

Wye Valley NHS Trust

Hereford County Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate	
Urgent and emergency services	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

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

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

Summary of findings

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

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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 5,791 attendances 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

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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 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 overflow area. However, there were too few nursing staff to care for the needs of patients in the majors overflow 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%).

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- 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 who 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.

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- 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

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- 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 not see them for another three hours. When they 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.

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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.

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- 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.

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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 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

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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.

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- 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.

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- 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

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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, particularly 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

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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, admissions 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 arrival of ambulances from Wales was unplanned and increased the pressure in 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.

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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

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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. Incidents were not always reported. This led to both the trust and clinical staff not being fully aware of all the safety issues in the service that may require their response.

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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

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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 have 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

Medical care (including older people's care)

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.
- 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.

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 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 safely.
- 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.

Medical care (including older people's care)

- 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 to 11 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 had 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

Medical care (including older people's care)

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.

Surgery

- 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 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 hatted 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 to 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.
- 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

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.
- 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.

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- 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

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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.

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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.

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- 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.

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- 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 if 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

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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.

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- 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

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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.

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- 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.

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- 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.

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- 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

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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

Critical care

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.

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- 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

Critical care

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

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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.

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- 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.

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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 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

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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

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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

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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

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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.

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- 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 woman 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.

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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 led 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

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- 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

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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

Services for children and young people

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.

Services for children and young people

- 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.

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- 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.

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- 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.

Services for children and young people

- 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

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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.

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.

Services for children and young people

- 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.

Services for children and young people

- 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 from 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.

Services for children and young people

- 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.

Services for children and young people

- 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.

Services for children and young people

- 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.

End of life care

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, 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.

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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.

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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

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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.

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- 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 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.
- 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.

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.

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 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

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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

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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.

Outpatients and diagnostic imaging

- 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.