas they held responsibility for. Staff were keen to develop and improve the service. Learning from mistakes and incidents had been embraced and procedures had been reviewed when needed. Further training had been identified to reduce the risk of repeat events.

However, the flow and effectiveness in surgical wards and operating theatres was severely impeded by the difficulties the trust had with bed flow and medical outliers (a patient admitted to one ward but placed in another department's ward).

Inappropriate use of the day surgery unit (for inpatients) and the operating theatre recovery area (to hold patients until beds became available) increased patient dissatisfaction and generated a risk to patients' safety and wellbeing. In December 2013 we had been concerned whether the day surgery unit was safe to support patients' wellbeing and safety. The use of the day surgery ward for patients staying longer than 23 hours remains a concern.

Safety protocols and national safety guidelines to keep surgery safe were being ignored and overruled by senior managers trying to mitigate the trust-wide bed flow problem. The impact on surgical areas was not taken into account.

Surgery

Medical staff were not able to report incidents on the trust incident reporting system; staff did not always get feedback on incidents they had reported and a culture of doubt on the value of reporting incidents existed.

The trust did not contribute to the fractured neck of femur audit, did not currently have an orthogeriatrician in post and had higher than expected mortality from musculoskeletal conditions.

Are surgery services safe?

Requires improvement

New procedures had been put in place to ensure learning from the previous two Never Events in surgery (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken). Operating theatre staff at all levels were aware of the procedures. Care was taken to control the risk and prevent hospital-acquired infection. All of the surgical areas we visited were clean.

Medical staff were not able to report incidents on the trusts systems. Staff did not receive feedback from incidents they reported and were dubious of the benefits of incident reporting.

The day surgery unit accommodated patients for longer stays (up to 5 days); but there were not regular ward rounds. These patients may not be reviewed promptly and as planned.

A trust-wide initiative to increase staffing levels had ensured that wards and departments were adequately staffed. Agency spend had been reduced and was now at 2% of staffing costs.

Incidents

- The trust had reported two Never Events that occurred in the last year. Although both of these never events involved surgical swabs; one of these events took place within the delivery suite. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.
  - In one case, three retained swabs were found in a patient following a perineal suturing (May 2013).
  - In the second case a small theatre swab found following a vaginal tape (August 2013).
- In response to the incidents theatres had developed better policy documents and were implementing these. They engaged widely with staff to empower and promote their confidence to reduce the risk of the incidents reoccurring. Staff training had been reviewed to ensure that staff were aware of the new procedures and how to use them.

- Theatre staff had reviewed the use of the cell salvage machine autosaver and ensured that staff received updated training in its use. The cell saver is designed to capture blood lost during surgery and safely process it back to the patient.
- The trust risk register showed that not all consultants had been compliant with the World Health Organisation surgical safety checklist (WHO SSC). Senior staff told us that surgeons were now monitored to ensure that they could not refuse to comply with the WHO checklist. On the second day of our inspection we saw that the theatre board identified that it had been fully compliant with WHO SSC for the previous five days. However, we found that one child had been through theatres with a consent form dated 2013 not 2014, and that the WHO SSC process had not identified this.
- Some staff reported incidents on the Datix (electronic incident reporting) system. However, all of the staff we spoke with told us that they did not receive timely feedback. Three of the staff we spoke with from surgical wards told us that the Datix system was new and had only been in place for a few months. The trust confirmed that Datix had been rolled across the trust in December 2013.
- Medical staff were not registered on the Datix system and unable to report through the system. The trust had planned open training days for the Datix system, but no dedicated strategy plan to target consultants or medical staff. Following the inspection the trust the trust told us that the incident reporting form was on the front page of the trust intranet.
- Four members of staff told us that it was a waste of time reporting things on Datix because nothing happened when they did. We asked more staff about feedback from incident reporting and were told that staff did not usually receive feedback from incident reporting.
- Orthopaedic ward staff had worked with physiotherapists to draw up new guidance to reduce the risk of falls for patients using crutches.
- Senior operating theatre staff told us that a trust director had removed the dedicated emergency team from theatres on one occasion to use elsewhere in the ho

Safety thermometer

- The orthopaedic wards had a visible display of the safety thermometer that indicated there had been a number of patient falls. For example, patients learning how to walk with crutches had not been shown how to open doors. We saw that the wards had worked with physiotherapists to find solutions to reduce the risk of patients falling.
- The general surgical wards did not have the safety thermometer information on display. However, ward sisters did monitor the thermometer and were able to show us the information. We saw that the general surgical wards achieved good scores for the safety thermometer data. The elective care service unit used a peer review process where band 7 nurses each reviewing audit data from another area. The head of nursing told us that this encouraged the band 7's to learn from each other.
- The trust had recognised that venous thromboembolism (VTE) assessments were not completed consistently. We saw monthly monitoring data that illustrated the inconsistency in the completion rate. There was evidence on general surgery wards that VTE assessments were carried out on, or shortly after admission. From the data the trust supplied they had reached 95% compliance during the year ended March 2014.

Cleanliness, infection control and hygiene

- There had been no episodes of **Methicillin-resistant Staphylococcus aureus** (MRSA) or Clostridium difficile (C. difficile) reported on the surgical wards during the last three months.
- Each ward had dedicated domestic staff responsible for ensuring the environment was clean and tidy. These were not employed directly by the hospital, but ward sisters told us they made every effort to make the domestic staff feel part of the team.
- We found hand gel available for visitors and staff at the entrance to wards.
- Ward and department staff wore clean uniforms with arms 'bare below the elbow'. Personal protective equipment (PPE) was available for staff to use in all clinical areas.
- We saw separate hand-washing basins, hand-wash and sanitiser in the ward bays.
- The two hutted wards had fewer hand-washing facilities available. With the exception of one patient contact during nursing handover on Monnow ward, we observed staff wash their hands thoroughly between every patient contact.

Surgery

- We observed staff wearing aprons and gloves when they delivered personal care to patients.
- There were no reports of surgical site infection rates. Staff told us that they did not have problems with the management of surgical wounds.
- We saw that the theatre and recovery areas were clean and well maintained.
- Operating theatres had placed clean air flow as an issue on the trust risk register. Operating theatres have dedicated air systems to ensure that air is exchanged at a specified rate, known as positive pressure. Some of the surgeons told us that the specification of the air plant was a problem. We observed surgeons and the senior nursing team restrict movement in the operating theatres. They used an ante room rather than the main internal corridor to enter or leave theatres to reduce air flow disruption. Orthopaedic consultants told us that best practice was followed, and had added 'no entry' signs to theatre doors to remind staff not disrupt the air flow during surgery. This was in line with NICE (National Institute for Health and Care Excellence) clinical guideline 74 – surgical site infection.
- We observed operating theatre staff use disposable gowns and drapes. Research shows that using disposable drapes and gowns are effective in reducing the number of hospital-acquired wound infections.
- The trust had launched a hand-washing challenge as part of its safety campaign. Surgical wards incorporated this in their monthly hygiene audit.

Environment and equipment

- Each ward area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Emergency equipment on wards and in operating theatres was maintained and checked to ensure it was safe to use. We found the resuscitation trolley on Leadon ward had been signed as checked and cleaned. However, the plastic dust cover that should have been replaced every week had not been. The sister told us that she would review the checking process.
- Specialised equipment for pressure relief such as overlay mattresses was available from the equipment library. Staff told us they received the equipment on the same day. Patients at risk of pressure damage should have suitable equipment as soon as possible to prevent further injury. There was no system to prioritise the equipment required, but staff accepted receiving it the same day was acceptable.
- The day surgery unit had two bays that could support 16 trolleys or 12 beds. Staff told us that extra trolleys were pushed into spaces when the unit was very busy. Reducing the size of the bed spaces could pose a risk to the prevention and control of infection. Estates staff had applied sticky tape labels to the curtain rails indicating where beds or trolleys could go to reduce this potential risk. The trust told us that this work was carried out in the middle of May 2014 and in the two weeks up to our inspection there had been no instances where more beds or trolleys than this area could safely accommodate had been present. However, at the time of our inspection sufficient time had not elapsed in order to demonstrate continued improvement.
- A bright orange backpack containing emergency airway management and suction equipment was available on each surgical ward. Staff wore the backpack when they collected patients from the theatre recovery room, which was some distance from the wards. We saw the backpacks being worn throughout the hospital, and observed that the daily checks were recorded.
- In December 2013 CQC found that day surgery was not delivered in a way that ensured patients' safety and welfare. CQC found that patients were being admitted to the day surgery unit (as an escalation unit) without appropriate risk assessments or consultation with medical staff.

Medicines

- We saw that lockable pods in patient lockers were secure and contained the patients' own medication.
- Drug trolleys used on surgical wards were secured to walls and kept locked when not in use. We found they were clean and tidy.
- Controlled drugs cupboards were well ordered with up–to-date lists of signatories for the controlled drugs register.
- Fridges for medicines storage were locked and the temperatures monitored on a daily basis. Staff told us that they knew who to report any problems to.
- There were agreed stock lists for both controlled and non-controlled drugs.
- Surgical wards and operating theatres were supported by the hospital pharmacy, which had a pharmacist and pharmacy technicians.

- We found that the doors to storage cupboards on Teme ward for intravenous fluids were kept open. Other surgical wards had their intravenous fluids appropriately secured.

Records

- Nursing notes were kept at the foot of each patient's bed. These contained observation charts, risk assessment for example MUST tool (a five-step screening to identify malnourished adults) and pressure assessments.
- Pre-operative assessments were recorded. Some procedures such as in women's health had dedicated short stay pathways.
- Medical notes were kept in secure note trolleys and contained decision- making information that included conversations with patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all patients had been given a copy of their consent form. For example, on Monnow ward two patients told us that they had not received a copy of their consent form.
- On the day of surgery the patient is asked to sign consent to treatment form and a doctor signs and dates this form with the patient. We saw that nursing staff had asked a doctor to return to the ward to redo a consent form because they had pre-signed and dated a consent form. The consent form was then correctly signed and kept in the patient's notes.
- Staff were able to describe how to determine whether or not a patient had the capacity to consent to their treatment. Staff could tell us who they would involve if patients did not have the capacity to do this.
- Senior nursing staff told us that Mental Capacity Act training and Deprivation of Liberty Standards training was being rolled out across the trust. Sisters and nurses in charge told us they knew who they would contact for support.

Safeguarding

- Staff knew who the safeguarding lead for the trust was, and they were able to tell us what type of concerns they would escalate. Staff were confident about what and how they would report to keep patients safe.

Mandatory training

- Each ward area and the operating theatres kept their own mandatory training records.
- We could see that mandatory training had been planned and places booked throughout the year.
- The trust had recently changed its health and safety training provider, which meant that some staff were able to complete further health and safety training with the new provider.
- Staff told us that they were sometimes called back to the wards and theatres from mandatory training due to staff shortages. We saw that band 7 nurses monitored this and ensured staff were rebooked for the training.
- There were satisfactory management arrangements in the department to ensure that staff attended all required mandatory training. Records we saw prior to our inspection identified that compliance with mandatory training was 55% for all staff in the elective care services unit. The trust did not hold separate information about training compliance for each clinical area.

Management of deteriorating patients

- The trust had a critical outreach team who were available seven days a week. Due to staffing constraints the service only ran 10 hours per day. Contact details were readily available on all wards and in the operating theatre department. A registrar or middle grade doctor with intensive care experience was available on call or the whole hospital between 6pm and 8am. This could result in the delay of a patient being reviewed.
- The trust completed the SBAR (situation background assessment and recommendation) tool to frame the questions they needed to ask when immediate medical assistance was required.
- The national early warning tool (NEWS) was used to identify patients whose medical condition was deteriorating. There were clear directions for escalating care and staff we spoke with were aware of the appropriate action to take if patients scored higher than expected on the NEWS tool.
- We looked at two completed charts and saw that staff had escalated their concerns correctly and repeat observations were taken in the necessary time.

Nursing staffing

- Ward and theatre areas had display/huddle boards ((information boards) that clearly identified how many staff were required to be on duty for each shift. This also

identified the theatre skill mix and emergency theatre team. The sisters and nurses who were in charge told us that they knew how to request additional staff if the ward was busy.
- The operating theatres had recruited new staff and had reduced their vacancies and use of agency staff from nearly 30% to 2%.
- Surgical wards had also been able to recruit new staff and had similarly reduced their agency use. When agency staff were used they completed an induction to the ward that included a checklist before they started their shift. Agency use on the surgical wards was 2%.
- There was a trust-wide process for monitoring the performance of agency staff and ensuring that consistent standards were maintained.
- Senior staff told us that they had received acuity tool training. The trust showed us that it was using part of the safer nursing care tool (SNCT) to record nurse-sensitive indicators. The movement in the ward, the numbers of transfers in and out and the complexity of patients' needs was not captured in this tool, despite the impact on staffing levels. We asked for further details about the acuity tool. The trust confirmed that they used the SNCT they had sent us.
- Nursing handovers took place at the change of every shift. We observed four handovers. Three handovers were conducted discretely and included safety information and support to the ward team. The handover on Monnow ward was conducted at the foot of each patient's bed and did not promote the dignity of each patient. For example, one patient had a catheter in place and was wearing a hospital gown. The catheter tubing was picked up by the sister conducting the handover, which raised the patient's gown. The sister did not wash her hands following this patient contact and was not challenged by her team.
- Operating department practitioners (ODP) form part of the qualified theatre team. Theatre cover over night and the need to ensure an emergency obstetric theatre is available at all times results in the on-call ODP being called in five or six out of every seven nights. Senior staff told us that they were reviewing this and planned to increase the night team to reduce the on-call requirement. ODPs we spoke with told us that they were not yet a part of this process.

Surgical staffing

- General surgical wards had a ward doctor available 24/7 shared between the surgical wards.
- Women's health had either a junior doctor or a GP trainee available for the ward area 24/7.
- Orthopaedics had junior doctor cover and was actively recruiting for a specialist grade surgeon. The vacancy is currently being covered by a locum doctor.
- Junior doctors told us that there were adequate numbers of junior staff on the wards and that the consultants were contactable by phone if they required advice or support. Junior doctors told us they felt well supported by senior colleagues.
- Wards had daily consultant-led rounds from Monday to Friday. The trust board papers demonstrated that they were committed to 24/7 working and were taking steps towards this. Middle grade doctors covered at weekends with consultants on-call for support.
- Daily ward rounds included the multidisciplinary team in the general surgery and orthopaedic wards.
- The only area that did not receive a daily ward round was the day surgery unit. Although this unit should not have required this, the use of the day surgery unit as a five-day ward for surgical and medical patients meant that patients were not routinely reviewed and supported by the multidisciplinary team.
- Medical students told us that they felt well supported and that the learning experience was positive.
- Middle grade doctors covered critical care, theatres and obstetrics and gynaecology out-of-hours.
- Handovers took place at night and in the morning. Junior doctors confirmed that they had handover with their teams at 8am when they started their shift.
- We found that the junior doctor's bleep for women's health had been left on the ward. The staff nurse answered the bleep and advised switchboard which numbers the junior doctor and registrar were contactable on that day. We could not be sure who was responsible for ensuring that switchboard had up-to-date doctors' rotas and bleep numbers.

Major incident awareness and training

- All surgical areas had up-to-date business continuity plans.
- All staff in the surgical areas were aware of the major incident plan. However, senior staff told us that they already had to defer elective surgery due to bed shortages.

Surgery

Changes to practice

- Staff on the general surgical wards told us there had been a recent change to practice to improve patient safety. Two nurses now checked the administration of intravenous solutions and carried out the double-checking system for insulin administration.

Are surgery services effective?

Requires improvement

The work carried out by the preoperative assessment unit was particularly good.

However, the lack of patient flow throughout some of the other surgical areas significantly impacted on the effectiveness of the elective care unit. The use of the surgical day unit as a long stay ward with inadequate facilities impacted adversely on patients' experience.

Evidence-based care and treatment

- The trust participated in a number of national audits.
- We saw that guidance was produced for pre-operative assessments in line with best practice, including the NICE (National Institute for Health and Care Excellence) and The Association of Anaesthetists of Great Britain and Ireland guidelines. This meant patients could be assured that appropriate assessments would be carried out to ensure they were medically fit for their operation.
- Best practice guidelines were followed for the enhanced recovery programme (ERP) for some elective surgery such as colorectal surgery.
- The trust told us it participated in the fractured neck of femur audit. We requested data relating to this, however, this was not supplied. The trust had implemented a fractured neck of femur pathway to ensure patients would be seen in 48-hours. The trust also planned to appoint an orthogeriatrician to support these patients.

Pain relief

- The trust used a trust-wide pain tool to evaluate and treat pain. Patients we spoke with told us that they received adequate and timely pain relief.
- The pre-operative assessment for post-operative pain relief prepared patients to use patient-controlled analgesia.
- There was a dedicated trust-wide pain nurse for acute pain. We observed that this nurse provided support across the hospital and that surgical patients who consulted the nurse told us they found the support helpful.

Nutrition and hydration

- Patients were offered a choice of food daily and could choose what they wanted to eat. Some patients we spoke with found the choices acceptable, others did not.
- When patients missed the opportunity to select food in advance they could choose from the hot food available on the day or from a range of sandwiches. Tea and toast or cereal was available on all ward areas.
- Patients were screened using the Malnutrition universal screening tool (MUST). If a patient was at risk of malnutrition staff kept a food diary.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital stay. There was evidence of good nutrition and hydration clinical practice on the wards, and the majority of patients were weighed in line with hospital policy.
- We observed a meal time on one of the surgical wards. We saw healthcare assistants helping people, who may have had dementia, eat their meal in a kind and caring way**.** They chatted with the patients and encouraged them to eat and drink.
- Surgical wards had a supply of high energy drinks for patients whose surgery had been cancelled and had been nil by mouth.

Patient outcomes

- The trust had higher than expected mortality rates in musculoskeletal conditions.
- The trust participated in the National Bowel Cancer Audit. The aim of this audit was to improve the quality of care and survival of patients with bowel cancer. It met the requirements set out in the NHS cancer plan and NICE (National Institute for Health Care Excellence) guidelines.
- The trust's performance for four of the six National Bowel Cancer Audit Project indicators was generally better than expected.
- The day surgery unit had a small kitchen area and hot drinks and toast available for patients having day surgery.

- Data collected and submitted by the trust to assess readmission rates indicated they were in the expected ranges for both elective and emergency surgery. Elective surgery was 13 cases below plan per month.
- The trust collected data on the average length of stay per surgical speciality and by ward area. For example, patients undergoing mastectomy or cholecystectomy had an average stay of 23 hours each. These lengths of stay are the average expected stay for these procedures.
- The trust had little data on outcomes, which made assessment difficult.

Competent staff

- The human resources (HR) department carried out monthly checks on nurse registrations and also on theatre operating department practitioners to ensure no member of professional staff was working with a lapsed registration.
- The average appraisal rate across the surgical wards was 66%. Staff told us that staff shortages had made it difficult to fit appraisals in and that they were hopeful this would improve now staffing levels had increased. Monnow ward report that they had reached 92% of completed appraisals. Band 7 nurses from some other wards in the elective care service unit told us they intended to achieve at least 92%.
- Medical staff also had an annual appraisal, which was a requirement of the five year revalidation process.
- Developmental training was available to the multidisciplinary team. For example, a nurse on Leadon ward had recently completed link nurse training for tissue viability. The trust scored worse than expected for local learning and study leave in general surgery in the 2013 General Medical Council (GMC) National Training Scheme Survey. However, the trust scored better than expected in the GMC survey for regional learning in trauma and orthopaedics.

Multidisciplinary working

- Daily board rounds were carried out with members of the multidisciplinary team. Physiotherapists and occupational therapists were available and were regularly on the wards.
- We saw that there was allocated physiotherapy and occupational therapy support to the surgical wards.

Seven-day services

- Consultant cover was available seven days a week. This meant that consultants were usually on site during the working day and an on call system operated out of hours and at weekends.
- Daily ward rounds took place seven days a week.
- The pharmacy was open seven days a week, but had shortened hours at the weekend when urgent medications were dispensed by an out of hours on call pharmacist.
- Radiology services were available seven days a week and there was out-of-hours cover for urgent CT scans.
- Pathology services were available between 8.45am and 5.15pm. Outside these hours on call cover was provided.

Pre-operative assessment unit

- The pre-operative assessment unit saw all elective (planned) surgical patients. This unit prepared patients for their surgical procedures and ran mini preparation theatres twice a week to help patients understand what to expect, and to encourage them to ask questions.
- Patients we spoke with told us that attending the pre-operative session had encouraged them to speak out without fear post-operation if they felt uncomfortable.
- The pre-operative assessment for post-operative pain relief prepared patients to use patient-controlled analgesia.
- The pre-operative unit included public health guidelines such as weight management.

Are surgery services caring?

Good

We saw that patients were well cared for and patients told us that they were happy with the care they received. Patients were given explanations they could understand and time to ask questions about their care and choices.

One surgical ward had received the trust award for the most improved Friends and Family Test score.

We observed that call bells were answered promptly.

Compassionate care

- We observed patients being spoken to with dignity and respect in all surgical areas.

Surgery

- Patients we spoke with told us that they were happy with the care they received.
- Some patients told us that they found the Nightingale-style hutted wards (a ward that has one large room without subdivision) noisy at night.
- From the CQC adult inpatient survey 2013 the trust scored 9.4 out of 10 for ensuring that all necessary information about a patient's condition was given to the specialist team on referral.
- The trust performed 'better than other trusts' for 20 of the 69 questions asked in the 2012/13 cancer patient experience survey. They performed 'worse than other trusts' for 11 of the other questions in the survey.
- Since April 2013 patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. This is known as the Friends and Family Test. The results provide an indicator of the level of patient satisfaction for each ward. The trust scores fell below the England average in December 2013, although it scored above the England average from January to March 2014. Staff were aware of the test. The general surgery ward for female patients (Leadon) won trust recognition for most improved ward in the Family and Friends Test score. The staff were proud of their achievement and told us they had spent the £50 prize on a water cooler so that patients could always have a chilled drink.

Patient understanding and involvement

- The patients we spoke with told us they had been given explanations they could understand about their care options and were given enough information about their conditions.
- Information given to patients at the pre-operative assessment prepared them for how they would feel after their surgery, and what they would and would not be able to do.

Emotional support

- The hospital had a multifaith prayer room that offered a peaceful environment and facilities for prayer and worship. This was near the main hospital reception making it easily accessible for patients and their families.
- Emotional support was available from the hospital chaplain, and ward sisters told us that they could contact leaders from other faiths when required.

Are surgery services responsive?

Requires improvement

Surgical wards and departments were trying to be resilient under the extreme pressure of the hospital-wide bed shortage. Access and flow were compromised by this serious situation. High numbers of elective procedures were cancelled and the target for the number of patients being rebooked in 28 days breached.

Planning for the elective care of people with learning disabilities was outstanding with family involvement part of the multidisciplinary team plan.

Service planning and delivery to meet the needs of local people

- Between April 2014 and June 2014 the trust's bed occupancy was consistently between 97% and 100%. This was above the England average of 85.9%. NHS England acknowledged that the quality of patient care and the orderly running of the hospital could be adversely affected if trusts ran occupancy rates over 85%.
- We saw that adult patients who attended the hospital as emergencies and whose surgery was unplanned were seen in A&E. They were then either transferred to the acute assessment unit (Frome ward) or sent straight to the theatre. Children were either taken straight to theatre or the paediatric unit.
- Elective surgical patients were assessed at the pre-operative assessment unit prior to their admission.
- The hospital served a population with a large number of older people who sustained limb fractures. The hospital had planned to provide sufficient beds for orthopaedic patients. However, we observed that other surgical patients were on orthopaedic wards. Orthopaedic consultants told us that this prevented patients from receiving prompt treatment, which could affect their quality of life even it was not life threatening.

Access and flow

- In the first three days of June 2014 the trust had cancelled 35 elective operations because of bed pressures. Of these patients nine had been cancelled on same day their surgery had been due to take place. From April 2014 28% of elective surgery had been

cancelled because of the number of medical outliers (a patient admitted to one ward but placed in another department's ward) on surgical wards. This is significantly above the national average of 1.1% in 2013.
- Patient flow in the day surgery unit was made difficult with the addition of long-stay (up to 5 days) patients and medical outliers.
- Day surgery patients were kept in the waiting room rather than being allocated a trolley in a bay.
- Bed occupancy across the trust was at 97%. The surgical wards did not have an empty bed, and every ward with the exception of women's health had patients from other areas as outliers.
- Elective patients were admitted through the surgical admission ward. Although available beds were identified when the patients arrived in the hospital and went for their operation, there were none when their operation finished, so the recovery area of theatre was repeatedly used, often for extended stays of up to six hours. The operating theatre recovery area does not have suitable facilities to support extended patient stays for recovering patients.
- Theatre planning meetings were held at 8am with site management to ensure bed availability and to prioritise patients having major surgery. We observed that theatre staff were clear in checking and rechecking that suitable beds were available before patients were taken to theatre. We observed that one patient undergoing major surgery had a bed confirmed before they went into theatre, but the bed was no longer available at the end of their surgical procedure. This put considerable strain on the recovery staff that had to support patients that required high dependency care in the unit until a bed could be found.
- Anaesthetists told us that it was not always possible to be sure that patients were on the wards indicated on the theatre list. This added extra delay and caused frustration to anaesthetists and theatre staff who tried to offer stress-free care to surgical patients.
- The trust reported in March 2014 that the percentage of patients whose surgery had been cancelled and not rebooked in 28 days was 35.7%. The number of cancellations had risen since March 2014 and we anticipated that the percentage of patients not rebooked for surgery in 28 days had also risen by June 2014. The national average for patients not treated in 28 days of cancellation for the period January to March 2014 was 5.6%
- Electronic discharge summaries were prepared by medical staff and were sent to GPs and the community hospital if required at time of discharge.

Meeting people's individual needs

- Translation services were available from either the ward sister (at any time) or the patient experience team located at the main hospital reception desk Monday to Friday between 8.30am and 4.30pm. Staff told us that the hospital had requests for translation services for: French; Polish; Spanish; Portuguese; Russian; and Arabic.
- The trust had an arrangement with the 2gether NHS Foundation Trust to support people living with learning disabilities. Each patient was given their own passport that included things that the person liked to do, what food they liked and how they liked to be supported. Patients were encouraged to bring their passport to the hospital at every visit.
- We saw that the trust had carefully planned a surgical admission for a patient living with learning disabilities that took family availability into account. There were clear records of the support given by the multidisciplinary team and the patient's family was included in the planning arrangements. This demonstrated that the trust considered the needs of people with learning disabilities and planned to meet them appropriately.
- The day surgery unit had not been designed as a long stay ward. It did not have the facilities to support patients who needed to stay for more than 23-hours. We spoke with a patient who had been on the unit for five days. They spoke about the lack of televisions and other distractions, which left them feeling unhappy with their surroundings. The unit was clean and clutter free.
- The trust did not use the best practice 'all about me' document to support people living with dementia. The trust had adopted its own version of the document 'nine important things about me'. This was supported with an above the bed sign with the blue flower, and a variety of daily activities a patient could require support with. We saw some of the signs in place and each had ticks for different requirements. However, we observed that not all staff understood the signs and had not ticked areas the patient would require support with. It is acceptable to deviate from nationally agreed systems or adapt them for local use. However, this increases the risk of implementation failures.

- Trust-wide volunteers were available to assist with protected meal times. However, Leadon ward had lost some of their volunteers and had to stagger when meals were given to people who needed help to eat. Surgical wards encouraged family members to support their loved ones during meal times, particularly if they may also have dementia. Relatives who wished to do this were given a protected meal time pass so that all staff knew why they were on the ward during protected time.
- During our inspection we found that the day surgery unit contained medical and surgical patients. We also found that one patient had been in the unit five days. This adversely affected the unit's ability to function effectively
- Patients on the day surgery unit whose procedure had resulted in a longer stay or who had not had their procedure were not happy with the facilities on the ward. Some of the patients we spoke with told us that they were bored.
- Patients told us that bathroom facilities were inadequate for people staying longer than a day, and one patient reported to us that they were told not to have a wash because they were going home.
- The environment was windowless, devoid of natural light and lacked stimulation for patients such as outliers (patient admitted to one ward but placed in another department's ward) transferred to the unit.
- Patient advice and liaison service (PALS) information booklets were circulated to patients on admission to the surgical assessment unit.
- We saw each clinical area had range of patient information leaflets about a range of medical conditions available for patients and their relatives.

Learning from complaints and concerns

- The sisters and nurses in charge of the surgical wards and departments we visited told us that they tried to resolve complaints with the person at the time wherever possible. We saw a variety of display/ huddle boards (information boards) that noted the numbers of complaints or compliments received for the past month. We saw large numbers of compliments recorded and no complaints. However, we could not readily find information on any of the surgical wards about how to complain or to whom a patient could complain.
- We saw from the trust data that the most often received complaint throughout the surgical area was staff attitude. We asked staff what this meant and we were told that when staff were busy or short staffed that they had been perceived as short tempered or abrupt with patients. We saw that the trust had started an initiative in March 2014 designed to improve patient experience by supporting staff with dedicated training sessions. Staff on the wards told us that staffing levels had recently been increased, which helped staff interact with patients.
- We saw that the trust received a large number of complaints about food. Some of the patients we spoke with told us that they had a poor choice of food and that it did not look very appetising. Other patients we spoke with told us that they were happy with the food on offer.
- Senior nursing staff told us that they had tried to encourage former patients to join a tasting panel to improve this. Staff told us that the panel had not been successful because patients had not been keen to get involved.

Are surgery services well-led?

Requires improvement

Surgical wards and departments were led by committed staff that were proud of the service they offered and keen to improve it. Not all senior staff knew how to escalate concerns to the risk register. We were told about staff being pressurised by senior managers out of hours. Not all issues were escalated to the risk register.

The clinical director had taken positive steps to ensure that surgical safety was promoted throughout operating theatres using the World Health Organization surgical safety checklist.

We saw no clear plan for surgical services. Governance arrangements were not always clear. Reporting of incidents via the Datix system was not possible for some staff groups (especially consultants).

Senior nursing staff had ownership of quality monitoring arrangements and were able to demonstrate their achievements.

Vision and strategy for this service

- The hospital-wide strategy of putting people first was recognised as the strategy for the surgical wards and operating theatres. Staff we spoke with across all areas

of surgery knew about the trust-wide strategy. There was no dedicated strategy to ensure access to surgery or to maintain the flow of patients through the elective care department.

Governance, risk management and quality measurement

- Not all of the surgical areas knew how to get concerns escalated to the trust risk register, for example in the operating theatre recovery area. Although the area raised concerns on an almost daily basis because patients were being kept on trolleys for up to six hours (sometimes more) every day, staff did not know how to check if this was on the trust risk register.
- Leadon and Monnow wards remained housed in the old Nightingale huts (a ward with one large room without subdivisions). Both reported incidents relating to poor environment and had successfully escalated the concern onto the trust risk register.
- Band 7 sisters took ownership of the quality monitoring and reported up to the head of service.
- We could not see that governance arrangements were functioning effectively. We considered that this could lead to incomplete information and assurance being given to the board. For example, staff did not receive feedback on incidents, and therefore not all concerns were reported. Some concerns such as the use of the recovery room where patients stayed for up to six hours was not on the trust risk register.

Leadership of service

- The senior nursing staff knew who the director of nursing was and told us that they had meetings with her about once a quarter. However, staff nurses and unqualified staff told us that the director of nursing rarely visited the wards and had only done so recently in preparation for our inspection. The trust told us that meetings occurred with the director of nursing and senior nurses (including ward sisters) on a monthly basis and that since the Rapid Response Review in 2013 a number of initiatives to increase executive visibility had occurred.
- Staff in the surgical unit spoke highly of the head of nursing for surgery and the new clinical director. Staff had confidence that these leaders had high visibility and were supportive when staff raised problems with them.
- The clinical director discussed with us some of the steps taken to ensure that safety initiatives were maintained and that they had achieved the appropriate outcome. For example, ensuring compliance with the World Health Organisation safer surgical checklist (WHOSSC).
- The operating department had senior management support from a service delivery manager, three band 7 nurse clinical leads and dedicated scheduling support, although they did not have a dedicated theatre manager.
- The band 7 ward sisters were confident and proud of their wards. They demonstrated clear ownership of their wards and led them with demonstrable passion and commitment to the patients they looked after. We saw that the band 7 ward sisters had protected supernumerary time that enabled them to spend time supporting staff. Staff told us that this support had improved the quality of the team spirit on the surgical wards.

Culture within the service

- We were concerned that some staff in the surgical areas reported they had been told not to talk to us, so we ensured that they felt safe to talk to us. Staff were emotional when they told us about the pressures they felt they were under. Some staff told us that they were OK during the day but one person said that they felt bullied at night by senior managers when capacity issues put pressure on bed availability; they told us they felt pressurised into working outside of protocols.

Public and staff engagement

- Staff were passionate about the work they did and the service they wanted to offer. Staff told us that they felt they did everything they could to ensure that their patients were safe and well cared for. Staff told us they felt better now that staffing levels had been increased and that the sickness rate was dropping. We saw that the trust sickness rate had been 4.2% for the last three months of 2013, which was above the NHS England average of 3.9%.

Innovation, improvement and sustainability

- The approach to pre-operative surgical assessment included promoting public health such as weight management, and demonstrating to people what to expect from their surgery.

Surgery

- The inappropriate use of the recovery and day surgery units as temporary ward areas for patients is not sustainable.
- The excessively high rate of surgical cancellations for elective surgery requires improvement.

Critical care

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

Information about the service

Hereford County Hospital provided up to eight critical care beds. There are six beds that can be used as intensive care or level 3 beds and two high dependency, level 2 beds in the main critical care unit. A further two high dependency beds were available in the coronary care unit. A critical care outreach team was available 10-hours-a-day to assist and advise on the care of critically ill patients who were on other wards throughout the hospital. An intensive care consultant was available nine–hours-a-day from Monday to Friday. Out-of-hours and at weekends consultant cover was provided by either a consultant anaesthetist or an intensive care consultant. The critical care unit admitted 616 patients between January 2013 and May 2014.

We visited the critical care unit and the separate high dependency area in the coronary care unit, although there were no patients during the time of our inspection in HDU. We talked with three patients, six relatives and 17 staff: nurses; doctors; a physiotherapist; domestic staff; and managers. We observed care and treatment and looked at four patients' records who were receiving care in the critical care unit. Before the inspection we had reviewed performance information about the hospital.

Summary of findings

Critical care services required improvement in safe, effective and responsive areas. Overall we found caring and leadership in the critical care services to be good.

The critical care bed capacity presents significant challenges for the hospital to ensure patients receive safe and appropriate care. The limited availability of the critical care outreach team needs further review to ensure that very ill and deteriorating patients receive appropriate care and treatment.

Staff were encouraged to report incidents, but did not receive feedback about when changes would be made. The lack of feedback does not convince staff to continue reporting incidents. The environment was clean and hygienic. Arrangements for medicines were generally appropriate, but improvements were needed.

The unit had a clinical audit programme to monitor adherence to guidance. There was good multidisciplinary working by critical care staff and mutual respect for all staff in the department. There was a need to ensure that suitably experienced doctors and nurses are available to provide care out-of-hours during weekends and evenings.

Patients and relatives told us that staff were caring and compassionate, and we also observed this during our inspection. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the unit.

Critical care

Are critical care services safe?

Requires improvement

Overall improvement was needed in critical care services, which had already been identified by senior staff. Plans were in place to increase the availability of the critical care outreach service from 10 to 12–hours-a-day and to improve the staffing skill mix with additional experienced critical care nurses, healthcare assistants and ancillary staff. The proposals to increase the availability of the outreach service do not meet good practice recommendations for a 24-hour outreach service. However, an additional senior nurse in critical care will address this to some extent.

Staff we spoke with said they were encouraged to report incidents, although did not receive feedback about the incidents they had reported. Critical care staff (including senior staff) were not confident that lessons learnt in other wards and departments were always shared with the department to reduce the risk of similar incidents occurring. There was good multidisciplinary working by critical care staff and mutual respect for all staff in the department. There was a need to ensure that suitably experienced doctors and nurses were available to provide out-of-hours care during weekends and evenings.

The environment was clean and hygienic. Arrangements for medicines were generally appropriate, but senior staff needed to consider alternative arrangements for storing intravenous fluids. For example, using a cupboard with closed doors and recording the minimum and maximum fridge temperatures to ensure medication was stored at the correct temperature.

Incidents

- There have been three serious harm incidents associated with the critical care department that were reported to the National Reporting and Learning System (NRLS). These incidents related to four grade three pressure ulcers and one grade four pressure ulcer between April 2013 and March 2014. Staff confirmed that an investigation (sometimes called a root cause analysis or an RCA) into their cause was undertaken. The trust forwarded requested information including RCAs which demonstrated learning into the cause of these incidents.
- The unit manager confirmed that despite staff reporting incidents such as treatment delays because of the lack of availability of critical care beds they had not received a summary of the reported incidents.
- All staff we spoke with said they were encouraged to report incidents, but did not receive feedback of the actions taken. Senior staff told us that they were not confident that actions to reduce the risk of similar incidents occurring and to improve patient safety were taken.
- Data given to the Intensive Care National Audit and Research Centre (ICNARC) identified that the critical care department had previously performed worse than expected for the number of deaths when compared to other similar critical care departments. However, ongoing audits have identified that critical care has reduced the overall patient death rate.

Safety thermometer

- Information about the incidence of pressure ulcers and infections was displayed in the critical care department.
- Staff confirmed that the 'Ward dashboard' which provided safety information of the ward on a monthly basis was usually displayed but this was not the case at the time of the inspection. Information we saw showed that the department was performing as expected for the safety indicators.
- Risk assessments for patient pressure ulcers and venous thromboembolisms (VTE) were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment. There was an identified cleaning programme, which had been completed correctly. Stickers were visible and identified when a piece of machinery or an area had been cleaned with an "I am clean" sticker, and the date it had been cleaned.
- Staff spoke positively about the role of the housekeeper, which included the cleanliness of the unit and infection control and hand-hygiene audits.
- The critical care unit had scored 100% when audited by the infection control nurses in September 2013.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to, hygienic hand-washing facilities and protective personal equipment were readily available and used appropriately by staff.

Critical care

- Hand gel was available at the entrance to the department, throughout the unit and at the end of every bed. Signs were visible throughout the unit to remind staff and visitors about the importance of hand washing.
- There were effective arrangements for the safe disposal of sharps (anything that can puncture the skin) and contaminated items.
- The unit supplied their patient data and outcomes to the Intensive Care National Audit and Research Centre data (ICNARC), which was evaluated against similar departments nationally. ICNARC data for infection rates showed that Clostridium difficile and Methicillin-resistant Staphylococcus aureus (MRSA) infection rated from April 2013 to March 2014 for the trust was statistically acceptable when compared to other trusts of similar size.

Environment and equipment

- The environment on the unit was safe and appropriately maintained.
- Equipment was appropriately checked and cleaned regularly.
- To ensure patient safety appropriate safety checks on equipment were undertaken. For example, we observed checks to portable capnography used to check the location of breathing tubes by monitoring carbon dioxide, respiratory rate and oxygen saturation.
- A buzzer system was used to enter critical care, but no camera to identify visitors and staff.

Medicines

- Arrangements for receipt, administration and storage of medicines were generally appropriate. The storage of intravenous fluids on open shelves in a treatment area that could be accessed by visitors was not safe.
- The medicines' fridge temperature was recorded daily, although the minimum and maximum temperatures were not recorded. This could mean there was a risk that medication was being stored at an incorrect temperature, which could reduce its effectiveness.

Records

- Nursing documentation was kept at the end of a patient's bed. Observations were checked and recorded at the required frequency.
- All records were in paper format. They were all filed in an identical way, which meant information could be found easily.
- All professionals involved with a patient during their admission to the unit added their notes to the same records. This ensured continuity and a team approach to care delivery.
- There were clear records of the treatment patients had received and any further treatment or follow-up they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. Staff were able to provide examples of patients who did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately.

Safeguarding

- Staff confirmed that they had received safeguarding awareness training and confirmed actions that would be undertaken to keep people safe.

Mandatory training

- Staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling and resuscitation.
- There were satisfactory management arrangements in the department to ensure that staff attended all required mandatory training. Records we saw prior to our inspection identified that compliance with mandatory training was 55% for all staff in the elective care services unit. The trust did not hold separate information about training compliance for to critical care staff.

Management of deteriorating patients

- The trust had a critical outreach team who were available seven days a week. Due to staffing constraints the service only ran 10 hours per day. Contact details were readily available on all wards and in the operating theatre department. A registrar or middle grade doctor with intensive care experience was available on call or the whole hospital between 6pm and 8am. This could result in the delay of a patient being reviewed.
- Records we looked at confirmed that ward staff had made timely contact with the outreach team and the team had made an appropriate and timely response.

Critical care

- The National Early Warning Score (NEWS) escalation process for the management of acutely unwell adult patients was used to identify patients who were deteriorating. This ensured early and appropriate treatment from skilled staff.
- The Rapid Response Review (RRR) of the hospital by NHS England was undertaken on 10, 11 and 17 October 2013. It identified that the identification and treatment of deteriorating patients needed improvement, together with improved availability of the critical care outreach team or other senior staff to advise wards and departments. The RRR action plan suggests that this work is still underway with the development of a case.
- Senior staff from the unit had facilitated acutely ill management care training (AIMs training) for staff in other areas of the hospital. The training contained both theoretical and practical experience of how to manage critically ill and deteriorating patients.
- Staff in other wards and departments contacted the critical care department for advice in the absence of the critical care outreach team. Staff reported their frustration that during busy times they were not able to leave the unit to assess patients and were only able to give telephone advice.
- Nursing handovers occurred twice a day during which staff were updated on all patients' conditions. We observed that during this handover patient confidentiality was maintained by staff speaking more quietly and also visitors to the unit were discouraged during handover.
- Visiting professionals to the units, for example, a physiotherapist or speech and language therapist, were also updated on a patient's condition and progress before giving any treatment.
- NHS Safety Thermometer information was displayed on the huddle board (information board) behind the main desk. This included information about whether there were any infections such as methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile. It also included information about the date of the last pressure ulcers. The unit was performing as expected for these indicators.
- Risk assessments for patients for pressure ulcers and VTE were being completed appropriately on admission.

Nursing staffing

- All level 3 patients were nursed on a one-to-one basis, and all level 2 patients were cared for by one nurse to two patients. There was usually one healthcare assistant per day shift and a housekeeper available from Monday to Friday.
- Staffing had been problematic and this had resulted in one bed closure. The unit was responding to increased patients' needs and the unit manager had presented a business case to increase staffing levels because of the increased acuity in patients. The business case identified the challenges of a split location service (CCU and HDU), increasing the availability of the critical care outreach service, an additional senior nurse on night duty, the availability of healthcare support workers on night duty, increased housekeeper support and the need for a ward clerk.
- If staffing levels were not met from permanent staff, the unit used agency or bank (staff who work overtime at the trust) staff to cover absences. There was a regular group of bank and agency staff, most of whom had experience of working on the unit before.
- While the local leadership was good, the absence of band 8 nursing staff did not meet best practice guidance
- A supernumerary senior nurse led each shift.
- The skill mix of the unit was diluted when the senior nurse had to work alone when the high dependency beds in the separate unit were open.
- A senior nurse was allocated to work in the high dependency unit **(**HDU). However, this reduced the skill mix of staff working in critical care. Senior staff identified the risk when they had to allocate staff over two sites while maintaining an appropriate level of experience in both areas.
- A member of staff from either the coronary care unit or from the critical care unit assisted the nurse working in the high dependency unit (HDU).
- The critical care outreach team was available from 8am to 6pm seven-days- a-week. There were plans to make this service available to 8pm, although this still does not meet good practice guidelines that advocate that the service is available 24-hours, seven- days–a-week.

Medical staffing

- There was not always sufficient medical staffing. Care in the critical care unit was led by a team of five consultants who were intensive care-qualified. An intensive care consultant was present on the unit from

8am to 6pm, Monday to Friday. Each consultant worked one week in five in the department. A specialist intensive care consultant or an anaesthetist was on-call outside these hours at weekends and nights.

- Staff said they were able to telephone the consultant for advice, but were unable to confirm that the on-call consultant could be in attendance in 30 minutes if required, which was not in line with recommended good practice.
- The consultant to patient ratio was 1:8 in the critical care unit, which did not exceed the national recommendations of 1:14.
- The consultants worked in the intensive therapy unit (ITU) in consecutive five-day blocks, as recommended in national guidelines for intensive care. They undertook ward rounds twice daily, although at weekends an intensive care consultant was not always available.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed by a consultant in 12 hours of admission. At weekends the review might be made by a middle grade doctor rather than an intensive care consultant.
- Consultants were supported by a team of other doctors that included a registrar and junior doctors. Out–of-hours (weekends and nights) cover for the critical care unit and the obstetric theatres was provided by two doctors/anaesthetists (middle grade and junior doctor).
- A registrar or middle grade doctor with intensive care experience was on-call between 6pm and 8am.
- Staff told us that when the registrar or middle grade doctor assisted in the obstetric theatres out-of-hours there would be no consultant support available for the critical care unit. Staff said that if they needed urgent medical assistance during this time they had to telephone a consultant to come into the hospital, who might not be able to get to the unit for more than 30 minutes. This could mean that patients did not receive the urgent medical care they needed.
- All potential admissions to the unit were discussed with a consultant.

Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. During our inspection we saw a part of this plan activated and staff responding as required. The critical care unit manager met with other senior staff to ensure that both existing and potential critical care patients received the treatment they needed.

Are critical care services effective?

Requires improvement

Staff had ongoing support and training provided in the unit by the unit manager and clinical lead nurse, and there was good multidisciplinary care. All staff reported that the unit provided effective care because of strong "team working".

Seven-day working for all staff and services was being developed. However, the small number of intensive care consultants meant that each of the five intensive care consultants work Monday to Friday in five-day blocks. The availability of an intensive care consultant should be reviewed to ensure that there are safe and appropriate arrangements to provide out-of-hours (weekends and evening) cover.

The unit had a clinical audit programme to monitor adherence to guidance. All staff were involved in quality improvement projects and audit. Patients underwent an assessment of their rehabilitation needs in 24-hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.

Evidence-based care and treatment

- ICNARC data showed previously higher mortality than expected, but we noted that this was falling to levels more in line with other units.
- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- The unit had an identified clinical audit programme to monitor adherence to guidance, and staff were delegated responsibility to carry out audits. For example, the housekeeper undertook hand-washing, cleanliness and environment audits. Clinical audits in

2013 had shown improvements in mortality rates. Staff told us that they were looking at further improvements and outcomes for patients that included improvements to the sepsis and acute renal injury pathways.
- The unit had implemented quality improvement initiatives. One example was “Matching Michigan" that identified improvements for the management of patients with central venous lines. An audit of performance had identified where improvements were needed and the clinical lead nurse was continuing to audit records of patients to ensure they received the appropriate care.

Pain relief
- The records we looked at confirmed that patients had regular pain relief. Patients who we spoke with told us that staff ensured they had the pain relief they needed and were kept comfortable.

Nutrition and hydration
- Staff had reviewed records to ensure that there were appropriate arrangements in place to highlight the risk of dehydration.
- A review of the care pathway for patients with acute renal injury was being undertaken included one of the critical care consultants. This was to ensure that appropriate arrangements were in place to protect patients from further health problems caused by dehydration.

Patient outcomes
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. The data demonstrated that mortality rates, delayed discharge and unplanned readmissions in 48 hours were higher than comparable units.

Competent staff
- On the critical care unit 56% of nursing staff had achieved a post-registration award in critical care nursing.
- There was no information available from the GMC National Training Scheme Survey 2013 results that gave specific information about doctor’s views on the training, support and supervision provided by the critical care department.
- The critical care unit had a clinical care lead nurse who provided teaching to enhance clinical skills, supervision and support to all unit staff.
- Nursing staff had an induction period during which they were supernumerary for at least six weeks.
- All nurse competencies were checked by nurses against standards identified by the National Competency Framework for Adult Critical Care Units. All nursing staff reported that they had an annual appraisal.
- Nursing staff were in three mentor groups and provided support to staff in each group.
- We spoke with one newly-appointed consultant who told us that they felt supported and was observed to have excellent rapport with patients and other staff.
- All staff we spoke with confirmed that they received an annual appraisal.

Multidisciplinary working
- There was a daily ward round with input from nursing and physiotherapy. Multidisciplinary team members such as the pharmacist, microbiologist and speech and language therapist had a handover every time they visited the unit.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy.
- Patients underwent an assessment of their rehabilitation needs in 24-hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.
- The unit had a dedicated team of physiotherapists.
- There was a dedicated critical care pharmacist and all patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietician provided support to the unit.
- A member of the critical care outreach team visited every patient following their discharge from the critical care unit.
- All staff reported that the unit provided effective care because of strong “team working”.

Seven-day services
- An intensive care consultant was present in the critical department from 8am to 6pm, Monday to Friday.
- Out-of-hours at weekends and nights there was an on-call consultant rota to provide cover in general theatres and critical care, but they might not be an intensive care specialist. The core standards for intensive care units identifies: “A Consultant in intensive care medicine must be immediately available 24/7, and be able to attend in 30 minutes”. The critical care unit was not meeting this standard for good practice.

Critical care

- Ward rounds took place twice-a-day, but at weekends and the rounds might not be undertaken by an intensive care consultant. This did not meet good practice guidelines.
- All potential admissions were discussed with a consultant, who reviewed the patients in 12 hours of admission.
- A physiotherapist was on duty at weekends.
- Radiology services were led by a consultant who was available for urgent x-rays and scans.
- The pharmacy was open on Saturday and Sunday mornings. Outside of these times a senior nurse had access to a stock of frequently used medication that wards and departments could use. A list of other more specialised drugs and where they were located was also available for staff.

Are critical care services caring?

Good

Patients and their relatives we spoke with said that staff were caring and compassionate. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients being treated with compassion, dignity and respect.

Staff provided good care by understanding what was significant to patients, and making arrangements to ensure they retained what was special in their lives.

Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients and relatives we spoke to were highly complementary about all the staff in the unit.
- Privacy and dignity arrangements were acceptable.
- Staff were observed to treat patients and their relatives with respect and ensured that patient's privacy and dignity were maintained at all times.
- The patient-centred culture was highly visible. Patients we spoke said that staff was caring and compassionate.
- Relatives were encouraged to visit. Visiting hours were from 10am to 1pm and 3pm to 9pm to allow patients time to rest. Flexible visiting time was at the discretion of the nurse in charge for new admissions and patients who were at the end of life. One relative told us that staff had arranged a bed for them to stay overnight in the hospital with their relative.
- The department did not take part in the Friends and Family Test (this is not a requirement until April 2015). However patients and relatives were asked to complete a survey to evaluate their experience of the critical care department. The survey report sent to us identified that patients were generally happy about their experiences of the care they had received.

Patient understanding and involvement

- The nature of the care provided in a critical care unit means that patients cannot always be involved in decisions about their care. However, whenever possible the views and preferences of patients were taken into account.
- Whenever possible patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support. For example, one relative told us: "The staff have all been excellent and very supportive."
- Staff made people aware of relevant support groups and or services such as the chaplaincy.
- After admission, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- All relatives we spoke with said they had been kept fully updated and had had opportunities to have all their questions answered.

Are critical care services responsive?

Requires improvement

The critical care services were not responsive to the needs of their patients.

The overall the capacity of the critical care unit meant that patients may not receive timely care in the unit and may

have prolonged stays in other wards or departments. Support for patients living with physical and learning disabilities or dementia was available if needed, and staff demonstrated a good understanding of people's needs.

The number of beds available in critical care was at times insufficient; operations were cancelled due to lack of availability of critical care beds.

Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those providing ongoing care.

Access to services

- Between April 2011 and December 2013 figures showed that the combined bed occupancy for adult critical care beds was 95%. This is above the national average of 86% and the 70% recommended occupancy rate by the Royal College of Anaesthetists'. Persistent bed occupancy of more than 70% suggests a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers that carry associated risks.
- Intensive Care National Audit and Research Centre (ICNARC) data showed that non-clinical transfers from critical care were below the national average. However, staff told us that the data did not include patient transfers from other wards or departments such as theatres and A&E and to other hospitals' critical care units.
- During 2013/2014 there were 22 operations cancelled due to the lack of availability of critical care beds. The figure did not include operations that went ahead and whether beds were available in the unit. At the time of our inspection a patient who was in theatre did not have the required critical care bed because of an emergency admission. The unit manager and consultant made alternative arrangements for the patient.
- Between 10 July 2013 and 26 March 2014 there were 92 patients who needed level 2 (high dependency care) care outside the critical care unit. The trust categorises these patients as unstable and at risk. There was a risk that these patients may not receive appropriate care.
- There were protocols to manage the safe transfer of patients.
- Intensive Care National Audit and Research Centre (ICNARC) data showed that sometimes a patient's discharge from the unit was delayed for more than four hours because of the lack of available bed space elsewhere in the hospital. This meant that other patients could not be admitted to the unit. We also noted that patients were occasionally treated in the theatre recovery area while waiting for a critical care bed.
- The majority of discharges from the unit occurred during the day between 8am and 10pm in line with national guidelines.
- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those providing ongoing care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the critical care unit to offer ongoing support.
- The unit manager actively ensured that admission was given to the patients in greatest need and prioritised patients who needed surgery and a period of critical care nursing.

Meeting people's individual needs

- Support for patients living with physical and learning disabilities was available if needed.
- Translation services were available both by phone and in person.
- Staff demonstrated a good understanding of people's social and cultural needs and explained to them how they could raise concerns or make a complaint.
- There had been one recent complaint. This complaint did not relate to care or treatment in the critical care unit but a delay accessing the critical care unit.

Complaints

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the shift leader. Staff would direct patients to the patient advice and liaison service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Complaints posters were displayed in the unit and information leaflets were available.

Are critical care services well-led?

Critical care

Good

There was strong local leadership in the critical care unit led by a unit manager and clinical nursing lead. Clinical leadership from the senior consultant was also seen to be good. The leadership team ensured that there was shared learning in the team and support for staff. While the local leadership was good, the absence of band 8 nursing staff did not meet the best practice guidance.

ICNARC data showed mortality to be higher than expected. More recent data shows that this is now improving. Reviews of all patients who had critical care intervention were undertaken, not just those who died in the unit.

There is insufficient capacity for the number of patients being managed on the unit. Operations were being cancelled and some patients cared for outside of the critical care unit. The HDU is not located in or near the critical care unit. There did not appear to be an urgency by the trust to manage this.

Locally, staff were encouraged to report incidents, but lack of wider trust feedback on incidents reduced staff confidence in this process.

Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for unit staff and encouraged at all levels. Staff were also encouraged to complete incident forms or raise concerns. Staff worked well together and there was obvious respect for everyone working in the unit. Risks in the unit were being managed appropriately, although risks outside the unit were not always obvious to staff. Staff were involved in quality improvement projects.

Vision and strategy for this service

- A strategy for reviewing and increasing the care provision of critically ill patients was in place. Two new beds had already been made available in the separate high dependency unit (HDU) and a business case had been drawn up with medium to long-term proposals to improve staffing levels.
- There was a plan to improve the care of deteriorating patients by increasing the capacity of the outreach team to provide a 12-hour, seven-days-a-week service. However, the plan also been identified that capacity would need further improvement in 12 to 24 months.
- Capacity issues for the service were identified. There appeared little urgency to progress this beyond the critical care unit.

Governance, risk management and quality measurement

- The division had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff.
- The critical care managers encourage staff to report incidents. Staff were not receiving feedback from the trust on this.
- The data from ICNARC shows a previously higher than expected mortality. More recent data suggests this is now falling. There was no detailed understanding of why this was falling, however:
  - The Matching Michigan initiative was part of the new work to progress improvements.
  - We did note that the team look at all deaths of patients who have had critical care unit intervention during that admission not just those who die whilst they are on the unit.
- Staff confirmed that an investigation (sometimes called a root cause analysis or an RCA) into their cause was undertaken. The trust forwarded requested information including RCAs, which demonstrated learning into the cause of these incidents.

Leadership of service

- A consultant anaesthetist who is an intensivist led the critical care service. The nursing leadership was provided by a unit manager and consultant clinical lead that were both band 7 nurses.
- A matron from the theatres/surgical directorate is the line manager for nursing staff. There was no band 8 nurse in the unit who was experienced and qualified in critical care nursing. The lack of availability of a suitably qualified and experienced band 8 nurse does not meet good practice guidelines.
- The unit manager and clinical lead provided effective team leadership and were respected by the staff we spoke with.
- The leadership ensured that there was shared learning and support for critical care staff.
- While staff reported good leadership in the unit they felt that improvements were needed from senior managers in other departments.

Critical care

- Each shift was led by a band 6 sister with supervisory responsibility for the staff working to them.
- The unit had a band 7 clinical nurse lead/educator whose role staff valued. However, this role was not fully supernumerary and not in line with good practice guidance.

Culture within the service

- Staff in the unit spoke positively about the service they provided for patients.
- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. We observed shift and unit leaders who were compassionate and led by example.
- Staff were encouraged to complete incident forms or raise concerns.
- Staff worked well together and there was obvious respect for colleagues. Staff reported that relationships with other departments in the hospital such as theatres worked well.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Staff were able to give examples of practice that had changed as a result. For example, the central venous line audit checklist led by the critical care clinical lead nurse led to improvements across the trust for patients with a central venous line.
- Improvements were identified in the management of patients with sepsis and with acute kidney injury that would lead to improvements in practice and patient care.
- Staff told us that innovation was encouraged in the department. However, staff said they were not confident they would be made aware of innovation in other areas of the hospital.
- Staff identified that the current split-site locations and insufficient bed capacity should be improved to ensure safe ongoing care for critical care patients.

Maternity and gynaecology

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

Information about the service

Wye Valley NHS Trust provides maternity care at Hereford County Hospital. Community midwifery services are provided throughout Hereford

Facilities in the hospital include:

- Antenatal, postnatal and transitional care provided on a 17-bed maternity ward, which has five side rooms with en suite facilities and three, four-bed bays. The hospital is a level 1 provider of neonatal services and has a special care baby unit. This is covered in the report in section 'Children's and young persons' services'.
- The birth suite has five rooms, one of which includes a birthing pool and one dedicated obstetric theatre.
- Antenatal clinic.
- One room used as a day assessment unit from 8.30am to 4.30pm, Monday to Friday.
- Community midwifery services.
- Ultrasound department.
- Triage takes place in a dedicated bay on the maternity ward that has two beds and one chair space.

Between 1 April 2013 and 31 March 2014 there were 1,835 births across the whole of the service, which included 45 home births and 19 births that occurred before arrival at the hospital.

Summary of findings

While staff were found to be caring, we also found that the maternity and family planning services required improvement to be safe, effective and responsive to the needs of local people.

Staff provided kind and compassionate care. However, there were risks that were not reported or monitored through the governance processes. The risk register did not reflect the concerns described to us. Changes following recent incidents had not been implemented.

The facilities were small for the number of births. There was not an effective second theatre. Lack of staff was causing a delayed response. There appeared to be a plan for addressing some of this, but staff told us they didn't think it was the right location, and had no opportunity to influence the decision making.

The service did not have a midwife led unit, although a plan was in place. There was a birthing pool.

There was a high induction, instrumental delivery and caesarean section rate. There was no bereavement facilities and little vision or innovation. Outcomes were monitored, but there were few actions to address outcomes that fell outside the national average.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Some improvement is required to ensure that maternity and family planning services are safe. For example, although incidents were reported, the service had not made safety changes following a serious incident in March 2014. While it was recognised that significant changes could not be made in a short timeframe, there were no contingency plans or changes to current practices to prevent a similar incident happening.

Areas were cramped and cluttered. The inflatable pools had no immediate access to emergency evacuation equipment. GPs and women were unable to access medical records on the electronic patient record. Not all staff had received training, and staff described being unaware of where to enter critical information such as safeguarding.

Staff working on the maternity ward were not always able to access electronic intrapartum (during childbirth or during delivery) patient records because they had not been trained. Obstetric support workers were used in theatre. They were not at the hospital out-of-hours and middle grade medical staff covered the birth suite, maternity and gynaecology wards and the emergency department alone from 8.30pm until 8.30am.

Incidents

- Incidents were reported on the trust electronic incident reporting system, and a trigger list was used to ensure staff were aware of the type of incidents to report. One Never Event (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) had been reported in the last year. Staff were able to describe learning from the incident and the changes in practice that were implemented. Staff we spoke with knew about the changes and we saw evidence of them.
- We reviewed the serious incident investigation reports following a recent serious incident. It identified that delay in the delivery of a baby had occurred because only one operating theatre was available. Staff told us this was a risk and although the incident had happened in March 2014, and actions had been put in place to reduce the risk of a reoccurrence, the risk remained. The risk had already been identified and prior to this incident and placed on the risk register in December 2013.
- Details of incidents reported were reviewed by senior midwives, the head of midwifery and also the risk management midwife. They ensured investigations took place when necessary. Staff graded incidents according to their severity. This was then checked by the lead midwives and risk manager. Serious incidents were escalated in the organisation to the organisational lead for risk.
- Incidents described as minor or negligible were investigated by ward managers. Actions and lessons learnt were printed out and kept in a folder in ward areas for staff to read.
- Staff received an email acknowledgment whenever they reported an incident.
- Trends were monitored at the monthly obstetric and gynaecological governance meeting. From the minutes we reviewed, it was unclear what actions were being taken as a result of the monitoring. For example, the number of postpartum haemorrhages (excessive blood loss after childbirth) caused by third and fourth degree perineal tears.
- Incidents and learning were reported in the staff newsletter Close encounters, which was produced by the risk midwife. This was also used to communicate key messages to staff. For example, the need to ensure communication followed the recognised situation-background-assessment-recommendation SBAR (situation background assessment and recommendation) pathway.
- All staff we spoke to stated that they were encouraged to report incidents and were aware of the process to use. Staff were knowledgeable about how to report incidents and what they would report.
- In reviewing the action points from the integrated family health (IFH) meeting it was unclear what information about incidents, trends and severity had been escalated other than numbers.

Cleanliness, infection control and hygiene

- The trust's infection rates for Clostridium difficile (C. difficile) and MRSA were in an acceptable range taking into account the trust's size compared to the national level of infections. There had been no instances of either

infection in maternity services for over 1,000 days. This information was displayed on large boards at the entrance to the maternity ward, the birth suite and the antenatal clinic.
- We saw no evidence of infection control audits taking place at the integrated family health (IFH) or the obstetric and gynaecological governance meetings for audits such as hand hygiene.
- The trust had a 'bare below the elbows' policy for anyone working in clinical area. We saw staff observed this policy at all times.
- Personal protective equipment (PPE) such as gloves and aprons were readily available for staff to use throughout the clinical areas, and we saw PPE in use throughout our inspection.
- Antibacterial hand gel was prominent at entrances with signs encouraging its use. We saw staff wash their hands and apply hand gel appropriately. During the inspection we observed one dispenser had broken. Staff identified this, reported it and a new dispenser was seen in place the following day.
- Areas and equipment were clean. We saw evidence that equipment had been cleaned and marked with stickers to indicate when it had been cleaned and who had undertaken the task.
- The unit was clean and bright, and there were no odours.

Environment and equipment

- Entry to all areas was through a locked door controlled by a buzzer. There were notices on the doors reminding people not to allow anyone access behind them. However, we saw one person being let in behind another without requesting entry.
- All areas in the maternity service were cluttered. Equipment was stored in corridors, which were also cluttered and cramped. This was unsafe for both people moving through the areas, and could make urgent access difficult. Staff reported feeling their working environment was cluttered.
- The antenatal clinic was also used as a gynaecological clinic for fertility treatment and also for 'social gynaecological 'clinics. There was one main waiting area and another in the corridor leading to the birth suite and maternity ward. This was located opposite the room used as a day assessment area. There was also a curtained-off area behind which there was a small area used for gynaecological patients. This meant privacy and dignity could at times be compromised.
- We reviewed the incidents reported by staff from December 2013 to March 2014 and identified incidents where the lack of space was an issue. One incident reported described two women and their babies were being cared for in one birthing room following elective caesarean sections. Following a clinical emergency staff had difficulty accessing a woman and could not administer emergency oxygen because she was too far away from the single oxygen delivery system. This placed the women and their babies at risk of delayed treatment.
- The review of incidents also identified that some clinical equipment was not available, particularly at weekends. On one occasion this resulted in staff attempting alternative methods of delivery. For example, obstetric staff undertook ventouse extraction (an instrument that is attached to the baby's head by suction) using silicon cups, but the unit had only three silicon cups. When unavailable metal cups were used. Staff also told us the bladder scanner had previously been broken and unavailable for a period of ten days.
- The unit had created a 'virtual midwifery led unit'. However, this had been created by merely adding additional birthing supports such as couches and a birthing ball to one of the delivery rooms. This room also included an inflated birthing pool and a delivery bed pushed to one side. As a result the room was very cluttered and cramped and risked causing access delays in emergency situations
- Staff spoke of plans to change a four-bedded bay on the maternity ward into a midwife-led birth unit. This would reduce bed numbers on the ward to 16.
- There were sufficient cardiotochograph machines available to monitor babies' heart rate during labour as well as telemetry.
- We saw emergency resuscitation trolleys had been checked, but not always on a daily basis. For example, when we reviewed the emergency trolley on the birth suite we noted it had not been checked for four days in April and five days in May.

- Resuscitaires (emergency resuscitation trolleys) were available at the birth suite. We saw evidence that resuscitation equipment was checked, although again not always on a daily basis.
- There was one dedicated obstetric theatre, which was next to the birth suite. Entry to the theatre was through the dedicated anaesthetic room. The recovery area was in a curtained bay off the corridor. The fifth delivery room was used to provide additional recovery space. If a second theatre was needed in an emergency, staff told us they would use room five on the birth suite. At the time of our inspection we saw the operating theatre in use, and room five also had a woman in labour. This meant the contingency plan could not be activated if required.
- The trust had an electronic database of all equipment. Each piece of equipment was given an asset number when it was purchased to cross reference information about it. Staff told us the medical electronics department responded to requests for assistance with faulty equipment and prompt when machinery was due for servicing. We reviewed the maintenance stickers on a wide variety of equipment such as pumps, and monitors. Not all equipment had stickers indicating they had been checked in the last year. For example, the date stamp on one pump recorded a date of December 2011 and It was unclear if this pump had been checked or not.
- The maternity service was located in the private finance initiative (PFI) build. As a result, maintenance was undertaken through a private company. Staff said if environmental changes were required there could be some delay.
- There was emergency evacuation equipment in the delivery room that housed the permanent birthing pool. Staff told us inflatable pools would be deflated in the event of a maternal collapse. However, this could cause a time delay by the need to drain away some water from the pool. If needed for an inflatable pool, access to the emergency evacuation equipment could be difficult if the room housing the permanent pool was in use. It risked intruding on the privacy and dignity of a woman in labour because staff would have to enter the room to retrieve the equipment.
- In evacuating the woman from the pool without the appropriate equipment such as a hoist or evacuation net could injure the mother through poor lifting techniques. In addition staff were at risk of musculoskeletal injury from manual handling practices. The recommended number of staff for lifting during an emergency evacuation is four. Additional staff could be summoned quickly to the birth suite and the maternity ward if required. However, incorrect moving and handling techniques would place the woman and midwives at risk of injury.
- Staff had identified that the Entonox ventilation system used to remove noxious gases had been identified as a risk to their health. Staff had undergone monitoring and accepted levels were up to 100 ppm (parts per million). However, three staff had breached this level and one recorded levels up to 300 ppm. This was recorded on the risk register as a moderate risk. In order to mitigate this risk, pregnant midwives were redeployed away from the area and staff were encouraged to open windows and use fans. The concerns had been raised with the company responsible to the private finance initiative (PFI) contractor. The trust was working with its PFI partner to ensure a permanent solution was found. This had been reported to the Health and Safety Executive who was satisfied with the actions the trust has initiated to manage the problems. Staff had undergone additional screening, but the results had not been received at the time of the inspection.
- There was only one dedicated obstetric operating theatre. This had previously been identified as a risk, but no mitigating actions had been instigated. A serious incident had also occurred in which the absence of a second theatre was felt to have contributed to a poor outcome. Despite this, staff were unable to describe how they would manage a similar situation. The absence of a second obstetric theatre was not on the maternity or integrated family health (IFH) risk register.

Medicines

- Medicines were stored in locked cupboards.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. We saw evidence that temperatures were checked and recorded regularly and were in acceptable limits.
- Gas and air for pain relief was piped into delivery rooms.
- Stronger analgesia was available for women in labour and was subject to a two-person check prior to administration.
- A display board at the central midwives station showed a readout indicating when controlled drugs cupboard was open.

Maternity and gynaecology

Records

- In March 2014 the service introduced a specific maternity electronic patient record system. Women who had already been booked had their antenatal care documented in the national antenatal care records. These records continued to be used until they presented in labour. Pregnant women who booked in after that date were not given any hand-held records and were unable to view their records. At booking they were given some health information leaflets, but had no means of reviewing entries made by healthcare professionals about their care.
- Medical records were obtained to allow staff to cross reference the woman's history and review the detail of previous deliveries.
- Once a woman presented in labour, all intrapartum and postnatal care records were documented on the electronic patient record. Staff spoke of concerns they had about their knowledge and the functionality of the system. A project lead had been appointed who was no longer in post. Daily trouble shooting meetings continued. However staff we spoke to felt this post was still required while issues were being addressed.
- There were ongoing training sessions on using the system. A number of staff reported not having had training before the system 'went live'.
- Senior staff held a daily meeting to address any issues that had been identified. Staff spoke of concerns that the system did not hold all the information they required. However, their concerns had had not been placed not on the maternity or integrated family health (IFH) risk register.
- Staff were not familiar with all aspects of the electronic patient record system. For example, when questioned, one midwife working on the maternity ward was unable to review the delivery records of one of the women they were caring for because they were unfamiliar with how to access information on the system. This meant that patients were at risk of inappropriate postnatal care.
- Some staff were unaware where safeguarding information was stored, or how to access it in the 'social booking' page.
- GPs were unable to access the records. This meant a woman's maternity care records could not be viewed if she consulted her GP. GPs had raised this as a concern together with concerns about a lack of information about women's care in hospital. These were not on the risk register and no solution had been identified.
- The system did not contain any patient pathways. While this had been requested, it had not been put into place before the project lead had left.
- Audits of record-keeping form part of each midwives' annual supervisory review. As the electronic patient record had only just been implemented, these had yet to be audited.
- During our inspection we identified some computer screens left unattended displaying patient-sensitive information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. At the time of the inspection, there were no women who did not have capacity to consent to their procedure.
- The women's health ward also carried out medical terminations. There was a standard operating procedure (SOP) that detailed the referral process, patient options and the legal implications of consent. Staff responsibilities relating to consent were explained explicitly. The SOP also included counselling support for the patient, which patients they could choose to access before or after the procedure.
- The Abortion Act 1967 requires a form (HSA1) certifying that the requirements for a termination have been met and is signed by two doctors before the procedure takes place. We saw the signatures were recorded and an acknowledgement of the discussion was also recorded in the note proforma.

Safeguarding

- Staff were aware of their responsibilities with regards to safeguarding and had undergone training at the appropriate level.
- Staff notice boards contained information regarding safeguarding and how to raise safeguarding concerns.

Mandatory training

- Compliance with mandatory training was good. There was a dedicated practice development midwife who monitored attendance and organised training sessions. Staff said access was good and midwives received the trust's mandatory training as well as obstetric emergency skills, neonatal and adult resuscitation training.
- Newly-qualified midwives undertook a period of preceptorship (practical experience and training) that lasted between 12 and 18 months. A midwifery academy

had been developed to aid recruitment and promote retention among new and existing midwifery staff. On joining the organisation, new midwives (including midwives recruited at band six) spent eight weeks in the academy. This was classroom-based and involved teaching, education and development sessions run by specialists and midwives working in other areas. Any existing midwife could also attend individual sessions if they wanted. Following the eight-week classroom sessions, midwives spent one week working supernumerary in all areas including the special care baby unit, before undertaking three-month rotations in all service areas. Staff spoke very highly of the academy. This had also been identified as good practice following a review by the local supervising authority.

- Staff undertook at least four training days each year. Two days were clinical refresher days and covered topics such as medicines management, infection control updates, moving and handling training and basic life support. A third day was described as a professional update day, providing safeguarding training, antenatal and newborn screening, infant feeding and a 'hot' topic, which is currently midwifery exemptions (medicines midwives may supply and administer on their own initiative). A fourth day of training was a multidisciplinary team intrapartum day, during which emergency obstetric skills were practiced as well as sepsis recognition, intrapartum foetal monitoring and wound management.
- Staff were also required to undertake learning that covered rhesus antibodies, the Mental Capacity Act and antenatal and newborn screening as well as CTG (continuous cardiotocography) interpretation.
- Approximately 90% of midwives attended their mandatory training (78.9% to 97.5% attendance, dependant on topic), while 100% of medical staff had attended mandatory training.
- Safeguarding training level 2 had 100% attendance by midwifery staff. They were also required to attend level 3 training in the following six months. We reviewed the training database and found that 38 midwives had yet to complete the level 3 training, the majority had been newly-appointed.

Management of deteriorating patients

- All staff attended obstetric emergency skills training.
- Emergency resuscitation equipment was available for both mothers and babies and was regularly checked.
- The unit used the modified emergency obstetric warning scoring (MEOWS) system. Staff we spoke with were able to describe at what point care would be escalated to a medical practitioner.
- Staff undertook 'fresh eyes' on the birth suite, ensuring that cardiotochograph readings were reviewed every two hours. This was usually the birth suite coordinator, who was generally supernumerary.
- Staff used the SBAR communication tool when handing over or discussing concerns (situation, background, assessment, response). Reminders to use the tool were paced at various points throughout the unit.
- Some midwives had completed additional training in acute illness management. Staff were able to apply for the course, although numbers able to attend were limited.
- Staff could give women 'HDU- level care on the birth suite. Any woman who needed additional support and care such as central venous lines was transferred to the intensive care unit (ITU). Staff described a good rapport with the unit and said the hospital outreach team would attend the birth suite if required. During the financial year 2013 to 2014 two women were transferred to ITU.
- Women were risk assessed throughout their pregnancy. Where they were deemed high risk, for example as a result of a high body mass index, or following previous anaesthetic concerns, they were referred to the consultant obstetrician and anaesthetist as appropriate. Referral was made to larger units for continuation of maternity care when required, for example following antenatal diagnosis of some foetal abnormalities.

Midwifery staffing

- During the first half of the financial year 2013 to 2014, midwifery sickness levels were high, ranging from 4.7% to 6.7%. Staff reported a reduction in sickness rates during the latter half of the year, which gave an overall sickness rate of 4.9% compared to an England average of 4.3%.
- At the entrance to each ward, a large display board detailed the expected number of staff on duty and the actual number on duty. We saw the actual numbers of staff was as expected in all areas apart from the antenatal clinic, where less midwives were actually on duty. Staff we spoke with told us there had been a positive increase in staffing numbers over the last few months. Prior to the recruitment of a number of new midwives, agency staff had been used. Staff identified

this as a risk. Agency staff were no longer used to cover shifts due to additional recruitment and the management of a bank (staff who work overtime in the trust) of midwives to cover vacant shifts.

- Staff reported one-to-one care for women in labour was always provided. At times this meant the midwife in charge of the birth suite would be required to provide care to a woman.
- We saw evidence of delay in treatment due to a lack of midwives to provide one-to-one care. For example during the inspection, augmentation of one woman with prolonged rupture of membranes was delayed. While reducing the risk in one area, this increased the risk in another.
- Staff told us at times they were called to support the nursing staff on the neighbouring gynaecology ward, for example to check the administration of medicines. Staff told us this could result in delayed care for women on the maternity ward.
- At times community midwives were called to provide care on the birth suite.
- The midwife–to-birth ratio on the service dashboard was 1:30, an improvement from a previous ratio of 1:36 in July and August 2013. However, this remains more than the national guidance (Safer Childbirth October 2007), which has a minimum ratio of 1:28.
- Board agreement had been given for an increase in staffing to reflect, among other things, the high pregnancy rate among midwives (currently 6%). The recruitment had not yet taken place.
- All midwives must have access to a supervisor of midwives at all times (NMC 2004 Midwives rules and standards - Rule 12). The ratio of supervisor of midwives to midwives was 1:13, which is better than the recommended ratio of 1:15. Supervisor of midwives are required to carry out annual reviews with all midwives. All midwives we spoke with had received a supervisory review and were aware how to contact a supervisor if required. There was information on supervision of midwives on notice boards. Women were also provided with information on how to contact a supervisor of midwives. The local supervising authority had undertaken the annual audit into the standards of supervision and midwifery practice, during which they had been commended on the support they provided to preceptorship (practical experience and training) midwives.

Medical staffing

- There was anaesthetic cover for the birth suite seven-days–a-week, 24-hours-a-day. However, out-of-hours and anaesthetic cover is shared with the intensive care unit (ITU). However, staff reported few delays in accessing anaesthetic support when needed, for example when they needed to provide an epidural to a labouring woman.
- There are five consultants employed for both obstetric and gynaecological care, and 44 hours of dedicated consultant cover for the labour ward. This is reported and monitored on the service dashboard presented at the integrated family health (IFH) meeting.
- Staff described a shortage of middle grade doctors. This risk had been identified and was on the maternity risk register.
- Following a review of the service by the Royal College of Obstetricians and Gynaecologists, it was recognised that the middle grade role was very reactive that made it difficult to receive a lot of training. This was reflected in the GMC Council National Training Scheme survey 2013 in which the response scores from trainees in obstetrics and gynaecology were worse than expected for handovers, receipt of clinical supervision, local teaching and study leave. As a result trust approval had been given to appoint two additional middle grade doctors and an additional consultant. This would increase the number of middle grade doctors to nine. The appointments had yet to be made.
- Junior medical staff are not available 24-hours-a-day because their period of duty ends at 8.30pm. One of the middle grade medical staff had to cover all activity on the maternity and gynaecological wards, birth suite and any obstetric or gynaecological emergency transferred from A&E. In the event of an emergency a consultant was called in who lived 20 minutes or 10 miles away from the hospital.
- Obstetric support workers were employed to work as surgical assistants in the obstetric theatre. At the time of our inspection they did not provide 24-hour cover, although there were recruitment plans to provide the cover. Where there were gaps in the 24hour coverage, these gaps were filled by a junior doctor. When not required in theatre, these staff support the work of the midwifery support worker. Newly-appointed obstetric support workers spent four weeks in the main operating theatres before starting work in the obstetric theatre. During their training period they completed supervised

practice and a competency framework. Competencies were then rechecked by a consultant obstetrician every six months. We reviewed the training matrix for the staff currently performing this role and saw they had all received competency reviews in the last six months. Obstetric support staff we spoke with told us they never felt under pressure to undertake tasks such as suturing that they had not been trained and deemed competent to undertake. In the event of an emergency during an operation the staff we spoke to told us a second person would be called to assist, who would not always be at the hospital if it was out-of-hours. This could mean the middle grade surgeon would not have surgical support for a period of time.

- Consultants were described as responsive and willing to attend out-of-hours.

Major incident awareness and training

- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least once a year.
- All midwifery staff we spoke with were aware how to contact a midwife supervisor at all times. The birth suite staff room and the ward had notice boards indicating who the midwife supervisors were, who was on call and how to contact them.

Are maternity and gynaecology services effective?

Requires improvement

The maternity and family planning services require improvement in order to deliver effective services. Staff followed nationally recognised policies and procedures.

Outcomes were monitored, but there were few actions to address outcomes that fell outside the national average.

Concerns about the high caesarean section, induction and instrumental (forceps and ventouse) delivery rates were addressed.

Evidence-based care and treatment

- Policies and procedures were available on the intranet. Hard copies were provided for community staff because using tablet computers for the electronic patient records did not link with other trust IT systems.
- Policies and guidelines had been developed in line with both National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists guidelines.
- Records were audited by the midwife supervisors. The audit records demonstrated good documentary practices. Audit of electronic patient records had not yet taken place, although the midwifery lead carried out a daily review to identify issues and problems.
- Staff reported undertaking monthly hand-hygiene and infection control audits. However, the results were not visible in the maternity or integrated family health (IFH) governance papers or posted on the walls in either the maternity ward or the birth suite.
- The governance and risk lead midwife supported the maternity service and all areas in the integrated family health (IFH) care group together with community services. The lead midwife developed an annual audit programme for midwives and obstetricians. Audits were primarily undertaken by medical staff, though there was a desire to encourage midwives to participate. The audits were presented to the monthly audit meeting, which also monitored actions. The audits were also reported to the integrated family health (IFH) governance meeting.
- A caesarean section rate of 26% for March 2014 was reported on the service dashboard. It had been as high as 36% in September 2013. The average across the financial year 2013 to 2014 was 31.5% (against a national average of 25.3%), and the service dashboard gave it a red flag for 10 out of the last twelve months. We spoke to staff about this figure and were told of initiatives planned to reduce the rate, including multidisciplinary team training sessions on normal birth. Learning from emergency caesarean sections was reviewed, and medical staff were undertaking the Robson project to review of all caesarean sections using a 10-group classification system based on four main areas: category of pregnancy; woman's previous obstetric record; type of labour and delivery; and the gestation of the pregnancy. Caesarean section rates for each consultant were published anonymously, but each consultant received their own individual statistics. Staff told us they hoped this would encourage individual practitioners to review their practice.
- A Vaginal Birth after Caesarean Section (VBAC) clinic was run by the head of midwifery and other midwifery supervisors. Women were referred to these clinics early

in their pregnancy so that they could be given the necessary information to make decisions on type of delivery following a previous caesarean section. While the performance dashboards reported the caesarean section rates, they did not report the number of women attempting a VBAC against the number of women who successfully achieved a VBAC. Therefore, it was unclear how the service was measuring the success of these innovations.

- The service followed the Perinatal Institute's Growth Assessment Protocol, a nation-wide tool to reduce the number of unexplained stillbirths. Stillbirths were reported as clinical incidents and the cases reviewed. The number of stillbirths was monitored and reported on the performance dashboard at the integrated family health (IFH) governance meeting.

Pain relief

- A birthing pool was available in one delivery room. In addition, the maternity service had a further two inflatable pools, one of which was erected in the room currently designated for midwife-led care.
- There was anaesthetic cover 24-hours-a-day, seven-days-a-week, to give women the option of an epidural if they wanted it.
- Staff told us one colleague had taken a hypnobirthing course. However, we saw no evidence of this either in practice or promotion.
- Delivery rooms had piped Entonox (a mix of nitrous oxide) supplied. Also, stronger opioid analgesia was available to women in labour if required.

Nutrition and hydration

- Women were encouraged to breastfeed and the service was about to apply for stage 1 UNICEF accreditation as a baby friendly unit. Breastfeeding initiation rates of 81% were equal to the national rate.

Patient outcomes

- The maternity service had a quality dashboard that was reviewed monthly at the obstetric and gynaecological governance meeting. This used a red/amber/green flagging system to highlight areas of concern. This was made available to us prior to our inspection.
- The maternity services achieved a normal vaginal delivery rate of 54.5%. The national average for normal vaginal deliveries was 60.7%.
- For the past 13 months the number of caesarean sections was flagged as either red or amber. Work was underway to address this. However, the number of instrumental deliveries (forceps or ventouse) also showed red or amber in six of the previous 12 months, with the highest reported monthly figure at 19%. There appeared to be no review to address this.
- The induction rate was between 20-28% and in line with the national rate of 20%.
- The home birth rate was 5.6%, above the national average of 2%.
- Key messages were posted throughout the service. These were to promote normal births and reduce the caesarean section rate by encouraging mobility, the use of water and to encourage women to stay upright.
- The number of women booked for maternity care before 12 weeks and six days gestation was now being collected on the electronic patient record and had yet to be recorded on the performance dashboard.

Competent staff

- Preceptorship (practical experience and training) midwives were rotated through all areas during the preceptorship to ensure they were fully competent midwives with the skills and confidence to work in all areas of the service. The preceptorship programme lasted from 12 to 18 months. We spoke to preceptorship midwives who described being well supported during this time.
- Additional skills training can be accessed through appraisals and supervision.
- Some staff were described as core staff, which meant they remained working in one area. Other staff rotated throughout all areas. Community midwives provided care for home births.
- Every midwife had a named supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 8, NMC 2012). They are someone that midwives go to for advice, guidance and support, and they monitor care by meeting with each midwife annually (Rule 9, NMC 2012), auditing their record-keeping and investigating any reports of problems/concerns in practice. All midwives we spoke with had received an annual supervisory review. The numbers of supervisors to midwives was 1:13, which was better than the recommended minimum of 1:15.

- Staff appraisals had not always been conducted annually, although most staff we spoke with reported having had an appraisal in the last year.

Multidisciplinary working

- Communication between obstetric, anaesthetic, neonatal and midwifery staff was described as good. Staff said it was particularly effective during times of stress on the service such as when there were no cots available in the special care baby unit (SCBU). During these times, meetings were held four times a day.
- The midwife in charge of the maternity service 'walked the floor' at least once a day to review activity, including the SCBU.
- Multidisciplinary perinatal mortality and morbidity meetings were held.
- A multidisciplinary approach was used to develop new guidelines.

Seven-day services

- Access to the single obstetric theatres was available at all times, with scrub nurse cover provided by the main theatres. Out-of-hours consultant cover was provided by on-call consultants.
- Routine pharmacy services were not available on Saturday afternoons or on Sundays. There was an on-call pharmacy facility.
- There was no out-of-hours availability for Doppler ultrasound scanning. However, out-of-hours consultants and middle grade staff used an obstetric scanner.

Are maternity and gynaecology services caring?

Good

The service provided was caring. Staff provided compassionate care and emotional support to women and their partners. However, the service lacked specific bereavement facilities.

99% of the respondents to the FFT said they were likely to recommend the service to friends and family

Women were involved in their choice of birth at booking and throughout the antenatal period

Compassionate care

- The CQC maternity service survey 2013 received responses from 127 women who had been asked about their care at the hospital. From the responses we saw, the trust was similar to other trusts for all aspects of maternity care, including: antenatal; during labour and birth; and in the first few weeks after birth. The comparison with the 2010 survey results showed an upward trend in three of the questions. This was associated with being spoken to in a way that could be understood, providing information or explanations where required and being treated with kindness and understanding by staff.
- The NHS Friends and Family Test was being carried out, and from the results that were available 99% of the respondents said they were likely to recommend the service to friends and family. This evidence was on display on the notice boards at each ward and department area.
- Throughout our inspection we witnessed women and their partners being treated with compassion, dignity and respect. We saw that call bells were in the main, answered promptly.
- We looked at patient records and found they were completed sensitively and detailed discussions had been had with women and their partners.
- Partners were encouraged to visit and visiting times were waived for mothers in labour. However, no overnight facilities were available for partners in the event of a stillbirth, neonatal death. Staff told us they could remain with their partner in the delivery room or maternity ward overnight. However, if a woman was being induced, there was no provision.
- The birth suite undertook pregnancy terminations for foetal abnormalities from 16 weeks gestation. Memory boxes were given to each set of parents who lost a baby on the birth suite.
- Staff told us that all postnatal care for women who had had a bereavement was carried out on the birth suite. However, we saw one women being cared for on the maternity ward after losing their baby below 16 weeks gestation. When questioned why, staff told us the gynaecology ward was full.
- Midwives and medical staff spoke of good team work, support and of enjoying coming to work.

Maternity and gynaecology

Patient understanding and involvement

- Women were involved in their choice of birth at booking and throughout the antenatal period.

Emotional support

- Staff were described as supportive at all times.
- Chaplaincy care was available.

Are maternity and gynaecology services responsive?

Requires improvement

The service did not have a midwife led unit, although a plan was in place. There was a birthing pool.

The services provided required improvement in order to be responsive to the needs of local people. There was little support for women and partners for whom English was not their first language**.** The maternity ward and birth suite were cramped and cluttered.

There were delays in transfer to the birth suite. There were insufficient facilities to meet the full needs of women in the service.

Facilities for partners accompanying women in labour were also poor. Chairs were hard, and there were no facilities to allow partners to remain with women who were being induced on the maternity ward or who were bereaved.

Women did not have access to their own records following the introduction of the electronic patient record.

Service planning and delivery to meet the needs of local people

- There was a birthing pool available for women using the service.
- This service did not yet have a midwife let unit. Women could elect for delivery at home or at the hospital. Following a review by the Royal College of Obstetricians and Gynaecologists in 2013, a room had been identified to provide midwife-led care. A bid had been put to the trust board for funding to develop a midwife- led unit. Notice that funding had been agreed had just been received prior to our inspection. Capacity in the maternity ward would be reduced with the current plans to change one four-bedded bay into the midwife-led unit. We spoke with staff about the options, and some felt the unit should be located elsewhere but felt unable to influence the decision-making.
- Anaesthetic clinics were held as were weekly multidisciplinary team (MDT) diabetic clinics.
- Glucose screening was undertaken Monday to Friday in the day assessment room to screen women for evidence of diabetes in pregnancy who had been identified as high risk.

Meeting people's individual needs

- Information was available regarding the trust on their website.
- Translation services were available, which mainly involved the use of telephone interpretation services.
- Some leaflets were available to print off in other languages such as antenatal screening literature. However, we saw very little evidence of signage or information in a language other than English.
- The trust did not employ a bereavement specialist midwife
- The birth suite did not have a dedicated bereavement room. Women who had lost their babies or had had a termination for foetal abnormality beyond 16 weeks of pregnancy were cared for in a normal delivery room. There were no facilities for partners or supporting friends to remain with the woman other than remaining within that room.
- There were no soft, comfortable chairs for partners in the delivery rooms. Chairs provided were firm and functional and would become uncomfortable over a prolonged stay. When asked, staff told us comfortable chairs had been removed because they had become worn. At the time of the inspection they had not been replaced.
- The location of the triage bay meant that women and their partners were admitted onto the maternity ward. The triage bay did not have separate toilet facilities, which meant that people had to use the ones on the main ward.
- Delivery rooms were bright and welcoming, and each had an en suite room. One room had a birth pool. Two additional inflatable pools were also available.
- The trust did not employ a bereavement specialist. One midwife had a special interest and provided support and guidance to other midwives as required

- Women no longer carried their own records throughout their pregnancy and postnatal period of care. They were given information leaflets at booking but had no way of accessing their notes during their pregnancy.

Learning from complaints and concerns

- Complaints and concerns were reported to the head of midwifery and were included on the performance dashboard for monitoring at the obstetrics and gynaecology governance meeting. When complaints were received staff offered to meet the complainant, and any meeting was followed up in writing with the outcome. Learning from complaints was shared with staff through team meetings and 'close encounters'.
- Staff gave us examples of changes that had occurred as a result of complaints. For example, changes had been developed for the care of women requiring a trial without a catheter following urinary retention. This included scanning for residual urine. However, staff also told us they only had one bladder scanner and it had recently been out of service for a period of at 10 days.

Are maternity and gynaecology services well-led?

Requires improvement

Improvements are required before the maternity and family planning services can be described as well led. Staff felt managers were visible and approachable. However, safety and performance concerns did not appear to be escalated and acted on. The governance functionality was weak. The risk register did not contain all the issues identified in the service.

The service was inward-looking and lacked innovation and vision for development and sustainability. There was no maternity support liaison committee.

The service was cramped in its current location. Options for change were not fully discussed. Staff felt unable to influence proposed changes, even though they felt the changes may not be correct.

Vision and strategy for this service

- There was Staff we spoke with were aware of the organisational strategy. They told us they felt the vision and strategy for the maternity services was that birth should be normalised through the development of a midwife-led unit. However, staff also told us that whilst the concept was right, the location of the unit was not correct. They told us they felt unable to influence the decision being taken.

Governance, risk management and quality measurement

- The service had a well-defined governance structure. There were meetings to oversee activity, performance, quality, safety, audit and risk. These then fed into the integrated family health (IFH) governance committee. From here issues were escalated to the trust. However, staff had little commitment to the governance process. They described how minutes were placed in folders, which they did not have time to review.
- Performance and outcome data was reported and monitored using the service performance dashboard.
- The maternity service had a risk register with three risks entered that were described as moderate. Other risks were identified to us by staff such as the electronic patient records which was not on the risk register. Staff were not generally aware of the contents of the risk register.
- There was no sense of urgency to address significant issues such as the need for a second obstetric theatre.
- Although performance dashboards were monitored and incidents recorded and collated, there was little evidence that trends were identified and acted on other than the high caesarean section rate.
- The service employed a governance and risk midwife (a post about to become job-shared).
- The maternity service had commissioned root cause analysis training from an external organisation because they felt the system for investigating serious incidents in the trust was not robust enough. As a result they undertook round table reviews and involved external investigators as well as an internal investigator to ensure the investigation was both robust and comprehensive.
- The maternity service achieved a risk management rating of level 1 (must be assessed at least once in any two-year period) when it participated in the clinical negligence scheme for trusts (CNST) in September 2012.
- We saw evidence during our inspection of women having to wait to transfer to the birth suite for augmentation of labour. Staff told us the delay was

necessary because there were insufficient numbers of staff to provide one-to-one care. At the time there were four women on the birth suite, two of whom were postnatal

Leadership of service

- Staff described the senior management team as visible and supportive. They knew who led the service and felt the service was promoted well in the trust by them.
- The head of midwifery undertook clinical work such as participating in the vaginal birth after caesarean section (VBAC) clinics. They were also a supervisor of midwives and participated in the on-call arrangements.
- Lead midwives were seen in clinical areas and had a good awareness of activity in the service during the inspection. Staff were clear who their manager was.
- Not all staff were aware of the development of a midwife led service, although all staff we spoke with told us they felt they needed a midwife-led unit to promote normal births and reduce the caesarean section rate.

Culture within the service

- Staff were aware of the whistleblowing policy and were encouraged to raise any concerns they may have.
- Staff spoke of an open, supportive and friendly culture with good teamwork.
- Staff spoke passionately about the service, and it was clear from all we spoke with that they enjoyed working at the trust. This included newly-qualified staff and students.

Public and staff engagement

- There was no maternity support liaison committee. Staff told us they were actively attempting to recruit lay users to become involved in the development of the service, and they had approached various local groups for support.

Innovation, improvement and sustainability

- Service development lacked vision... Staff we spoke with told us they had to work in 'the footprint' of the current unit. This was already cramped and cluttered. Some staff described other options for development of the midwife-led unit, but were not able to describe how they could influence the changes.
- Future changes and plans were not innovative or visionary. Finance had been secured for development of the midwife-led unit, but firm operational plans had yet to be made. There was no overarching strategy for development and improvement.
- All staff we spoke with felt the establishment of a midwife-led unit was vital to the sustainability of the service. Other options for growth and development were not raised with us and did not appear in any of the governance papers reviewed.

Services for children and young people

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

Information about the service

The services consisted of a special care baby unit and a children's ward on the second floor of the hospital. The special care baby unit had 12 cots. One cot was for babies that needed intensive care and two were for babies with high dependency needs. The unit was able to manage the care of babies born at 30 weeks or over. Babies outside these criteria were transferred to other hospitals in the West Midlands. The children's ward had 16 beds, four of which were in the paediatric assessment unit on the ward. There were also an additional four beds that operated from 8am to 8pm for day surgery patients. There was one bed for children with high dependency needs and four cubicles which could be used for isolation. The beds were in bays of four or single cubicles. There were parent's facilities and play areas on the children's ward.

During the inspection we visited the special care baby unit and the children's ward. We spoke with: three ward managers; eight nurses; two consultants; two housekeepers; four parents; four patients; one physiotherapist; and a diabetes clinical nurse specialist. We spoke to two nurses in A&E and the trust's lead for children's safeguarding. We observed interactions between staff, patients and parents. We read care records, policies and procedures and other documentation as necessary. We reviewed data provided by the hospital.

Summary of findings

Staff in the special care baby unit and the children's ward were polite, caring and kind. Patients and parents said the care was "very good" and described staff as "helpful" and said they were kept well informed. All areas of the departments were clean and tidy. The children's ward offered a child-friendly environment, with play areas for various ages. There was 24-hour consultant cover seven-days–a-week. The development of the paediatric assessment unit had led to rapid access for children. Staff were supported by their managers.

However, in the domains of safe, effective and lead we saw the service required improvement.

Senior staff members said they were not integrated with the other departments in the hospital and worked in isolation of them. Records seen at inspection showed that staff were not up-to-date with mandatory training, which included the safeguarding of children for medical staff. Records did not demonstrate that staff were having their competence assessed. Following the inspection the trust provided us with information that stated the compliance rate for mandatory training for clinical refresher updates and health and safety on the children's ward was 82%, and that this had been updated on the trust training department records. Some policies and procedures with regard to the care and safety of patients were not present.

Services for children and young people

There was a lack of personal and environmental risk assessments, and actions to reduce risks had not been taken. We noted that the edges of the children's play area required cleaning, but this had not been done. Some systems had failed in practice such as those to monitor that correct procedures had been followed for consent to treatment. There was a lack of provision for the emotional support of patients. Nursing staff numbers were meeting the needs of the service by relying on the good will of the staff to work overtime, which was not sustainable.

Are services for children and young people safe?

Requires improvement

Patients on the children's ward and in the special care baby unit received high level medical support due to the provision of 24-hour consultant cover seven-days-a-week. The medical and nursing staff worked well as a team and had tools and systems in place to manage the care of a deteriorating patient.

The ward was clean and tidy and there was provision of necessary equipment and a supportive environment for the children and parents. However we did see the children's play area required attention.

The records of mandatory training of nursing staff seen on our inspection were not clear. The records did not contain the same training requirements for every member of staff. The records showed that not many staff had completed mandatory training, or the records were out-of-date. We could not see a system for monitoring staff training.

We were told medical staff were not required to complete training in the safeguarding of children as part of their induction or on a mandatory basis.

Following the inspection the trust provided us with information that stated the compliance rate for mandatory training for clinical refresher updates and health and safety on the children's ward was 82%, and that this had been updated on the trust training department records.

Some risks to patient safety were not identified or assessed, and actions were not in place to protect all patients from potential harm. The procedures for obtaining consent were not in line with current guidance.

Incidents

- No Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) had been reported in the departments for children and young people in the 12 prior to our inspection.
- Incidents were reported using the online system and staff told us they knew how to access this. We were told this had '"tightened up" in the past few months and there was a reminder system. The ward manager could

identify incidents that had been reported and were waiting for their action. There were six in the children's ward manager's system which were still in the seven day timescale for review.
- We saw incidents and near misses had been reported and were told actions had been taken to reduce the likelihood of recurrence.
- Recent incidents included the wrong notes accompanying a patient to theatre. Managers explained the actions that had been taken to reduce recurrence. We saw these were not being followed in practice. This meant learning from this incident and subsequent actions did not ensure it would not recur.
- Learning from incidents was shared with staff during handover and information to be shared could be documented on the handover sheet. One of the nursing staff had started a newsletter in the month prior to our inspection, and they had dedicated an area of this to sharing learning from incidents.
- We were told root cause analysis took place when it was required following a serious incident. An example was discussed where actions had resulted in changes to the management of 17-year-old patients who attended A&E to ensure that they had access to the children's rather than the adult team. The diabetic team had set up a transitional service for young adults moving into the adult services, which included a specialist who worked in both areas. This showed that practice was changed as the result of root cause analysis where it was required.
- There was no system for sharing learning from incidents in the wider trust, and staff were not informed of any incidents or outcomes other than Never Events.

Cleanliness, infection control and hygiene

- The children's ward and the special care baby unit (SCBU) were clean and tidy.
- A sticker system indicated equipment had been cleaned.
- Staff wore personal protective clothing as required and this was available throughout the ward areas.
- Hand gel was available at each doorway on the wards. The hand gel dispenser outside one of the infection control cubicles on the children's ward was empty. This meant the process to ensure hand gel was available in all areas had not worked in practice, and could present an infection.
- Isolation facilities were available on both the children's ward and SCBU. Signs to inform staff of the need for isolation procedures were visible.
- The outside play area on the children's ward had a drainage ditch around it that contained stagnant water and debris such as tissue paper. This was easily accessible to children. We were told there was a problem with the drainage system that had been reported to the estates facilitator. Staff said children would not be allowed to play alone in this area. However, it would be impossible to ensure children never came into contact with the water. This accessibility of dirty water presented an infection risk.
- There were sufficient isolation facilities provided on both units.

Environment and equipment

- The resuscitation equipment contained varied sizes of apparatus to cater for the potential range in ages and sizes of the children.
- There were records that daily checks had been carried out on the resuscitation equipment.
- Children's ward staff had altered the resuscitation trolley and the layout of equipment in the paediatric A&E to ensure it was identical to that on the ward. This meant that when medical staff from the children's ward assisted in A&E they knew the necessary equipment was available and where to locate it rapidly.
- The children's outpatients department was not a safe environment for children. We saw unsecured sharps (anything that can puncture the skin) disposal boxes on top of trolleys. Staff were not always around so these were potentially accessible to children. Syringes were stored in corridors in open boxes. We observed one child putting their hand in a box of syringes to take a look what was inside (these did not have needles attached).

Medicines

- Medicines were securely stored in both the children's ward and SCBU.
- A medicine administration record specific for children had been developed. This meant that necessary information such as weight could be recorded for the safe administration of medicine to children.
- The controlled drugs were safely stored and the records for checking of stock and administration were kept.

- Parents could continue to administer a child's medicines if they wished, and lockable facilities for the safe storage of such medicines were provided.

Records

- Records were kept confidential on the wards and stored in lockable cabinets.
- Staff said there were no problems with obtaining the records they required for patients.
- A member of the children's ward staff had undertaken an audit of the records used for patients and found there was room for improvement. They had developed and trialled new charts that were in use and due to be audited after one year. This meant staff had identified weaknesses in the record system and made changes to improve them.
- One staff member had developed the booklet "all about me", which was designed to give staff the information they needed about the child including their thoughts and feelings on visiting hospitals. This was not yet in use at the time of our inspection. There was no other system of recording information for children with complex needs who may visit the ward frequently that would prevent repetition of information. Staff said they had few of 'frequent visitor' patients so knew them well.

Consent

- Staff told us there was no guidance about allowing a competent child to sign their own consent with a parent's counter signature. The trust document "parental agreement to investigation or treatment for a child or young person" states: "Where children are legally competent to consent for themselves they may sign the standard 'adult' consent form. There is space on that form for a parent to countersign if a competent child wishes them to do so." This meant staff were unaware of the procedure for legally competent children to consent for themselves.
- We were told there had been no training for staff regarding the management of children who lacked capacity to consent. This meant staff were unaware of the correct procedures and might not follow current guidance.

Safeguarding

- Nursing staff told us they felt able to report any concerns they had regarding the safety or suspected abuse of children. No one we spoke with had experienced the need to do so.
- They said they would discuss any concerns with their line manager. They told us there was a whistleblowing policy on the intranet if they needed to escalate any concerns.
- There was no whistleblowing information on display in the ward or staff area for staff without access to the intranet, or to inform the general public.
- There was an alert displayed on the electronic patient record system to indicate if a child was on the child protection register. There was a mandatory field on this record to remind staff to check the register, and they said they knew the importance of this and would "always do it".
- Staff said in order to know the nature of the risk to a particular child they would have to speak to social services. They had telephone access from Monday to Friday and to the emergency duty team at weekends so they were always able to do this.
- Staff said there was no system for alerting them that specific adults should have restricted or no access to a child. They told us they would rely on the child or accompanying adult to tell them this information. This meant staff could be unaware that a child was at risk from a visiting adult.
- The records from 2009 for 12 of the 25 relevant staff contained no completion dates for safeguarding training. When staff were asked if they had completed this training they told us they had, but could not recall when they had done so and some thought it was out of date. They were aware of how to identify risk factors for abuse of children and how to report concerns. The lack of up-to-date training meant staff were delivering care and support unaware of the latest guidance on their safeguarding responsibilities.
- Medical staff did not receive training in the safeguarding of children as part of their induction. This had been entered on the risk register in June 2011 and remained unresolved. This meant there was no system for ensuring medical staff had the knowledge to protect children from abuse, identify the signs or knew their responsibilities for reporting concerns.
- The safeguarding lead said they could not "report accurate compliance reports" regarding safeguarding training. This meant staff could be delivering care and support who had never received the necessary training and were therefore not aware of how to recognise potential abuse or raise concerns.

- An audit of compliance that staff in A&E were checking the patient record system for safeguarding alerts had been completed. In March 2013 31% of the records had an incomplete or incorrect check. The system was changed and re-audited in September 2013 when the number decreased to 22% of records being incorrect or incomplete. This meant that children received care and treatment from staff that were unaware of child protection concerns.

Mandatory training

- We looked at the training records on the children's ward and the special care baby unit. There was no trust-wide system for recording mandatory or other training. Therefore, each manager devised their own training system.
- The training records on the special care baby unit were handwritten and it was not possible to follow a specific staff member's training record because they were not clearly documented.
- Those records we saw for staff on the children's ward were handwritten individual records for each member. There was no overall training plan and no record of when training was required or was out of date.
- The records did not contain the same training requirements for every member of staff. For example, some records for qualified nurses had 'tracheostomy management' included, while some did not. This meant there was a variation in the training requirements for staff of the same grade.
- We looked at the training records for nine qualified staff members. Eight of them had not completed the annual clinical refresher training in the past 12 months. We were told this training included mandatory requirements such as moving and handling, and fire safety. The manager confirmed these records were, to their knowledge, correct. This meant they were delivering care and treatment without up–to-date knowledge and skills.
- Following the inspection the trust provided us with information that stated that the compliance rate for mandatory training for clinical refresher updates and health and safety on the children's ward was 82%. The trust said that this had been updated on their training department records.
- The manager of the children's ward told us 11 staff had completed European paediatric life support (EPLS) training. They used the rota to identify the staff who had EPLS training, not the training records. They said there would always be a qualified nurse on every shift who had completed this training. They would ensure the rota accommodated this because the staff member who developed the rota "knows who is EPLS-trained." The system on the special care baby unit was the same. Staff who were EPLS-trained were identified from memory by the person drawing up the rota. This meant if staff needed to cover shifts for a colleague who had EPLS training there was no procedure to ensure their replacement had the EPLS training. Therefore, there was a risk that no staff member on duty had up–to-date life support skills.
- Following the inspection the trust told us they had increased EPLS training and they now achieved 100% compliance for having EPLS-trained nursing staff on each shift.
- We were told that training in the safe management of blood transfusion should be completed annually. The nurse in charge of the ward said their training was "out of date" and records showed they had last completed it in April 2011. When the manager looked at these records they commented "I hope (the nurse in charge) has done that". This meant the manager was not aware that staff training was out of date. Therefore, there was no recognition or management of the risks that they would perform tasks where their knowledge had not been refreshed or checked.
- We were told there was an online medicines management module that formed part of the annual mandatory for all staff administering medicines. On the nine training records we saw none had a completion date recorded for this training. One staff member told us they had recently tried to log onto the system to complete it while on night duty, but had been unable to do so. This meant staff administering medicines had not received up–to-date training in line with the policy of the trust.
- We were told there were no competence assessments used for any practice or procedure, including medicine administration. This meant there was no system for monitoring the ability of staff to deliver care and treatment competently.
- There were no completion dates for anaphylaxis management on any of the records we saw.

- The manager of the children's ward stated they knew there were "issues" around training and they did not know who had completed specific training courses. They said there was "no system for keeping on top of training".
- Staff told us training did get cancelled and made keeping up–to-date more difficult. They said the training was "good when you get it".
- Staff we spoke with had received no training to care for people with mental health issues, which included understanding mental capacity. We were given examples where staff had been expected to manage the behaviour of patients with mental health issues who had been placed temporarily on the ward. They said they were "keen to learn more" about this.

Management of deteriorating patients

- A nursing and a medical staff member had developed a new paediatric early warning score (PEWS) system, adapted from the former NHS Institute for Innovation and Improvement PEWS scoring system. There were four varied records for different ages. Nursing and medical staff said the tool was working well and alerted them to when a child was at risk.
- On the special care baby unit they used an 'amber alert' scheme which was used to record the status of SCBU to admit babies.
- Nursing staff spoke highly of the support received by the medical staff if they were concerned about the deteriorating condition of any baby or child. They said the response was rapid and consistent, and they had would not hesitate to call for assistance if they were at all worried.
- Out of hours children who were waiting psychiatric assessment were admitted to the children's ward. This was to provide a place of safety for children at risk such as those who had attempted to take their own life. The ward environment was used as a temporary emergency measure. Staff said they got one-to-one support to care for these children from an agency for the duration of their stay. They described the support as variable, and staff said they helped out when they could or when they needed to ensure the safety of that patient or others on the ward. This meant staff who had not received appropriate training were providing support for patients with mental health issues.
- The clinical commissioning group assurance visit on 30 April 2014 identified that there were no risk assessments carried out when the children were on the ward. This included risks to the children's own safety and to other children on the ward. The lack of any risk assessment to the health and safety of children or staff resulted in a failure to identify the actions needed to reduce the risks. Following this visit an action plan was put in place to address the concerns.
- The ward manager was not aware if all identified risks to patients were on the risk register such as the dirty water in the drain in the play area. We were told the management of patients waiting for psychiatric support was on the register. However, this data was not included on the information provided by the trust. This meant there was a lack of understanding of which risks had been identified and escalated and how they were to be managed.

Nursing staffing

- Staff on the children's ward and the special care baby unit said they thought there were sufficient staff on duty most of the time to meet patients' needs safely.
- They said at very busy times staffing was "tight", but described a good team spirit that meant staff helped out.
- Managers described how they relied on the goodwill of staff to work overtime to ensure satisfactory staffing levels. They did not use agency staff, which they said helped them to deliver a consistent quality of care.
- The skill mix of staff was appropriate. All qualified staff had qualifications in the care of children or neonates. The majority of staff on any shift were qualified nurses with one healthcare assistant per shift for support.
- On the children's ward there was a qualified nurse acting as the ward coordinator each day to ensure the flow of patients through the unit was managed safely. This meant one person on the ward had oversight of all areas in the ward and deal effectively with the rapid turnover of patients.
- On the special care baby unit there was a "floor manager" who visited the unit three times-a- day from Monday to Friday to assess the potential challenges for that day. This meant they could pre-empt potential over occupancy by discussing delaying inducing labour if the special care baby unit was at full capacity. The consultants and nursing staff were involved in these discussions to ensure over capacity occurred only in emergency situations.

- Medical and nursing staff completed a night-to-day handover every morning, which the floor manager for the day also attended. Information about every patient in the special care baby unit and on the children's ward was shared. Treatment plans were discussed and some teaching opportunities were used such as the education of families. The medical team consisted of consultants, middle grade doctors, senior house officers and GP trainees.
- The ward manager on the children's ward was not aware of some of the information discussed at handover. This meant the staff member who had attended handover had not passed on all the information, which could present a risk to patient care and treatment.

Medical staffing

- Staff on the children's ward and the special care baby unit said they thought there were sufficient staff on duty most of the time to meet patients' needs safely.
- They said at very busy times staffing was "tight", but described a good team spirit that meant staff helped out.
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Major incident awareness and training

- Staff were aware of their responsibilities in a major incident.

Are services for children and young people effective?

Requires improvement

Current guidance was used to inform some practice. Not all policies to ensure the safe care of patients were in place. Pain relief was provided for patients. There was no agreed pain relief policy, and not all patients received an assessment of their pain level. Patients were provided with a choice of food and drinks.

Staff were supported to do their job. The monitoring of staff competence was inadequate, and no assessments in place. The equipment and facilities to meet patients' and parents' needs was available. There was established multidisciplinary working with an increase in specialist nurses planned. Few of the allied health services were available seven-days-a-week, and the service relied on on-call support or delayed care until the working week began.

Evidence-based care and treatment

- 'Red flag awareness' based on National Institute for Health and Care Excellence (NICE) guidelines was discussed at handovers to ensure the guidelines were followed.
- Staff said some policies to ensure current guidelines were followed were not in place. These included the use of chaperones, pain relief in children and. This showed that practice was not based on current guidance.

- There was no policy to give female patients a pregnancy test. We were told this was under discussion. This meant that procedures could be carried out without identifying potential risks to a pregnant patient or an unborn child.
- The trust told us that there was a policy regarding the chaperoning of patient having an examination or treatment. However, staff were not aware of this and told us there was no policy to chaperone patients. We were told patients would be asked if they required a chaperone, but there was no procedure for staff to follow.
- Parents were encouraged to stay with their children as much as possible. Facilities for them to do so were provided in line with NHS advice.
- Staff on the special care baby unit were part of the Southern and West Midlands Newborn Network. The group agreed guidelines for shared working and developed audit tools to assist consistency of approach, and to provide continual improvement of services. This showed participation in local groups and sharing of knowledge and learning.
- Participation in the former National Patient Safety Agency's (NPSA) nasogastric tubes audit had resulted in changes to care and practice in the special care baby unit.
- A Gentamicin audit was completed in the special care baby unit and attached to the sepsis guidelines with a checklist for staff. This meant that learning from audits was shared and informed future practice.
- On the children's ward staff had links with Birmingham Children's Hospital NHS Foundation Trust. They could attend training and conferences and shared learning with them. This showed there were working links with specialists to improve practice.
- A paediatric assessment unit had been developed in one bay of the children's ward to ensure that children referred to the hospital by a GP could be seen quickly. Staff had researched how best to manage the unit and had been developed with nursing and medical staff input. An audit of the unit showed that the average waiting time for a child to see a triage nurse was 5.8 minutes and a consultant 123 minutes. This showed that practice was changed to improve patient care as a result of exploring successful practices in other trusts.
- The guidelines for children's surgery were followed, and no surgery on a child under the age of two years was carried out.

Pain relief

- Various types of pain relief were available on the children's ward and we saw it administered. Nursing staff discussed pain management with the doctors.
- There was no paediatric pain policy. This meant staff had no guidance to follow for pain management.
- There was a pain assessment as part of the paediatric early warning system (PEWS) record, but no other assessment. This meant that children about to undergo surgery, or for children where PEWS had not been used, did not routinely have a pain assessment and their pain could go unrecognised.
- There was no child-friendly information regarding pain relief management or analgesic medication.
- In the special care baby unit staff were aware of the importance of pain relief. They were using sucrose (sugar) as oral pain relief prior to procedures such as cannulation. Studies show that this is as an effective pain relief in neonates. This was being added to the pathway for pain management, which showed effective pain relief was part of continuous learning on the unit.
- Non-medication interventions such as comfort holding were seen as an important part of pain relief for neonates.
- Additional pain relief such as morphine for ventilated babies were used as required.

Nutrition and hydration

- Staff on the special care baby unit promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- A paediatric dietician took part on the special care baby unit ward rounds. They provided advice and support to staff and families regarding nutritional needs on both the special care baby unit and the children's ward.
- There was a nutritional special interest group on the special care baby unit led by a qualified nurse. This was a multidisciplinary group that worked with families to finalise transitional feeding for babies being discharged.
- Snacks were available on the children's ward snacks 24–hours-a-day. These included fruit, sandwiches, crisps and cereals. This meant that patients could have food at any time outside of meal times.
- There was a hot meal served twice-a-day, and the choices included healthy options as well as more traditional children's foods. The meals were designed to cater for a variety of ages.

- Special diets such as gluten-free and diabetic were catered for. Staff said they could order specific foods if required and there were no problems obtaining them. This showed a variety of nutritional needs were catered for adequately.
- On both units patients were weighed and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support.
- Hot and cold drinks were available on the children's ward at any time.
- Patients on the children's ward told us the food was good and they could choose what they wanted. One parent said staff had got them something their child would enjoy to encourage eating.
- Parents could make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- The trust told us they participated in national audits relating to diabetes, childhood epilepsy and neonatal and special care as well as the paediatric asthma survey. We did not see any data regarding these audits with the exception of the National Paediatric Diabetes Audit from 2010-2011.

Competent staff

- Staff said they received annual appraisals and these resulted in personal development plans.
- They did not receive one-to-one supervision sessions. Staff said there was no formal opportunity to discuss performance and practice with a line manager between the annual appraisals.
- If staff needed information and assistance they said they could discuss any clinical issues informally with each other, the medical staff or the ward manager.
- There were monthly ward meetings during which staff discussed clinical issues triggered by events on the ward. They saw these as clinical supervision sessions. Staff said they could not always attend due to pressures of work, but were provided with written notes following the meeting. This meant there was a mechanism for sharing knowledge. However, not all staff would benefit from this.
- Time off could be given to attend training courses, if the staffing levels allowed. Staff said this was often not possible, which meant they may not be up–to-date with the latest practice.
- There was an acceptance among nursing staff that attending training and keeping their clinical competence up-to-date was challenging due to operational pressures.
- There was no mechanism for monitoring nursing staff competence. The person in charge of the ward had not completed any competence assessments. This meant there were no checks that nursing staff remained competent to carry out care and treatment.
- Medical staff said they were well supported by the consultant team and received supervision from them to enhance learning.

Equipment

- There was equipment available on the children's ward to meet a variety of needs such as hoists for children with mobility problems. This showed that patients with complex needs could be accommodated safely on the ward.
- On the special care baby unit there was sufficient equipment to meet babies' needs. This included infusion pumps, breast pumps, syringe drivers and a variety of cots.
- The equipment required to ensure the safe transfer of a baby from the special care unit to another hospital was available.

Multidisciplinary working

- There was evidence of multidisciplinary working on both the special care baby unit and the children's ward. This included multidisciplinary attendance at handovers and meetings that included all specialities involved in a patient's care.
- There was a dedicated paediatric and respiratory physiotherapist. They provided treatment, support and advice to staff. They had provided training to other physiotherapists in the care of babies and young children to ensure the service needs could be met.
- Specialist dieticians were involved in the nutritional care of patients and liaised with families to discuss any specific ongoing needs.
- Nurse specialists in oncology and respiratory medicine were employed to provide expert support to patients and parents in the wards.
- Play specialists were used to support patients, and were considered a part of the ward team and praised by staff for their input. For example, they would support and calm distressed children after surgery.

Services for children and young people

- The trust had agreed to employ nurse specialists included allergy and epilepsy specialists to enhance the services provided, which showed a commitment to expand services.
- Babies below 30 weeks or which required a higher level of care than the unit could provide were transferred to another hospital once stabilised. There were good working links between the nearby hospitals, and patients were quickly transferred.
- A multidisciplinary diabetic team was available to work with children and young people to manage their diabetes. They had worked to reduce hospital admissions, and in the past 12 months there had been no admissions with diabetic ketoacidosis. The educational element of this team-working resulted in improved outcomes for patients.
- This team had one specialist diabetes nurse who worked with children and adults, which ensured that children making the transition to adult services had continuity of care and support.
- Patients were not receiving age-specific mental health support. Staff said there was difficulty in accessing support from a paediatric psychiatrist, which meant children were sometimes seen by an adult practitioner instead.

Seven-day services

- The consultants provided 24-hours–a-day, seven-days-a-week cover. This meant there was a specialist consultant available at all times.
- Some concern was raised about out-of-hours care for children in A&E. One consultant was undertaking an audit in order to understand this further.
- Pharmacy support was available on Saturday and Sunday mornings for discharge medicines only.
- Radiology services were provided on an on-call basis, which meant there could be a delay in accessing the service.
- Physiotherapy was available out-of-hours, but we were told that the on-call physiotherapist may not have completed training in children's care. This could mean if a patient needed specialist physiotherapy support out–of-hours to relieve a condition such as congestion in the lungs it may not be available. We were given an example where the specialist children's physiotherapist had attended the hospital in the early hours out of good will. If they had been unable to attend the patient would have required ventilation. This means that unnecessary medical procedures could result if there is no specialist out-of-hours support.
- A housekeeper was responsible for the oversight of cleaning the unit. On the children's ward they were employed for 30-hours-a- week from Monday to Thursday. There was a cleaner dedicated to the ward, and when they were not on duty the healthcare assistants completed the cleaning. There was an on-call housekeeper for any emergencies. On the special care baby unit the housekeepers worked five-days-a- week from 9am to 3pm with out-of-hours on-call support. This meant a full housekeeping service was not provided seven-days-a- week, and routine tasks could be neglected.
- There were cleaning schedules to cover all ward areas and equipment, but in some cases such as cleaning play equipment the schedule was Monday to Friday only. This meant not all equipment was cleaned after use every day and it could present an infection risk.
- Access to psychiatric services was available from Monday to Friday. Staff said the lack of support at weekends and bank holidays meant children had to wait on the ward, sometimes for prolonged periods such as at Easter. This had resulted in patients absconding form the ward. Staff said they found this difficult to manage and it was "not fair" on the patients.
- Care of children with mental health issues was sometimes provided by ward staff who did not have the appropriate training. Specialist agency nursing staff were employed to provide care for these patients, including out-of-hours. Staff said the agency support was variable and at times inadequate so they were also involved in the care of these patients.

Are services for children and young people caring?

Good

Medical and nursing staff were caring, calm and kind when delivering care and interacting with patients and families. They were described as "very good" by patients and parents. There were mechanisms in place to include patients and families in their care if they wished. This included discharge planning and education.

Services for children and young people

There was no system to obtain formal feedback from patients and families. There was no specialist psychological or emotional support available for those in distress, including staff.

Patient understanding and involvement

- There was a board visible that gave the name of the nurse caring for each patient. Patients said they knew which nurse was caring for them.
- Patients and parents told us the doctors had discussed the care and treatment in a way which they understood.
- Patients and parents said they could be involved in their own care and treatment if they wished
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child.
- Staff discussed the need to educate and support parents to ensure the welfare of the child was protected prior to discharge. This showed discharge planning included the patient and parent with mechanisms for support if required.
- The views of those receiving care were not routinely sought. Staff in both units said they did not have a formal system for obtaining the views of patients or parents on the children's ward. They informally asked for feedback and used this as discussion points to review the care.

Emotional support

- There was no professional psychologist or counselling care available to provide emotional support for patients or parents. The psychological support for patients or families, who may be distressed, was provided by the medical and nursing team, not specially-trained professionals.
- There was a chaplain with special interest in maternity and children's services. Staff on the special care baby unit were vague about the scope of their assistance.
- There was no bereavement team to offer support to patients or parents. The chaplain told us they were sometimes used to provide support, but felt they could be called on more by staff to support patients or those bereaved. When staff on the children's ward were asked about emotional support they did not identify specific professionals they would use to assist those who required it.

Are services for children and young people responsive?

Good

Systems were in place for senior staff to identify and respond to any potential pressures on the capacity of the special care baby unit and the children's ward. Changes had been made to ensure the rapid consultation of children who attended the hospital. The staff had mechanisms to learn from complaints made in their department.

There was a lack of information in any other language or format other than in written English, except for the special care baby unit.

Service planning and delivery to meet the needs of local people

- Contingency plans to manage busy periods were effective. Senior staff we spoke with told us that the contingency plans had been used recently, and frequently, to manage busy times when there was over-capacity in the special care baby unit (SCBU). The plans included the provision of a bay in the children's ward for babies managed by staff from SCBU.
- A senior manager did a walk-around three-times-a-day. They visited the maternity and SCBU units to discuss their capacity for admissions. This information was shared with the obstetric and paediatric consultant and decisions were made about inducing women's labour and planned caesareans. These decisions were based on safety and capacity of the unit. This showed forward-planning to avoid over capacity that could increase the risks to new-born babies if some facilities were not available.
- Medical staff said they had developed links with the nearest hospitals to receive support for severely ill babies and children who needed to be transferred. They were aware of the difficulties parents would have travelling long distances and considered parents' needs in the planning for 'transfer and return'.

Access and flow

- The special care baby unit (SCBU) had 12 cots, including one intensive care bed and two high- dependency beds. The average occupancy was 70%, which meant the risks associated with over-capacity were reduced.
- The children's ward had 16 inpatient beds, with four in the paediatric assessment unit.

- A consultation with the accident and emergency department, local GPs and out-of-hours doctors had resulted in the development of the paediatric assessment unit. This had ensured that children referred by their GP or the out-of-hours doctor were admitted directly to that unit. This reduced the number of patients waiting in A&E because they had already been assessed by a medical practitioner. The waiting time was vastly reduced to an average of 5.8 minutes before being seen by the triage nurse in the paediatric assessment unit. Children were not kept waiting and they direct access to the children's ward environment.
- Children were admitted to the ward from A&E only after they had been seen by a medical practitioner. The consultants said they would visit children in A&E to prevent them being admitted unless it was necessary. This process was available 24-hours–a-day, seven-days-a–week.
- On the children's ward there were bayed areas with four beds and single occupancy cubicles. Staff said they would accommodate patients in whichever area met the child's needs.
- Staff discussed concerns about patients admitted to the children's ward who needed a psychiatric assessment. If they were admitted out-of-hours they had to wait for specialist assessment, and this could mean they would have to stay on the ward over a weekend or bank holiday. This not only added to ward capacity problems, but also potentially harmful to some individuals' mental health.
- There was an understanding by medical and nursing staff that a patient's stay on the ward should be as short as possible. A patient's plan of care was to get them home as soon as it was safe to do so.

Meeting people's individual needs

- Staff said they had a small number of children with complex needs who needed medical and nursing staff on the ward. These patients had open access and there was a file with their information available to all staff. This meant if they were admitted staff had ready access to information about their needs and care.
- We were told there was no specific support available on the wards for children with learning disabilities.
- There was a stock of medicines to use when patients were discharged. This was designed to reduce the waiting time for children because discharge medicines from the pharmacy might not arrive until 4pm when the child had been told they could be discharged in the morning. The store included pain relief, antibiotics and steroids.
- There was no written information in a child-friendly format or in other languages about a patient's management of their medicines.
- Staff told us translation services were available, but said that they did not have much cause to use them.
- On the children's ward there was no information or signage in a child-friendly format or any language other than English. This meant not all information was accessible to every potential patient.
- On the special care baby unit there was written information in a variety of languages provided by an outside agency.
- Patients' education did not need to be interrupted while they were on the ward because there were teachers working for the local authority to provide education support. Staff could access their services if this was part of a patient's planned admission.
- There was a variety of equipment available on the wards including beds and cots in a variety of sizes, and different chairs including those that converted to beds for parents.
- There was a large variety of play equipment available to accommodate a variety of ages and needs. Toys could be provided at the bedside as well as games and books.
- A local artist had painted a brightly coloured mural on the walls that was appropriate for a variety of ages and provided a bright and colourful environment.
- There was one breastfeeding chair available in SCBU, which meant not all mothers could use this equipment.
- The facilities on the children's ward included separate accommodation for parents. They could stay overnight in bedrooms, had dedicated showers, kitchen and lounge areas.
- There was a room dedicated to teenagers with a pool table and televisions. Another room for younger children had many toys and a playhouse.
- Staff said they would use the bay areas in the children's ward to ensure older children were kept separate from younger children. They would also not mix male and female patients in the same bay.
- In the children's outpatients department, one relative told us that a consultation had taken place in the lounge on the children's ward because there was insufficient space in the outpatients department.

- We were told access to mental health services for specialist assessments and care could take some time. Often an adult practitioner would see the child, which staff thought was not always suitable.

Learning from complaints and concerns

- There was a proactive approach to investigating potential complaints. Senior staff told us they learnt from complaints made in their unit by investigating any actual or potential complaints. For example, a patient's carer was concerned about that the PEWS record was not used to identify deterioration in a patient. A root cause analysis was undertaken and the results shared with the nursing team. This carer had not raised a formal complaint, but had discussed their dissatisfaction with a professional from another agency.
- The approach to complainants was altered to meet patients' needs. We were told that when a young person wished to complain they were visited at their home, with their consent, to discuss the issues. This decision had been taken because it was thought to be more appropriate to have a meaningful discussion than sending official letters to find out what the concern was.
- Staff told us they shared learning from complaints made on the ward during handover. There was a section dedicated to this in the monthly newsletter that had recently been developed.
- Staff told us there was no mechanism for sharing learning from complaints made in any other part of the organisation. This meant opportunities to improve practice as a result of investigations into complaints were not shared with the paediatric department.

Are services for children and young people well-led?

Requires improvement

Staff were not aware of the vision for the service. There was a lack of quality measurement of day-to-day practices on the ward. Some of the information provided on the ward was different from that given by the trust. There was a lack of risk assessments.

The service was not measuring data on outcomes.

Staff said they received good support from their managers at ward level. They were not aware of the trust board members.

Staff said they were not integrated into the rest of the hospital and worked separately to them. Staff were able to be innovative in the ward environment. There was a reliance on good will to ensure the staffing levels remained safe and there was no plan for sustaining this in the longer term.

Vision and strategy for this service

- Senior staff told us their vision was to expand the services available to children and young people. This included the addition of more specialist nurses such as dermatology, epilepsy and allergy management.
- They said they wanted to increase the working links with community services, which had improved over the past year. This included expanding the knowledge of staff into the work of each area that would help them to develop their skills and knowledge.
- Nursing staff told us they wanted to expand their own knowledge and skills, but they did not discuss any vision for the service as a whole. This showed a lack of sharing of the overall vision for the service with all staff grades.
- The medical staff said they wanted to continue to improve the reputation of the service with junior doctors, which was already good. They wanted to build on the positive view that the trust was a good place to learn for junior doctors.
- The senior medical staff said they would like to increase the working across the acute and community services to improve the integration of care.
- It was not apparent to us how acute services and community services worked together.

Governance, risk management and quality measurement

- Various staff had undertaken specific audits and reviews to make changes to the service. There was a lack of formal review of day-to-day activities in children's services. Although there was a formal review of medical records, we were not provided with evidence of audit or review of nursing records. This led to an absence of data to demonstrate that adequate quality assurance was carried out. This meant many aspects of the service were not monitored routinely to identify and rectify shortcomings such as in care records.

- There was a lack of risk management at ward level. This included environmental and personal risk assessments. This meant risks may not be identified or actions taken to prevent harm.
- The information we were told was on the risk register did not appear on the data provided by the trust. This meant there was a disparity of information that could result in lack of actions.

Leadership of service

- Staff said they could discuss any concerns or ideas with the ward manager. They described them as approachable and helpful and willing to listen.
- The ward manager was unable to produce some of the information we requested such as specific policies and procedures. They were unsure of some detail about activities on the ward such as what was on the risk register and how resuscitation competence was maintained. This showed they were not aware of all aspects of the service they managed.
- The ward manager said they had good support from their senior manager who provided them with supervision and advice when required.

Culture within the service

- Staff said they were not "integrated" with the other services in the hospital. They told us they did not liaise with colleagues, but wanted to do this because they could benefit from shared learning.
- Senior managers said they felt they worked as a service separate to the rest of the trust. They were self-sufficient in their day to day running. This meant both good practice and areas for improvement may not be recognised by the trust's management.

Public and staff engagement

- The diabetes management team had set up a group for young people with diabetes. This consisted of social trips as well as educational sessions. They said it was a service they wished to expand.
- The trust told us there were other groups for children using the rheumatology and oncology services which provided social events for patients. There was no evidence provided to demonstrate the involvement of patients attending these groups in the development of, or providing feedback about the service.
- The trust collated the Friends and Family test for the children's ward locally. However, staff were not aware of formal mechanisms for engagement with the public. Staff said they engaged informally with patients and parents when they were on the ward.
- The processes for staff engagement were through handover and monthly meetings. One staff member had recently started a newsletter to share general news and ideas among the staff team.
- Staff stated they did not see members of the trust board. The director of nursing had visited the ward one month prior to the inspection and staff said they had not seen them there before that or since that date.

Innovation, improvement and sustainability

- Senior managers told us there was scope for innovation from all grades of staff. They gave us examples of junior nurses who presented ideas and were supported to develop them. This included changes to record-keeping and understanding and improving opportunities for mother's to breastfeed on the ward. This showed staff were encouraged and able to be innovative.
- There were development roles advertised that staff could apply for. This was designed to motivate staff to improve and develop themselves.
- Nursing staff were working extra hours because it was acknowledged that agency staffing were not suitable for the ward environment. They said they had discussed this because it was not sustainable in the long term, particularly in winter when work pressures increased. They had discussed some form of financial incentive, but were unclear if this would be agreed. The safety of the service is dependent on the nursing staff remaining at least at the current level. There was no agreed plan of how to maintain this in the long term.

End of life care

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

Information about the service

End of life care is delivered in most wards in the trust. The end of life care team is made up of the specialist palliative care team, allied healthcare professionals and medical cover from another provider outside of the trust.

The specialist palliative care team were available from 9am to 5pm, Monday to Friday. Outside of these hours a consultant based at the local hospice provided a telephone on-call service. They received 372 inpatient hospital referrals each year.

We spoke with four patients and one relative. We also spoke with 24 staff, including: the specialist palliative care team of nurses; ward nurses; doctors; consultants; senior managers; allied health professionals; a chaplain; bereavement and mortuary staff.

We observed care and treatment and looked at care records. We received comments from our listening event and we also reviewed the trust's performance data.

Summary of findings

We found end of life care was caring and responsive of patient's needs.

Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not always completed in line with trust policy. In one case a patient who wanted to be resuscitated had a completed DNACPR form.

The rapid discharge pathway enabled patients to leave the hospital within four hours.

All of the patients we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment.

Following the removal of the Liverpool Care Pathway (LCP), there was no clear pathway for staff to follow when delivering end of life care. The trust had developed its own end of life care records that had replaced the Liverpool Care Pathway. This had yet to be implemented because it was going through an assessment process before sign-off by the trust board.

Improvements were needed to make sure all patients' records in relation to 'do not attempt to resuscitate' decisions were completed in line with trust policy. The forms were not filled in to clearly demonstrate how decisions had been arrived at. Nursing and medical notes lacked detail of conversations with patients and families about their wishes regarding resuscitation.

End of life care

We found the deceased were cared for by a team of dedicated staff who maintained a patient's dignity after death. Bereavement staff supported families effectively.

Are end of life care services safe?

Requires Improvement

Systems were in place to ensure end of life care was safe and met the needs of patients.

There were no dedicated wards for the provision of end of life care at the Hereford County Hospital. Patient care was delivered by general staff on the hospital medical wards. A specialist palliative care team provided both direct care and advisory care for patients with palliative care needs. The hospital consultant-led specialist palliative care team coordinated and planned care for patients at end of life on the wards.

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were safe and well cared for on the ward we visited

Staff were aware of the process for reporting any identified risks to patients, staff or visitors. Staff had access to the electronic system and confirmed that reporting incidents was encouraged by managers, although they told us they did not receive feedback after incidents had been reported.

'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were not always completed in line with trust policy. In one case a patient who wanted to be resuscitated had a completed DNACPR form.

Incidents

- There had been no Never Events (serious largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in the specialist palliative care service in the past 12 months.
- The specialist palliative care team were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, Never Events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system.
- Staff told us that although the electronic incident reporting system was straight forward, it did not allow them to save a report if it had not been fully completed.

They also reported of a lack of feedback after incidents had been reported. This meant that staff were not able to give us examples of where practice had changed as a result of incident reporting.

Cleanliness, infection control and hygiene

- We saw that the wards, day units and mortuary viewing area we visited were clean and bright. Surfaces and floors in all patient and clinical areas were covered in easy to clean materials that allowed high levels of hygiene to be maintained.
- General and clinical waste bins were covered and appropriate signage was used. When we entered wards we observed that hand gel was available at the entrances for visitors and staff to use.
- Ward and departmental staff wore clean uniforms with arms 'bare below the elbow' and that personal protective equipment (PPE) was available for use by staff in all clinical areas.
- We saw that in the ward bays, separate hand washing basins, hand wash and sanitiser were available.
- We observed staff sanitised their hands between patient contacts and wore aprons and gloves when delivering personal care to patients.

Environment and equipment

- Each ward area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was maintained and checked to ensure it continued to be safe to use.
- All patients were able to reach their call bell to attract the attention of a member of staff if they needed to.

Medicines

- Staff told us patients who required end of life care medicines were written up for anticipatory medicines. This is medication that they may need to make them more comfortable.
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed

Records

- In all of the ward areas we saw that records were stored securely in order to ensure they could not be accessed by people who did not have the authority to access them.
- Patient medical notes were completed sensitively and detailed discussions that had been had with patients and their relatives.
- We looked at eight Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms throughout the ward areas. We saw that there were variations in the completeness of the forms across the hospital:
- We found that four forms had not been completed in line with national guidance published by the General Medical Council (GMC).
- One of the forms did not show evidence that a discussion had taken place with the patient or any of their relatives before the form had been signed by medical staff. This failure could impact on how people were supported to make decisions around resuscitation if families were not involved in the formal decision-making process.
- Another form stated that the patient lacked capacity to make the decision around DNACPR but we found no evidence of a Mental Capacity Assessment (MCA).
- The four DNACPR forms which had been completed correctly showed that three had been completed at the request of the patient and another at the request of a family member with lasting power of attorney. This meant that the patient or their family's wishes had been taken into account.
- We saw that all decisions were recorded on a standard form with a red border. The DNACPR form was at the front of the notes, allowing easy access in an emergency.

Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms

- The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were easily identified by their red colour at the front of patient notes.
- There had been a DNACPR audit in December 2013 that had highlighted issues with incomplete forms and documentation in medical notes. An action plan had been produced, but DNACPR forms and documentation were still not completed in line with trust policy. We looked at 21 forms from AAU, Stoke, Arrow and Lugg wards.
- The DNACPR form clearly indicated where discussions with the multidisciplinary team, patient and/or relative should be entered. Despite this, we found 11 cases where DNACPR discussions were not documented in medical notes.

End of life care

- In one case a patient who wanted to be resuscitated, told us: "I cannot remember having this discussion." We spoke with the family of another patient and they said: "We've not had a discussion about resuscitation." We reported these to the doctor caring for the patients, who told us that they had not received training on how to complete DNACPR forms but would report these concerns to their consultant.
- The forms require the most senior doctor/health care professional available to sign the form and then the consultant/GP should ratify the decision at the earliest opportunity. In eight cases the DNACPR form was only signed by a single health professional. Yet the consultant had seen the patients after the form had been dated. In two cases there was no date, time or countersignature on the form. This did not meet the trusts DNACPR policy.
- We saw no examples of where mental capacity assessments had been completed, despite five of the 21 DNACPR forms indicating that the patient did not have capacity to make informed decisions about their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the consent systems appropriately when patients did not have capacity to consent to care and treatment. However, we saw there was no assessment of capacity within the records of one of the DNACPR forms we examined.
- Staff told us they had received 'consent' training.
- The next of kin/advocate was involved in decisions about the care for a patient who could no longer make decisions for themselves. We saw this on one of the care records we reviewed.

Safeguarding

- The specialist palliative care team told us that safeguarding training was mandatory and all the staff we spoke with had undertaken it.
- Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns.
- Staff also knew about their whistleblowing policy and how to report concerns if they had them.
- Patients told us they felt safe being cared for in the hospital.

Mandatory training

- The specialist palliative care team and staff in the Macmillan Renton Unit reported that they had received mandatory training in health and safety, safeguarding and infection control.

Management of deteriorating patients

- There was a recognised early warning tool being used to identify when patients were deteriorating.
- Specialist support was available for staff on the wards from the palliative care clinical nurse specialists when required.
- The specialist palliative care team provided patients who were returning to their home with a supply of their medication and a leaflet listing the medicines that they were taking.

Nursing staffing

- The hospital specialist palliative care team comprised a lead palliative care nurse supported by three nursing staff. The team supported ward staff in delivering end of life care and was also responsible for rolling out the programme that aimed to develop the end of life care and support available in the trust further.
- There was a 'link nurse' on each of the wards. These were usually band five nurses who had received additional training in end of life care and were responsible for cascading training throughout wards.
- We observed a lunchtime handover on Frome ward. Handover was concise and the information exchanged was relevant and covered all relevant aspects of the patient's care. All patients were referred to with dignity and respect and appropriate further actions were communicated appropriately.

Medical staffing

- The trust had employed a whole time equivalent (WTE) consultant in palliative medicine.
- Specialist telephone advice was available from the on-call consultant for palliative medicine at St Michael's Hospice in Hereford.
- Ward rounds were held daily and end of life care assessments were carried out.

Major incident awareness and

- The mortuary manager told us they had a contingency plan if the mortuary became full. The trust had an agreement with a local undertaker, and the mortuary manager was aware of the circumstances under which they should use this plan.

End of life care

Are end of life care services effective?

Requires Improvement

During our inspection we followed the cases of four patients receiving end of life care, who the specialist palliative care staff had identified. Patients we spoke with were positive about the way they were being supported by all staff to meet their care needs.

Some aspects of end of life care were not provided in line with national guidance in relation to access to medicines. We saw there was an eight hour delay in providing pain relief to one patient.

Following the removal of the Liverpool Care Pathway (LCP), there was no clear pathway for staff to follow when delivering end of life care.

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

Staff were appropriately trained and supported and there were regular multidisciplinary meetings.

Evidence-based care and treatment

- The clinical nurse specialists for the palliative care team told us care was based on the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This quality standard defines clinical best practice in end of life care for adults.
- Following the independent review of the use of the Liverpool Care Pathway (LCP) for the dying patient and the subsequent announcement to phase out use of LCP, the trust had made some interim amendments that included the removal of direct and indirect references to the LCP. Some elements of the LCP were still in place because the staff had found the assessment tools were useful. However, there was no clear pathway in place for staff to follow, which could lead to variability in care provided.
- The trust policy and procedure was under review and there was a steering group reviewing the recommendations to replace the LCP.
- We saw evidence across all the wards we visited that the specialist palliative care team supported and provided evidence-based advice to other health and social care professionals such as complex symptom control.

Pain relief

- Patients under the care of the specialist palliative care team had their pain control reviewed daily and ensured that PRN (when required medication) medication was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, scheduled pain relief.
- A patient on one of the wards told us they were in pain because there were delays in the administration of their pain relief.
- We reviewed the patient's medical records and noted it had been agreed that a syringe driver was necessary. The ward staff were requested to attach a syringe driver from the equipment library. The patient told us that they had been waiting eight hours for the pain relieving medication to be administered because the ward staff had to request a syringe driver and also the medication.
- We spoke with the patient again on the following day and they confirmed that their pain relief had been administered in a timely manner following the attachment of the syringe driver. Medication administration records we reviewed confirmed this.
- We were shown the results of a survey sent to relatives/ friends of people who died at the hospital. The survey was completed in June 2013 and asked people their opinion of the care their relative had received. Two people commented that their relatives had not received their pain relief as prescribed and were in "considerable pain" as a result.
- The trust had undertaken an analgesic prescribing and pain scoring audit in September 2013. The audit included 11 inpatient clinical areas with a total of 54 patients. The audit found that 91% of patients had their pain assessed and scored appropriately. The audit also found that 4% of the prescribed analgesia was identified to be an inappropriate dose, which was linked to three PRN analgesic prescriptions.
- A number of recommendations were made and the findings of the audit were shared with the director of nursing and head of quality and safety.

End of life care

Patient outcomes

- Patients identified as requiring end of life care were commenced on an end of life care plan.
- The specialist palliative care team had produced guidance for ward staff. This took the form of a box file that we saw in wards. Staff we spoke with were aware of this guidance on the ward. For example, staff told us the file contained information such as rapid discharge forms and bereavement information.
- When staff contacted a member of the specialist palliative care team, they responded by giving telephone advice that was followed up by the specialist nurse, usually on the same day.
- Referrals were usually responded to in 24 hours, except on weekends when out of-hours cover was provided by a telephone advice service.
- We were told by the specialist palliative care team that as part of their role they had developed end of life and palliative care processes and procedures for ward staff, which included communication skills when speaking with families.
- The trust had participated in the 2013 National Care of the Dying audit. The results showed that overall, the trust performed well in comparison to other trusts. The trust scored below average in two areas: assessment of spiritual needs and a review of the care after death.
- The audit demonstrated that the trust did not offer specialist support for care in the last hours or days of a person's life because there were no face-to-face specialist palliative care services available from 9am to 5pm, seven days a week. There is a national recommendation that this level of care should be provided. Nationally 21% of trusts have achieved this level of support. Hospital staff did have access to out-of-hours telephone support at all times.

Competent staff

- Staff in the specialist palliative care team had clinical supervision to support them in their role and all staff had an annual appraisal.
- Wards had link nurses to act as a resource to improve knowledge and skills for ward staff. The link nurses were supported by the palliative care team and attended training days and monthly link meetings with the team.
- Training sessions had been delivered by the palliative care team to staff on wards that included health care assistants.

Equipment

- The former National Patient Safety Agency (NPSA) recommended in 2011 that all Graseby syringe drivers should be withdrawn by 2015. The trust recognised this on their risk register, but no plans to replace the drivers and reduce the risk had been developed.

Multidisciplinary working

- The specialist palliative care team members attended regular multidisciplinary team meetings (MDT) at the hospital for specialist teams such as gynaecology, lung, GI l, and haematology. This meant that patients under specialist teams could benefit from specialist palliative care team involvement and that care, treatment and support was delivered to meet the patients' individual needs.
- There was also a weekly specialist palliative care multidisciplinary (MDT) meeting at St Michael's Hospice in Hereford that was attended by relevant hospital and community staff to ensure effective continuity of care and facilitate discharges.
- Staff on the wards reported that there was effective multidisciplinary team working and decision making approach to end of life care.

Seven-day services

- The specialist palliative care team were available Monday to Friday from 9am to 5pm.
- Out-of-hours support was available from an on-call palliative care consultant at St Michael's Hospice. Ward staff confirmed that this service was easily accessible and available.
- The specialist palliative care team lead told us that they ensured patients had a care plan to meet their needs over the weekend.
- The chaplaincy service provided pastoral and spiritual support and provided cover out-of-hours.

Are end of life care services caring?

Good

We saw that patients were treated with dignity, respect and compassion from staff working on the wards to staff working in the mortuary

End of life care

Patients we spoke with told us they had been given sufficient information about their illness and treatment options. They said they were very satisfied with their care and said staff were kind and caring.

Compassionate care

- We observed staff interactions with patients and their families that were compassionate and appropriate at all times.
- Staff ensured that privacy was maintained by staff when they assisted patients with their needs
- Patients and a family member we spoke with told us they were happy with the level of care they or their family members received.
- One patient described the staff on their ward as "excellent"
- Staff we spoke with demonstrated commitment and compassion to providing good end of life care and the importance of dignity after a patient had died.
- Staff in the mortuary demonstrated compassion and respect while preserving the dignity and privacy of patients following death.

Patient understanding and involvement

- Patients were able to make decisions about their care and had the opportunity to identify preferred places of dying.
- Staff we spoke with were able to describe conversations they had had with patients about their wishes. We saw some of these conversations were reflected in the patient records we reviewed.
- The mortuary had a viewing suite where families could come to visit their relatives. We visited the area and saw that the viewing suite was divided into a waiting and viewing room.
- The suite was clean and provided facilities for relatives such as comfortable seating, tissues and information booklets about bereavement. The suite was neutral with no religious symbols which allowed the suite to accommodate all religions. We were told by the mortuary manager that relatives were supported by staff so that relatives knew what to expect before viewing their relative.
- The mortuary manager told us that they accommodated all faiths.
- We saw that the specialist palliative care team had provided each ward with telephone contact numbers for ministers and leaders of all faith communities in the area.
- Staff spoken with in the ward areas confirmed they could access religious representations from all denominations
- The hospital had a multifaith prayer room that offered a peaceful environment and facilities for prayer and worship close to the main hospital reception, which made it easily accessible for patients and their families. The chaplain and bereavement officer confirmed that the chapel could be used for all faiths.

Emotional support

- The specialist palliative care team supported people emotionally. The team had received training to enable them to support patients and families. They also delivered training to ward staff. For example, one of the training sessions they delivered was entitled 'Breaking Bad News'.
- Junior medical and nursing staff told us they felt supported in their roles when caring for a person at the end of life.
- The mortuary manager talked us through the process of admitting deceased patients into the mortuary. We were told that a 24-hours on-call service is in place. A request for a quick release of a body could be accommodated to meet family's needs. For example, if the person was of Muslim faith.
- The hospital did not have a dedicated bereavement counselling service for family members of patients who had died in the hospital. Staff at the bereavement centre told us that people were given details of local counselling services they could access.

Are end of life care services responsive?

Good

The specialist palliative care team worked across the hospital and in community settings. A partnership had been formed with a local hospice to provide patients with a streamlined service when they were in the hospital and after discharge.

Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were committed to ensuring patients receiving end of life care had a positive experience.

End of life care

There was specific support for people with a learning disability, for people living with dementia and for people from different cultural, religious and spiritual backgrounds.

A pathway had been developed to support patients to be cared for and to die in their preferred place and the hospital was in line with the national average in support of patient's preferences.

Service planning and delivery to

- The specialist palliative care service had formed an alliance with St Michael's Hospice in Hereford to ensure support was available 24-hours-a-day.
- Patients who required end of life care were referred to the specialist palliative care team by individual consultants, ward staff or GPs.
- We saw from the team's annual report for 2013 they had received 372 inpatient hospital referrals.
- Link nurses from each ward had been identified and trained to support staff on the wards. The link nurses also cascaded end of life standards of care to staff.
- An end of life care strategy had been implemented for use in the trust when patients were to be discharged. This was aimed at working in partnership with community services such as a local hospice to provide a streamlined service for patients receiving end of life care.
- Staff were able to explain to us how they meet the complex needs of patients on the wards. Care and treatment records provided detailed information and set out how to meet those patients' needs effectively.
- We did not see any patients who did not speak English, but staff told us that translation services were available in the hospital.
- Support was available for patients living with a learning disability. Staff told us there was nurse qualified in the care of people with a learning disability in the trust who they could contact if support was needed.
- Support was available for people living with dementia. Training records provided by the trust showed that staff had undertaken a basic dementia awareness course. We were told that there was a dementia nurse specialist who would provide support if needed.

Access and flow

- Where possible, side rooms on the wards were prioritised for patients at their end of life.
- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The lead specialist palliative care nurse explained that a multiprofessional approach is in place that included an occupational therapist to secure rapid discharges to the preferred place of care.
- The specialist palliative care team told us that they were able to 'fast track' patients to return home in 24-hours, if that was their preferred choice.
- Staff told us that they were in regular contact with community teams to facilitate discharges and we saw evidence of discharge notification forms that allowed patient treatment information to be shared appropriately with community teams.

Meeting people's individual needs

- We saw that multidisciplinary team board rounds were undertaken on each of the ward areas each morning where plans relating to appropriate discharge were discussed.
- Ward staff provide families with a bereavement booklet and contact numbers and families do return to the wards following the death of their family member.
- If a patient died when the family were not present, the staff ensured that they offered the family the opportunity to come to the ward before the deceased person was moved to the mortuary.
- We saw an audit for January to March 2014 that showed that 80% of patients achieved their preferred place of dying.
- The collection of death certificates usually took place the following day. Any delays in completing the certificates was kept to a minimum because the bereavement officer attended the medical handover each morning to ensure the necessary documentation is signed in a timely manner by the appropriate doctor.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust policy. Staff encouraged patients and relatives to speak to them about concerns. If a patient or relative wanted to make a formal complaint staff were aware to direct people to the patient advice and liaison service (PALS).
- Complaints relating to end of life were not identified specifically. When PALS received a complaint or compliment that mentioned end of life care, the information was shared with them.

End of life care

Are end of life care services well-led?

Requires Improvement

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

We saw a service with lack of clear replacement for the Liverpool Care Pathway.

We saw a service with challenges over its approach to DNACPR documentation and process.

The specialist palliative care team were passionate about their work in supporting and caring for patients and their families.

Governance arrangements were in place to ensure that quality was monitored effectively and that there was learning from incidents, complaints and concerns.

Patients and their families were asked to provide feedback to improve services.

Vision and strategy for this service

- The palliative care team had an annual general meeting where they discussed and agreed their operational policy and work plans and priorities for the following year. We saw a copy of the meeting held in December 2013. We were also given a copy of the annual report produced by the team for the year end 2013.
- We saw a copy of the team's work plan for end of life care and priorities for 2014. The main priorities were listed as service development, education and audits/ surveys/guidelines.

Governance, risk management and quality measurement

- The specialist palliative care team held regular team meetings in which performance issues, concerns, complaints and general communications were discussed.
- An operational policy was in place that set out the aims and objectives of the team. We saw this was updated annually.
- Multidisciplinary team meetings took place weekly. Complaints, concerns or issues were raised, discussed and planned for.

Leadership of service

- There was good leadership of the specialist palliative care team. The team was led by the palliative care consultant and the specialist palliative care nurse team leader.
- All of the ward staff we spoke with knew who the leads were for end of life care. Staff spoke highly of the team and felt they were supportive and visible in the ward areas.
- We saw that the trust had withdrawn the Liverpool Care Pathway before a robust process for its replacement was in place.
- The process for DNACPR was inconsistently applied.

Culture within the service

- All staff spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility. This was very evident in the specialist palliative care team and their patient-centred approach to care.
- The specialist palliative care team were committed to delivering good care through training and support to ward staff. They had a proactive approach to ensuring the training of staff fitted the changing needs of the patients. For example, they delivered short training sessions on the ward at the same time as reviewing their patients.
- Across the wards we visited we saw that the team worked well together with nursing and medical staff and there was good communication between not only the specialities but across disciplines.
- The specialist palliative support team and Macmillan support and information services worked closely and supported each other in ways to improve the patient's experience. This teamwork was also supported by staff in the bereavement office, mortuary and chaplaincy

Public and staff engagement

- Relatives/friends of people who died at one of the trust's hospitals were invited to complete a survey in June 2013. It was unclear from the documentation shared with us how many had been sent out to relatives/ friends, but we saw that 12 completed surveys were returned. Staff told us that the return rate was probably low because they related to a very sensitive subject that people may not want to think about.
- In the main, people were very satisfied with the end of life care their relatives received at the hospital.

End of life care

- Staff told us that they would engage with people at the time if there were any concerns.
- We saw that there were a number of thank you letters from relatives outlining areas of care they appreciated, such as support and comfort.
- Staff who attended courses run by the team were asked their opinion of the training. A majority indicated that the courses helped them considerably in recognising a dying patient and how they could support them.

Outpatients and diagnostic imaging

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

Information about the service

Wye Valley NHS Trust runs a range of outpatient services from Hereford County Hospital and in community settings.

At Hereford County Hospital the outpatient clinics are located throughout the hospital with reception desks and waiting areas in each clinic.

During our inspection we observed a range of outpatient clinics including: general surgery; cardiac rehabilitation; anticoagulant; dermatology; diabetes; orthopaedics; fracture, children's respiratory; maxillofacial; and ophthalmology.

We met with 32 staff including: receptionists; nursing staff; healthcare assistants; consultants; and clinic coordinators. We spoke with 37 patients and relatives. We looked at the patient environment and observed waiting areas and clinics in operation.

Summary of findings

We observed patients were cared for in a clean and hygienic environment. There was a system for reporting incidents, but this was not always being used in a consistent manner.

In some areas we saw practices that could compromise the safety of staff and patients.

Patients' care pathways were adversely affected by the limited availability of beds. This meant when outpatients needed to be admitted there were delays in starting treatment.

There were systems to triage referrals and send appointments to patients.

The trust was struggling to meet the demand for outpatient appointments so overbooking of clinics was commonplace, causing delays for patients. The impact of this was not being monitored.

Patients were treated with dignity and respect. Staff were well regarded by patients who were overwhelmingly positive about the care they received.

The managers of outpatients departments were accessible and respected by staff. Steps were being taken by managers to improve the service offered to patients.

The facilities in the Arkwright (temporary) Suite were inappropriate.

Outpatients and diagnostic imaging

Trust-wide governance systems were not strongly established and there was a lack of adherence to, and knowledge of policies and procedures.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We observed patients were cared for in a clean and hygienic environment. There was a system for reporting incidents, but it was not always being used in a consistent manner.

Medications were on occasions accessible by staff who were not suitable trained. Staff had an awareness of the Mental Capacity Act, but did not have a working knowledge and confidence to implement the requirements of the act. Staff had received safeguarding training and were familiar with reporting systems.

Most equipment was clean and checked as safe to use.

In some areas, we saw practices that could compromise the safety of staff and patients. For example, we saw unsecured sharps (anything that can puncture the skin) bins and there was equipment in use without a schedule of service checks.

In all outpatient clinics there were regular occurrences when patient records were not available. This was not being consistently monitored. Patient records were not held securely.

Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or serious incidents reported in the outpatients department.
- Staff received feedback on incidents at trust level, but there was no local analysis or feedback of incidents available. The manager told us this would be fed back if trends or themes were identified.
- An electronic incident recording system was in place, which staff confirmed they were trained to use. However, some staff told us they completed paper incident reporting. Therefore, there was not a single system in use to report incidents. The trust told us that where staff completed paper reports these were

included on the electronic system to ensure the system was unified. The use of two systems increases the risk of a loss of paper records and potential delays in combining the paper and electronic systems.
- There was not always personal responsibility taken by staff for recording incidents. Some staff told us that if they had concerns they would report these to their manager, but would not necessarily use the reporting system.
- We saw there was inconsistency between departments in recording of incidents. One department recorded incidents where patient records were not available, but other departments where this had occurred had not reported this as an incident.
- Staff were not always aware of what was reportable or where to find the guidance. An example of this was that receptionists were not recording incidents of verbal abuse towards them.

Staffing

- In some outpatient departments the manager had developed a staffing calculator tool to ensure there were sufficient staff on duty. However, this was not used throughout all outpatient departments.
- Some recruitment of staff was in process and currently bank staff were being used to cover known absences through sickness or leave.
- Some volunteers worked in the outpatients clinics. The manager told us volunteers were recruited with suitable checks in place. There had been work done to develop a clear role and remit for volunteers.

Cleanliness, infection control and hygiene

- An external contractor provided the routine cleaning service. Nursing staff took responsibility for cleaning equipment and any additional unforeseen cleaning that was required during clinics.
- Spillage and cleaning products were available to staff.
- Clinical areas appeared clean and there were systems to monitor checks of cleanliness.
- Toilet facilities were clean.
- Hand-hygiene gel dispensers were located at the entrance to each clinic, but were not prominently signposted.
- Patients told us they considered the hospital was clean.

Environment and equipment

- Most environments in the outpatient areas were safe and fit for purpose.
- Most equipment was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in outpatients were centrally located and checked on a daily basis.
- In one outpatient area new equipment and stocks were stored next to the dirty sluicing facilities, increasing the risk of cross infection.
- We saw medical gases stored in corridors and in cupboards without suitable signage in place.
- There was an efficient 'air tube' system in place to deliver samples and requests to other departments in the hospital.

Medicines

- Room and fridge temperatures were checked to ensure medicines were stored at correct temperatures.
- Some medications had been removed from original packaging so it was not possible to identify the batch number of the medicines should recalls of medicines be necessary.
- We saw that some patients' medicines had been changed and they had left medications with staff to be disposed of. These were kept securely, but there was no record of what had been received and staff would not be aware if these went missing.
- FP10 prescription pads were securely locked away. However, we saw one recent incident report where there were missing FP10s. This was under investigation.
- In one outpatient clinic a healthcare assistant held the medicine keys. We observed that one drugs trolley was locked, but some medications were stored on the shelf below the lockable compartment. Medication keys were kept in an unlocked cupboard in another area, so medicines were not always securely stored.
- We saw some audits of medicines management had been completed and where actions were needed they had been taken.

Records

- Staff told us they frequently did not have the full set of a patient's notes available. The unavailability of patient notes was included in the trust risk register. Staff told us they made up temporary sets of notes by obtaining copies of recent letters, but these did not contain all a patient's records.
- The potential harm to patients due to inadequate and inaccurate condition of health records is included in the trusts risk register.

- There were no regular audits undertaken to monitor the availability of records. Some outpatient departments recorded missing records as an incident, but other areas did not. This meant there was not accurate information available about to how often this occurred.
- We observed patients' notes on trolleys outside consulting rooms. Staff were not always in the vicinity so were vulnerable to theft and unauthorised access. In some areas records were held appropriately outside consulting rooms in secure, purpose-built trolleys with number locks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly, where they had capacity to make decisions.
- Staff were aware of the Mental Capacity Act 2005 and told us that most patients visiting the outpatient department had the capacity to make decisions about their care.
- Some staff had received training in the Mental Capacity Act 2005.
- Staff were not always clear about how they would proceed if they became aware that a patient may not have the capacity to make an informed decision.
- Staff were not familiar with the procedure to follow and were not able to clearly describe what steps they would take if it was considered a patient may not have capacity. The manager told us they would seek advice from the trust's safeguarding lead. One staff member told us they would need to look up how to implement the Mental Capacity Act if they needed to use it. Therefore, staff did not have a working knowledge or confidence to implement the requirements of the Act.

Safeguarding

- Safeguarding training was included as part of the mandatory training package. All staff we spoke with told us they had completed training in either safeguarding adults or children, whichever was most relevant to their area of work. Some staff had completed both.
- All staff were aware who the designated safeguarding lead was for the trust and knew what their role was.

Mandatory training

- Managers told us there was good availability of training opportunities and staff were encouraged to take responsibility for organising their own training dates.
- Each staff member had a training record, but managers did not have a clear overview of what staff training had been completed in outpatients departments. Training records were kept for individual staff, but these not been collated.
- One manager told us mandatory training update now took place over two days rather than one day. We were told that releasing staff from day-to-day duties was a barrier to staff completing updates.

Management of deteriorating patients

- Each outpatient department had emergency resuscitation equipment, which was checked regularly.
- When patients attended outpatients and then required admission, staff undertook risk assessments and monitored their condition while they were waiting for an available bed.

Are outpatient and diagnostic imaging services effective?

There was good multidisciplinary working in the hospital and community settings to provide joined–up patient care.

There were no facilities for patients to access drinks in outpatients departments. Some vending machines and a coffee shop were available to patients.

Some staff had received training to extend their role and responsibilities.

Pain relief

- Staff told us that they could give paracetamol to patients if they were in pain, but all other painkillers were prescribed.

Nutrition and hydration

- There were was no drinks facilities provided by the trust in outpatient waiting areas. This was important because of appointment delays, and if a patient was waiting to be admitted. Staff told us they could offer water to patients if they needed a drink, but during our visit, we did not observe any drinks being offered. Where drinks were offered by staff they told us they used provisions that were purchased by staff. Some areas had vending machines and a coffee shop was located near the front of the hospital but patients would need to leave the outpatients departments to use this.
- Staff told us that if patients were waiting for a bed and were being cared for in the outpatient department they

could access food. However, this occurred during our visit and staff struggled to get food for the patient. A meal was eventually offered and patient was cared for, but the hot drinks they were given were made with staff's own supplies because the trust did not provide drinks for outpatient patients.

Competent staff

- There was no regular Staff clinical or caseload supervision.
- Annual appraisals were held with staff, which included a review of staff training. Some statistical information as available for some areas, but not for others. In the Oxford Suite 79% of staff had completed appraisals, while in the Eign Suite it was 88%.
- There were no role-specific training standards set by the trust to state what staff had to complete as a minimum for their designated area of work. One manager told us they had developed what they considered to be a minimum level of training and staff were working towards this.
- We spoke with some staff who had completed training to extend their role. This included healthcare assistants who had been trained to do dressings or develop X-rays.

Multidisciplinary working

- Patients told us that where they received care from different services in the hospital staff were aware of this. An example of this was where a patient had received a knee replacement and was under the care of the consultant and physiotherapist.
- Some clinics were jointly run by consultants and nurses. We saw this in the children's outpatient department.
- We saw examples during our visit where community services were organised to provide care to patients in their own homes.
- One patient told us they considered teamwork across departments was good telling us "I have been treated excellently and won't have a word said about the staff".

Seven-day services

- Most clinics were held on weekdays with some additional clinics organised on Saturdays to meet demand and waiting time targets.
- Managers told us there plans to extend clinics to seven-day–working, but significant work was required before this was implemented.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with dignity and respect.

Staff were well regarded by patients who were overwhelmingly positive about the care they received.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- Most outpatients departments had suitable rooms for private consultations. Chaperones were offered and provided where patients attended the department alone.
- Staff were said to be professional, compassionate, polite, kind and helpful.
- We observed that staff were busy but they always had a smile for patients.
- Receptionists were observed to be welcoming and respectful to patients.

Patient understanding and involvement

- Patients we spoke with stated they felt that they had been involved in decisions regarding their care.
- Patients told us they had received information about their conditions and medications.
- One patient told us "you can ask them anything" and staff are "Good at explaining things".

Emotional support

- Patients told us they usually saw the same doctor or nurse, which helped them to build a trusting relationship with staff.
- We observed staff supporting patients in a compassionate manner.
- We saw some staff go the extra mile, for example, fetching newspapers for patients while they were waiting for a bed.
- Patients told us that staff listened to them if they had any worries. One patient told us "they listen to me and don't treat me like I am a nuisance".

Are outpatient and diagnostic imaging services responsive?

Outpatients and diagnostic imaging

Requires improvement

Patients' care pathways were adversely affected by the limited availability of beds. These meant where outpatients needed to be admitted there were delays in starting treatment.

There were systems to triage referrals and send appointments to patients.

The trust was struggling to meet the demand for outpatient appointments. As a result overbooking clinics was commonplace, which caused delays for patients. The impact of this was not monitored.

The confidentiality of patients was mostly protected because consultations were conducted in private. However, the Arkwright Suite which was a temporary facility with poor soundproofing.

Service planning and delivery to meet the needs of local people

- In all outpatients departments we were told it was common practice for clinics to be overbooked. This meant some time slots for appointments were reduced to as little as five minutes each. Staff gave us examples where this had resulted in significant over-running of clinics that meant delays for patients and a lack of breaks for staff.
- Staff kept patients informed if clinics were running late and there were delays.
- Most patients we spoke with were tolerant and accepted if they were not seen at their scheduled appointment times. However, some complaints had been received about delays in clinics.
- When we asked if the frequency that clinics ran late was monitored and to what extent they were being overbooked, we were told was not being monitored.
- Managers and staff told us there were capacity issues with clinics that meant that there were an insufficient number of clinics. However, this did not correspond with trust data which indicated that since April 2014 the utilisation rate of clinics had fallen.

Access and flow

- Referrals to outpatient clinics were triaged by the urgency level indicated by the referrer.
- There were standard operating procedures to ensure patients were seen in 18 weeks of referral.
- Patients were sent appointment times with maps of the hospital. Some specialities used a 'choose and book' system where patients were sent letters to inform them how to make an appointment at the time of their choice.
- The lack of beds meant that patient care did not always progress as planned. Delays in surgery were common due to bed shortages.
- Some patients we spoke with told us about cancelled appointments.
- Staff in the adult's outpatient department appeared to be very busy and told us that this was usual. Staff told us that the volume of patients seen in short time frames placed them under pressure. We saw a list where 36 patients were seen in a two-hour period. At times staff were struggling to find the time to make a patient a drink.
- Overbooking of outpatient clinics impacted on staff wellbeing. Staff told us about one clinic where nine patients were typically seen that had been overbooked and 26 patients were in fact seen in one morning. This had resulted in staff working without breaks and the clinic ran overtime

Meeting people's individual needs

- A translation service was available to enable staff to communicate with patients where English was not their first language.
- Staff told us that it was usual that patients living with a learning disability or dementia would be accompanied by a carer or relative.
- Patients could be provided with transport following an assessment of their eligibility.
- Written information was available in several languages and large print. One patient told us they would like letters to be provided for them in Braille. Staff told us that patient information was not available in Braille.
- A text message reminder service was being developed, but was not yet fully operational.
- Some patients told us they were not given a choice about the gender of the staff member they saw when they would like to have been offered this.
- Some temporary accommodation was being used to provide outpatients services known as the Arkwright Suite. We were told these were to be used for a six-month period. However, these have been used for

five months and no replacement facility has been located. The Arkwright Suite was found to be cramped with insufficient soundproofing to protect patients' privacy. Staff had the radio on to limit the risk of other patients overhearing, but this was not successful.
- One further breach of confidentiality occurred when a doctor was heard dictating a letter with the door to the consulting room left open.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. The outpatient manager dealt with initial complaints. If they were unable to deal with a patient's concerns satisfactorily they would be directed to the patient advice and liaison service (PALS).
- The PALS service was located prominently at the front entrance of the hospital.
- For the period between April 2013 and March 2014 the incidence of complaints relating to outpatients departments had increased by 12%.
- Managers told us that analysis of complaints was completed by PALS and that feedback on any trends or themes would be provided if it was relevant to each department.
- Where PALS received complaints that required investigation by managers there was an electronic system to delegate responsibilities and track progress of the complaint.
- There were some leaflets available in outpatients departments including comment cards, which patients could complete and post. The complaints process was detailed in the leaflets, but this did not inform patients of the timescales in which they could expect a response. The Trust told us this was done intentionally as complaints were graded individually and a letter was sent to complainants to inform them of the timescales they should expect. The trust told us complaints were responded to between 10 and 25 days
- Most patients we spoke with were not familiar with the complaints process.
- The trust policy stated that there was no mandatory complaints training provided to staff, but it was provided on an ad hoc basis. The principles of good complaints handling were included in the policy.

Key responsiveness facts and figures

- The average wait time from referral to appointment time was 31 days over all specialities. However, the individual wait times varied significantly. Referrals to adult and paediatric respiratory medicine, plastic surgery and urology had the longest referral to treatment times.

Ensuring attendance

- The trust target for DNAs (patients who did not attend appointments) was 4%. The data for March and April 2014 indicates that this was not being achieved. In the week beginning 21 April 2014 the DNA rate was 6.6%, a rise from the previous month.
- Rebooking statistics for new and follow-up appointments were improving.
- Systems for rebooking appointments for patients who had failed to attend varied between each speciality. Patients who had been referred under the two-week-wait system were routinely offered a further appointment.
- GPs were informed when patients were discharged because they had failed to attend appointments.

Communication with patients and GPs

- Patients told us they received copies of the letters that were sent to GPs, which they said arrived shortly after their appointments.
- Relatives we spoke with in the children's outpatients told us there was excellent communication with GPs and community services.

Environment

- Car parking was available, but many patients we spoke with complained that it had limited capacity and was expensive, particularly for short stays. Some patients told us that car parks were located a long way from some clinics, which caused problems for patients with limited mobility.
- The trusts complaints record indicated that some patients had complained about the car parking availability and costs.
- Staff told us that if patients experienced delays in appointment times they could give concessionary passes if additional car parking costs or fines were incurred.
- In waiting areas used by children there were a range of toys and books available to keep them occupied.

- There were sufficient seats in most waiting areas apart from the Arkwright suite, which we observed was crowded.
- There was a wide range of information leaflets available to patients, but these were in corridors adjacent to consulting rooms and not immediately noticeable to patients in waiting areas.
- A shop and café were located near to the front entrance of the hospital run by private companies.

Are outpatient and diagnostic imaging services well-led?

The managers of outpatient departments were accessible and well regarded by staff. Steps were being taken by managers to improve the service offered to patients.

Trust-wide governance systems were not strongly established, and there was inconsistency in adherence to, and knowledge of policies and procedure from department-to-department.

We were not assured that the trust had recognised the issue of lack of availability of notes and was able to quantify the scale of the problem. As such, they were unable to deal with the impact of this adequately.

Outpatient clinics were regularly overbooked.

Vision and strategy for this service

- Staff were aware of the recent changes at board level. They knew the names of some board members and told us that on occasions board members visited the outpatients departments.
- Staff were not able to describe the vision and strategy that the board was adopting.
- Outpatient managers told us of recent changes and recruitment that was taking place to develop the service. This included environmental changes and changes to staff structures.
- Staff told us that they were emailed a staff newsletter. Most said they did not read it regularly and were not aware of the trust's latest plans.

Governance, risk management and quality measurement

- The quality and safety board reported directly to the trust board on a quarterly basis.
- In January 2014 the trust undertook a Safety Culture Survey. All staff were invited to complete the survey, which identified the top five concerns of staff: inadequate staffing levels; too much paperwork; lack of beds; not enough hours in the day; and uncertain future of the organisation.
- The board held discussions about the analysis of incidents, complaints and health and safety. Managers received feedback on this, but told us it was trust-wide and not always assessed analytically at departmental level. We saw that data was broken down to service unit level but did not see evidence of further breakdown which focused on the outpatient services or areas.
- Managers described that some governance processes were led top-down, while others were bottom-up arrangements. An example of a top–down process was how incidents were analysed trust-wide and then fed down with no breakdown on a local level. A bottom-up process example related to managers who determined individual training requirements for staff depending on the area they worked in because there were no trust-wide standards.
- Policies and procedures were not always implemented or adhered to. Incident reporting was inconsistent, and staff were not familiar with the mental capacity policy and how to implement it.
- There were no governance procedures to monitor the frequency of overbooked or late running clinics. Therefore, the impact was unknown and no actions were taken to address the issues.

Leadership of service

- All staff we spoke with told us their immediate line managers were approachable. All outpatient managers told us they had an open door policy.
- The trust had a staff involvement and engagement action plan.
- Reception staff were not managed by the nurses who coordinated the outpatient clinics. This meant they did not attend team meetings that other outpatient staff attended. Some receptionists told us they did not feel fully integrated into the team.
- Staff in adult outpatients' teams regularly attended staff meetings, but staff in children's outpatients did not.
- There was no statistical information about staff training available for outpatients departments.

Outpatients and diagnostic imaging

Culture within the service

- Staff in outpatients departments spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team. They showed concern where patients could not quickly be transferred to inpatient beds.
- Staff we spoke with were aware of the whistleblowing procedure. They told us they would report any concerns they had.
- Service level staff survey data was not available, but overall the trust scored worse or tending towards worse in 18 of the 28 key indicators in the NHS Staff Survey 2013.
- Staff were not receiving supervision, so there was no monitoring of their practice. The trust staff guide for supervision described it as a formal process, but there was no implementation of the process.
- Staff were receiving annual appraisals that included a review of completed training.

Innovation, improvement and sustainability

- One consultant and clinical nurse specialist had developed guidelines on the management of wheeziness in children. This was being introduced to other areas of practice such as GP surgeries.

Outstanding practice and areas for improvement

Outstanding practice

- The work carried out by the pre-operative assessment unit was outstanding. This included public health initiatives.
- A midwifery academy had been developed to aid recruitment and promote retention among new and existing midwifery staff. When new midwives (including midwives recruited at band six) join the trust they spend eight weeks in the academy. This was classroom-based teaching, education and development sessions run by specialists and midwives working in other areas. Any existing midwife could also attend individual sessions if they wanted.

Areas for improvement

Action the hospital MUST take to improve

The trust must ensure that:

- There are enough doctors with the right skills in A&E and critical care at all times to meet patients' needs.
- There are suitable numbers of nursing staff in A&E and in the medical service to meet patients' needs and to ensure suitable leadership.
- There are robust systems to identify children attending A&E who are at risk and systems to protect these children while receiving care.
- There is a clear system for ensuring that all patients in A&E are seen in order of medical priority.
- Ensure that there is a robust system to refer all adults and children to a speciality doctor in a timely way.
- Evidence-based practice is used to provide treatment in A&E.
- Records are kept of all medicines prescribed and administered to patients in A&E services.
- Medications are only accessible to staff with suitable training and authority.
- Medicines and medical gases are stored securely and there is suitable signage in place.
- Assessments of patients' capacity to consent to care and treatment are completed where necessary; documentation is completed appropriately; and staff have sufficient knowledge of the Mental Capacity Act to ensure they are competent in implementing the Act lawfully if a patient lacks capacity to make decisions.
- Staff across the hospital receive suitable mandatory training to ensure they are competent to fulfil their role.
- There are suitable systems to report, analyse and learn from incidents and that all staff understand and use them.
- There is an environment in all departments to ensure that patients are made safe while receiving care.

Action the hospital SHOULD take to improve

- Provide a suitable area for children to wait and be seen in A&E.
- The hospital should review the use of the day surgery unit and the operating theatre recovery area for holding patients when beds are not available.
- The hospital should ensure that safety protocols and national safety guidelines to keep surgery safe are not ignored and overruled without due consideration by more senior managers of the risk to, and impact on the surgical areas in attempts to mitigate the trust wide-bed flow problem.
- The trust should consider monitoring the impact of overbooked and over running clinics to establish the impact on staff and patients.
- The trust should consider providing drinks facilities in outpatient areas.
- An environmental check of the children's outpatient department must be undertaken to ensure it is a safe environment for children to use.
- An effective supervision system should be implemented to ensure staff practice and training are monitored.
- Ensure there are systems to ensure equipment is serviced and calibrated.

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
Urgent Care Improvement Programme																	
1	High	CQC	Implement the new pathways relating to non elective activity	Whole Report	All	All	Implement all ECIST recommendations (Trust accepted actions)	Majors and minor streaming and see and treat in ED	SUM (Urgent Care)	COO	03/11/2014	In Progress	On track to be delivered within timescale.	Urgent Care Governance Group Service Unit Performance Quality Committee	1) Achieve recovery plan trajectory plan - ED 4 hour waits (95% compliant from December 2014 and maintained) 2) Reduction in bed occupancy by a minimum of 10% 3) LOS to be at national average as a minimum 4) Reduction in avoidable harm and at 'front door'. 5) Reduction in ED/Acute admission in relation SIRIs 6) Increase in incident report with an associated reduction in harm profile of incidents		
								CAU - expand numbers, lower admissions/acceptance threshold. Accept GP referred patients for admission, overnight staffing arrangements clarified, SOP, adjusted accordingly.	SUM (Urgent Care)	COO	01/12/2014	In Progress	CAU open but need to increase the throughput			
								EPOD roll out	SUM (Urgent Care)	COO	01/12/2014	In Progress	Pilot is underway. SOP for the role are under development.			
								Discharge ward round improvement at weekends - either consultant or middle grade driven	SUD/SUM (Urgent Care)	COO	31/03/2015	In Progress				
								Discharge bundle implementation	AD (Patient Flow)	COO	30/11/2014	In Progress	11/11/2014 - Undertaking a system wide of patients over a 7 day stay.			
								Escalation policy review, including protocols for resolution of DIPC issues etc.	SUM (Urgent Care)	COO	01/12/2014	In Progress				
								Develop business case and secure investment in additional bed capacity at Hereford County Hospital	Head of Estates	COO	01/04/2015	In Progress	Steering group has been set up. The programme and project owners have been identified and the clinical model is being developed. Additional 32 beds agreed - logistics to be decided. Outlying specification to be drawn up.			
2	High	CQC	Need to improve emergency flow	Whole Report	All	All	Become the most capable provider for the Urgent Care pathway	Engage in and successfully respond to CCG outcomes board commissioning contract for all Herefordshire urgent care.	Head of Programme Management	COO	31/10/2015	In Progress		Trust Executive Management Quality Committee Trust Board	1)Amalgamation of services currently sub contracted to ensure greater coordination and improved patient care. 2)Sustainable delivery of 4 hour wait		
3	High	CQC	Shortfall of medical staffing impacts on admissions/discharges	Whole Report	All	All	To quantify the true nature of WVT medical staff shortage to enable improvements to be planned appropriately.	To undertake a review of medical staffing part of annual business plans against capacity , demand and royal collage guidance for all grades medical staff	SUD's	MD	31/03/2015	In Progress	Ahead of the planned medical staffing review, two new physicians have been recruited. Due to start at the Trust February 2015.	Trust Executive Management Quality Committee Trust Board	1) Allow Trust to identify shortfalls across all grades of medical staff. 2) Ensure funding secured as part of business planning process to reduce shortfalls. 3) Improved patient care ensuring patient seen, treated and discharged in a timely manner. 4) Quarterly reporting in medical staffing against required establishment		
							Ensure Wye Valley NHS Trust has correct number of trainee medical staff	Associate Director of Medical Education and Development to liaise with deanery	AD (Clinical Effectiveness)	MD	31/01/2015	In Progress			1) Quarterly reporting in medical staffing against required establishment		
								Ensure appropriate training in place for junior doctors with mechanisms for evaluation and feedback.	AD (Clinical Effectiveness)	MD	31/03/2015	In Progress				
								Ensure Wye Valley NHS Trust participates in interviews for junior medical staff to increase and improve profile of Wye Valley NHS Trust	AD (Clinical Effectiveness)	MD	31/03/2015	In Progress				
							To Increase the number of senior physicians to improve patient care and medical staff supervision	Seek to establish/appoint 4 additional senior clinical decision making grades covering medicine for 6 months (deployed across 7 days to CAU, medical wards out of hours and overnight)	SUD (Urgent Care)	COO	03/01/2015	In Progress	Winter funding agreed. Job descriptions in place. Recruitment commenced.		1) Quarterly reporting in medical staffing against required establishment		
								Two new consultant physician recruited start Feb 2015	SUD (Urgent Care)	DONQ	31/01/2015	In Progress	One consultant in place. One acute physician post to recruit to. This position is out to advert and the Trust is actively recruiting.				
4	High	CQC	Trust should review hospital at night arrangements	Whole Report	All	All	Ensure appropriate clinical cover 24/7	Hospital at night arrangements under review.	SUD	MD	30/06/2015	In Progress	First meeting with the Hospital At Night Committee has been held. A clear plan is being drawn up to make sure this is sustainable.		1) Ensuring appropriate clinical cover across the Trust 24/7 2) Patients seen in a timely manner and treatment pathways initiated.		
5	High	CQC	Need to improve uptake of Consultant job planning	Whole Report	All	All	Ensure medical staff have clear lines of accountability in relation to their roles	Ensure all consultants have up to date and relevant job plans.	SUD	MD	31/03/2015	In Progress	Team job planning approach used. Urgent care plans: of 17 consultants, 11 agreed and are compliant with 3 Ward round/ 2 Board Round. Remainder in process with no problems anticipated since there is broad agreement with exception of 1 consultant (job plan in dispute).		1) Consultant staff fully aware of their roles, responsibilities and lines of accountability. 2) Greater engagement of consultant staff in governance processes. 3) Improved communication and feedback to consultants.		
6	High	CQC	Need to improve Emergency Flow	Whole Report	All	All	Improve Discharge Planning across the Trust	Implement a system whereby discharge should occur within 4 hours of decision being taken	SUDS	COO	30/11/2014	In Progress	EDS performed on or immediately after consultant ward rounds; 1) League table to report/monitor 2) Consultants requested to support prioritisation of EDS promptly 3) Launch of direct patient flow bundle	Urgent Care Governance Group Service Unit Performance Quality Committee	1) Timely and appropriate discharge. 2) 30% of discharges occur before midday. 3) 65% of discharges occur before 4pm. 4) 30% admission avoidance (following 6 months) with a trajectory to increase to 50% (once all ECIST recommendations in place and imbedded over a 2 year period).		
								Implement Ambulatory emergency care system & EPOD	CAU Clinical Lead	COO	31/05/2015	In Progress					
								Develop and implement a discharge lounge tracker	AD (Patient Flow)	COO	31/10/2014	Completed	In place. Daily reports received.			31/10/2014	
								Set targets and monitor decision to discharge with an aim of each team being set a target of ensuring one discharge 10am and two discharges by 2pm.	Service Delivery Manager	COO	01/12/2014	In Progress					
								Real time patient tracker system implemented	Head of Information	COO	31/12/2014	In Progress					
								Clear systems in place to ensure that all patients within A&E are seen in order of medical priority	Lead Nurse for A&E	COO	31/01/2015	In Progress					
								Ensure robust systems in place to refer adults and children to speciality doctors in a timely manner	SUD	COO	01/12/2014	In Progress					
								To undertake a review of the use of Day Surgery Unit and Theatre recovery area for holding patients when beds are not available	SUD	COO	30/11/2014	In Progress					
							Clear and realistic plans for the implementation of changes across urgent care and develop acute medicine in own right	Implement Frailty Unit	SUM (Urgent Care)	COO	31/12/2014	In Progress	This will go live on 3/11/2014.		1) All patients over 85 years are directly admitted to assessment beds. 2) Expectation that the average length of stay will be reduced by 1 day. 3) 10% admission avoidance.		
								Re run 'perfect week'	SUM/SUD (Urgent Care)	COO	14/01/2015	In Progress	Agreed a whole system resilience group. Group attending ECIST conference on the 12/12/2014 on running a perfect week. Plan to run in second week of January 2015.				
7	High	CQC	Report identified there was a lack of leadership, both medical and nursing, within the A&E department.	Whole Report	All	All	Improve leadership in A&E	SUD appointed (Urgent Care) October 2014	SUD and Lead Nurse	COO	01/10/2014	Completed		Urgent Care Governance Group Service Unit Performance Quality Committee	1) Strengthen leadership in A&E and urgent care 2) Support and develop team work 3) All staff have Professional Development Plans (PDPs) 4) All Band 7 and above staff attended a leadership programme 5) Positive Staff Friends and Family Test responses. 6) Positive Team culture survey. 7) Zero minor breaches. 8) Adherence to SOP and monitoring through incident reporting.	01/10/2014	
								SUD & CD – on Warwick University Medical Leadership Programme	SUD	COO	31/10/2014	Completed				31/10/2014	
								New senior A&E consultant (Sept 2014)	SUD	COO	01/09/2014	Completed				01/09/2014	
								7 WTE nursing staff – recruited to A&E	HON	COO	30/10/2014	Completed				30/10/2014	
								To undertake a review of new ways of working (Physicians assistant, ACAP' s and evaluate the effectiveness	SUM	COO	31/03/2015	In Progress					
								Team (MDT) development sessions	HR	DHR	31/01/2015	In Progress					
								Recruit lead nurse for A&E	HON	COO	31/10/2014	Completed	Internal acting into position and permanent appointment to take place in January 2014.			31/10/2014	
								Recruit to vacant consultant post	SUD	COO	31/03/2015	In Progress	Out to advert for two positions.				
								Recruit to vacant middle grade posts	SUD	COO	31/07/2015	In Progress	Out to advert but interim solutions being sought.				

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
8	High	CQC	Access to mental health services for adults and children provided through SLA does not provide sufficient cover for the A&E/department	A&E	All	All	To ensure provision of mental health and learning disability services are accessible and appropriate for WVT patients 24/7.	To undertake a review of the SLA in relation to the provision of mental health services with provider Trust	SUM/Lead Nurse for Children's	COO	31/05/2015	In Progress	SLA with a mental health Trust but will be working with commissioners during this years commissioning round to strengthen response times.	Adult and Child Safeguarding Group Quality Committee	1) Ensure appropriate and timely treatment and care of patients who require mental health and learning disabilities services.		
9	High	CQC	Patients did not have printed name bands in A&E	A&E	All	All	To ensure that IT within the department meets NPSA name band requirements.	Initiate a review by IT regarding the wrist band printers to ensure that they are in full working order.	Lead Nurse for ED	COO	30/10/2014	Completed	Datix being completed, wrist band printers have been reviewed. Patient flow facilitators will become trained super users for Symphony so will be able to trouble shoot any issues. Review of equipment to deliver this is now aligned with printing project, a departmental wide review planned	Health & Safety Committee Quality Committee	1) All patients have printed name bands.	30/10/2014	
								To report incidents via Datix where the wrist band printers fail.	Lead Nurse for ED	COO	30/11/2014	In Progress					
								Super users for Symphony to be developed to enable the department to trouble shoot any issues.	Lead Nurse for ED	COO	30/11/2014	In Progress					
								Spot check audit to be undertaken on a quarterly basis	Lead Nurse for ED	COO	31/12/2014	In Progress					
								Ensure equipment to deliver this is now aligned with printing project, a departmental wide review planned	Lead Nurse for ED	COO	30/11/2014	In Progress					
10	High	CQC	Symphony does not automatically highlight specific safeguarding alerts	A&E	All	All	To ensure systems are in place within A&E to ensure staff have access to alerts for safeguarding children.	Action plan regarding alert system was already commenced prior to inspection, in addition this is audited fortnightly to ensure the alert system is working appropriately.	Children's Safeguarding Lead	DOF	30/11/2014	In Progress		IT Programme Board Trust Executive Management Trust Board	1) System in place to ensure safeguarding alerts are identified and acted upon by A&E staff. 2) 100% compliance against fortnightly audits and any failure to achieve this results in an action plan to address the deficiencies		
11	High	CQC	Within A&E, during times of maximum capacity patients basic care needs were not met	A&E	All	All	Ensure at all times patients basic needs are attended to and privacy and dignity is maintained.	SOP for escalation to ensure at times of greatest pressure that basic care needs are met. This includes ensuring: - observations are carried out as needed - patients have access to buzzers - patients have access to fluids and nutrition - appropriate emotional and physical support provided at all times - how to access additional support for A&E	HON (Urgent Care)	COO	30/11/2014	In Progress		Urgent Care Governance Group Service Unit Performance Quality Committee	1) Adherence to SOP 2) Improved Friends and Family Test score 3) Reduction in complaints		
								Development of 2 Support Worker posts who will be mobile workers trained to assist with basic care needs.	HON (Urgent Care)	COO	31/12/2014	In Progress					
								Monitoring spot checks and random spot checks during a level3/4 to be undertaken by Quality & Safety Department within A&E, Frome Ward and outlier areas.	HoQS	DONQ	31/01/2015	In Progress					
Stroke Care																	
12	High	CQC	WVT stroke services requires additional work to ensure it is fit for purpose	Whole Report	All	All	Provision of optimal stroke services for the people of Herefordshire	Multi-agency stroke board in place to monitor the implementation and improvement of stroke services across Herefordshire	SUM	COO	30/06/2014	Completed		Urgent Care Governance Group Service Unit Performance Quality Committee	1) National stroke and the best practice indicators met. 2) Achievement of TIA and stroke targets 3) Reduce length of stay	30/06/2014	
								Business case developed, submitted and agreed with to the CCG & Powys (contains: development of single site stroke unit with hyper acute, acute and rehabilitation areas, early supported discharge team, additional consultant, therapy and nursing staff to support this, partnership arrangements with another Trust/s to provide 24/7 senior level clinical decision making supported by telemedicine) (agreed September 2014)	SUM	COO	31/12/2014	In Progress	Still in negotiation with Powys on how this service can be provided.				
								Implementation plan in place pending approval from the CCG (including identification of strategic partner)	SUM	COO	30/09/2014	Completed	Strategic partner has now been agreed at Trust Board.			30/09/2014	
								New Stroke pathway defined (meets Midlands and East Service Specification and RCSP requirements)	SUM	COO	30/09/2014	Completed				30/09/2014	
								A&E – specific thrombolysis training	SUM	COO	31/12/2014	In Progress	Service Unit currently exploring outsourcing of training with the manufacturer of Alteplase. This will be supplemented by training from stroke physician in local policies, procedures and protocols.				
								Activity profiled against new pathway (based on national profiles)	SUM	COO	30/09/2014	Completed				30/09/2014	
								Risk log in place	SUM	COO	30/09/2014	Completed				30/09/2014	
								Management of change paper prepared	SUM	COO	30/11/2014	In Progress					
								Staff briefing undertaken	SUM	COO	30/09/2014	Completed				30/09/2014	
								Staff partnership board briefed	SUM	COO	30/09/2014	Completed				30/09/2014	
								Job descriptions are being prepared and clinical protocols under development	SUM	COO	30/11/2014	In Progress	Job descriptions complete. Protocols under development.				
								Ensure clinical leadership of stroke pathway	SUM	COO	28/02/2015	In Progress					
								Recruit to consultant post	SUD	COO	28/02/2015	In Progress					
								Recruit to therapy post	AHP	COO	28/02/2015	In Progress					
								Recruit to nursing posts	HON	COO	28/02/2015	In Progress					
								Assurance process to be undertaken by NHS England	NHS England	NHS England	31/12/2015	In Progress					
								Commence early supported discharge for stroke patients	SUM (Urgent Care)	COO	31/03/2015	In Progress					
Mortality																	
13	High	CQC	WVT has a high mortality rate	Whole Report	All	All	To reduce WVT mortality figure to be in line with or below national comparators	Clearly define terms of reference for the Wye Valley NHS Trust Mortality Committee. This will include clearly articulating how progress will be monitored and reported to the Trust Board. Membership and reporting arrangements to be reviewed in light of recommendations from TDA. Work programme, outcomes, and action log to be to be managed in line with recommendations from TDA.	Trust Lead for Mortality	MD	31/12/2014	In Progress	4.11.14 Terms of reference of WVT clinical mortality group have been amended in line with recommendations from TDA, and timings of meetings altered to enable greater clinical input in line with recommendations from TDA. Internal mortality group to provide clear action log, outcomes, and to report monthly to HMOG in line with recommendations from TDA.	Mortality Review Group Service Unit Performance Quality Committee Trust Board	1) Reduction in HSMR and SHMI. 2) Increased use of care bundles to support patient care. 3) Quarterly report by Associate Medical Director for Clinical Effectiveness to highlight; - Implementation of measures to reduce mortality - Evidence of effectiveness of measures to reduce mortality - HSMR/SHMI 4) MD to share key issues with consultants at monthly HMC and clinical senate meetings.		
								Clarify Terms of Reference for Joint Mortality Group with CCG /TDA/AT. This will include clearly articulating how progress will be monitored and reported to the Trust Board.	Trust Lead for Mortality	MD	31/10/2014	Completed	Report by TDA on observation of HMOG to be an agenda item on next HMOG meeting. Work programme for 2015 to be agreed at next HMOG. CCG to report regularly to HMOG, including update on work of group reviewing 'management of deteriorating patient in the community'.			31/10/2014	

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
								New mortality tracker system to be implemented with individual consultant responsibilities for review of all deaths under their care.	Trust Lead for Mortality	MD	31/01/2015	In Progress	4.11.14 Mortality tracker system is due to be implemented 5.01.15 This will enable consultants to verify coding with coding department; and ensure multidisciplinary review of all inpatient deaths with process for escalation where any substandard care is identified.				
								Working groups to be developed based upon care bundles	Trust Lead for Mortality	MD	31/10/2014	Completed			31/10/2014	
								Regular live audit of care bundle adherence rate.	Trust Lead for Mortality	MD	28/02/2015	In Progress	4.11.14 Discussed at clinical leads meeting on 30.10.14. Agreed to update all care bundles, ensure adequate training, and re-launch care bundles by January 2015. Live audit to be facilitated by Clinical audit team.				
								Additional care bundles to be developed; Amber care bundle and end of life care bundle	Trust Lead for Mortality	MD	31/03/2015	In Progress	4.11.14 In progress				
								New Policy on review of inpatient deaths (service unit /consultant owned) to be implemented	Trust Lead for Mortality	MD	31/01/2015	In Progress	4.11.14 Policy on review of internal deaths has been circulated widely and all consultant are aware of individual responsibility to review inpatient deaths in line with recommendations from TDA. Policy includes link to appraisal in line with recommendations from TDA.				
								Training - developing more specific training packages for care bundles and how to use	Trust Lead for Mortality	MD	31/01/2015	In Progress	4.11.14 Discussed at clinical leads meeting on 30.10.14. Agreed to update all care bundles, ensure adequate training, and re-launch care bundles by January 2015.				
								New Mortality and Care Bundle Audit Lead to be appointed.	Clinical Effectiveness and Audit Manager	MD	28/02/2015	In Progress					
								The results of audit will be used to drive clinical effectiveness and improve patient outcomes across the Trust.	MD	MD	31/03/2015	In Progress	4.11.14 the JD for the Associate Medical Director for mortality governance is being reviewed. The AMD will take on a lead role in Clinical Effectiveness and have responsibility for mortality governance and clinical effectiveness across the Trust. A work programme will be agreed with the post holder.				
Governance																	
14	High	CQC	WVT needs to improve its complaint responses to ensure they are; 1) Open and honest 2) Address issues identified 3) Comply with statutory duty of candour	Whole Report	All	All	The complaints process should be open, honest, transparent and truthful	To develop and implement a complaints training plan for all staff groups across the Trust (Band 7 or equivalent and above)	HoQS	DONQ	31/07/2015	In Progress		Service Unit Performance Trust Executive Management Quality Committee	1) Improvement in complaint response rate with an associated decrease in reopened complaints rate 2) Improved response to complaint survey and actions in place to implement recommendations that have been made		
								Develop and implement post complaint survey to gain feedback on the complaints process	HoQS	DONQ	31/01/2015	In Progress				
								Audit of reopened complaints to establish reason for returned complaint and share lessons with Service Unit	HoQS	DONQ	31/01/2015	In Progress				
								Establishment of Service Unit Governance Coordinators	SUM	COO	30/11/2014	In Progress	Positions recruited to. Due to commence in November 2014.				
								Bi annual report in relation to Learning from Incidents, Complaints and Claims to be presented to Quality Committee	HoQS	DONQ	30/04/2014	Completed			30/04/2014	
								Learning from complaints to be addressed at appraisals for all staff.	Head of Education & Development/ Appraisers	DHR	31/01/2015	In Progress				
								Mandatory customer care training	Head of Education & Development	DHR	31/01/2015	In Progress				
15	High	CQC	**Risk Management** Poor correlation between risks discussed by staff and the Trust Risk Register. Lack of knowledge on how to get concerns escalated and added to risk register. Lack of awareness of content on risks registers with some staff. Lack of risk management at ward level.	Whole Report	All	All	To ensure that the risks that staff discuss throughout the Trust are captured on the risk register	Attend monthly ward meetings and other local meetings where governance issues are discussed to remind staff of the importance of getting risks added to the risk register and advise them of the process for doing so.	CS	CEO	31/12/2014	In Progress		Trust Executive Management Quality Committee	1) Risk register reflective of risks raised by staff. 2) Staff knowledgeable about risks in their areas of operation and how to get risks added to the register. 3) Ward level/local risk registers in place.		
								Add a question to the walk rounds in relation to getting risks onto the risk register.	CS	CEO	31/12/2014	In Progress				
								Regularly advise staff and raise awareness of risk management processes through already established means - monthly training session, Trust Talk, Team Brief and screen savers.	CS	CEO	31/12/2014	In Progress				
								Implement ward level risk registers in areas where there are no registers in place.	CS	CEO	31/12/2014	In Progress				
16	High	CQC	**Governance Systems** Trust wide governance systems not strongly established and little commitment to governance processes in Service Units.	Whole Report	All	All	To ensure that Trust wide governance systems are strongly established and there is clarity throughout the Trust on those systems	Ensure effectiveness of meetings which take place below Board and Committee level	CS	CEO	31/12/2014	In Progress		Service Unit Governance Groups Service Unit Performance Trust Executive Management	1) Staff awareness of governance and reporting structures throughout the Trust. 2) Effective meetings taking place each with terms of reference, appropriate reporting upwards, good attendance.		
								Advise Service Unit Governance Meetings of the Governance Structures in place.	CS	CEO	31/12/2014	In Progress				
								Regularly advise staff of the structures through established means of communication such as Trust Talk & Team Brief	CS	CEO	31/12/2014	In Progress				
								Attend medical meetings to discuss governance structures	CS	CEO	31/03/2015	In Progress				
								Attend meeting of physicians and surgeons to discuss governance processes	CS	CEO	31/03/2015	In Progress				
17	High	CQC	**Policies and procedures** Lack of knowledge and adherence to policies & procedures	Whole Report	All	All	Ensure staff understand the policies and procedures applicable to their areas of operation	Attend monthly ward meetings and other local meetings where governance issues are discussed to remind staff of the policies and procedures applicable to them.	CS	CEO	31/12/2014	In Progress		Policy Group Trust Executive Management	1) Staff knowledgeable about policies and procedures in their areas of operation and how to access them.		
								Add a question to the walk rounds in relation to awareness of policies and procedures.	CS	CEO	31/12/2014	In Progress				
								Regularly advise staff of the policies and procedures through established means of communication such as Trust Talk & Team Brief	CS	CEO	31/12/2014	In Progress				
								Provide brief guides to relevant policies e.g. DNACPR	Policy Authors	CS	30/06/2015	In Progress				
								Briefing sessions for new policies	Policy Authors	CS	31/12/2014	In Progress				
18	High	CQC	Poor culture of reporting incidents and lack of feedback from incidents.	Whole Report	All	All	To improve the culture in relation to incident reporting within WVT	Review SIRI reporting process to ensure greater Executive leadership: - On call Executive for the week to lead round table on any SIRIs reported within their on call week. - On call Executive responsible for quality assuring final SIRI and signing off.	HoQS	DONQ	31/12/2014	In Progress	Discussion at Quality Committee on 23/10/2014 and agreement to implement revised process from 01/12/2014.	Quality Committee Trust Board	1) Improved leadership and quality in relation to the management of SIRIs 2) Greater learning from SIRIs 3) Improved Executive awareness		
								Develop a screen saver on importance of incident reporting for all staff and use quarterly (Oct, Jan, Apr and Jul)	Communications Department	DONQ	31/10/2014	Completed	Screen saver in place.	Service Unit Performance Quality Committee	1) Increased incident reporting culture taking Wye Valley NHS Trust into the top quartile in NRLS reporting. 2) Increased understanding of learning lessons evidenced by staff survey in 2015.	08/10/2014	

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
								Additional Datix training sessions to be run	HoQS	DONQ	31/07/2014	Completed	Seven additional sessions run including evening sessions (July 2014). Individual or group training already offered as required.		3) Improvement on Safety Culture Survey results. 4) Culture of tolerance of mistakes without tolerance of routinely poor or mediocre performance.	31/07/2014	
								Datix reporting to be added as annual refresher training for all staff	Head of Education & Development	DHR	31/03/2015	In Progress	To discuss Datix becoming a fixed refresher on all mandatory training from new financial year				
								Develop Datix how to guides for staff (pocket size) and distribute to staff at induction for all new starters.	HoQS	DONQ	30/11/2014	In Progress	Small pocket size guides to be developed. These will be held within each area within their communication folder				
								Memo sent out to all staff reminding them of the importance of reporting incidents and raise awareness of fair blame culture.	HoQS	DONQ	30/11/2014	In Progress	Memo to be sent out once CQC report published				
								Add the percentage of staff groups reporting incidents to the Service Unit dashboards	HoQS	DONQ	30/11/2014	In Progress					
								Targeted incident reporting training to be implemented for; Medical Staff - During November 2014 Community Staff - During December 2014 AHP's - During January 2015	HoQS	DONQ	31/01/2015	In Progress	Training programmes under development				
								Datix training to be included on mandatory training database.	HoQS	DHR	30/11/2014	In Progress					
								Additional training to be provided to managers (in all staff groups) in relation to signing off incidents and reporting actions taken to staff.	HoQS	DONQ	31/12/2014	In Progress					
								Develop programme for Human Factor Training and Patient Experience Training	Head of Education & Development	DHR	30/06/2015	In Progress					
								Repeat Safety Culture Survey with staff	HR Department	DHR	31/01/2015	In Progress					
							To Improve feedback for staff in relation to incidents to ensure they feel they are aware of any lessons learnt across the Trust	Make feedback from incidents a standing agenda item at Service Unit Performance Meeting	HoQS	DONQ	18/10/2014	Completed	Added to Service Unit Governance Meeting	Service Unit Performance Quality Committee	1) Improved staff awareness of feedback and lessons learnt in relation to incidents, complaints and claims. 2) Improved Safety Culture Survey Results 3) Reduction in reoccurring themes in incidents as a result of lessons learnt 4) Increase in incidents (due to increased awareness) with an associate reduction in the harm profile of incident reported.	18/10/2014	
								Medical Director to feedback lessons learnt and any key issues monthly at Hospital Medical Committee.	Patient Safety Lead	MD	30/11/2014	In Progress	Case scenarios to be discussed in relation to learning at the Hospital Medical Committee.				
								X5 key service specific lessons will be fedback to each SU governance meeting monthly as hand-outs to be disseminated to all staff	HoQS	DONQ	31/12/2014	In Progress					
								Continue to report lesson learnt in Team Brief from incidents, complaints, claims and audit.	Communications Team	DONQ	18/10/2014	Completed				18/10/2014	
								Ensure Team Brief is disseminated to all staff and becomes a vehicle for key messages to be sent to Trust staff and develop process of spot audit to test out dissemination of team brief.	Communications Team	CEO	31/01/2015	In Progress	Ensure medical staff representation at monthly CEO team brief meeting				
								Amend Patient Experience Walkround template to incorporate reporting and learning from incidents and feedback from CQC inspection report.	HoQS	DONQ	31/12/2014	In Progress	Review content of Patient Experience Walkrounds to incorporate learning from incidents				
								Change DATIX feedback as currently links to actions taken by person reporting the incident – in future, actions taken by manager should be automatically sent to the reporter.	HoQS	DONQ	30/11/2014	In Progress					
								External RCA training to be commissioned by Trust approx. 50 key staff mandatory to attend training (SUD, SUM,CD,HOM,8A or above).	HoQS	DONQ	31/03/2015	In Progress	DON reviewed external providers of RCA training and will commission their services once funding secured. £20k approx. cost.				
								SDU Governance Manager to compile and produce monthly SDU newsletter to spotlight leaning and changes linked to incidents.	SUM	DONQ	31/01/2015	In Progress					
								SDU newsletter to be a standing agenda item at ward and departmental meetings.	SUM	DONQ	31/01/2015	In Progress					
								Learning from incident to be included in Quality Improvement section during medical appraisals.	Appraisers	MD	31/01/2015	In Progress					
								Add a learning from incidents, complaints and claims on Trust intranet site.	HoQS	DONQ	30/11/2014	In Progress					
							Areas of best practice/expertise are shared and available to anyone who requires it	Identify areas of best practice	SUMS/SUDS/HoQS	DONQ/MD	30/06/2015	In Progress		Service Unit Performance Trust Executive Management Quality Committee	1) Reduction of silo working 2) Intranet is populated with best practice/case studies 3) Increase staff awareness of best practice occurring across the Trust, ensuring this is shared with all staff.		
								Develop systems to capture and share staff Facebook facility and professional social networking facility	Communication Lead/IT	DONQ/MD	30/06/2015	In Progress					
19	High	CQC	Need to develop systems and processes to gain greater feedback from patients to help improve the care the Trust provides	Whole	All	All	To gain vital intelligence from feedback from the public and other stakeholders to improve the care that WVT provides.	Inpatients, A&E, Community Hospitals and Maternity To improve scores and response rates for FFT and ensure monthly feedback is provided to service units including narrative from FFT forms.	HoQS	DONQ	31/10/2014	Complete		Service Unit Performance Trust Executive Management Quality Committee	1) To achieve a 30% response rate to patient FFT with a score of 70 or above for inpatients, community hospitals and maternity. 2) To achieve a 20% response rate to patient FFT with a score of 70 or above for inpatients, community hospitals and maternity.	31/10/2014	
								Quarterly meetings with Healthwatch to discuss any issues at WVT.	HoQS	DONQ	31/10/2014	Complete		Service Unit Performance Trust Executive Management Quality Committee	1) Increased engagement with stakeholders 2) To gain additional patient feedback on their hospital experiences 3) To take appropriate actions to remedy any issues identified and improve patient care.	31/10/2014	
								Agreed 3 Enter and View visits to be conducted by Healthwatch (with Trust representation) to gain feedback from patients about the care and treatment received at WVT. 3 areas identified: - Leominster Community Hospital - Ross Community Hospital - Frome ward (AAU County Hospital)	HoQS	DONQ	31/01/2015	In Progress	Dates currently being agreed.	Service Unit Performance Trust Executive Management Quality Committee	1) Increased engagement with stakeholders 2) To gain additional patient feedback on their hospital experiences 3) To take appropriate actions to remedy any issues identified and improve patient care.		
								To continue with quarterly patient forums.	HoQS	DONQ	31/01/2015	In Progress	Patient forums have been held quarterly since September 2013.	Service Unit Performance Trust Executive Management Quality Committee	1) Increased engagement with stakeholders 2) To gain additional patient feedback on their hospital experiences 3) To take appropriate actions to remedy any issues identified and improve patient care.		
								Voluntary services undertake patient reviews on a monthly basis. There is a set template which includes asking questions in relation to: - Food - Environment - Communication - Cleanliness - Safety	HoQS	DONQ	31/10/2014	Complete	Voluntary services have been undertaking these for the past 12 months.	Service Unit Performance Trust Executive Management Quality Committee	1) Increased engagement with stakeholders 2) To gain additional patient feedback on their hospital experiences 3) To take appropriate actions to remedy any issues identified and improve patient care.		
Medicines Management																	
20	High	CQC	Poor systems for Medications Management	Whole Report	All	All	To improve medicines management practices throughout WVT	Set targets for improvements against administration errors and prescription errors	Clinical Director for Pharmacy	MD	30/11/2014	In Progress		Medicines Safety Committee Quality Committee	1) Reduction in the harm profile of medication error incidents reported (including administration, prescription). Reduction by 10% by March 2015 followed by a further 10% reduction in 2015/16. 2) Compliance against medicines safety NPSA alert. 3) Targeted actions to decrease medication administration, prescription		
								Undertake quarterly audits within ward areas including A&E to identify appropriateness of obtaining, recording, handling, using, safe keeping, dispensing and safe administration and disposal of medicines.	Clinical Director for Pharmacy	MD	30/09/2014	Completed				30/09/2014	
								Undertake 24 hours CD check	Clinical Director for Pharmacy	MD	30/09/2014	Completed				30/09/2014	
								Undertake a review of current audit tools and process to ensure fit for purpose	Clinical Director for Pharmacy	MD	31/01/2015	In Progress					
								Develop mini RCA for administration and prescription errors (1 A4 sheet)	Clinical Director for Pharmacy	MD	31/03/2015	In Progress					

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Corporate Actions																	
								Lessons learnt to be added to Team Brief and Trust Talk and to be monitored through quarterly report to Medicines Safety Committee and Service Unit Performance	Clinical Director for Pharmacy	MD	30/11/2014	In Progress						
								Comply with NPSA alert in relation to medicines management	Clinical Director for Pharmacy	MD	19/12/2014	In Progress						
								Named medicines safety officer for Wye Valley NHS Trust to be appointed	Clinical Director for Pharmacy	MD	19/12/2014	In Progress						
								Working party (medical, nursing, pharmacy and quality and safety representation) to be established to review prescription and administration errors fortnightly across the Trust	Clinical Director for Pharmacy	MD	04/11/2014	In Progress						
Organisational Development																	
21	High	CQC	Organisational development	Whole Report	All	All	To develop, implement and monitor a number of interventions to deliver organisational improvement based on the priorities identified in the CQC report.	Revisit Vision, values strategy and objectives	Director of HR	Chair/CEO	31/12/2014	In Progress	Away day planned for 24/25 November	Trust Executive Team Quality Committee	1) Increase in percentage of WVT related media stories which are neutral/positive 2) Set of Trust values with behaviours identified and known by staff 3) Recruitment, appraisal and reward systems in place linked to values. 4) Learning outcomes from development/training processes are and shared. 5) Improved Staff survey responses. 6) Staff are engaged in issues affecting workplace. 7) Improved responses in Staff Friends and Family Tests. 8) Number of staff nominated for leadership awards 9) Staff recognition scheme linked to values		
								Roles of NEDs/Execs	Chair	Chair	30/11/2014	In Progress	Away day planned for 24/25 November				
								Gap analysis of board capability and skills	Chair	Chair	31/01/2015	In Progress	Away day planned for 24/25 November				
								Leadership programme at all levels	Head of Education & Development	DHR	31/01/2015	In Progress	Programmes in place for all levels in organisation Priority will be magic tier – line management development				
								Undertake a review of organisational structure/ management capacity/reporting lines/accountability arrangements	CS and DHR	CEO	31/01/2015	In Progress					
								Cultural change	DHR	CEO	31/01/2015	In Progress	Widen understanding of organisational position, and purpose (planned following board session) Flexible adaptable and responsive – open to change Communication – internal and external Reward/recognition scheme for "living the values" implement health and well-being initiatives including resilience training				
								Staff engagement and involvement	DHR	CEO	30/11/2015	In Progress	In progress clinical staff – Implement Medical Engagement Scale, strategic change to be led by clinicians. SUDs to be in driving seat at TEM other staff – responsive to listening events and surveys,(listening into action) developing of bottom up values, - plan in place needs updating and monitoring Information in relation to staff engagement and involvement to be included in: - Team Brief - Trust Blog - Twitter				
								Reputation management	Communication Lead	CEO	31/01/2015	In Progress	A positive message needs to be portrayed, sustained and believed by TDA/CCG/public etc. Similar message internally to current staff and potential new staff				
								Launch of the Nursing, Midwifery and Clinical Professional strategy	HON/HOM/Clinical Professionals Lead	DONQ	12/11/2014	In Progress					
								Implementation of the Nursing, Midwifery and Clinical Professional strategy. Progress against the strategy will be monitored through the Nursing and Midwifery Committee and Clinical Professionals Committee.	HON/HOM/Clinical Professionals Lead	DONQ	01/07/2015	In Progress					
22	High	CQC		Whole Report	All	All	Improve communication between senior management and staff through leadership/managemen	Develop programme of engagement with CEO to roll out with staff	Head of Education & Development	DHR	31/01/2015	In Progress		Trust Executive Team Quality Committee	1) Increased visibility and interaction between staff and senior management/executives/Board. 2) Increased staff attendance at leadership programmes. 3) Improved staff survey response in relation to leadership and management.		
								Ensure communications skills are included in management development programme	Head of Education & Development	DHR	30/09/2014	Completed				30/09/2014	
								Coaching programme to be implemented for line managers	Head of Education and Development	DHR	30/04/2015	In Progress					
23	High	CQC		Whole Report	All	All	Benefits of MDT meetings to improve communication / collaboration between	SUDs/ SUMs to increase number of Multi-Disciplinary Team (MDT) meeting and opportunities for improved team working	SUDS/SUMS	COO	31/12/2014	In Progress		Trust Executive Team Quality Committee	1) Increased staff knowledge in relation to MDT working. 2) Improved staff satisfaction through Safety Culture Survey and Staff Friends and Family Test.		
								Use Aston Team Performance Toolkit to improve team working	HR	DHR	30/03/2015	In Progress					
24	High	CQC		Whole Report	All	All	Medical leadership	Formal induction for all new consultants into governance processes within Trust	Medical Staff Manager	MD	31/01/2015	In Progress		Trust Executive Team Quality Committee	1) Improvement in medical staff engagement 2) Increased awareness of governance arrangements amongst medical staff 3) Improved feedback and incident reporting from medical staff. 4) Improvement in involvement in complaints/RCA processes.		
								Use Medical Engagement Scale to identify strengths and weaknesses across the Trust and use this as a basis of a programme to improve medical engagement.	MD	DHR	28/02/2015	In Progress	MES to be undertaken by end of February 2015 and repeated in December 2016.				
								Provide annual Medical Leadership training for staff	Head of Education and Development	DHR	31/07/2015	In Progress					
								Use Medical Leadership Competency Framework for appraisal and development of senior medical staff training	AMD	MD	31/03/2015	In Progress					
25	High	CQC		Whole Report	All	All	Improvement of 'organisational health'	Undertake diagnostic exercise to identify hotspots in organisation where triangulated data suggests leadership concerns	HR	DHR	31/03/2015	In Progress		Joint Negotiating Committee Trust Executive Management	1) Improved staff morale. 2) Reduced sickness 3) Improved training and appraisal figures 4) Positive Staff Friends and Family Test 5) Reduction in complaints.		
								Develop and agree a number of department initiatives. Prioritise according to resource.	HR	DHR	31/03/2015	In Progress					
26	High	CQC		Whole Report	All	All	Develop a learning organisation	Develop 'buddy' system/peer review between wards and departments	HR	DONQ/DHR	30/06/2015	In Progress		Joint Negotiating Committee Trust Executive Management	1) Improved joint working between wards/departments 2) Positive Staff Friends and Family Test 3) Reduction in complaints		
								Evaluate effectiveness	HR	DONQ/DHR	30/06/2015	In Progress					
								Results of pilot shared	HR	DONQ/DHR	30/06/2015	In Progress					
27	High	CQC		Whole Report	All	All	NHS Constitution is embedded into Trust literature and owned by staff	Promotion of NHS constitution and Trust objectives and values	HR	CEO	31/03/2015	In Progress		Joint Negotiating Committee Trust Executive Management	1) Improved joint working between wards/departments 2) Positive Staff Friends and Family Test 3) Reduction in complaints 4) Improved staff survey results		
Professional Development																	
28	High	CQC	Appropriate supervision for all health professional staff	Whole Report	All	All	Improve support for staff and ensure appropriate and on-going supervision of practice to improve care and reduce errors	Undertake review of where supervision is currently happening	Head of Education and Development	DONQ	01/02/2015	In Progress		Trust Executive Team Quality Committee	1) Supervision embedded across all healthcare professional groups. 2) Improvement in staff feeling supported, confident and capable to undertake their roles.		
								Undertake a review of the existing Clinical Supervision Policy and amend if needed.	Head of Education and Development	DONQ	30/11/2014	In Progress					
								Address the gaps and monitor implementation through quarterly reporting at Nursing and Midwifery Committee and Clinical Professionals Group	Head of Education and Development	DONQ	15/01/2015	In Progress					
29	High	CQC	Ensuring staff are fully engaged and competent and capable to undertake their work	Whole Report	All	All	All staff have a well structured appraisal and a personal development plan.	Cascade training plan to all levels of staff.	Head of Education and Development	DHR	31/12/2014	In Progress	A central system has been developed to record staff appraisals and training. Appraisal policy has been revised. Engagement is a key strand of the OD plan.	Service Unit Performance Trust Executive Management Quality Committee	1) Improved appraisal rates and PDPs. 2) 90% of staff have PDPs 3) All staff understand where they contribute to the organisations objectives. 4) Improved staff satisfaction through the staff survey.		

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
			their work.					Provide appropriate training to enable staff to undertake appraisals.	Head of Education and Development	DHR	30/04/2015	In Progress	A central system has been developed to record staff appraisals and training. Appraisal policy has been revised. Engagement is a key strand of the OD plan.				
								Provide development to managers on improving team engagement.	Head of Education and Development	DHR	30/11/2014	In Progress	A central system has been developed to record staff appraisals and training. Appraisal policy has been revised. Engagement is a key strand of the OD plan.				
								Pay progression policy implemented that links pay progression to achievement of appraisals.	Head of Education and Development	DHR	31/12/2014	In Progress	A central system has been developed to record staff appraisals and training. Appraisal policy has been revised. Engagement is a key strand of the OD plan.				
Education/Training																	
30	High	CQC	Lack of coordination of annual mandatory training across the Trust.	Whole	All	All	All staff to complete annual mandatory training.	Cascade training needs analysis plan to all levels of staff.	Head of Education and Development	DHR	31/12/2014	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.	Service Unit Performance Trust Executive Management Quality Committee	1) 80% compliance for mandatory training by 31/03/2015 2) 90% compliance for mandatory training by 31/12/2015 3) 95% compliance for mandatory training by 31/03/2016		
								Provide monthly reports to service units in relation to compliance with training.	Head of Education and Development	DHR	30/11/2014	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.				
31	High	CQC	Specific mandatory Training (not annual) for key staff was not in place for a number of topics e.g.; MCA DOLS Safeguarding (children & Adults)	Whole Report	All	All	An overarching, accurate and robust training database which is able to produce reliable and accurate data for all mandatory training.	ESR - now loaded with accurate data and reports will be produced for Service Unit Governance meetings monthly	Head of Education and Development	DHR	30/11/2014	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.	Safeguarding Groups Quality Committee	1) 80% compliance for mandatory training by 31/03/2015 2) 90% compliance for mandatory training by 31/12/2015 3) 95% compliance for mandatory training by 31/03/2016		
								Compliance with mandatory training to be aligned with the pay progression policy. Therefore, incremental pay rises will only be paid to staff who can demonstrate they have completed mandatory training.	Head of Education and Development	DHR	30/11/2014	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.				
								Compliance rates for mandatory training to be monitored through Service Unit Performance meetings	Head of Education and Development	DHR	30/03/2015	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.				
								Project lead to be establish 'self service' online learning management within ESR.	Head of Education and Development	DHR	30/03/2015	In Progress	A central system has been developed to record staff training. Completion of training is now linked to pay progression.				
32	High	CQC	Lack of understanding and training in relation to MCA and DOLS	Whole Report	All	All	Enhance the experience of patients with reduced mental capacity and ensure appropriate treatment whilst in the care of WVT	Annual Plan of MCA & DOLS Training	Head of Education and Development	DHR	31/01/2015	In Progress		Safeguarding Groups Quality Committee	1) Achievement of training target set: - 80% compliance for mandatory training by 31/03/2015 - 90% compliance for mandatory training by 31/12/2015 - 95% compliance for mandatory training by 31/03/2016 2) Increase in number DOLS referrals 3) audited improvement in MCA assessment documentation. 4) Named clinical champions in place. 5) Improvement in mandatory training rates in MCA,DOLS and Safeguarding.		
								Specific MCA Training for Medical Staff	Head of Education and Development	DHR	31/01/2015	In Progress					
								Consider purchasing online package	Head of Education and Development	DHR	31/01/2015	In Progress					
								Training targets to be set as part of 2015/16 CQUINS	Head of Education and Development	DHR	31/03/2015	In Progress					
								Clinical champion to be identified in each Service Unit for MCA/DOLS, Adult Safeguarding and Child Safeguarding	SUD	MD	31/01/2015	In Progress					
33	High	CQC	DNACPRCPR - Processes not being followed by Trust staff	Whole Report	All	All	To ensure all patients who should have DNACPR in place have one that is in line with Trust Policy	Provide training breaking bad news - medical staff	SUD and HONs	MD and DONQ	31/03/2015	In Progress		Resuscitation Committee Trust Board	1)Appropriate and timely use of DNACPR 2) Increased staff awareness of DNACPR policy 3) Improved family involvement in decision making process 4) Improved results from audits undertaken.		
								Improve system for identifying DNACPR patients	HONs	DONQ	30/11/2014	In Progress					
								Regular live audit of DNACPR forms	HoQS	DONQ	31/12/2014	In Progress	To be undertaken by CQUIN Support Worker				
								Bi monthly audit to Quality Committee	Resuscitation Officer	DONQ	31/01/2015	In Progress					
								To go on the SU dashboard	HoQS	DONQ	31/01/2015	In Progress					
								Monitor SUP	HoQS	DONQ	31/01/2015	In Progress					
								Monitor by Resuscitation Committee and report to Mortality Group.	HoQS	MD	31/01/2015	In Progress					
Workforce																	
34	High	CQC	NIV care not provided in accordance to national guidance.	Medical care	Medical care	All	To ensure competent staff and nursing establishment to meet the needs of delivering the safe high quality service to patients requiring NIV	Business case developed and approved to provide substantive nursing care for NIV patients 1:2.	SUM/HON	CEO	31/08/2014	Completed	Out to advert for additional RGN's - nil recruited yet	Trust Executive Management Trust Board	1) To provide NIV treatment in accordance with national guidance	31/08/2014	
								Advertise nursing posts	SUM/HON	CEO	31/01/2015	In Progress					
								All staff to report incidents when nurse staff shortfalls are identified in relation to caring for NIV.	SUM/HON	CEO	31/01/2015	In Progress	Incident reporting commenced in October 2014.				
35	High	CQC	The Trust did not have sufficient numbers of staff within District Nursing services	Community	Community Health services for adults	All	To ensure sufficient and competent numbers of staff within District Nursing to meet patient care needs.	Review of District Nursing workforce with Director of Nursing & Quality and Head of Nursing for District Nursing.	HON	DONQ	30/11/2014	In Progress	Review undertaken in February 2014. Meeting arranged for 28th November 2014.	Trust Board	1) to provide safe nursing care.		
Estates																	
36	High	CQC	Lack of medical gas signage and systems in place to ensure equipment is serviced and calibrated	Whole Report	All	All	Ensure appropriate medical gas signage and storage	Estates to request assurance from PFI partner that all medical gases are appropriately stored and signposted	Head of Estates	COO	31/12/2014	In Progress	Agreement on the type of holder to be used for the gas cylinders. (Completed - July 2014) Established the precise locations for these and Head of Estates has written to each area to confirm this. (Completed - September 2014) Temporary labels issued to mitigate the risk in the short term due to procurement time and installation. These labels have been issued to each area.	Medical Gas Group Health & Safety Committee Quality Committee	1) Ensuring safe storage and signage of medical gases.		
							All equipment to be appropriately PAT tested and subject to PPM programme	Estates to request assurance from PFI partner in relation to PAT testing	Head of Estates	COO	31/05/2015	In Progress	Negotiations on-going with PFI partner in relation to how assurance will be provided to the Trust.		1) All equipment requiring PAT testing and PPM to be completed annually and subject to on-going monitoring.		
								Establish on-going monitoring and reporting to the Trust on progress against annual programme of PAT testing and PPM	Head of Estates	COO	31/05/2015	In Progress	To be incorporated as a Trust Board KPI.				
								Bi monthly reporting to medical devices committee	Head of Estates	COO	31/12/2014	In Progress					
37	High	CQC	Lack of space and inadequate design within A&E department to enable patients to be seen within a timely manner	A&E	All	All	To redevelop the A&E department to ensure adequate space and the design is fit for purpose	Business case to be agreed for expansion of A&E	Head of Estates	COO	30/09/2014	Completed	Increase majors capacity by one addition room. This is due to be implemented in April 2015.	Urgent Care Governance Meeting Service Unit Performance Quality Committee	1) Achieve appropriate expansion of A&E to meet the needs of Herefordshire population. 2) Increased flow within A&E Department and reduction in breach of national targets.	30/09/2014	
								A&E redesign plan to be undertaken	Head of Estates	COO	30/11/2014	In Progress					
								Implement and build the redesign for A&E	Head of Estates	COO	30/06/2015	In Progress					
								Develop a suitable children's area within the A&E department in line with national recommendations	Head of Estates	COO	30/06/2015	In Progress	Reviewing to see if this can be brought forward.				

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
38	High	CQC	No allocated security staff for the A&E department. Staff reliant of local constabulary for support services.	A&E	All	All	To protect staff and patients within the A&E department	Provide 24/7 security services for WVT, to include A&E.	Security Officer	COO	30/06/2015	In Progress	Understand the security issues i.e. review of incidents etc. to quantify the risk. Development of business case to follow this review. Review of the current systems to identify element of risk to our patients and staff.	Urgent Care Governance Meeting Service Unit Performance Quality Committee	1) Decrease in security incidents in Emergency Department year on year. 2) Reduction in harm profile of incidents. 3) Improved staff and patient Friends and Family Test response.		
39	High	CQC	The Trust has high caesarean section and induction rates for its patients and does not have a midwifery led unit to promote normalised birth	Maternity	All	All	To promote normalised birth	Funding to be secured for MLU	SUM	DOF	31/12/2014	In Progress	Charitable funds approached for funding of a new MLU. To be agreed in December 2014.	Integrated Family Health Service Unit Governance Meeting Service Unit Performance Quality Committee	1) Decrease in C-section rate to below national average 2) Appropriate promotion of normalised birth.		
								MLU design plan to be undertaken	SUM	DOF	28/02/2015	In Progress					
								Implementation plan for MLU	Head of Estates	DOF	31/05/2015	In Progress					
40	High	CQC	Potential ligature point in A&E quiet room	Accident and Emergency	All	All	To ensure that the quiet room meets national recommendations as a psychiatric interview room.	All staff are aware of the required use of the room and no patients who are potentially at risk of further harm are not left unsupervised in the room.	Lead Nurse for ED	CEO	01/09/2014	Completed	Ligature point removed	Urgent Care Governance Meeting Service Unit Performance Quality Committee	1) Provision of a suitable and safe environment for patients with mental health needs.	01/09/2014	Datix.
41	Med	CQC	There was not an effective second theatre. Lack of staff was causing a delayed response. There appeared to be a plan for addressing some of this, but staff told us they didn't think it was the right location, and had no opportunity to influence decision the making	Maternity	All	Maternity & Gynae/Family Planning	To ensure access to a second obstetric theatre is available 24/7.	Anaesthetic room is now able to be converted into a second obstetric theatre	SUM	COO	30/09/2014	Completed	There is a second theatre available with standing operating procedures including staffing processes.	Integrated Family Health Service Unit Governance Meeting Service Unit Performance Quality Committee	1) Ensure the ability to run 2 obstetric theatres simultaneously providing safe and effective care for ladies requiring emergency caesarean sections or other interventional procedures.	30/09/2014	
								SOP developed to direct staff on the conversion of the anaesthetic room into a second obstetric theatre.	SUM	COO	30/09/2014	Completed	SOP in place.			30/09/2014	
								Skills and drills implemented to familiarise staff on weekly basis	SUM	COO	30/09/2014	Completed	Skill and drills training in place.			30/09/2014	
42	High	CQC	Unlocked clinical waste bin found during the inspection at one of the Community Hospitals. This was also noted to be unclean.	Community	All	All	All clinical waste bins should be locked and appropriately cleaned.	New PPM agreed with external provider at community hospital. Maintenance for broken or faulty equipment is now replaced within 24 hours.	Head of Estates	COO	31/10/2014	Completed	New PPM in place which includes 24 hour replacement and agreed cleaning programme.	Health & Safety Committee Quality Committee	1) All clinical waste bins appropriately locked and cleaned across the Trust and appropriate systems to monitor this to be in place.	31/10/2014	
43	High	CQC	The Trust did not have suitable arrangements to protect staff engaged in lone worker activity, particularly at night and supply mobile phones that were fit for purpose.	Community	Community Health Services for Adults	All	Appropriate systems in place to ensure the safety of lone workers.	Review of safe and well checks	HON	DONQ	31/12/2014	In Progress		Health & Safety Committee Quality Committee	1) A safe working environment for lone workers		
								Monitoring of incident forms	HON	DONQ	31/01/2015	In Progress					
								Review of phone providers (looking to trial roaming network sim card devices and phone tracker system with identified company)	HON	DONQ	31/12/2014	In Progress	Risk assessment undertaken and is currently on the Trust risk register. Head of Nursing for District Nursing services is in negotiation with the company who have agreed to allow us to trial roaming network sim cards to alleviate phone issues. LSMS also looking at other solutions such as amending network provider or provision of "reliance lone worker devices" which monitor location of staff and contact them directly with a call centre to provide assistance as required.				
Infection Prevention and Control																	
44	High	CQC	Cleanliness across the hospital was not always of an acceptable standard in all areas.	Whole Report	All	All	Improve the standards of cleanliness across WVT	Roll out more robust monitoring process for hygiene and cleanliness (credit for cleanliness audit tool)	Head of Estates	DONQ	31/12/2014	In Progress	Please note there is a more comprehensive IPC action plan underpinning the actions identified	Infection Prevention and Control Committee Quality Committee Trust Executive Management	1) Delivery of contractual cleanliness standards. 2) Cleaning for credits consistently at 100% across all areas.		
								Meeting DON and IPC with Sodexo to clarify their monitoring of hygiene and cleanliness and to agree a feedback mechanism to the Trust to provide assurance these are being completed to an acceptable standard.	IPC Lead Nurse	DONQ	30/11/2014	In Progress	See above				
								Increase training in relation to bioquell cleaning and train additional staff to undertake this duty	Head of Estates	DONQ	31/12/2014	In Progress	See above				
								Renegotiation of terms of SSA cleaning contract with PFI	Head of Estates	DOF	31/12/2014	In Progress	See above				
								Increase awareness of the SSA reactionary team to ensure staff are aware they have access to emergency cleaning teams 24/7.	IPC Lead Nurse	DONQ	30/11/2014	In Progress	See above				
								Cleanliness charter in screensaver schedule	IPC Lead Nurse	DONQ	30/12/2014	In Progress	See above				
								Introduce Sodexho communication books to wards and departments	IPC Lead Nurse	DONQ	14/11/2014	In Progress	See above				
								Introduce Sodexho communication cleaning boards that include cleaning schedule, cleanliness charter and contact details for staff , patients, visitors to report cleanliness issues.	IPC Lead Nurse	DONQ	30/11/2014	In Progress	See above				
								Review of complaints and Datix incidents at cleanliness committee on an on-going basis/agenda item	IPC Lead Nurse	DONQ	30/12/2014	In Progress	See above				
								Wipe packs for mobile pieces of clinical equipment	IPC Lead Nurse	DONQ	30/11/2014	In Progress	See above				
								Regular joint DIPC and Lead IPN nurse ward visits	IPC Lead Nurse	DONQ	31/12/2014	In Progress	Walkabouts have commenced.				
Outpatients Department																	
45	High	CQC	Outpatient appointments were overbooked and there	Outpatient	All	All	To improve outpatient response times and improve patient	Capacity planning process linked to consultant job planning. Subsequently, business cases for substantive additional clinical capacity will be commenced.	Lead for Outpatients and SUDS	COO/Clinical Directors	11/11/2014	In Progress	Undertaking a demand and capacity review. Outsourcing/Insourcing will be carried to reduce	Elective Care Service Unit Governance Meeting Service Unit Performance	1) RTT improvement, overbooking reduction 2) Decrease in complaints relating to Outpatient Patients Department 3) Outpatient wait times reduced to optimum wait times.		

No.	Priority	Source	Comment	Report	Domain	Area	Objective(s)	Agreed Actions	Owners (Operational)	Owners (Executive)	Timescales	Progress (Status)	Progress (Comments)	Reporting Committee	Outcomes	Date Completed	Evidence provided
Corporate Actions																	
			was no system for monitoring the impact of this.				experience	Demand and capacity review to be undertaken	COO	COO/Clinical Directors	11/11/2014	In Progress		Quality Committee	4) Non admitted RTT over 95%. 5) Improvement at speciality level by April 2015 where all specialities are 95% for admitted. 6) Improved Friends and Family Test score.		
								Strengthen patient target list and waiting list management. Identify a validations team and information process that supports waiting list management.	Head of Information	DOF	30/11/2014	In Progress					
								Expand outpatients to accommodate more clinics.	Head of Estates	DOF	31/10/2015	In Progress	2 stage plan already agreed by TEM - Fred Bulmer Unit.				
								Consider utilising clinics at community/other sites	Lead for Outpatients	COO/Clinical Directors	11/11/2014	In Progress					
								Ensure adequate drinks facilities are available in all outpatient areas	Lead for Outpatients	COO/Clinical Directors	31/01/2015	In Progress					
								Review of medical capacity part of annual job planning process	SUDS	MD	30/06/2015	In Progress					
								Implementation of patient Friends and Family test.	Lead for Outpatients	DONQ	31/10/2014	Complete	Early implementer of FFT within outpatients and community.		1) Baseline scores for FFT 2) Month on month improvement on FFT response rates and scores	31/10/2014	
46	Medium	CQC	The Arkwright Suite - Soundproofing found to be an issue if standing outside close to the Unit and report from CQC was a single incident whereby the clinician did not close the door when dictating. The Arkwright Suite is a temporary solution.	Outpatients	All	All	To ensure the Arkwright Suite is an environment which is suitable for patient consultations.	Estates to confirm that consultation dignity can be maintained through appropriate sound proofing inside and outside unit.	Lead for Outpatients/Head of Estates	COO	31/12/2014	In Progress	The Arkwright Suite surrounding area is roadway and it is not for pedestrian access therefore no persons should be legitimately stand close to the unit which mitigates the risk. There should be no-one directly outside the Arkwright suite where one can hear. At Trust Executive Meeting (9th September) agreed proposed plans for exit strategy to re-configure the existing Fred Bulmer Building to accommodate the capacity within the Arkwright Suite.	Elective Care Service Unit Governance Meeting Service Unit Performance Quality Committee	1) Ensure, when in use, the temporary outpatient facility maintains privacy, dignity and confidentiality for patients. 2) Removal of temporary outpatient facility and replaced with permanent facilities within the hospital current facilities.		
								To ensure maintaining data protection and securing notes at all times.	Lead for Outpatients	COO	31/12/2014	In Progress	Lockable notes trolley in place. Spot checks to be undertaken by Quality & Safety				
End of Life Care																	
47	Medium	CQC	No apparent End of Life pathway	End of life care	End of life care	All	To improve patient experience at end of life	Implementation (including training and education) of the new Multidisciplinary Care Record for the last days of life for adults.	Consultant in Palliative Care/ Lead Specialist Palliative Care Nurse	DHR	15/09/2014	Completed	Education sessions delivered July 2014. Multi Disciplinary Care record in place September 2014.	Health Records Committee Trust Executive Management	1) To ensure patients receive appropriate end of life care in accordance with the Trust end of life care pathway.	15/09/2014	
								Audit implementation of Multidisciplinary Care Record through annual Health Records audit.	HoQS	DONQ	30/06/2015	In Progress					
Elective Care																	
48	High	CQC	Inappropriate use of Day Surgery	Surgery	Surgery	All	To ensure appropriate use of day surgery unit according to standardised operating procedure	Continue to use current SOP in place to prevent DSU to be used as an escalation area with Director on Call authorisation required for a SOP breach.	SUM & HON	DONQ	01/10/2014	Completed	Day surgery pod business case completed (booked at risk)-monitoring of breaches being reported monthly via EC risk register and through Q&P meetings	Elective Care Service Unit Governance Meeting Service Unit Performance Quality Committee	1) Reduced reliance on the use Day Case Unit for inpatient, therefore improving patient experience. 2) Reduce length of stay for inpatients on Day Case Unit. 3) Improved patient Friends and Family Test response. 4) Improved staff Friends and Family Test response.	01/10/2014	
								Continuous monitoring and reporting of breaches; escalation onto the Risk register.	SUM & HON	DONQ	01/10/2014	Completed				01/10/2014	
							To ensure timely review of patients on surgical wards, day surgery unit and outlying patients; and associated workloads.	Nurse in charge tasked with identification of patients not having been reviewed by 11am.	SUD / HON	DONQ	30/11/2014	In Progress	Escalation SOP for site team to be contacted if any senior decision making review has not been completed before 11am. Pilot on-going with metrics monitored by Pharmacy for EDS. Planned debate and discussion at medical business meetings to explore ward based doctors instead of individual consultant designated junior doctors.				
								Escalation to site team to chase the medical teams.	SUD / HON	DONQ	30/11/2014	In Progress					
								Immediate updating rota's and bleep numbers and ensure that this available in every ward area and at switchboard.	SUD / HON	DONQ	30/11/2014	In Progress					
								Current pilot: junior doctors post ward round debrief to streamline workload (e.g. EDS, bloods, diagnostics) to improve effectiveness and efficiency.	SUD / HON	DONQ	30/11/2014	In Progress					
Other																	
49	High	CQC	The Trust needs to ensure responsibilities for implementing the high level corporate actions from the PCIP are clear and that there is ownership across the Trust.	Whole Report	All	N/A	To ensure high level corporate actions from the PCIP are fully implemented.	The Executive Team to develop a corporate PCIP and processes to monitor its implementation along side the Service Unit PCIP's.	HoQS	DONQ/MD	31/10/2014	Completed	Corporate PCIP developed. This will be monitored monthly commencing October 2014. Final version to CQC and TDA by 05/11/2014. Draft to Quality Committee in October 2014. Second draft to Board by 29/10/2014 and TDA by 31/10/2014.	Trust Executive Management Trust Board	1) Delivery of all outcomes, with appropriate associated monitoring and sustainability of the action points and outcomes identified within this PCIP.	31/10/2014	
50	High	CQC	The Trust needs a robust system to monitor the implementation of the Service Unit PCIP's (Patient Care Improvement Programme) to ensure actions are taken by each Service Unit in a timely manner and that there is ownership across the organisation.	Whole Report	All	All	To ensure there is local ownership within the Service Units.	Each Service Unit has developed a local action plan to address concerns within the CQC. This contains actions they are taking with agreed timeframes and expected outcomes.	Service Unit	All Executive Leads.	30/11/2014	In Progress	Service Unit PCIP's under development. These will be monitored monthly commencing November 2014 Executive Leads appointed 30/09/14. Service Unit Leads to be identified by 31/10/14 Roles responsibilities to be defined and agreed with Service Unit leads	Trust Executive Management	1) Board assurance that the PCIP is being delivered and monitored appropriately.		
								Spot check audit by the Quality & Safety Team of evidence provided.	HoQS	DONQ	30/12/2014	In Progress					
								PCIP to be standing agenda item at monthly Service Unit Governance meetings.	SUMS	CS	30/11/2014	In Progress					
								Each Service Unit will have an Executive sponsor who will work with each Service Unit to ensure the PCIP action plans are implemented and are ultimately accountable for the failure to deliver any action point. Each Service Unit will nominate a lead for the PCIP from a member of the Medical Staff Nursing Staff AHP Staff Ancillary Staff . These individuals will be responsible for local dissemination and implementation of the PCIP. Roles and responsibilities will be clearly defined to ensure continuity across all Service Units.	Service Unit Leads	All Executive Leads	30/11/2014	In Progress					

COO	Chief Operating Officer
SUD	Service Unit Director
SUM	Service Unit Manager
MD	Medical Director
DONQ	Director of Nursing and Quality
HON	Head of Nursing
DHR	Director of Human Resources
HoQS	Head of Quality & Safety
CS	Company Secretary
DOF	Director of Finance
CEO	Chief Executive Officer

Herefordshire Council

MEETING:	**HEALTH & SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**
MEETING DATE:	**3rd December 2014**
TITLE OF REPORT:	**Local Account 2013/14**
REPORT BY:	**Director Adults & Wellbeing**

Classification

Open

Key Decision

This is not a key decision.

Wards Affected

County-wide

Purpose

To note the publication of the Adult Social Care Local Account 13/14.

Recommendation(s)

THAT:

(a) The Committee note the publication of the report

Alternative options

1 It is a Department of Health requirement that a Local Account be published. It would be possible to change the content and presentation but the draft complies with best practice guidance.

Reasons for recommendations

2 The reasons to approve the Local Account as attached are that:-

a. it meets the Department of Health's requirements

b. the content and layout reflect best practice recommendations from the regional ADASS Performance network and national LGA conference

Further information on the subject of this report is available from
Paul Harris – Performance Lead (Adults & Wellbeing) on Tel (07792) 881832

Key considerations

3 All councils with a remit for adult social care are required by government to produce an annual local account of services. This relates to the replacement of the role of the regulator, the Care Quality Commission (CQC) in assessing council performance by a lighter-touch approach, which emphasises local accountability and sector and peer-led assessment. A peer challenge of adult social care was undertaken in June 2014 with the recommendations and action plan published and reviewed by Cabinet in October 2014.

4 The purpose of local accounts is twofold; to communicate with and promote accountability to the local community, and to support benchmarking, peer review and sector led improvement.

5 National guidance leaves the format and content to be determined locally. The approach agreed for Herefordshire is to address the challenges and requirements by:-

a. Producing the document as a web based PDF, available online but easy to print off hard copies;

b. Having a tone and style aimed at citizen audience;

c. Having the comprehensive underpinning data published separately and referenced, interwoven and analysed throughout the account. (e.g. statutory returns, user and carer surveys, complaints reports, CQC reports on providers, national census data)

d. Being balanced and therefore credible– good news **and** bad news, both in context and evidence based

e. Giving the context of national policy, financial challenges and the range of organisations that deliver social care

f. Having a structure based on the national performance framework (Adults Social Care Outcome Framework)

g. Consulting and involving a range of stakeholders during the production

Community impact

6 The final document and the process of producing it is an important element in ensuring local authorities make themselves accountable to their local communities.

The local account specifically gives a true and fair outline of key issues and performance to a general reader and reflects and refers to the detailed evidence available on the council's "Facts and Figures" webpages and in the wider public domain. The document will signpost people with detailed interest to the underlying evidence base

Equality and human rights

7 The local account identifies how we support our vulnerable people with a range of tailored services.

Financial implications

8 There are no financial implications

Legal implications

9 All councils with a remit for adult social care are required by government to produce an annual local account of services. Local accounts are referred to in the Department of Health's "Transparency in Outcomes: a framework for adult social care" consultation paper (November 2010) in the context of localism and transparency, and in the subsequent Adult Social Care Outcomes Framework published in March 2011.

This guidance leaves format and content to be determined locally.

The attached local account fulfils this requirement.

Risk management

10 The proposal does not contain any specific / direct risk management implications

Consultees

11 During the production of this Local Account we have engaged with service users to include their opinions on service provision and some of these are included within our case studies within the report. Much of the content of the account is based on our annual survey of social care users and also the opinions of residential and nursing care service users, through the quality and review team survey. The Local Account will also be shared with the Making It Real board, and in future will be co-produced with members of this board as we develop and improve our engagement programme.

Appendices

Appendix 1 – Local Account 2013/14

Background papers

None identified.

Further information on the subject of this report is available from
Paul Harris – Performance Lead (Adults & Wellbeing) on Tel (07792) 881832

Appendix 1

Adult Social Care in Herefordshire 2013-14

Our Local Account

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Herefordshire Council

Contents

Our vision is: **"To enable residents to live safe, healthy and independent lives and to maintain service provision, to those with eligible need, within the available resources".**

Introduction - social care in a changing world

Herefordshire's elderly population is increasing at a faster rate than in many other areas. Although they are generally more affluent than the English average, their need for support is increasing.

Over the last few years we have had to rise to the challenges presented by reduced funding and changes to national policy. As well as caring for the elderly population, we have to meet the needs of future generations of older people and young adults with complex disabilities.

In addition, we have a duty to meet the support needs of a growing number of family carers.

During the past year we have worked with partners in the NHS, service providers, community groups, service users and their families, to make changes to the way services are provided. These changes were not just about managing our finances better, but about making sure that people who use our services have choice and control about their care and have a greater say in who provides that care.

Our aims are clear. We want to make sure Herefordshire residents:

- Are kept safe, healthy and able to remain independent for as long as possible
- Have choice and control with services that are affordable
- Are offered services that are integrated across health and social care
- Have access to supportive local communities
- Are able to access efficient and effective services that meet their support needs

This Local Account (2013-14) tells you our story so far and how we plan to continue our journey over the next few years. We have included case studies which illustrate how some of the changes made have had a positive impact on local people.

We would like to thank our service users, their families, our providers and all staff involved in the changes that have taken place, and that lie ahead, for their continued support.

Cllr Graham Powell
Cabinet member for health and wellbeing

Helen Coombes
Director of adults and wellbeing

How care is provided in Herefordshire

Friends and families

According to the 2011 census, 21000 citizens regularly provided at least one hour of care per week for someone with long term ill health, disability or frailty. 6700 of them reported giving over 20 hours of care per week[1].

The council

- Conducts community care assessments and helps people plan how to meet their needs
- Funds services for people whose needs are eligible (based on national guidance)
- Gives grants or contracts with other organisations for support services
- Gives support to carers
- Gives advice
- Provides some services itself, for example, handyman services, Blue Badges

The third sector (voluntary and community sector)

- Advice and information
- Practical support
- Day services
- Community transport
- Mutual support

The health service

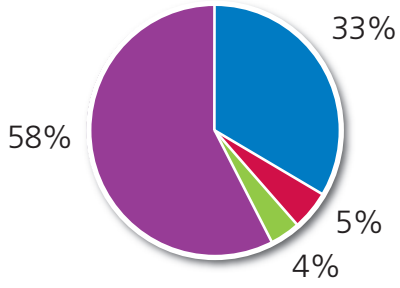
- Meets people's needs for health, social care and support often intertwine and local GPs and hospitals work closely with social care organisations, especially following a period in hospital
- Funds the nursing element of all nursing home costs and will meet the full costs where a person has overriding continuing health needs
- Through 2Gether NHS Trust undertakes social care assessments and care management of local people with significant mental health problems on behalf of the council as part of a wider mental health provision

Independent residential and nursing homes and homecare agencies

87 residential and nursing care homes and 40 care agencies worked with some of the most vulnerable people in the county, including people lacking in mental capacity, people with mental health problems, learning disabilities, and physical frailty and disability.

The majority of care home places in the county are not paid for by Herefordshire Council[2].

Who uses care home beds in Herefordshire?



Supporting carers

Herefordshire Carers Support is a local organisation commissioned by the council to offer advice, information and support specifically to unpaid carers of all ages. Over 4,500 carers are registered with the organisation and can receive help and support to make positive changes to their caring roles. For example, registered carers receive:

- Help with taking stock and planning for future needs on an individual basis and with others in regular support groups
- Information on taking a break from the caring role and looking after yourself
- Signposting to other services that provide information about specific conditions
- Training to help build skills knowledge and confidence
- Networking opportunities, to name a few

1 Details of carers can be seen in the strategic needs assessment called "Understanding Herefordshire" on the website http://factsandfigures.herefordshire.gov.uk/2205.aspx.
2 Data based on a snapshot at 31st March 2014, from the ASC-CAR return (available from http://factsandfigures.herefordshire.gov.uk), CQC and CSU

Challenges identified in our last Local Account	Progress in 2013-14
We aimed to:	**What we achieved:**
Provide sustainable, value for money services	Redesigned and recommissioned a range of services with new contracts taking effect 2014 - 15 Undertook an open book review of costs with independent sector care homes
Give clients more choice and control	Increased number of people signed up for personal budgets and direct payments
Work with partners and communities	Facilitated regular meetings with the Making it Real Board (see page 7) Agreed a joint action programme with local NHS for the Better Care Fund
Shift from high cost services such as residential care, to supporting people in their own homes for longer	Managed the increase in the number of clients supported in residential care

Other achievements

Continued to receive high levels of user satisfaction and quality of life

More vulnerable adults were kept safe from abuse than in the previous year

Managed to stabilise spending

Established an Adult and Wellbeing directorate within the council - bringing together adult social care and housing

Key highlights of the journey so far

2008
Herefordshire Council and Herefordshire Primary Care Trust establish a single management structure to become Herefordshire Public Services.

April 2011
Health and social care join forces to form Wye Valley NHS Trust – the first integrated provider of acute, community and social care in England.

2012
National reforms lead to primary care trusts being relaced by clinical commissioning groups.

Sept 2013
The council brings social care back into the council. It also changes the way some of the social care services is provided so that service users can use direct payments to buy these services.

Health services for people with learning disabilities is transferred from Wye Valley NHS Trust to 2gether Foundation Trust.

The council develops a new structure and Adults becomes a single directorate.

Council embarks on a programme of commissioning to bring new providers and a fresh approach to services in the county.

March 2014
The council extends arrangements for 2gether NHS Trust to provide mental health and substance misuse services pending a strategic review in 2014.

Some of the things we have achieved in 2013-14

Following national NHS reforms, we ended the agreement with Wye Valley NHS Trust in 2013 and took back the social care aspects of the service, such as initial contact, assessment, safeguarding and review, as well as welfare rights.

The council also decided that a number of other services would be reviewed and put out to tender. These included:

Day opportunities

We embarked on a series of conversations with existing users of day opportunities about how activities run in the council's day centres could be packaged together and put out to tender.

As a result of talking to service users and their carers, we put a membership-based scheme out to tender and appointed Aspire Living Ltd to deliver a new-style service.

Shared Lives

Ategi, a registered charity with extensive experience of supporting adults with learning disabilities, was appointed to manage the council's former Adult Placement service. Transition to the new arrangements was carefully managed to minimize disruption to service users. Ategi plans to expand the service and further develop the respite break service.

Norfolk House (sheltered housing scheme)

Working very closely with existing tenants, we appointed Reach (Supported-Living) to take over the management of Norfolk House. The closure of the kitchen service created a dilemma – we needed to save money but at the same time make sure residents continued to receive the services they need. Staff helped tenants to explore different options for purchasing a meal and the majority vote was to use a local pub to deliver lunches instead of providing an in-house kitchen facility.

Community Equipment Store

The council worked in partnership with Herefordshire's Clinical Commissioning Group to appoint NRS Healthcare to manage the county's Integrated Community Equipment Store. Community equipment stores provide equipment to adults and children to help them live safe, healthy and independent lives.

NRS Healthcare is an experienced contractor of these services and has a strong performance record. As the store will remain on the same site, the impact of the management changeover was minimal to service users.

Sensory Impairment

Vision Links was awarded the contract for providing sensory impairment services in Herefordshire. Disruption for service users was kept to a minimum as existing council staff were transferred across to the new provider and the service was delivered from the same locations.

We set up a Making it Real programme

We established a Making it Real programme to help make social care more personal for the people who use it.

This was part of a national campaign to encourage service users and their carers to become involved in helping local authorities agree priority areas for future developments. Age UK, Herefordshire Council, Herefordshire Disability United and Services for Independent Living registered with the programme and surveyed adults receiving adult social care using the Making it Real survey questions that were set nationally.

160 people responded to the questionnaire and feedback set the three priorities for Herefordshire as follows:

- To make good quality information available for prospective service users, their families and carers
- To make self-directed support from the council more widely understood and less complicated
- To promote active and supportive communities so that people feel valued, know about and can attend a wide range of activities.

Following the survey we appointed a principal social worker to work with the teams on improving practice and dealing with changes to systems and processes, both designed to provide better, more effective services to people.

We signed up to the Social Care Commitment

This means we promise to:

- Work responsibly
- Uphold dignity
- Work co-operatively
- Communicate effectively
- Protect privacy
- Continue to learn
- Treat people fairly

We published a policy, Community Care and Meeting Your Eligible Needs

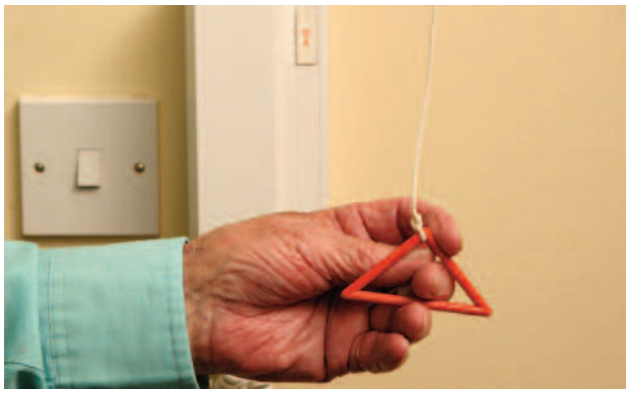
In March 2014 we published this policy, which sets out our vision for the next three years and pledges to actively ensure that Herefordshire residents:

- Are safe, healthy and are able to remain independent for as long as possible;
- Have choice and control with services that are affordable;
- Can access services that are integrated and joined up at the point of delivery across adult social care and health;
- Have access to supportive local communities;
- Are able to access efficient and effective services that meet their support needs.

The policy also explains what services are available to people needing help and support, how that support will be provided, how people's needs will be assessed and how funding will be allocated.

We launched a telecare service to help people live independently

Following a review in October 2013, we began a 12 month campaign to develop the use of technology to support our service users and carers. This involved setting up a training programme for all professionals across health and social care to help them understand what tools are available (such as telecare) and how individuals can be supported at home with this equipment. We also created a telecare adviser service in the council to help health and social care professionals find the right solution for individuals they are working with.



We reviewed Home and Community Support (domiciliary care)

Helping as many people as possible continue to live independently in their own homes is a major priority for health and social care. Home and community support (domiciliary care) helps to achieve this, and as a result, demand for the service is growing. As well as making sure we get good value for money, we also need to make sure we have good systems in place so that support is provided in a targeted way to those that need it most.

During 2013-14 we consulted with the organisations that provide this service in Herefordshire about reducing the rates the council pays. We also talked about a framework that providers could apply to be part of, and that service users could choose from, in order for the council to purchase their care needs. The framework includes electronic care monitoring and arrangements to make sure all care and support is linked to people's care plans.

We created new homes for people with learning disabilities

Working in partnership with the Sanctuary Housing Group, the development of 10 new homes for people with learning disabilities began at Coningsby Street, Hereford. The apartments are all self-contained but the development also has some communal areas (kitchen/living room/training rooms) to enable the residents to share and enhance their life skills to live independently. The homes are located in the city centre close to all necessary services including travel, shops, training and close proximity to other services for support.

Henffordd Gardens

Herefordshire Housing Ltd (HHL) opened their first assisted living scheme in Edgar Street, Hereford to provide accommodation for people over 50+ years. Henffordd Gardens provides 30 high quality apartments offering the very latest in assistive technology, providing telehealth and telecare support to individuals, fully supporting the principles of Homes for Life and responding to economic changes by bringing together housing care and support.

How are we doing?

1. Improving the quality of life for people with care and support needs

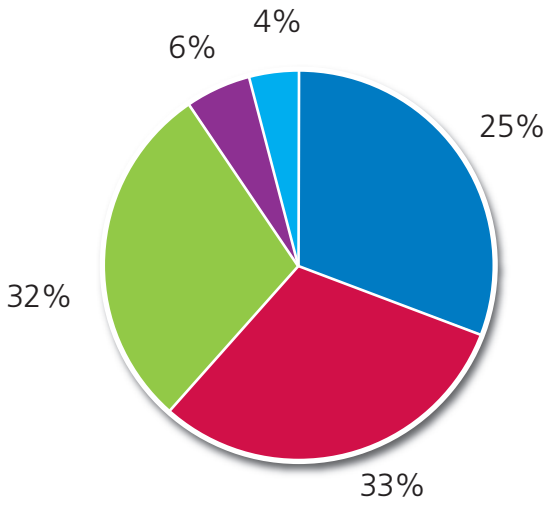
Social care service users report high quality of life

More personal budgets and direct payments making a difference

Work needed to improve how direct payments are managed

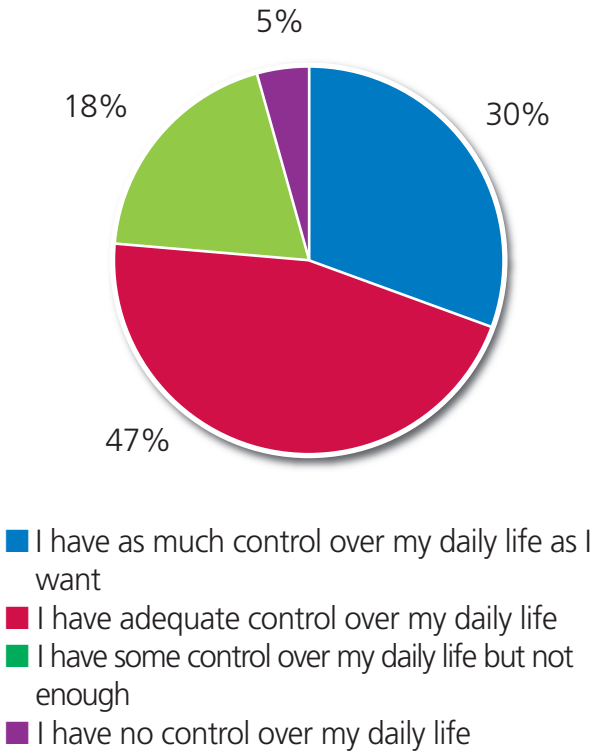
In a survey of service users funded by the council in 2014,[3] most people said they thought their quality of life was good.

Herefordshire - Thinking about all the different things in your life, good and bad, how would you say you feel about your life in general?



Most people also said that they had enough control over their lives.

Herefordshire - Which of the following statements best describes how much control you have over your daily life?



3 Full results and details can be found at Adult Social Care User Survey 2014 http://factsandfigures.herefordshire.gov.uk/1915.aspx

Direct payments

One way to increase people's control over their lives is to let them know how much money is available to pay for their support (personal budget) so that they can be more involved in planning their care. Greatest control can be achieved when clients choose to receive this budget in cash as a direct payment to use to purchase their own care.

The numbers of clients receiving personal budgets and direct payments rose in 2013-14 but is still just at or below the national average.[4]

Feedback from service users highlighted that many found the direct payment process too restrictive and complicated. We have now appointed direct payment advisers to help make the process less complicated and answer any questions people may have.

"15 years ago I had a Direct Payment and it gave me my life back"

"The direct payments process is cumbersome"

CASE STUDY

Direct payments - Jonathon's Story

28 year old Jonathon has learning difficulties, can't communicate verbally, is visually impaired, has mobility problems and has severe seizures. He uses a direct payment from the council to employ personal assistants to support him to enjoy a good quality of life by participating in activities that he enjoys. Thanks to his staff team, family, support from the local community and the direct payments, Jonathan has a rich and varied social life.

His mum, Rose, said: "Jonathan attended Barrs Court Special school when he was younger and we worried about what support he would have when he left.

"Without having the choice that direct payments provide us with, it is likely that Jonathan would have attended a day centre. We felt that wasn't the right option for him.

"Employing personal assistants has worked out really well for him. They all know and understand him well and make sure that he gets to do the things he enjoys doing and making the most of his life. He's also able to pay for occasional overnight and/or holiday care

which helps his family take a break from time to time. And I have been able to go back to work."

Emma is his lead personal assistant and she helps him with staffing, paying bills, organising holidays and regular activities. "I've worked with Jonathan for nine years now and although he can't communicate verbally, I know him well enough to understand what he enjoys doing," says Emma.

"I can tell by his body language and the sounds that he makes – he's very good at letting us know if he doesn't want to do something or wants to have a lie in!"

4 Data based on annual Adult Social Care Outcome Framework return, made available on http://factsandfigures.herefordshire.gov.uk

2. Delaying and reducing the need for support

Getting the right information at the right time is often what people and their carers need to continue living with maximum independence.

- over 40% of contacts made to the council's social care team received advice, information or were signposted to other organisations and did not need further assessment or support[5]
- 73% of council supported service users who looked for it, found information about services easy to find. This is similar to the English average and similar councils.[6]
- 758 people received advice and support during 2013-14 from the council's welfare benefits team, to help them claim all their benefits

It is almost impossible to count how much support voluntary groups give to keep people independent. There is a rich tapestry of support in Herefordshire for people who may need support but who do not meet the criteria for council support.

The council's reablement service worked with 640 referrals in the first half of 2013-14 to give short, planned programmes of help to reduce people's needs for long term support. The service was changed in the latter half of the year to focus more on giving rapid response to emergency situations while a new reablement service was designed to be contracted in 2014-15.

Some of the support provided by voluntary organisations is funded by the council and the organisations also raise money from charitable sources and grants. A lot of support is provided by people giving their time freely. Social workers will refer people to these support groups where appropriate.

Public Health became a council responsibility in 2013 and works with all age groups to promote healthy lifestyles. The focus in 2013-14 has been to help people make healthier lifestyle choices and work with partners and share intelligence to make a difference.[7]

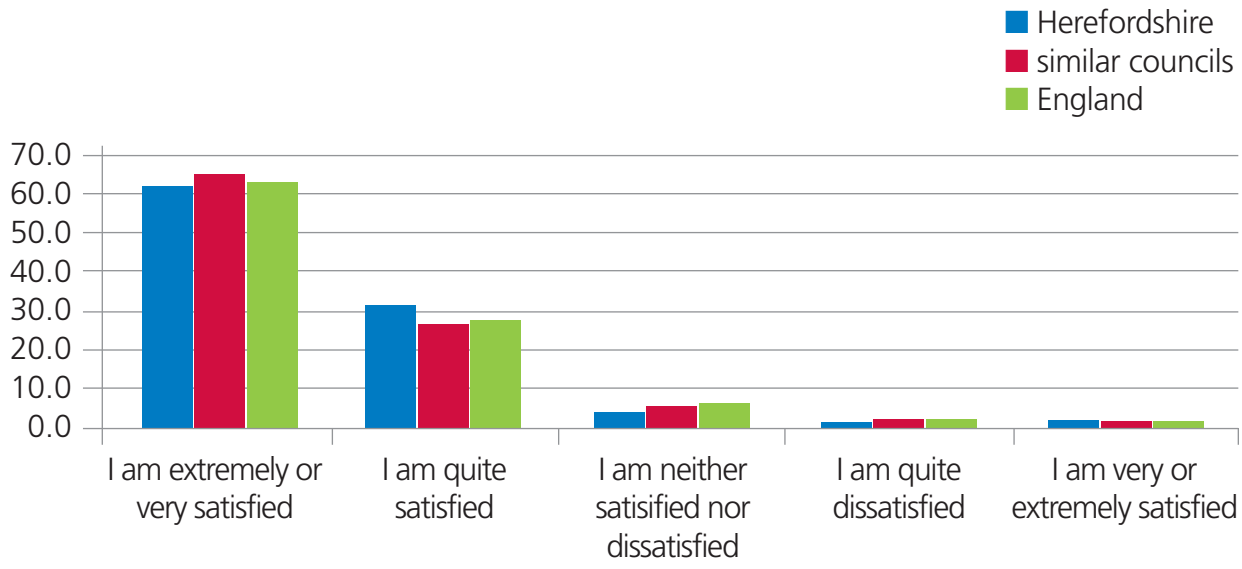
5 Data based on annual RAP return made available on http://factsandfigures.herefordshire.gov.uk
6 Data based on annual Adult Social Care Outcome Framework return made available on http://factsandfigures.herefordshire.gov.uk
7 Priorities and work to promote the health of Herefordshire's population is described in the annual report by the Director of Public Health. http://factsandfigures.herefordshire.gov.uk/2286.aspx To see data about Herefordshire's position follow the links on the page http://factsandfigures.herefordshire.gov.uk/health.aspx

3. Ensuring people have a positive experience of care and support

Most service users felt positive about the care they received most of the time, and the large majority of key services met national standards. However, some reported poor experiences and raised concerns over standards of care in some places.
Respondents to the annual survey of users reported similar high levels of satisfaction as in previous years.

- Over 60% said they were extremely or very satisfied with overall services.[8]
- Respondents scored their quality of life as 19 out of 24 based on factors such as their personal hygiene, comfort, nutrition, social contact. The national average was 19.1[9]

How satisfied are you with the care and support you have received?



Care homes: What did the regulators think?[10]

The Care Quality Commission (CQC) regulates care in England and inspected 84 of Herefordshire's 87 homes.

- 66 were compliant with all the national standards
- 18 were non-compliant in some respects and were required to make improvements
- The CQC issued formal warning notices in three cases
- This is slightly worse than last year when the CQC inspected 85 homes and found 14 of them non-compliant in some areas.

What the residents said about care homes

61 care home residents answered the annual user survey

- 69% said they were satisfied or very satisfied with their support and care
- 74% said their quality of life was good or very good
- 89 relatives responded to questionnaires from the council's quality team. 85% of these agreed that they were satisfied with the care provided for their relatives.

8 Data based on annual Adult Social Care Survey report made available on http://factsandfigures.herefordshire.gov.uk
9 Data based on annual Adult Social Care Outcome Framework return made available on http://factsandfigures.herefordshire.gov.uk
10 CQC inspection data available from the CQC website (www.cqc.org.uk)

Care home experience

CASE STUDY

In one care home, a quality assurance visit by the council identified that 18 out of 20 residents were satisfied with the overall quality of care. However, concerns raised by one resident included:

- Occasionally at busy times, I have to wait a bit long to be helped to the toilet.
- Sometimes I have to wait for assistance to get out of bed due to work load of staff and breaks they need.
- Plenty of activities but unsuitable for a blind person with osteoporosis
- Meals tend to be on the heavy side.
- Feel vulnerable and the care is not as good as I got in my own home with carers coming in.
- I have a large room with all my own things except the bed which is most uncomfortable.

"We know that this is a very suitable placement for our son in many ways. He is comfortable and happy, and he is part of a community. This is very important. He has shown a marked improvement in his life skills, and he has occupation and leisure activities that he enjoys and in which he excels. Pottery, for example, has been a source of great satisfaction to him and has revealed a serious talent and skill. His keyworker and most of the staff are doing a great job, but there have been issues: he was manhandled on the previous unit; one of the teams is inconsistent and unhelpful in their dealings with our son; and some staff are less than vigilant. The majority of staff are very professional and look after the residents in a professional, warm and dignified manner. Our son is happy."

Comments from a relative

Inspections

During the year the council had concerns with three care homes and worked with them to improve standards of care successfully.

Homecare agencies

There were 40 homecare agencies registered in the county in 2013-14.

The CQC inspected 25 of them.

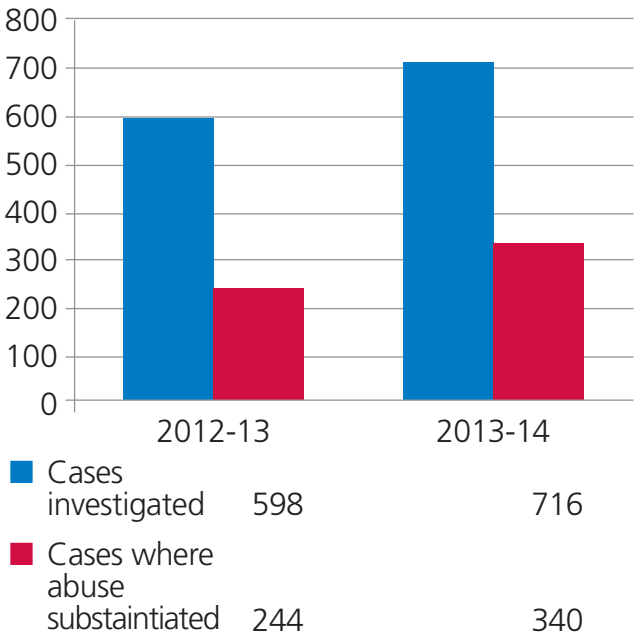
- Four did not meet all the national standards and one of these achieved compliance within the year.
- Last year, the CQC inspected 25 agencies and found that two of them did not meet all requirements.

More vulnerable people protected in 2013-14

Safeguarding vulnerable adults from abuse in Herefordshire is led by the Herefordshire Safeguarding Adults Board which co-ordinates the responses of different organisations.[11] 716 safeguarding investigations were concluded in 2013-14[12]

- 47% of them were fully or partly substantiated

Safeguarding investigations and conclusions



- A larger number of concerns were raised, which were reviewed and judged to not need a safeguarding investigation
- Most concerns were raised by staff in social care or health care but also by police officers, relatives and friends
- Most abuse was alleged to occur in the user's own home (48%), followed by care homes (35%) and hospitals (8%)
- In 44% of cases the alleged perpetrator was known to the subject but not a care worker; in 43% of the cases the alleged perpetrator was a care worker. In 13% of cases the perpetrator was a stranger
- Most subjects of investigation were over 85, and in 36% of completed investigations some question was expressed about the person's mental capacity

11 Details of the board can be found at https://www.herefordshire.gov.uk/health-and-social-care/adult-services/herefordshire-safeguarding-adults-board-(hsab)
12 Data based on annual Safeguarding Adults Return made available on http://factsandfigures.herefordshire.gov.uk

Keeping people safe from...

CASE STUDY

Domestic violence

Social workers were informed that Mrs Philip, an older lady receiving social care, had been taken to hospital following a suspected assault by a relative.

A social worker met with the police, social care staff, hospital staff, Mrs Philip and Mrs Philip's family to plan how she could return home safely. The police were able to prevent the suspected attacker coming near Mrs Philip; her relatives and care agency agreed a plan to give her extra support in the short term. In the longer term, with police advice, a security camera was installed at Mrs Philip's home.

Neglect

Nurses in a community hospital noted that Mr Ellis had pressure sores. Equipment and nursing care was put in place at once to relieve his condition and senior nurses investigated to see if his sores had arisen because of poor nursing. The conclusion in this case was that the pressure sores could have been avoided by following the hospital's nursing guidelines more closely. Extra training was given to the staff in the relevant wards to improve their practice and reduce the chances of other patients suffering. The incident was notified to the safeguarding board and recorded as a case of abuse by neglect.

When someone lacks mental capacity to consent to care or treatment, it is sometimes in their best interests to deprive them of their liberty to protect them from harm. Having mental capacity means being able to understand and retain information and being able to make a decision based on that information.

Where a person is at risk of deprivation of liberty within a care home or hospital, Herefordshire Council will arrange an independent assessment. In 2013/14, 83 cases were processed. Following a recent Supreme Court judgement, this number is expected to rise significantly in 2014/15.

13 Data based on annual Deprivation of Liberty Safeguards return made available on http://factsandfigures.herefordshire.gov.uk

An example of how our social workers keep people safe

CASE STUDY

Jane is an elderly lady who receives care in her own home. Reports are received claiming that she isn't being looked after properly. The social worker would typically think:

1. How can I find out about Jane's wishes and needs?
2. How can I find out more about the situation? Are the concerns justified?
3. Who do I need to involve? For example, Jane's relatives, her care agency?
4. Does Jane understand what is happening and can she make her own decisions about the situation? (Does she have mental capacity)?

If it turns out that Jane had suffered due to neglect

5. How can we stop this happening and reduce the risk of it happening again?

They would then use the procedures agreed by the Herefordshire Safeguarding Adults Board to arrange meetings, record what happened and work with others to put things right. In this case the outcome is likely to include agreeing improvements with the care agency, arranging regular visits by social workers and relatives to check that care had improved, and informing the Care Quality Commission (the Government body which inspects and regulates care agencies).

Types of alleged abuse

	Number	Percentage
neglect	294	32%
physical	227	25%
psychological and emotional	153	17%
financial	153	17%
institutional	47	5%
sexual	41	4%
discriminatory	9	1%
	924	100%

Examples of cases investigated included:

- allegations that patients had developed bed sores due to neglect or poor care
- concerns that staff members, strangers or family were using their position to benefit unfairly from the vulnerable person's money.
- physical and verbal abuse by carers or other service users

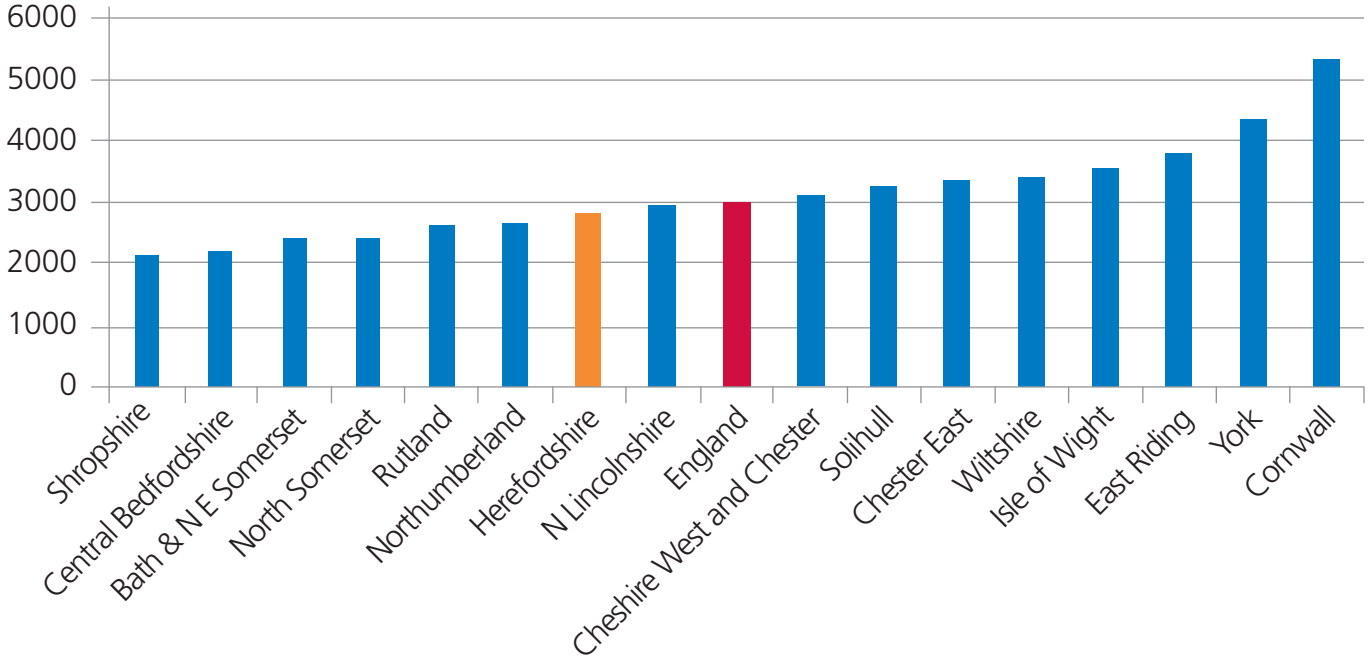
16

Spending and service levels

Does Herefordshire Council support more social care services users than elsewhere in the country?

Compared to similar councils, Herefordshire is 7th out of 16 and supports less than the English average.[14]

Herefordshire and similar councils.
Social care clients per 100,000 adult population



Like most councils in recent years Herefordshire has been targeting resources on people with most needs and consequently supports fewer people with more intensive services to enable a return to independence.

How dependent are the users of Herefordshire's adult social care services?
Do they have more needs than other areas?

Herefordshire's clients have significant disabilities:[15]

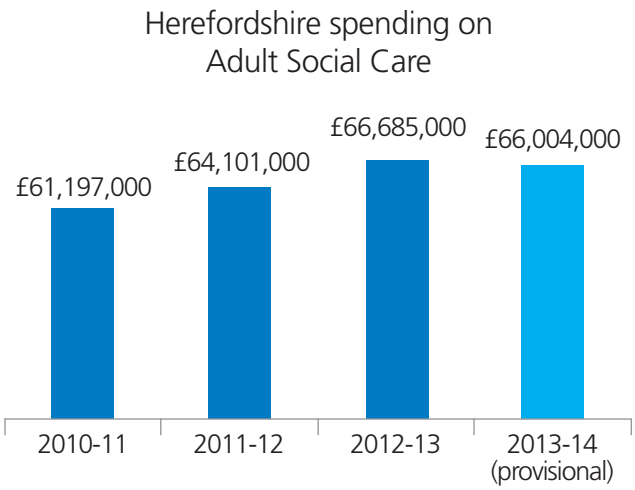
- 20% cannot get around indoors without help
- 23% cannot get in and out of bed or a chair without help
- 6% cannot feed themselves without help
- 66% cannot manage their finance and paperwork without help
- 47% cannot bath or shower without help
- 33% cannot dress or undress without help
- 23% cannot use the toilet without help
- 18% cannot wash their hands and face without help
- 27% do not go out of their home at all
- 61% report a degree of physical pain or discomfort
- 54% report a degree of anxiety or depression
- 19% report the design of their home meets a minority of their need

This is similar to the English average so Herefordshire clients do not appear to have significantly greater or lesser needs than clients in other counties.

14 Data based on annual RAP return made available on http://factsandfigures.herefordshire.gov.uk. Similar counties are identified by the Dept. Of Health and Professional Accountancy Associations
15 Data based on annual Adult Social Care Survey report made available on http://factsandfigures.herefordshire.gov.uk

How much does Herefordshire Council spend on social care?

The need for adult social care has risen in recent years and as a result spending has increased in Herefordshire.[16] Spending stabilised in 2013-14 and the council has a strategy to respond to the funding gap created by the cuts in government funding.[17]



The growth in need is caused by the increasing number of older people and the complex needs of some younger disabled people.

Herefordshire Council supports slightly fewer social care clients than the national average.

Clients have similar level of needs to the English average.

Spending was similar to 2012-13.

Plans are in place to respond to reductions in government funding and the council's new responsibilities.

16 The figures in the graph are the council's cost after accounting for income such as client contributions as shown in the statuory finance return PSSEX1 as "Gross expenditure including SSMS". Details of this return are published by the Dept of Health
17 The forward strategies are set out in the council's medium Term Financial strategy and Market Position Statement

How does Herefordshire's expenditure compare?[18] Although not among the highest spending authorities, Herefordshire does spend more than most similar councils. For comparison, 2012-13 is the latest year with national figures available.

	Spend per 10,000 population	Spend per service user
Herefordshire 2012-13	£4,475,000	£13,165
Average spend by similar councils in 2012-13	£4,205,000*	£11,902

*median of aca comparator group

Most of the money that Herefordshire Council spends on social care is spent on care homes or homecare agencies. 2012-13 is the latest year with national figures available for comparison Herefordshire paid less for an hour of homecare but more for residential and nursing care.

	Herefordshire (2012-13)	Similar councils (2012-13)
Cost of one hour of homecare	£15	£17
Cost for a week in a nursing home for an older person	£571	£470
Cost for a week in a residential home for an adult with a learning disability 18-64	£1,364	£1,274

18 Data based on annual PSSEX return made available on http://factsandfigures.herefordshire.gov.uk

Our plans and challenges for 2014-15

Helping you stay independent for longer

Our commitment to keeping people independent for longer will continue as we grow our telecare and assistive technology service and put it out to tender: simple technology can be used to remind people to take their medicine and to help monitor falls amongst other things. We will also develop short intensive programmes of support (known as reablement) to help people return to independence quickly following a period in hospital, illness or a crisis.

Direct payments

Working with service users we will develop a new direct payment policy which will be easier for people to understand and will offer people more flexible use of their payments.

Working closer with health

We will also be working much closer with our health colleagues to join up services better and help prevent admissions to hospitals and residential care. This is part of a national priority to integrate health and social care, and will help people in need of urgent care, have their care and support needs met more effectively.

Part of this includes changing the way people's needs are assessed so that they take place outside the intensity of the hospital environment and allow people to make better informed choices around their future care.

The Care Act (2014)

2014/15 will also see the biggest changes in social care legislation in 60 years with the introduction of the Care Act. This will have many implications for the local authority and a team of people will be working to ensure the council complies with its new statutory duties from April 2015.

Some of the key areas will focus around:

- Information, advice and guidance to ensure that people get the right care and support at the right time to maximise choice and control over their lives.
- Market shaping to ensure that services are available to meet the needs of Herefordshire residents.

Safeguarding

Keeping adults safe from harm is everyone's business. The council will review its safeguarding processes in 2014-15 and put plans together to improve our safeguarding services with a focus on better outcomes for service users.
We aim to make safeguarding personal so that people who need support are listened to and given choice over how that support is provided.

Involving you more

Over the next 12 months, we will continue to focus on putting individuals at the centre of their care planning and refresh our approach to personalisation. We will do this by working with an expert by experience: someone who has first-hand experience of using services themselves. This person will refocus our Making it Real Board and develop a toolkit to provide guidance and support for meaningful involvement and co-production. This will involve service users and carers and run across all adult social care projects. This will help improve the range of services available so that people can choose how their needs are met.

CASE STUDY

Andrew's personalisation story

How living with the Gilbert family has given him the confidence to make choices

Andrew has been living with the Gilbert family since 1997. Born with a learning disability and very little hearing which has had an impact on his speech, he came to live with the Gilberts when he was 31. He'd been in care all his life, and as a result, was quite institutionalised and lacked confidence.

When Andrew first came to live with the Gilberts, he used to go to a day centre each day, but as he began to build up his confidence, he went to Holme Lacy College to develop his literacy skills, horticulture and work with small animals. He did incredibly well there winning awards including Student of the Year and this, together with the support he received from living in a family environment, gave him the confidence to make choices for himself. Andrew likes to go to the Ryefield Centre once a week where he helps to cook in the café. He also goes to the Widemarsh Centre, works in the garden one day a week, goes out with his friends and family (he loves dancing) and works at Hereford Community Farm.

Sandra said: "A lot of people don't know about the Adult Placement Scheme which is now known as Shared Lives, but it's been going for years in Herefordshire. We think it's marvellous. It doesn't always work for everyone but can be a stepping stone to help people gain confidence, become more independent and make decisions about the way they want to live their lives."

Useful information

1. Access to adult social care
Adult social care enquiries: 01432 260101
ASCAdviceandReferralTeam@herefordshire.gcsx.gov.uk

2. Healthwatch Herefordshire
01432 364481
www.healthwatchherefordshire.co.uk

3. Care Quality Commission
The independent regulator of all health and social care services in England.
03000 616161
www.cqc.org.uk

Further Reading

1. Facts and figures about Herefordshire
www.factsandfigures.herefodshire.gov.uk

2. Making it Real
www.thinklocalactpersonal.org.uk/

3. Spotlight on adult and wellbeing
www.herefordshire.gov.uk/subscribe
Sign up to receive an email alert every time we publish a new edition of Spotlight on adult and wellbeing, our regular newsletter for people interested in adult social care

Feedback

This document has been produced by Herefordshire Council. We'd like to know what you think of this report and how you would like to get involved in developing future reports. Please complete our feedback form online at www.herefordshire.gov.uk/lafeedback

Alternatively you can email your views to adultscpip@herefordshire.gov.uk or you can use the form on the reverse of this page and return it to:

Adult social care performance team
Herefordshire Council, Nelson House, Whitecross road Hereford HR4 9DG
We will use your feedback to help shape the next Local Account (2014-15)

Feedback form

1. How did you find out about the Local Account?

Poster ☐ Website ☐ Newspaper ☐ Library ☐ Herefordshire Council website ☐

Other - please specify

2. What do you think of the:

Content with 1 being poor and 4 being excellent — Please select 1 2 3 4

Facts & figures with 1 being poor and 4 being excellent — Please select 1 2 3 4

Case studies used in the report with 1 being poor and 4 being excellent — Please select 1 2 3 4

Photographs used with 1 being poor and 4 being excellent — Please select 1 2 3 4

3. Overall, how would you describe this Local Account? Tick as many as necessary

Interesting ☐ Confusing ☐ Informative ☐ Boring ☐

Structured ☐ Not enough information ☐

Comments (to add further information or if you would like to be involved in future reports please fill in your email address in the box below)

4. If you have any ideas on how we can improve our Local Account, please tell us (i.e., design, more information, language used, etc.)

5. Are you a user of our adult social care services, or do you care for someone who does?

herefordshire.gov.uk

Herefordshire Council

MEETING:	**HEALTH & SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**
MEETING DATE:	**3rd December 2014**
TITLE OF REPORT:	**Outcome of Adult Social Care Peer Challenge and action plan**
REPORT BY:	**Director for Adults and Wellbeing**

Classification

Open

Key Decision

This is not a key decision.

Wards Affected

County-wide

Purpose

To note the outcome of the Adult Social Care Peer Challenge undertaken in June 2014 and to consider the council's response to the areas for improvement identified.

Recommendation(s)

THAT:

(a) note the outcome of the review attached at Appendix 1;

(b) note the action plan attached as Appendix 2 as the response to the areas for improvement identified

Further information on the subject of this report is available from
Helen Coombes, Director for Adults and Wellbeing on Tel (01432) 260048

Alternative Options

1 No alternative options presented. This report is for information purposes and has been approved by Cabinet in October 2014.

Reasons for Recommendations

2 The council is required to submit a response to the report outlining how it intends to address each of the identified areas for improvement, the timescales for action to be undertaken, and the monitoring and evaluation arrangements.

3 To provide Health Overview and Scrutiny Committee with an opportunity to make further recommendations as part of the improvement process of a key priority area for the council.

Key Considerations

4 A peer challenge was undertaken in June 2014 (23rd June – 26th June 2014).

5 The review was led by Mr David Stevens, Director of Adult Social Care, Sandwell Metropolitan Borough Council and supported by the following people:

- Keymn Whervin – Expert by Experience
- Liam Waldron – Expert by Experience
- Councillor Yvonne Davies – Cabinet Member Sandwell
- Sue Alexander – Head of Service (Worcestershire)
- Chris Lewington – Head of Service (Warwickshire)
- Eddie Clarke – WMADASS Peer Challenge Programme Lead

6 The Peer Challenge team were provided with a number of key documents prior to the visit including a self-assessment completed by the Adults and Wellbeing directorate leadership team.

7 During the onsite visit, the review team interviewed a number of stakeholders including:

- Service users and carers (both at the council offices and at the service locations)
- Front line staff and managers
- Clinical Commissioning Group Senior Leaders
- Senior leaders within NHS provider organisations
- Members, Health Overview and Scrutiny and Group Leaders
- Chief Executive, Leader of the Council
- Directorate management team
- Commissioners
- Project teams
- Finance managers

- Independent and Voluntary Sector Providers
- Key stakeholders and partners including Healthwatch, Herefordshire Carer Support Service, Herefordshire Disability United
- Making it Real Board

8 Following the publication of the findings from the Peer Challenge, the report has been shared initially with the directorate leadership team to undertake a high level analysis of where work is currently underway and where we need to further develop our work plans.

Scope of the review

9 As part of the West Midlands Peer Challenge process, the host authority outlines the scope of the review. In this instance, the following questions were set to provide the focus for the review:

1. Does the Adult and Wellbeing Transformation programme have the structures and mechanisms in place to deliver its objectives including the financial plans and closer integrated commissioning and delivery set out in the Better Care Fund?

2. Do we have sufficient focus on service user and carer (families) experience and the mechanisms to allow them to influence commissioning, service redesign and audit of delivery to enabling personalisation?

3. A focus on our workforce is a key priority in the next 12 months. Will our organisational model and improvement plans for our operational staff enable us to deliver our quality, personalisation and financial aspirations?

Key Findings from the Review

10 The main points identified during the Peer Challenge visit:

a) There is already much progress in developing a vision for adult social care, transformation programmes and related structures:

- Clear vision and leadership from the Director
- Strong political support
- Buy in from staff

b) There is a need for stronger links with people who use services, carers, staff and partners to deliver:

- Market shaping to extend care and support options
- Better commissioning processes and outcomes
- Effective care management and creative support planning

c) There remain important areas for further focus:

- Safeguarding

- Service user/carer engagement with real co-production
- Personalisation
- Integration with the NHS
- Community capacity building
- Performance/financial reporting systems

These things together, will lead to improved individual and personalised outcomes.

Key Strengths

11 As part of the Peer Challenge review, the team identified a number of key strengths within the service area including:

- Substantial activity in re-integrating adult social care back into the Council
- Clear feel of a brand new Directorate
- Strong leadership from the Director
- Sense of drive and direction from the new leadership team
- Staff stated they were up for the challenge
- Good support from lead Members and the Chief Executive
- Re-launch of engagement Boards and Groups will support better commissioning and outcomes for service users and family carers who now felt they were being heard again
- Focus on the development of the workforce (internal and external) was a real strength

Areas of focus

12 Where the review team identified some of the critical areas requiring focus, these areas have been prioritised as part of the action planning process and a number of changes have been initiated. These include:

a) Safeguarding

Safeguarding practice was not in scope for the review, however the team identified that this is an area for improvement, this supports the experience of the new service lead. This area is a known weakness and a number of changes are being initiated.

These include the following:

- Restructuring of the Safeguarding Adults Board and business unit to develop a multi-agency approach to strategy, planning, process, public awareness, training and development and service user participation. This review is due for completion in November 2014.

- Implementation of new practice in line with the Making Safeguarding

Personal initiative from the Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS). This enables an outcome focussed approach and will bring front line practice in line with the national expectations set out in the Care Act, which will come into force in April 2015.

- Undertaking of a Peer Challenge review of Safeguarding so that the changes identified above are implemented into practice and a set of performance measures can be analysed to review the effectiveness of the transformation. This review is planned for April 2015.

b) Personalisation and Service User/Carer engagement

The Peer Challenge team found that progress made around the personalisation agenda and the drive for service users and carers to take more control over the support they receive needed acceleration. This is an area which will be at the heart of the Adult Wellbeing transformation programme and a number of changes are under way in this area.

These include the following:

- Recruitment of an Expert by Experience as a Personalisation Lead to project manage the programme of work and drive the transformation of self-directed support and personalisation.

- Re-launch of the personalisation programme with front line staff to ensure the cultural change required is understood in practice.

- Revise and refocus the Making it Real Board ensuring that the board has a clear terms of reference and work programme.

- Development of a toolkit and framework to provide guidance and support with involvement of service users and carers in all service redesign.

- Revision of the council's Direct Payment policy and embedding it into social work practice.

c) Integration with the NHS

The review team identified that in order to optimise efficiency and achieve better outcomes; the development of a whole system approach must be taken.

The following work is underway:

- Key strategic partners are working together on a number of projects to design and connect services in a more coordinated way. This work will be managed through a system wide change programme and a Transformation Board.

- The Better Care Fund, System Resilience Fund and DCLG Transformation Challenge Award submission are all recent developments that have required integrated planning and commissioning arrangements with our

Clinical Commissioning Group NHS partner to be developed. A joint Commissioning Board with the CCG is now providing a clear governance structure for integrated decision making between the two organisations.

- Redesign of integrated urgent community services to ensure the pathway supports optimum discharge from acute hospital care and prevent admissions.

d) Community Capacity Building

Herefordshire's strong community and volunteer base provides a real opportunity to develop local services led by communities. This will be a fundamental strand of the Adults and Wellbeing prevention and early intervention strategy.

As part of the System Leads Transformation Programme, there is a workstream focussed on the role of communities in the care, support and wellbeing of the population.

This workstream is being led by the Director of Adults and Wellbeing to ensure that the work currently underway within public health, housing and social care is visible and priorities and objectives across the health and care system are aligned.

e) Performance and financial reporting systems

The weakness of the reporting systems and data quality was identified and this is an area that has been a focus for the directorate over the past six months.

The following activity is in progress (or completed):

- A comprehensive integrated performance dashboard is now in place and reviewed monthly by the Directorate Leadership Team and will feed into the Quarterly Performance Reviews. The dashboard integrated operational data, with national performance reporting on outcomes, business and finance metrics and quality metrics.

- Recruitment to fill a number of vacancies in the performance team to ensure the right skills and capacity are now in place has been completed (from September 2014).

- System integration between a number of key systems to provide automated payment of invoices against care packages commissioned.

- Implementation of a "no purchase order no payment policy".

- Embedding the new resource allocation system (RAS) which went live in April 2014 to provide indicative personal budgets. This indicative budget is calibrated against the amount of financial resource within the overall Adult Social Care budget so enabling much closer monitoring and identification where overspend is occurring.

- Quarterly performance reviews being run by the Chief Executive are now in place and provide an opportunity for members and other senior officers to challenge each directorate's performance against agreed metrics. These will include financial targets.

13 The action plan, attached at Appendix 2 is and iterative process and will continue to be refreshed and updated as part of the transformation programme. Cabinet will be kept informed of progress against the action as part of the corporate performance reporting process.

Community Impact

17 The implementation of the action plan will deliver further improvement towards achieving the council's priorities of enabling residents to live safe, healthy and independent lives.

18 Vulnerable adults and their carers will experience different approaches to service delivery as a consequence of the implementation of the actions set out in the plan and through the delivery of the wider transformation programme.

Equality and Human Rights

19 As the action plan is implemented, equality impact assessments will be carried out where relevant.

Financial Implications

20 The actions included in the plan in Appendix 2 are included within the Adult Social Care budget. Where additional resource is being procured, this is included within the planned spend against the overall transformation programme budget.

Legal Implications

21 The local authority is required to comply with key legislation and guidance including NHS and Community Care Act (1990); Mental Capacity Act (2005); Deprivation of Liberty Safeguarding (2009); Mental Health Act (1983); No Secrets (2000). The improvements will also bring the council into line with key legislative changes in the Care Act 2014.

Risk Management

22 The risks associated with the failure to implement the action plan are:

- Financial risk – if Adult Social Care is unable to effectively monitor closely the commissioned care packages against the overall budget
- Reputational risk – this is both from a professional (Peer Challenge, LGA and ADASS) perspective and to the service users, staff and key partners
- Operational and practice risk – there is a risk of failing to understand and meet the individual outcomes for service users and carers including safeguarding

Ongoing risks to the implementation of the action plan will be identified and captured as part of the risk management process within the transformation programme

Consultees

23 The following people have been consulted on the recommendations of the review and their views incorporated into the action plan; management board, directorate staff and managers, group leaders, health overview and scrutiny and service users.

Staff and service users will continue to play an active role in the further development of this action plan. The continual improvement of services will be led by service users and carers as part of the council's commitment to coproduction in design and delivery of services.

Appendices

Appendix 1- Herefordshire Peer Challenge Feedback and Recommendations

Appendix 2- Action Plan

Background Papers

None identified.

IL2 - Protect

Sandwell
Metropolitan Borough Council

Helen Coombes
Director of Adult Wellbeing
Brockington
35 Hafod Road
Hereford
HR1 1SH

Our Ref:	DS/SAG
Your Ref:	
Matter being dealt with by	Mr D Stevens
Telephone:	0121 569 5887
Date:	11 July 2014

Dear Helen

I write to give you formal feedback following the Peer Challenge. This builds on the provisional feedback we shared with you at the end of the Challenge Visit on Thursday 26 June 2014.

I was pleased to lead the Peer Challenge and I was joined by Keymn Whervin and Liam Waldron, both Experts by Experience Solihull; Councillor Yvonne Davies Cabinet Member Sandwell; Sue Alexander Head of Service Worcestershire; Chris Lewington Head of Service Warwickshire; and Eddie Clarke WMADASS Peer Challenge Programme Lead.

I would like to thank you for putting Herefordshire forward to host this Peer Challenge. There were many positive things that we will take away from our visit, including the examples of good policy and practice that we all observed.

I would like to thank all the people who use services, family carers, staff, partners, the Chief Executive, and the Cabinet Member (and others) who participated in the Challenge. We were made very welcome and the process was very well organised by Meg Swain and John Gorman. We were very impressed with the way in which people embraced the peer challenge and this helped make it constructive and fruitful.

This letter provides our findings and recommendations on the 3 main subject areas on which you asked the Team to report. The headline scope was:-

Sandwell Metropolitan Borough Council
P.O. Box 2374, Sandwell Council House
Oldbury, West Midlands, B69 3DE
(Post Code for SAT NAV B69 3DB)

Email: david_stevens@sandwell.gov.uk
Web: www.sandwell.gov.uk

1. Does the Adult Wellbeing (AWB) Transformation programme have the structures and mechanisms in place to deliver its objectives including the financial plans and closer integrated commissioning and delivery set out in the BCF?

2. Do we have sufficient focus on service user and carer (families) experience and the mechanisms to allow them to influence commissioning, service re-design and audit of delivery to enabling accelerated personalisation?

3. A focus on our workforce is a key priority in the next 12 months. Will our organisational model and improvement plans for our operational staff enable us to deliver our quality, personalisation and financial aspirations?

The following includes an Executive Summary, an initial Overview of the positives we identified and then a section on each of the three main areas of the scope.

Executive Summary

The main points identified during the Peer Challenge visit are:

- There remain important areas for further focus:-
  - safeguarding
  - service user/carer engagement with real co-production
  - personalisation
  - integration with the NHS
  - community capacity building
  - performance/finance reporting systems

- Stronger links need to be forged with people who use services, carers,
  - staff and partners to deliver:-
  - market shaping to extend care and support options
  - better commissioning processes and outcomes
  - effective care management and creative support planning
  - ➢ which together lead to improved individual and personalised outcomes

- There is already much progress in developing a vision for adult social care, transformation programmes and related structures:-
  - clear vision and leadership from the Director
  - strong political support
  - buy in from staff

Overview

The Peer Challenge Team (hereafter referred to as the Team) identified a number of main strengths.

There has been substantial activity in re-integrating adult social care back into the Council following the end of the arrangement with Wye Valley NHS Trust. The Team acknowledged that this had been very onerous for the Council on top of all the other challenges faced across the country for adult social care. There was a clear feel of a brand new Directorate as a consequence.

There is strong leadership and vision from the Director and this was commented on positively by staff and partners. There is a real sense of drive and direction from the new leadership team and staff stated that they were up for change.

There is good support for Adult Well-Being (AWB) from both lead Members and the Chief Executive.

The AWB Transformation Board (internal) and the Health and Social Care Transformation Board (across the Council and the NHS) have the potential to provide effective and co-ordinated leadership on current and emerging change programmes.

The re-launch of engagement Boards and Groups will support better commissioning and outcomes for service users and family carers who now felt they were being heard again.

The focus on the development of the workforce, both Council staff and those employed by external providers, was a real strength too.

What follows are the Team's observations and recommendations on the three main areas of the scope, and the strengths and areas for consideration by the Council and its partners.

Main Comments and Recommendations

1. Does the AWB Transformation programme have the structures and mechanisms in place to deliver its objectives including the financial plans and closer integrated commissioning and delivery set out in the Better Care Fund?

Strengths

The Team identified that transformation is under-pinned by clear work programme areas and reporting to the AWB Transformation Board. The new Health and Social Care Transformation Board will support a whole system focus and those supporting the new Board acknowledged the benefit to be gained from early service user/carer involvement in shaping innovation.

In discussions with Health partners there was recognition that the Council is committed to partnerships and change whilst facing its own funding and demand pressures.

The Council has some good initiatives to develop community capacity across the County such as those involving libraries.

The re-tender for reablement, including telecare and a 24/7 response service, will enhance the promotion of independence and co-ordinated care.

The Care Act will pose extra challenges and pressures for Councils, and the Team were pleased to note the establishment of a dedicated person to work on the implications of the implementation of the Care Act.

Areas for Consideration

The Advice and Referral Team (ART), with three staff, appears under-resourced although referral demand is not high at a stated 320 average calls per month. This figure, provided to the Team during the visit, contradicted the reported ASCOF data supplied to the Team of 500+ per month. Even at the lower figure of 320 per month, 25% were going through to an answer machine. The Team did a “mystery shopper” exercise one afternoon and of four calls made in a 40-minute period at 10/15-minute intervals, 50% went through to the answer machine.

1. *The Team recommends that an analysis is done of the demand and performance of ART in order to improve calls answered in person*

There are at present multiple ways by which people could receive information and advice, including welfare rights and benefits advice. The options included ART and referral on to the Council's Welfare and Financial Assessments service as well as the Citizen's Advice Bureau. With the advent of the Care Act the demand for information and advice will grow and the Team determined that there should be a single point of access.

2. *The Team recommends that options for a single point of access for information, advice and guidance be explored as part of the preparation for the Care Act*

The Team were informed that Brokerage struggles to respond quickly and that there are delays in procurement, possibly connected to there being only two staff. Also it was stated that it should be a 7-day service. This may be necessary once the 7-day working requirements of the Better Care Fund are in place.

3. *The Team recommends that the Brokerage Service be reviewed with a consideration of whether 7-day working is required now or in the future*

The Council acknowledged that performance and financial information systems and reporting should be more integrated. This will improve the monitoring and reporting of progress on the Transformation programme.

4. *The Team recommends that performance and financial reporting be reviewed to ensure that that the Directorate has full and integrated reports on both activity and performance for care support and the related financial framework*

In looking at the reports for the AWB Transformation Board, the Team felt that further details on challenges and progress could be provided, and that the risk rating was at times veering on the side of being overly generous - in terms of not giving due weight to risks, particularly if savings have not yet been achieved or implementation has not yet begun. This meant that the assurance required by the Board might not be sufficiently rigorous.

5. *The Team recommends that enhanced progress reports to the AWB Board be considered and that the risk rating be subject of greater challenge*

The performance on Personalisation, in terms of direct payments and the establishment of a wider range of care and support, is not strong. There was no clear and visible leadership on personalisation and areas such as support planning could be improved. A culture change is required to drive forward a different and more outcome focussed service from frontline teams. Northamptonshire has trained over 300 staff in the last year on support planning so as to give greater impetus to personalisation and this may be useful for the Council to follow up.

6. *The Team recommends that a re-launch of personalisation be considered which includes training and support for social work teams on creative support planning*

A number of staff stated that whilst strategic change decisions are made by the Directorate Leadership Team, the actual implementation could sometimes lag or lack full forethought and preparation. The phrase "unintended consequences" was used by staff to reflect the need to more fully understand the impact of decisions for the frontline services and staff.

7. *The Team recommends that closer alignment be sought between strategic change and related implementation or delivery*

The Team asked for a copy of the care pathway and were given a very detailed step-by-step guide of the whole process. What was not available was a care pathway "on a page" that was based on prevention, early intervention and reablement such as that utilised by Walsall. Whilst prevention and reablement are part of the Council's approach to adult social care there did not seem to be a consistent and comprehensive default position undertaken on early intervention and prevention.

8. *The Team recommends that the care pathway be reviewed including the emphasis given to early intervention and reablement*

It has already been stated that the Council should seek to provide a wider range of care and support as part of its approach to personalisation. This means that there should be a greater focus on market shaping, involving both service users/carers and providers. Commissioners and operational staff should work together to make this happen.

9. *The Team recommends that market shaping be further developed*

As the new Health and Social Care Transformation Board is established over the next few months there should be close alignment with the AWB Transformation Board. Without this there is the risk of duplication or for work-streams to be unsynchronised. Worcestershire has two similar programmes with its Well Connected programme across health and social care as well as the Council's own programme. It may be useful to liaise with them to see how they have tackled this risk.

10. *The Team recommends that the AWB Transformation Board and the new Health and Social Care Transformation Board work programmes be closely aligned*

The Team were acutely aware of the history surrounding health and social care integration and the recent dis-engagement from the contractual relationship with Wye Valley NHS Trust, who had managed services including adult social care. However, the Care Act requires that integration be progressed by local health and social care partnerships, although no particular model is prescribed. Therefore, it is essential that integration options and models be explored in Herefordshire that can improve the access and care support services for local people and the outcomes they experience.

11. *The Team recommends that integration options be explored with local Health organisations*

The local acute hospital experiences severe demand pressures similar to others such as that on A&E services and length of stay. No alleviation of these pressures can occur without a joint strategy and approach as envisaged via the Health and Social Care Transformation Board. This will take time and in the meantime there is the opportunity to work with the Wye Valley NHS Trust to examine any impact from the recent changes of re-integration of services back into the Council and the outcome from the new reablement service and rapid response.

12. *The Team recommends that the relationship with Wye Valley NHS Trust be built upon through reviewing the changes in recent arrangements and the effectiveness of the new reablement service*

IL2 - Protect

One of the national conditions for the Better Care Fund (BCF) was that "Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally." The Team could not identify from the local submission any additional funding or investment that was being made to protect adult social care. Other Councils have used the BCF in part to sustain current adult social care services (in addition to any existing S.256 transfer) and/or to fund some of the impact from the Care Act. Neither could be identified from the Herefordshire submission, which means that the Council will be under further demand pressures without the benefit of BCF support.

13. *The Team recommends that any review or refresh of the BCF should include consideration of additional opportunities to protect adult social care in line with the national condition for the BCF*

Some examples of initiatives to develop community capacity were shared with the Team, such as at Kington, but there did not appear to be a comprehensive Council led strategy. This is a key element of prevention and early intervention for health and social care, but is not limited to these areas in terms of communities supporting themselves wherever possible.

14. *The Team recommends that the Council, with partners, consider a more extensive strategy to enhance community capacity building*

A number of people commented to the Team that they felt the impact from the Health and Wellbeing Board had been limited so far. Given the important role the Board has to play on subjects like the BCF and the overall health and social care transformation, it will be essential that the Board has a high profile and effective influence in the future.

15. *The Team recommends that the Health and Wellbeing Board considers how it can extend its impact, influence and future outputs/outcomes across health and social care*

Some elected Members stated that they felt the Scrutiny role could be strengthened, including public participation. Also, that the current Scrutiny arrangements across the Council were under-resourced. The Team also identified that the Scrutiny oversight of adult social care performance and financial plans/spend could be more rigorous.

16. *The Team recommends that:-*
    i) The Council consider how the scrutiny function could be strengthened and resourced in the future

ii) The Scrutiny Panel for Adult Well-Being consider regular (at least bi-annual) reports, and consequent discussion and debate, on the budget and performance of adult social care

2. Do we have sufficient focus on service user and carer (families) experience and the mechanisms to allow them to influence commissioning, service re design and audit of delivery to enabling accelerated personalisation?

Strengths

Parents of people with a learning disability stated that they felt involved in some of the commissioning and shaping of services, such as supported living. They welcomed such opportunities.

The re-launch of the Making it Real Board was similarly welcomed by service users and carers. Representatives from the Voluntary and Community Sector also supported this development.

Carers see Herefordshire Carers' Support as providing strong and effective support.

Representatives from the Autism Partnership Group stated that they felt that they are now beginning to have a voice which is an important step for a group that often feels marginalised or lacking recognition across the country.

The Quality and Review and Monitoring of providers of adult social care services includes service user and staff questionnaires, as well as a provider self assessment. These are used to cross check whether there are commonly viewed strengths and issues in people's experience of their care.

Areas for Consideration

The Day Opportunities model introduced at Canal Road is at risk of replicating traditional day centre provision with activities such as arts and crafts and bingo. Day Opportunities should be more focussed on assisting people to improve life options, such as employment, or work experience, or micro-enterprise developments, and the promotion of their independence.

17. The Team recommends that commissioners monitor new service contracts, particularly where a new model is introduced, and ensure that future day opportunities are in line with the commissioning intentions

The experience of people with a direct payment was described very negatively, with people stating that they felt dictated to by the Council on what they could spend the direct payment. Examples were given of an apparent inflexible approach to expenditure. Service users said they were scared to spend the money and received inconsistent advice on appropriate expenditure. Also, that the audit of direct payments by the Council was too formal with the records kept by service users being rated by auditors.

18. *The Team recommends that the Council reviews its policy and approach to direct payments with further guidance on appropriate expenditure that offers flexible use of the monies within the policy*

The Team were informed that the Council had "clawed back" £929,000 of unspent direct payments in 2013/14. Given the comments by service users that they were scared to spend the money and received inconsistent advice, there is a risk that this money, at least in part, could have been used to meet appropriate needs.

19. *The Team recommends that the underlying reasons for the "claw back" be assessed and appropriate action be taken on any findings*

The Team were informed that service users and carers were not always involved in care assessments and support plans. People, or their representatives, should always have a copy of their assessment and should contribute fully to their support plan, which should reflect the outcomes to which they aspire.

20. *The Team recommends that the Council considers how it can ensure that service users and carers receive a copy of their assessment and that they contribute fully to their support plan*

The care pathway and processes would benefit from an end-to-end review of access, assessment, support planning and review, with a simple and clear emphasis on prevention, early intervention and reablement.

21. *The Team recommends that an end-to-end review of the care pathway be undertaken through co-production with service users and carers (see also recommendations 6 and 8)*

The Team asked a number of managers and staff about their understanding of co-production. Inconsistent views were received and the experience of service users and carers was expressed as more one of consultation.

22. *Team recommends that managers and staff work with service users and carers to define and shape the Councils' future approach to co-production on commissioning and service reviews*

The Team were informed that engagement and involvement mechanisms were being re-established for some service user and carer groups such as the Autism Partnership Group and the Learning Disability Partnership Board. However, other groups such as older people, people with a physical disability and people with mental health issues were not involved in similar arrangements. Representatives of Boards and Groups stated that information was not always simple, clear and with contact details.

23. *The Team recommends that engagement mechanisms be established for all service user and carer groups with clear, simple communication and always with contact details*

Both service users and staff were unclear what would happen when the Independent Living Fund (ILF) ceases. They also stated they were unclear on other policies and procedures such as that to do with direct payments.

24. *The Team recommends that:-*
    i) the position on the ILF be clarified with service users and staff

    ii) the Council consider how a wider knowledge of policies and procedures can be better communicated to service users, carers and staff

The Team were informed that the previous medical model of criteria for access to the Learning Disability social work service was still in place though the team was now not an integrated team.

25. *The Team recommends that the criteria be withdrawn and new guidance be issued to managers and staff*

The Council acknowledged Adult Safeguarding as an area for further development. In discussion with managers it became clear that there are some significant risks for the Council on the performance of some adult safeguarding practices. Areas where risks exist are in the Deprivation of Liberty Safeguards (as regards timescales for assessments/reviews), the tracking of cases through the safeguarding process, and the historic leadership of the Board (which had queried performance but not ensured that improvements had taken place).

26. *The Team recommends that remedial action is taken to ensure these safeguarding risks are reduced and that practice improvements are made in line with legislation where relevant*

One of the ways in which the Council, and the Safeguarding Adults Board, could be assured about the quality of safeguarding practice is through questionnaires for service users and family carers about their experience of the safeguarding process, and whether their desired outcomes were met. A number of Councils undertake questionnaires and this can play a key part in informing improvements in practice and achieving better outcomes.

27. *The Team recommends that the Council, its safeguarding partners and the Safeguarding Adults Board consider the use of questionnaires regarding the experience of service users and family carers*

3. A focus on our workforce is a key priority in the next 12 months. Will our organisational model and improvement plans for our Operational staff enable us to deliver our quality, personalisation and financial aspirations?

Strengths

The Council has made very good progress on the re-integration of adult social care back into the Local Authority. This has been achieved alongside all the other pressures and transformation plans that are being experienced by all Councils.

There was consistent and strong support for adult social care across political parties from senior Members such as the Leader, Cabinet Member for Health and Wellbeing, Group Leaders and Scrutiny lead Members. This was complemented by equally strong support from the Chief Executive. The challenges for adult social care were well understood.

As regards the workforce there a strategic multi-agency group, which has an integrated workforce plan on adult social care.

Staff that the Team met stated they felt able to be open and honest. With the AWB Forums for staff this will support constructive dialogue and the staff contribution to service developments and transformation.

There is a good use of "I" statements in the social care commitment action plan for recruitment and staff appraisal/development, and there is a plan to develop a cultural change strategy. Again, these will support staff development and their contribution to both good practice and change initiatives.

Areas for Consideration

The AWB Forums are a positive development although some staff stated that they were primarily information giving sessions. The Team felt that they were a real opportunity for two-way communication on the challenges and issues faced by the Directorate as well as an information-sharing event.

28. *The Team recommends that the Council consider how the AWB Forums can be utilised for real dialogue and discussion with staff on transformation and change*

Many interviewees expressed concerns about the use of interims and the changes in staffing. It was stated that the retention of staff should be a priority and that home grown talent should be supported further.

29. *The Team recommends that the Council consider how it can reduce the number of interim staff and retain and develop the existing workforce*

Reference has already been made to the important role played by creative support planning in enhancing personalised outcomes for service users and carers. Training should be considered on support planning for staff and frontline managers. See recommendation 6.

Comments were made to the Team about some of the limited functionality of the client database system – Frameworki. The Council had visited Worcestershire, as it used the same system, and had developed it to provide performance and financial data for use by both frontline managers and senior managers. The system has the capacity and capability to be developed further.

30. *The Team recommends that the functionality of Frameworki be expanded to assist both frontline and senior managers to receive improved reports on activity and performance*

Herefordshire has a large geographical area, and staff often have to travel many miles to visit people who have been referred or who already receive care and support. The development of broadband in the County will assist the increase in mobile and flexible working, which can be a much more efficient way of working for many staff.

31. *The Team recommends that the Council explore the additional benefits that could be realised from increased mobile and flexible working*

Whilst staff stated that they feel they can be open and honest, they also stated that they do not feel empowered to innovate and take risks. They felt that there could be more delegation to frontline staff and managers.

32. *The Team recommends that delegated authority to frontline staff and managers be considered, including both operational and budget decision making*

External provider forums have recently re-commenced with the Council. There will be areas of difference but on-going discussions will be important as transformation and market shaping progress. External providers have a key role to play in contributing to market shaping and commission intentions and they stated that they would wish to engage further with the Council.

33. *The Team recommends that the provider forums be continued and that they be involved in the planning on market shaping*

Staff stated to the Team that some of the training providers were risk averse and not up to date in their workshops and courses. This would be unhelpful in areas like personalisation.

34. *The Team recommends that training programmes are quality monitored and reviewed where necessary*

As the Directorate continues to focus on improvement and transformation, integration with the NHS will again come to the forefront. Workforce issues will emerge during the consideration of integration models and options for the future. These should not prevent the consideration of models and the consequent improvement of access to services and outcomes for service users and patients. See recommendation 11.

Conclusion

Finally, we have sought to make the findings of the peer challenge constructive and helpful to the Council and also to strike an appropriate balance between support and challenge. We hope that you are able to receive positively the comments in this context. We have learnt from the process ourselves and we have really appreciated the opportunity to take away many good policy and practice examples that we can share with our own Councils.

On behalf of the Team I would like to thank you for hosting this peer challenge, and for working so positively with us. I hope you will agree this has resulted in a helpful and constructive outcome.

Yours sincerely

David Stevens
Director of Adult Social Care, Sandwell Metropolitan Borough Council

cc:- Alistair Neill, Chief Executive, Herefordshire Council
Peer Challenge Team Members

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ADULT SOCIAL CARE PEER CHALLENGE (JUNE 2014) – ACTION PLAN APPENDIX 2

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
1	The Team recommends that an analysis is done of the demand and performance of ART in order to improve calls answered in person	Head of Operations	Agreed – The council is implementing a discharge to assess urgent care model, as part of this it is modelling and analysing the front door activity	**H**	**Oct 2014**	Service Management System resilience operational group
2	The Team recommends that options for a single point of access for information, advice and guidance can be explored as part of the preparation for the Care Act.	Assistant Director of Commissioning	Agreed - The LA will be seeking in its commissioning of information, advice and guidance specification provision of a single point of access within the community and voluntary sector	**M**	**Jan 2015**	Adults and Wellbeing Commissioning Board Cabinet lead member approval
3	The Team recommends that the Brokerage Service be reviewed with a consideration of whether 7-day working is required now or in the future.	Head of Operations	Agreed- Immediately implemented, in addition the brokerage service is now the point of contact for all access to discharge to assess beds	**H**	**Sept 2014**	Service Management Directorate Leadership Team
4	The Team recommends that performance and financial reporting be reviewed to ensure that the Directorate has full and integrated reports on both activity and performance for care support and the related financial framework.	Head of Transformation and Safeguarding	Agreed and implementation started. The council has put in place a Quarterly Performance Review process, a Chief Executive service review/challenge, and the Directorate Leadership Team receive a monthly dashboard report	**H**	**Sept 2014**	Quarterly performance reviews Directorate Leadership Team

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
5	The Team recommends that enhanced progress reports to the AWB Board be considered and that the risk rating be subject of greater challenge.	Programme Lead	Agreed – monthly highlight reports to be reviewed to include greater consistency of analysis of progress and risks	**H**	**Sept 2014**	AWB programme Board
6	The Team recommends that a re-launch of personalisation be considered which includes training and support for social work teams on creative support planning.	Head of Transformation and Safeguarding	Agreed – The council has appointed a Personalisation Lead Project Manager who is an Expert by Experience to relaunch personalisation and lead the Making it Real Board putting person centred practice and commissioning at the heart of transformation	**H**	**Sept 2014 onwards**	Making it Real Board AWB programme board
7	The Team recommends that closer alignment be sought between strategic change and related implementation or delivery	Assistant Director of Commissioning	Agreed – A clear commissioning strategy with underpinning commissioning plans are in progress. This will be enable service users, staff, partners and providers to understand our commissioning intentions and how this will be implemented	**M**	**Dec 2014**	AWB programme board
8	The Team recommends that the care pathway be reviewed including the emphasis given to early intervention and reablement.	Assistant Director of Commissioning	Agreed- Reablement service recently re-commissioned. Further training and monitoring is underway to ensure that this service is being optimised. As part of this evaluation and training, a clear pathway will be developed to ensure staff across the health and care system are aware	**M**	**Dec 2014**	AWB Commissioning Board Service management

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
9	The Team recommends that market shaping be further developed.	Assistant Director of Commissioning	Agreed – Provider forums for residential and domiciliary providers are being re launched. Market Position statement will be refreshed as part of the Care Act implementation	**M**	**Dec 2014**	AWB Commissioning Board
10	The Team recommends that the AWB Transformation Board and the new Health and Social Care Transformation Board work programmes be closely aligned.	Programme Lead	Agreed – All transformation programmes will be mapped across both Boards and the Better Care Fund plans will bring together both programmes of work	**L**	**Dec 2014**	AWB programme board System Leads Transformation Board
11	The Team recommends that integration options be explored with local Health organisations.	Assistant Director of Commissioning	Agreed – The new Health and Social Care Transformation programme, and the Joint Commissioning Programme all focus on integrated pathways. An early example of this is the Integrated Urgent Care Service which will go live on 1st October 2014	**M**	**Dec 2014**	Joint Commissioning Board (CCG and LA)
12	The Team recommends that the relationship with Wye Valley NHS Trust be built upon through reviewing the changes in recent arrangements and the effectiveness of the new reablement service.	Assistant Director of Commissioning	Agreed – At a strategic level the Health and Social Care Transformation programme, and the Better Care Fund Programme are bringing together the health and social care. At an operational level, this is been developed through the Integrated Urgent Care service	**M**	**Dec 2014**	System Leads Transformation Board

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
13	The Team recommends that any review or refresh of the BCF should include consideration of additional opportunities to protect adult social care in line with the national condition for the BCF.	Director of Adults and Wellbeing	Agreed – Part of national assurance process and Council submissions have been reviewed to reflect this	**H**	**Sept 2014**	National assurance process
14	The Team recommends that the Council, with partners, consider a more extensive strategy to enhance community capacity building.	Director of Adults and Wellbeing	Agreed – the is part of the Health and Social Care Transformation Supportive Communities Workstream	**L**	**Mar 2015**	System Leads Transformation Board
15	The Team recommends that the Health and Wellbeing Board considers how it can extend its impact, influence and future outputs/outcomes across health and social care.	Health and Well Being Chair	Agreed – The Health and Well Being Board terms of reference are currently been reviewed and the governance of the Health and Social Care Transformation programme will be through the HWBB	**M**	**Dec 2015**	Health and Wellbeing Board Governance Officer (Scrutiny)
16	The Team recommends that:- (i) The Council consider how the scrutiny function could be strengthened and resourced in the future (ii) The Scrutiny Panel for Adult Well-Being considers regular (at least bi-annual) reports, and consequent discussion and debate, on the budget and performance of adult social care.	Statutory Scrutiny Officer	Agreed – the council continues to review its governance structures to ensure that they remain fit for purpose and roles are performed effectively Agreed – A cycle of reporting to Heath & Social Care Overview and Scrutiny will be incorporated into the work plan.	**M**	**March 2015**	Statutory Scrutiny Officer AWB Performance Function
17	The Team recommends that commissioners	Assistant	Agreed – Commissioning resources	**M**	**Oct 2014**	AWB Commissioning

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
	monitor new service contracts, particularly where a new model is introduced, and ensure that future day opportunities are in line with the commissioning intentions.	Director of Commissioning	have been realigned and an evaluation of key performance indicator will be completed to reflect this action			Board Service management
18	The Team recommends that the Council reviews its policy and approach to direct payments with further guidance on appropriate expenditure that offers flexible use of the monies within the policy.	Personalisation Programme Lead	Agreed – The council will be reviewing and implementing a new Direct Payment Policy as part of its personalisation refresh	**H**	**Oct 2014**	AWB programme board
19	The Team recommends that the underlying reasons for the "claw back" be assessed and appropriate action be taken on any findings.	Head of Operations	Agreed – the Council has already identified that support planning requiring a focus on outcomes. This is a key factor in setting the right amount of personal budget from the beginning rather than having to then reclaim unspent monies	**L**	**Mar 2015**	Directorate Leadership team
20	The Team recommends that the Council considers how it can ensure that service users and carers receive a copy of their assessment and that they contribute fully to their support plan.	Head of Operations	Agreed – The implementation of the Community Care policy refreshed in April 2014 will be reviewed and regular audits will take place to ensure that copies of assessments are been shared	**H**	**Oct 2014**	Directorate Leadership team
21	The Team recommends that an end-to-end review of access, assessment, support planning and review, with a simple and clear emphasis on prevention, early intervention and	Assistant Director of Commissioning	Agreed – The Integrated Urgent Care Service, a review of locality based social work and preparation for the Care Act are all focused on an	**M**	**Dec 2014**	AWB programme board

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
	reablement.		emphasis on early intervention			
22	The Team recommends that managers and staff work with service users and carers to define and shape the Council's future approach to co-production on commissioning and service reviews.	Personalisation Programme Lead	Agreed – see action 6	**H**	**Dec 2014**	AWB programme board Making it Real Board
23	The Team recommends that engagement mechanisms be established for all service user and carer groups with clear, simple communication and always with contact details.	Personalisation Programme Lead	Agreed – see action 6	**H**	**Dec 2014**	AWB programme board Making it Real Board
24	The Team recommends that:- (iii) The position on the ILF be clarified with service users and staff (iv) The Council considers how a wider knowledge of policies and procedures can be better communicated to service users, carers and staff.	Head of Operations	Agreed – All statutory and relevant policies and procedures will be reviewed and implemented as part of the Care Act	**M**	**Mar 2014**	AWB Commissioning Board
25	The Team recommends that the criteria be withdrawn and new guidance be issued to managers and staff	Head of Operations	Agreed – re-education of staff will be undertaken	**H**	**Oct 2014**	Directorate Leadership team
26	The Team recommends that remedial action is taken to ensure these safeguarding risks are reduced and that practice improvements are made in line with legislation where relevant.	Head of Safeguarding and Transformation	Agreed – A rapid intervention and recovery plan has been put in place to reduce risks in relation to safeguarding and this is been monitored on a	**H**	**Apr 2015**	Safeguarding Adults Board Directorate

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
			monthly basis by the Safeguarding adults steering Group			Leadership team
27	The Team recommends that the Council, its safeguarding partners and the Safeguarding Adults Board consider the use of questionnaires regarding the experience of service users and family carers.	Head of Safeguarding and Transformation	Agreed – the council is adopting Making Safeguarding Personal and is aiming to have a Peer Challenge on Safeguarding in April 2015	**H**	**Apr 2015**	Safeguarding Adults Board
28	The Team recommends that the Council consider how the AWB Forums can be utilised for real dialogue and discussion with staff on transformation and change.	Programme Lead	Agreed – the council has reviewed the AWB forum to ensure that it is more interactive and is continuing to do so based on feedback from each session	**L**	**Dec 2014**	AWB Programme Board
29	The Team recommends that the Council consider how it can reduce the number of interim staff and retain and develop the existing workforce.	Head of Operations	Agreed – the council has recently recruited a number of permanent staff, and is continuing to look at innovative ways of attracting the required workforce to come and work within Herefordshire to reduce the reliance on interim staff	**M**	**Oct 2014**	Directorate Leadership Team
30	The Team recommends that the functionality of Frameworki be expanded to assist both frontline and senior managers to receive improved reports on activity and performance.	AWB Performance Lead	Agreed – The council has developed performance reports and dashboards on key national indicators and is currently reviewing FWI functionality on activity and performance as part of the Care Act implementation	**H**	**Oct 2014**	Directorate Leadership Team Management Board
31	The Team recommends that the Council	Strategic Lead -	Agreed – the council is currently	**L**	**Apr 2015**	Directorate

No.	Recommendation	Lead	Our Response	Priority (H/M/L)	By When	Monitoring and Evaluation
	explore the additional benefits that could be realised from increased mobile and flexible working.	IM&T	trialling new mobile hardwire before making a decision on the equipment t required for mobile working and has a flexible working policy in place			Leadership Team Management Board
32	The Team recommends that delegated authority to frontline staff and managers be considered, including both operational and budget decision making.	Head of Operations	Agreed – this will be completed by the end of the financial year and budget training is been put in place for all first line managers	**M**	**Apr 2015**	Service Management Directorate Leadership Team
33	The Team recommends that the provider forums be continued and that they be involved in the planning on market shaping.	Assistant Director of Commissioning	Agreed – Forums are a key part of the approach to market facilitation and partnership working	**M**	**Ongoing**	AWB Commissioning Board
34	The Team recommends that training programmes are quality monitored and reviewed where necessary.	Head of Safeguarding and Transformation	Agreed – the council is currently refreshing its workforce strategy and implementation plan to ensure that training delivered particularly to social work staff is relevant and of high quality	**M**	**Dec 2015**	Directorate Leadership Team

Herefordshire Council

MEETING:	**HEALTH AND SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE**
MEETING DATE:	**3 December 2014**

TITLE OF REPORT:	**COMMITTEE WORK PROGRAMME**
REPORT BY:	**GOVERNANCE SERVICES MANAGER**

1. Classification

Open

2. Key Decision

This is not an executive decision

3. Wards Affected

County-wide

4. Purpose

4.1 To consider the Committee's work programme.

5. Recommendation

THAT: The work programme as appended be noted, subject to any comments the Committee wished to make.

6. Alternative Options

It is for the Committee to determine its work programme as it sees fit to reflect the priorities facing Herefordshire. Any number of subjects could be included in the work programme. However, the Committee does need to be selective and ensure that the work programme is focused on the key issues, realistic and deliverable within the existing resources available.

7. Reasons for Recommendations

7.1 The Committee needs to develop a manageable work programme to ensure that scrutiny is focused, effective and produces clear outcomes.

8. Key Considerations

8.1 The Committee is asked to note its work programme and to note progress on current work.

9. Community Impact

9.1 The topics selected for scrutiny should have regard to what matters to the County's residents.

10. Equality and Human Rights

10.1 The topics selected need to have regard for equality and Human rights issues.

11. Financial Implications

11.1 The cost of the work of the Scrutiny Committee will have to be met within existing resources. It should be noted the costs of running scrutiny will be subject to an assessment to support appropriate processes.

12. Legal Implications

12.1 The Council is required to deliver an Overview and Scrutiny function.

13. Risk Management

13.1 There is a reputational risk to the Council if the Overview & Scrutiny function does not operate effectively. The arrangements for the development of the work programme should help mitigate this risk.

14. Consultees

14.1 Following initial consultations on topics for scrutiny with Directors and Members of the Cabinet, all members of the Council were invited to suggest items for scrutiny.

15. Appendices

15.1 Appendix 1 - An outline work programme for the Committee.

16. Background Papers

16.1 None identified.

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE
ITEMS IDENTIFIED FOR INCLUSION IN THE WORK PROGRAMME

Draft Work Programme

Wednesday 4 February 2015 at 2:30pm	
Accountability Session	To hold a public accountability session for organisations within the health sector. This session shall focus on Public Health, Health and Wellbeing Board and Healthwatch Herefordshire.
Children's Safeguarding Performance Data	To examine and challenge the performance data on children's safeguarding.
Healthwatch update	To receive a verbal report on any issues of concern
Wednesday 29 April 2015 at 10:00am	
Accountability Session	To hold a public accountability session for organisations within the health sector. This session shall focus on Herefordshire Clinical Commissioning Group and Arden, Herefordshire and Worcestershire Area Team
Healthwatch update	To receive a verbal report on any issues of concern
Corporate Parenting	To receive a report on the proposed training programme for Members following the elections in May 2015

The following issues are suggestions from the public for inclusion

The impact of housing developments in Herefordshire on Hereford hospital and other social services

The following matters shall be dealt with via briefing notes

- Changes to the scrutiny arrangements of Herefordshire Council including risks, mitigation and proposed changes
- An update on the use of mobile devices by social workers
- 2gether NHS Foundation Trust headlines for Key Performance Indicators