Wye Valley NHS Trust

Quality Report

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

Date of inspection visit: 5, 6, 7, 8, 11, 17, 18 July 2016
Date of publication: 03/11/2016

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Inadequate
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

Overall, we rated Hereford Hospital as requires improvement with three of the five questions we ask with safe, effective and well led being judged as requiring improvement. We rated Hereford Hospital as inadequate for being responsive as patients were unable to access all services in a timely way for initial assessments, diagnoses and/or treatment.

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

Our key findings were as follows:

Safe

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

Effective

- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated more patients were dying than would be expected. This had been reported to the trust board and an action plan was in place to understand and improve results.
- The caesarean section rate was significantly higher (worse) than the national average and the deteriorating rate was not recorded on the risk register.

Summary of findings

- Most care was delivered in line with legislation, standards and evidence-based guidance. However, some trust guidelines needed updating.
- The service had a series of care bundles in place, based on the appropriate guidance for the assessment and treatment of a series of medical conditions. However, there was no hip fracture pathway within the hospital although we were told that this was being drafted.
- The trust had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. Performance in national audits had generally mixed results compared to the national average. Actions plans were in place to address areas needing improvement.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Caring

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

Responsive

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

Well-led

- The trust had governance oversight of incident reporting and management. The board assurance framework and corporate risk register identified most of the keys risks.
- The executive team could demonstrate good understanding of the risks, issues and priorities in human resource management. However, overcoming some of these issues, such as recruitment, remained a significant challenge.
- The trust implemented a new organisational structure in June 2016, with three service units reduced to two divisions, medical and surgical. Although staff felt the reconfiguration was positive and provided more support we were unable to assess the sustainability and effectiveness of the restructure as this had not yet been fully embedded into the trust.
- The trust had a vision, their mission and their values. However, these were not fully embedded or understood by staff.
- There was no equality and diversity strategy.
- Following the trust being placed into special measures in October 2014, a comprehensive quality improvement plan was developed, which included a number of projects and actions. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.
- We were assured that appropriate steps had been taken to manage the 'Fit and Proper persons' legislation implementation.

We saw several areas of outstanding practice including:

- Services for children and young people were supported by two play workers (one was on maternity

leave at the time of inspection). The play workers regularly made arrangements for long term patients to have days out to different places, including soft play areas or bowling. An activity was arranged most months and the play workers sourced the activities from local businesses who donated their good and/ or services. This meant that patients with long term conditions could meet peers who also regularly visited the hospital. Patients found this valuable and liked the opportunity to meet patients who had shared experiences.

- There was a children's and young people's ambassador group which was made up of patients who used or had used the service. We spoke with some members of the ambassador group who told us that they were involved in the service redesign when developments took place and improving the service for other patients.
- The respiratory consultant lead for non invasive ventilation had developed a pathway bundle, which was used for all patients requiring ventilator support. The pathway development was based on a five-year audit of all patients using the service and the identification that increased hospital admissions increased patient mortality. The information gathered directed the service to provide an increased level of care within the patient's own home. Patients were provided with pre-set ventilators and were monitored remotely. Information was downloaded daily and information and advice feedback to patients by the medical team. This allowed treatments to be altered according to clinical needs. The development had achieved first prize in the trust quality improvement project 2016.
- The newly introduced clinic for patients with epilepsy had enlisted the support of a patient with epilepsy; their views had helped the clinic develop so that the needs of patients were met.
- Gilwern assessment unit was not identified as a dementia ward, however, this had been taken into consideration when planning the environment. The unit had been decorated with photographs of "old Hereford" which were used to help with patients reminiscing. Additional facilities included flooring that was sprung to reduced sound and risk of harm if patients fell, colour coded bays and wide corridors to allow assisted mobility. Memory boxes were available for relatives to place personal items and memory aids for patients with a history of dementia, and twiddle mittens provided as patient activities. The unit provided regular activities for patients, which included monthly tea parties and games.

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

Importantly, the trust must:

- The trust must ensure that all staff receive safeguarding children training in line with national guidance, in particular in the emergency department.
- The trust must ensure that enough staff are trained to perform middle cerebral arterial Doppler assessments, to ensure patient receive timely safe care and treatment.
- The trust must ensure there are enough sharps bins available for safe and prompt disposal of used sharps.
- The trust must ensure that patients' weight is always recorded on patients' prescription charts, to ensure the correct prescribing of the medicine.
- The trust must ensure that medicine records clearly state the route a patient has received medicine, in particular, whether a patient has been given the paracetamol orally or intravenously.
- The trust must ensure all medicines are stored in accordance with trust polices and national guidance, particularly in outpatients.
- The trust must ensure that all patients receive effective management of pain and there are enough medicines on wards to do this.
- The trust must ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role.
- The trust must ensure all staff are supported effectively via appropriate clinical and operational staff supervisions systems.
- The trust must ensure staff receive appraisals which meet the trust target.
- The trust must ensure that patients are able to access surgery, gynaecology and outpatient services in a timely way for initial assessments, diagnoses and/or treatment, with the aim of meeting trust and national targets.
- The trust must continue to take action to address patient waiting times, and assess and monitor the risk to patients on the waiting list.

Summary of findings

- The trust must ensure the time taken to assess and triage patients within the emergency department are always recorded accurately.
- The trust must ensure effective and timely governance oversight of incident reporting and management, particularly in children and young people's services.
- The trust must ensure all policies and procedures are up to date, and evidence based, including the major incident policy.

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

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

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Wye Valley NHS Trust

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

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

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

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

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

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

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

Our inspection team

Our inspection team was led by:

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

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

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive of people's needs?

Summary of findings

- Is it well-led?

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

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

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

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

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

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

What people who use the trust's services say

The trust results from the 2014 National Cancer Patient Experience Survey (published 2015) showed little variances from their 2013 results. Areas which had deteriorated included: patient's rating of care, emotional support and pain management. However, patients said the trust had improved in controlling the side effects of chemotherapy, they had received clear information about what they should/should not do post discharge and they felt there were enough staff on duty.

The trust scores in the Patient Led Assessment of the Care Environment (PLACE) were mostly in-line with the England averages for both 2014 and 2015.

The CQC Inpatient Survey was sent to 1,250 inpatients between August 2015 and January 2016 within the Wye Valley NHS Trust. We received responses from 674 patients. The responses showed that the trust was "about the same" as other trusts for all 12 selected questions with the exception of the emergency department which was worse in comparison with other trusts.

The percentage of friends and family that would recommend the trust as a place to receive treatment was in-line with England averages for the period March 2015 to March 2016.

Facts and data about this trust

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

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

Activity

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

Summary of findings

The first quarter of 2016/17 the bed occupancy at the hospital was 95%. For 2015/16 the bed occupancy was 94%, this was worse than the national average (88.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of a hospital.

Population served

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

Deprivation

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

Population age

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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the hospital as requires improvement for being safe. For specific information please refer to the report for Hereford Hospital. We found that three of the eight services required improvement. We rated five services as good for being safe. • There was a high staff vacancy rate which meant an increased use of agency and bank staff. The safer nurse staffing levels were planned in line with the national recommendations. The trust fill rate for registered nurses remained below 95%, however, for health care assistants was over 116%. • Mandatory and statutory training compliance was at 86%, this did not meet the trust target of 90%. • We were not provided with evidence to show if staff had completed basic life support training. Therefore, we could not be assured that staff had the right skills to care for patients. • Patients' weight were not always recorded on patients' prescription charts, which could potentially lead to the incorrect prescribing of medicines. • The anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby. • Staff were aware of their responsibilities regarding safeguarding procedures. • The incident management policy detailed the requirements of the Duty of Candour regulation. Staff understood the importance of reporting incidents and had awareness of the duty of candour process. However just prior to the inspection the trust had identified that it was not following all the requirements of the regulation in that it was not confirming their discussions with patients in writing and had put actions in place to address this. • Staff understood their responsibility to report concerns, to record safety incidents and near misses. Staff received feedback on all incidents. • Ward and clinical areas were visibly clean and staff were observed following infection control procedures • There were systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. **Duty of Candour**	**Requires improvement** 

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The incident management policy dated January 2014 last updated December 2015 detailed the requirements of the Duty of Candour regulation.
- All incidents which triggered a duty of candour were notified to the patient safety lead and overseen by the quality and safety group. A record of all disclosures were kept on the incident investigation file and included in the root cause analysis (RCA) file. The patient/relevant person was informed that an incident had occurred and it was being investigated. The week before the inspection the trust identified that it was not following all the requirements of the regulation in that it was not confirming their discussions with patients in writing and had put actions in place to address this.
- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. We saw there was no training attributed to duty of candour although the trust had developed a leaflet to support staff's knowledge.

Safeguarding

- The trust did not have an individual adult safeguarding policy. They contributed to the "Adult Safeguarding: Multi-agency policy and procedures for the protection of adults with care and support needs in the West Midlands' to ensure consistency across the region in the way adults were safeguarded from abuse. All key partners of the Herefordshire safeguarding adult's board had agreed that the regional policy for safeguarding adults should govern all safeguarding work with adults at risk in Herefordshire. However, we noted that the policy was a working draft policy issued on April 2015. We saw no evidence of a review of the policy.
- For end of June 2016, across the trust there was 91% compliance with safeguarding adult training across all levels. However, the patient access team had achieved 64% which did not meet the trust target of 90%. The adult safeguarding lead confirmed they were monitoring and tracking the training across the trust. An additional band 5 nurse had been employed by the trust to work alongside the adult safeguarding lead to provide support with adult safeguarding referrals

Summary of findings

- The safeguarding leads were trained to safeguarding level 4 and delivered a range of training to all staff, which was a combination of e-learning, and face to face.
- The safeguarding younger people training was 88% for level 1, 69% for level 2, 85% for level 3 and level 4 training was at 100%. Training sessions for level 2 continued to be on-going and the trust had sent out communication through the electronic data capture system to staff.
- The trust did not meet intercollegiate guidance for safeguarding training in the emergency department, which states all doctors and qualified nurses should be trained to level 3. Only 71% of nursing staff and 63% of medical staff in the emergency department had completed level 3 safeguarding children training.
- The 2014/15 safeguarding annual report showed there had been 472 safeguarding alerts raised by the trust. We requested the safeguarding annual report but was told by the trust that the report would not be available until August 2016, so we did not have the total numbers of safeguarding alerts for 2015/16.
- There were key themes identified through the analysis of safeguarding applications which included:
  - Pressure ulcers. A tissue viability nurse had been to the wards identified with sacral and heel sores. An audit of patient chairs was carried out in February 2016 which resulted in the order of 100 replacement chairs.
  - Documentation. All documentation was being reviewed to consider their functionality. For example; the wound care documentation was reviewed which resulted in the number of pages being condensed from 16 to eight to make it more efficient.
  - At the time of our inspection, there were three domestic homicide deaths with the home office. There was no individual action for the trust but they had resulted in the patient passport “This is me” being implemented. The safeguarding lead confirmed that once the findings had been published this would be disseminated to staff.
- A Safeguarding and Promoting Children’s Health and Welfare Policy. The procedures within the policy were used in conjunction with Herefordshire Safeguarding Children Board Inter-agency Child Protection Procedures for Safeguarding Children. However, the policy was dated May 2014 and we saw no evidence of a review of the policy to ensure it contained the most recent information.

- The trust had an independent domestic violence advisor working three days a week who was based within the emergency department. They provided support and advice to domestic abuse staff/victims. This was a six month contract and was under review by a task and finish group.
- The trust quality improvement plan had actions in place to improve safeguarding younger people across the trust. This included completion of audits, learning from audits and appointing a paediatric safeguarding lead. Progress made against the actions were reported to the trust board monthly.
- We reviewed of a sample of patient files on the paediatric ward and found that safeguarding referrals had been made appropriately and in accordance with trust policy. Staff told us that their confidence had increased since the new safeguarding lead had been in post and that if they needed assurance they would speak with the lead. This had improved since the September 2015 inspection, when we identified that safeguarding referrals were not made consistently and in accordance with trust policy.

Incidents

- Staff understood their responsibility to report concerns, to record safety incidents and near misses. Staff told us that they were familiar with the incident reporting process and that they received feedback when they reported incidents.
- There had been no never events reported for the period March 2015 to February 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- From December 2015 to February 2016, the patient safety quarterly report identified 20 serious incidents. There was no identified themes but some of the categories included; falls, ward closures, delayed diagnosis and pressure ulcers. All acquired pressure ulcers within the trust were subject to a root cause analysis investigation. Following the investigation, these may be reported externally if it was found that there were omissions in care which resulted in the development of the pressure ulcer. Ward sisters and department managers had dashboards which showed their current week, current month, falls incidents which they could share with their staff.
- A total of 6,338 incidents were reported to the National Reporting and Learning System (NRLS) between December

2014 and November 2015. Of these incidents 78% were categorised as no harm and 17% as low harm incidents. The trust had a lower reporting rate (5 per 100 admissions) compared to the England average (8.8 per 100 admissions).

- During our September 2015 inspection, we observed that the trust approach to incident management did not enable timely assessment of the risks relating to the health, safety and welfare of patients. On this inspection, we found that the trust had implemented a patient quality and safety group that oversaw all incidents. The patient quality and safety quarterly report for December 2015 to February 2016 outlined the review of all serious incidents during this period which included the resume of the facts, the action taken and whether the duty of candour regulations had been implemented.
- Staff received feedback on all incidents through summarised lessons learnt via the "team brief" and the "safety bites." Additional learning was also periodically added to "trust talk." Line managers were encouraged to provide feedback on an individual and collective basis at their team meetings. The exception to this was in paediatrics, where most paediatric staff we spoke with were unsure whether shared learning took place and were unable to recall recent incidents which had occurred within the previous 12 months either within their unit or within other departments within the hospital.
- A new process for monitoring the national safety alerts was introduced in September 2015. This was undertaken by the clinical effectiveness and audit department (CEAD). We saw the reviewed cases from September 2015 to April 2016 which included the actions taken by the alert leads. The review was to establish whether or not clinical audits were relevant/ required for the alert. The CEAD informed the health and safety officer/ administrator the outcome of the review. Any clinical audit project required was undertaken and forwarded as appropriate. We saw a copy of the report which outlined the outcomes and the actions taken.

Staffing

- The overall vacancy rate for June 2016 for the trust was 7.9%, which was worse than the trust target of 5%. This was highlight as a significant risk on the risk register.
- Nursing and midwifery remained the highest staff group with vacancies at 72% of the total vacancies, 83% of which were band 5 nurses. Some wards had a greater than 50% vacancy rate which meant an increased use of agency and bank staff.

Summary of findings

- The trust remained under establishment with 211 whole time equivalent vacancies. This was a decrease from 241 the previous month.
- We saw the starters and leaver's statistics from February 2015 to June 2016. Overall, the trend showed there were more staff across the trust starting than leaving, thus reducing the vacancies. However, for nursing and midwifery staff there were generally more staff leaving than starting. For example, in June 2016 there were 10 starters and 12 leavers.
- Staff turnover in June 2016 showed a decrease from 1.15% the previous month to 0.73%. The 12 month rolling figure had decreased from 14.1% to 13.9%. The trust target was 10%.
- The trust was taking actions to actively recruit staff and had a recruitment and retention strategy which included; recruitment events across the country, enhanced recruitment advertising and golden hellos. An analysis of the results of exit interviews were to present at the September 2016 finance and performance committee as part of the wider issues of recruitment and retention. However, nurse trajectory figures showing the gap between budget and staff in post was not closing. The number of band 5 nurse vacancy posts had increased in June 2016 compared to the previous month.
- The safer nurse staffing levels were agreed in line with the national recommendation of 1:8 (registered nurses :patient ratio). However, it was recognised that with the growing difficulties of recruitment into substantive registered nurses positions, the initiatives being taken to address this would challenge the 1:8 assumption. As a consequence the determinants for appropriate safe staffing become more complex, and a revision of the acuity tool and its application in the decision making process for nurse staffing levels was planned. All senior staff we spoke with understood the recruitment and financial pressures associated to staffing but remained dedicated to ensuring staffing levels were adequate to keep patients safe.
- The trust fill rate for registered nurses remained below 95% between January and June 2016 except for May (95.7%). There was a strategy to cover unfilled registered nurse shift with health care assistants where appropriate. The fill rate for health care assistants was better than the target for both day and night shifts (116% and 122% respectively) for June 2016.
- Nursing agency and bank usage had risen in June 2016. Nurse agency spend had increased to 19.3%. This was the highest percentage since recording started in October 2015**.**
- The sickness absence rate had improved from 5% in October 2015, to 4.2% in June 2016, with both divisions worse than the

trust target of 3.5%. Long term sickness had decreased to 78 staff. All cases were being actively managed. Short term absence was 1.7% for June 2016. The main reason for sickness absence remained as 'stress and anxiety' with a total of 407 staff absent from working during June 2016. This was a decrease from March 2016 which was at 532.

- The trust continued to experience issues recruiting to consultant posts, accounting for 13% of all vacancies. We saw the vacancy rate had increased from 10 in March 2016, to 28 in April 2016. The trust confirmed this was due to the submission of the business development plan. The trajectory up to January 2017 showed a requirement of 23 consultants. However, the workforce statistics provided by the Health and Social Care Information Centre (HSCIC) showed the consultant percentage was just above the England average at 40%. The proportion of middle career (at least three years as a foundation year 2 or a higher grade within their chosen speciality) was at 14%. This was higher than the England average of 9%. Specialist registrars were below the England average of 38% at 25% and junior medical staff (foundation year 1/2) was at 21% which was above the England average of 15%.
- The performance indicator for mandatory and statutory training was at 86% in June 2016. This did not meet the trust target of 90%. The trust had RAG (red, amber, green) rated themselves as red. It was noted that compliance had improved since 2015/16 when the rate was 77%.
- We were not provided with evidence to show when staff had completed basic life support training. Therefore, we could not be assured that staff had completed this training when required. The Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training (2013) states that all healthcare staff should undertake resuscitation training at regular intervals to maintain knowledge and skills.
- Any concerns/incidents identified with agency staff would be linked with the agency by means of a proforma to discuss any issues. The agency nurse/locum would be requested to complete a reflective statement which would be reviewed. All agency and locum staff are included in the trust training. If there was an allegation made against a professional this would be reported to the local authority and discussed with the staff member.

Cleanliness, infection control and hygiene

- Ward and clinical areas were visibly clean, with the appropriate green 'I am clean' stickers on clean equipment. Staff were observed cleaning equipment after use.

- Personal protective equipment, such as gloves and aprons, were used appropriately and were available in sufficient quantities.
- Instructions and advice on infection control was displayed in the ward entrances for patients and visitors providing information on how to prevent and reduce infection.
- Hand hygiene gel was available outside the wards, in bays and side rooms. Hand-wash basins were also available in bays and side rooms. We observed staff washing their hands as necessary during our inspection.
- There had been no reported cases of MRSA since March 2013.
- There had been six cases of Methicillin-sensitive Staphylococcus aureus (MSSA) (a type of bacteria) reported during April 2015 and March 2016. The six cases were reported in October 2015 to November 2015 and in February 2016. The number of cases reported was worse than the England average for six of the 13 months. There had been one MSSA case reported between April and June 2016.
- There was 17 Clostridium difficile cases reported between April 2015 and March 2016, with the highest number reported in July 2015 (five cases). This was against an upper limit of 18. There had been six cases of Clostridium difficile reported between April and June 2016, against an upper limit of 18 for 2016/17.
- Systems and processes in maternity were not always reliable or appropriate to keep patients safe. The anaesthetic room used as a second theatre on the delivery suite was not fit for purpose. This could lead to increased risk of infection for mother and baby, and injury to staff from moving and handling within a small space. The trust had implemented mitigating actions to reduced the risk. However, the environment did not meet patient demand and could impact on patient care.

Medicines

- The trust had amended their approach to medicines management by becoming more patient focused with an outcomes approach (medicines optimisation). This was to ensure patients were getting the maximum benefit from their medicines. The medicines optimisation dashboard report for February 2016 showed that 57% of clinical staff had attended face to face medicines optimisation training in the preceding 12 months. The trust had set a target of 40% compliance.
- The trust had a medicines optimisation key performance indicator dashboard. This dashboard provided an indication of the trust's compliance with for example; the safe and timely dispensing of medicines, safe storage and handling of

medicines, clinical review, missed does and the timely transfer of discharge information to GP's. There were a number of actions undertaken to address poor performance. Examples included;

- Although the pharmacy uses a double check system when issuing medicines, it was found that the first check was not being met. This was due to the pharmacy's reliance on a significant number of trainee/locum staff which increased the error rate in dispensing medicines. The trust anticipated that the number of locum staff would reduce during the first two quarters of 2016/17 resulting in better compliance.
- Discharge and outpatient turnaround times for dispensing of medicines did not meet the trust standards resulting in patients not receiving their medicines in a timely manner and resulting in a poor patient experience. The divisions were investigating other models of utilising trained administrative staff to complete electronic discharge summaries to release junior medical staffs' time and ensure discharge medicines was available in a timelier manner.

- During the September 2015 inspection, medicine incidents were not always reported. The patient safety quarterly report for the period December 2015 to February 2016 showed that the rate of reporting medicine incidents through the NRLS was at 13%. This was seen by the trust to be a positive sign of good reporting which they attributed to the medicines safety officer's heightening the awareness of recording issues.
- The majority of medicine incidents were administration or prescription of medicines. Wye ward, Frome acute assessment unit (AAU) and the emergency department were the areas with most reported administration medicine errors during December 2015 to February 2016. AAU reported the most prescription errors. All medicine errors were reviewed and fed back to the medicines safety committee. Learning from incidents was cascaded to staff in a monthly MedsTalk newsletter.
- The administration of insulin and the management of inpatients with diabetes had been recognised through the incident reporting system as an area of concern. Both the medicines safety officer and the diabetes specialist nurses had provided training and support to the wards. This was confirmed by the diabetes specialist nurses spoken with who said they had raised awareness of hypoglycaemia to staff through the implementation of diabetes boxes to support staff with their knowledge. The records showed that 36% of staff had not completed their "Safe use of insulin eLearning" or had not declared they were exempt from completing this training.

Summary of findings

- We saw that insulin training as of April 2016 was behind schedule and showed an overall figure of 66% which was lower than the trust target of 90%.
- Patients' weight were not always recorded on patients' prescription charts, which could potentially lead to the incorrect prescribing of the medicine.
- There was no policy available for parents to administer medicines to their children. The administration of medicines by a parent was an identified concern during the September 2015 inspection. The quality improvement plan identified that an audit of parent administration was undertaken in February 2016 which showed 70% compliance regarding the administration of medicines by parents. A further audit was planned for the end of August 2016.
- 60% of inpatient medicine charts were being reviewed by pharmacists due to the vacancy rate of pharmacists and pharmacy technicians. 16% of the pharmacy department's qualified workforce were locums.
- The quality committee's medicine optimisation dashboard report dated February 2016 showed that the safe handling and storage of general medicines was at 63% which did not meet the standard target of 100%. We saw this was identified on the trust's medicines optimisation risk register together with the actions to manage the identified risk. The register was last reviewed in April 2016.
- The medicines optimisation dashboard report for February 2016 showed that 75% of electronic discharge summaries were not arriving with GPs within 24 hours of patient discharge and 9% of inpatients were discharged without an electronic discharge summary. This did not meet the target of 90% and 100% respectively.
- Antibiotic stewardship compliance was achieved by ensuring patient's medicine charts were accurately recorded when an antibiotic was prescribed. The overall compliance was 70%. Poor compliance was mainly due to not recording the duration of treatment and why an antibiotic was indicated. Ongoing support by pharmacists was in place at ward level.

Are services at this trust effective?

Requires improvement

We rated the hospital as requires improvement for being effective. For specific information please refer to the report for Hereford Hospital.

We found that four of the eight services required improvement. We rated three services as good for being effective. Outpatients and diagnostic imaging was inspected but not rated for effective.

Summary of findings

- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated more patients were dying than would be expected. This had been reported to the trust board and an action plan was in place to understand and improve results.
- Monitoring by the Care Quality Commission had identified four areas where medical care was considered a statistical outlier when compared with other hospitals.
- The caesarean section rate was significantly higher (worse) than the national average and the deteriorating rate was not recorded on the risk register.
- Care was delivered in line with legislation, standards and evidence-based guidance. However, some trust guidelines needed updating.
- The service had a series of care bundles in place, based on the appropriate guidance for the assessment and treatment of a series of medical conditions. However, there was no hip fracture pathway within the hospital although we were told that this was being drafted.
- The trust had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. Performance in national audits had generally mixed results compared to the national average. Actions plans were in place to address areas needing improvement.
- All necessary staff were involved with the assessing, planning and implementation of patient care
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff and teams worked well together to deliver effective care and treatment.
- Overall 78% of staff had received an appraisal in the preceding 12 months. This was an increase from the period 2015/16 which was 59%. However, this did not meet the trust target of 90%.

Evidence based care and treatment

- Staff provided care to patients based on national guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. Staff were aware of recent changes in guidance and we saw evidence of discussion based on these guidelines in patient's health care records. Staff had access to guidance, policies and procedures via the trust intranet.
- The service had a series of care bundles in place, based on the appropriate NICE guidance for the assessment and treatment

of a series of medical conditions including; community acquired pneumonia, dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), gastro-intestinal bleeding, sepsis and acute kidney injury. Wards had posters on display to provide staff guidance on these care bundles.

- The hospital followed the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards did not have "sepsis boxes" available but did have access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- There was no hip fracture pathway within the hospital although we were told that this was being drafted. Patients who suffer a fractured hip have a high mortality and morbidity rate and often need long term care post fracture. A hip fracture pathway ensures that care is coordinated and is evidence based to reduce length of stay and mortality and morbidity.
- The quality improvement meeting minutes identified guidelines and documentation which needed review and updating. We observed that guidelines were mostly in date. However, several were at least one year beyond their review date, for example the trust major incident plan was dated October 2013 with a review date of October 2014. This had not been reviewed since the identification at our September 2015 inspection.
- Local audits monitored adherence to policies and procedures such as, National Early Warning Score (NEWS) and the Five Steps to Safer Surgery.

Patient outcomes

- The trust had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. The trust board used information gathered to benchmark practices against similar organisations.
- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. The trust's HSMR for the 12 month period May 2015 to April 2016 was higher than expected, with a value of 113.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In

June 2016, the trust reported a 12-month rolling figure of 115, worse than expected (100). However, this had slightly improved since March 2015, where the trust reported a 12-month rolling figure of 117.

- The trust had implemented a series of actions to address these concerns and a mortality governance improvement plan had been implemented by the medical director. A consultant lead for safety to support this plan commenced in April 2016. All deaths were reviewed weekly. Either deep dives or root cause analysis (RCA) were conducted where concerns were raised. A communication plan from reviews had been implemented for all lessons learnt.
- Monitoring by the Care Quality Commission had identified areas where medical care was considered a statistical outlier when compared with other hospitals. The outlying areas for the trust were chronic obstructive pulmonary disease (a collective name for lung disease such as chronic bronchitis); sepsis; acute kidney injury (AKI); urinary tract infection; and fractured neck of femur. Actions were monitored through the hospital reducing mortality group. Improvements had been made with the exception of fractured neck of femur, where there were concerns regarding identification and management of end of life care and recruitment of orthogeriatricians.
- The caesarean section rate was 42.5% in April 2016 and 39.2% in May 2016 in comparison with the national average of 26.5%. This was worse than the caesarean section rate in the two previous years. The deteriorating caesarean section rate was not recorded on the risk register.
- Performance in national audits had generally mixed results compared to the national average. Actions plans were in place to address areas needing improvement.
- The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. In the March 2016 the trust was rated as band D (A being the best and E the worst). We saw actions taken in response to the audit.

Multidisciplinary working

- All necessary staff were involved with the assessing, planning and implementation of patient care.
- We observed the multidisciplinary team meetings on all wards visited and found they included all relevant nursing, medical and allied health professional staff. Meeting were well structured and inclusive of all disciplines. All staff were observed contributing to the meetings and the teams were open to ideas and suggestions from individuals.

- Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment. Wards reported consultant lead ward rounds were held daily.
- Patients were referred to specialist consultants if their condition changed and we saw evidence of effective referrals within patient notes.
- Play therapists were available on the ward, Monday to Friday and every other Saturday. Play therapists provided communication between medical and nursing staff, and patients and their parents to ensure the child's needs were catered for during procedures. Play therapists also provided additional support in distraction for younger children whilst undergoing procedures.
- Access to psychiatric services was available Monday to Friday from the Child and Adolescent Mental Health Service (CAMHS). This service was unavailable at weekends. Therefore if a child with mental health needs presented over the weekend, they were admitted and waited until Monday morning for a comprehensive assessment. The trust were working closely with the CAMHS to improve provisions and provide a weekend service for patients admitted to the ward. Agency nurses were employed to care for patients with mental health needs as required; patients were not admitted to the ward from the emergency department until one to one care was in place.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The MCA training was 56% against a target set by the trust of 80% with the aim to achieve 90% by July 2016.
- The DoLS training had achieved 63% compliance. The action log from the safeguarding working group meeting of March 2016 identified the aim to achieve 90% by July 2016.
- The trust had previously recognised there was no DoLS or MCA lead for the trust. This had been rectified with the appointment of a MCA/DoLS lead that was due to commence in September 2016 for a two year fixed term.
- The trust did not have any DoLS champions. The safeguarding lead confirmed this had been recognised by the trust and this was a work in progress.
- The audit regarding the completion of mental capacity forms was identified on the quality improvement plan as an area which required improvement. The safeguarding lead confirmed they were continuing to monitor the completion of documents

monthly which had improved. The improvement was also identified in the safeguarding quality group meeting minutes for March 2016. A further audit was planned to be completed by the trust auditors in November 2016. We found no concerns with the completion of mental capacity forms.

- The hospital as of July 2016 had 31 patients listed with a DoLS in place. The trust had received 237 applications since April 2016. The safeguarding team and the local authority had a daily morning meeting to discuss all safeguarding applications and any outstanding issues which meant the trust team had up to date knowledge regarding all patients within the hospital that either had a DoLS in place or were waiting for an assessment.
- Staff confirmed capacity assessments had taken place and described actions taken as a result. We saw written evidence in patients' notes which outlined the outcomes of capacity assessments, and details of best interest actions staff should take to maintain the patient's safety.
- We looked at 33 completed DNACPR forms across all ward areas, all were completed accurately, in line with trust policy and the MCA. This was a significant improvement since the September 2015 inspection, when we saw 21 cases where decisions had been made about a patient's capacity, which were not line with trust policy or the MCA.
- Staff we spoke with had a good understanding of gaining consent from children applying the Gillick competency assessment where appropriate.

Competent staff

- Staff generally had appropriate qualifications, skills, knowledge and experience for their roles and the trust had processes in place to identify development needs.
- The number of staff who had received an appraisal in the preceding 12 months was 78% in June 2016. This was an increase from the period 2015/16 which was 59%. However, this did not meet the trust target of 90%.
- The number of medical staff that had received an appraisal in the preceding 12 months was 98.2% in June 2016. This met the trust target of 90%.

Are services at this trust caring?

Good

We rated caring as good for all eight core services. For specific information please refer to the report for Hereford Hospital.

Staff were observed being polite and respectful during all contacts with patients and relatives. Staff protected patients' privacy and dignity.

Summary of findings

Patients felt involved in planning their care, in making choices and informed decisions about their care and treatment.

Staff understood the impact that a patients care, treatment or condition had on their wellbeing and on those close to them emotionally.

Compassionate care

- Staff respected patients, their individual preferences, habits, culture, faith and background.
- Staff were observed being polite and respectful during all contacts with patients and relatives. This included when patients and relatives attended each ward, during telephone calls and in public areas.
- Privacy and confidentiality were promoted through closing doors and screens when discussing patients or completing tasks. .
- Patients told us staff were caring, with compassionate attitudes and they were well looked after.
- The percentage of friends and family that would recommend the trust as a place to receive treatment were in-line with England averages for the period March 15 to March 16.
- The trust scored about the same as other trusts in the 2014 CQC In-patient survey for all but one question which were scored as amongst the worst performing trusts (Were you involved as much as you wanted to be in decisions about your care and treatment?). Trust scores in 2014 were marginally worse for most questions in comparison to 2013.
- Trust scores in the Patient Led Assessment of the Care Environment were mostly in-line with England averages in both 2014 and 2015. Although performance in regard to privacy, dignity and wellbeing showed a downward trend.
- The trust scored in the top 20% compared to all trusts for nine of the 34 questions in the Cancer Patient Survey (2013/14). Trust scores were in the bottom 20% for five questions and in the middle 20% for the 20 remaining questions. Trust scores worsened in 2013/14 compared to 2012/13 for 17 and improved for 16 of the 33 questions for which data were available.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts with privacy and dignity reported as better than other trusts and communication about care and treatment reported as worse than other trusts.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in planning their care, in making choices and informed decisions about their care and treatment.
- Discussions regarding treatments and plans with patients and family members were documented in patient records. This included discussions relating to resuscitation and ceilings of treatment.
- Staff took time to explain to patients and those close to them the effects or progress of their condition, communicating with patients in a way that would help them understood their care and treatment and condition.

Emotional support

- The chaplaincy department represented a number of Christian denominations. The team were trained to offer pastoral and spiritual care to patients, their families and staff. An emergency mobile phone was carried by a member of the team which all wards and departments had access to. A prayer room for those belonging to other faiths was located in the chapel and contact details of the leaders of these faiths were kept in the chaplain's office.
- Staff understood the impact that a patients care, treatment or condition had on their wellbeing and on those close to them emotionally.
- The supportive palliative care team told us emotional, psychological and bereavement support and advice for families was an important component of the service. People we spoke with told us the supportive palliative care team had provided them with emotional support.
- Patients had access to clinical nurse specialist, for example, breast care nurses and stoma care nurses. This meant that patients received specialist support when coming to terms with any adaptions in their everyday lives.

Are services at this trust responsive?

Inadequate

We rated the hospital as inadequate for being responsive. For specific information please refer to the report for Hereford Hospital.

We found surgery and outpatient and diagnostic services were inadequate for being responsive. We found that four of the eight services required improvement. We rated two services as good for being responsive.

- Patients were unable to access the majority of outpatient services in a timely way for initial assessments, diagnoses and/

or treatment. This remained a challenged since the September 2015 inspection. However, the trust had put a system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.

- The trust did not consistently meet all cancer targets for referral to treatment times, including the gynaecology cancer pathway.
- Overall referral to treatment indicators within 18 weeks for admitted surgery patients was worse than the England average
- The percentage of patients that had cancelled operations was worse than the England average. 22 operations cancelled were due to the lack of an intensive care unit bed. Cancelled operations were not always rearranged within 28 days as per NHS England standard.
- The emergency department consistently failed to meet standards in terms of the amount of time patients spent in the department and waited for treatment.
- Bed occupancy was consistently worse than the national average.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches on the intensive care unit each month.
- The trust did not have an electronic system in place to identify patients living with dementia or that had a learning disability.

- Staff adapted care and treatment to meet patient's individual needs.
- We saw examples of services planning and delivery care to meet the needs of patients.
- Systems and processes were in place to provide advice to patients and relatives on how to make a complaint. Face to face meetings with a complainant were seen as the way forward in effective complaint management. Learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- The trust aimed to ensure that services were planned and delivered to meet the needs of local people. However, we saw that transfers of care was occasionally delayed due to waiting for further NHS non-acute care (46%). The waiting for packages in the patients' own home was at 20%. The trust score was significantly higher than the England average for both factors.
- The service was working collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners to identify the needs

for the local community and planning of clinical pathways to meet demands. This was particularly noticeable within stroke services with the development of the early discharge team and discharge lounge.

- The trusts quality improvement plan included service planning for patients with long term conditions, such as diabetes. The service aimed to improve the working relationships with GPs, the introduction of health promotion and wellbeing care plans, and staff training in every contact count. Making every contact count is a system used by the NHS to utilise day-to-day interactions with patients to support them in making positive changes to their physical and mental health and wellbeing.

Meeting people's individual needs

- The trust did not have an electronic flagging system for patients with a learning disability. This meant that the trust was unaware of the number of patients with a learning disability admitted the hospital. The trust informed us that all patients with a diagnosis of learning disability were encouraged to have a "patient passport" outlining their preferences. This did not meet the National Institute for Care and Health Excellence (NICE) guidance "Challenging behaviour and learning disabilities: prevention and intervention for people with learning disabilities whose behaviour challenges" (May 2015); and the guidance set out in the Improving Health and Lives: Learning Disability Observatory in conjunction with the Department of Health which outlined key actions that all NHS trust and health services needed to consider, which included to ensure that patients with a learning disability are easily identified in records systems.
- The trust linked with the learning disability nurses in the community if they were notified of an admission of a patient with a learning disability. More complex cases were included in the multidisciplinary meeting to plan their admission.
- Elective patients with a learning difficulty had a pre-operative assessment in an environment that was most appropriate for the patient, to enable staff to adapt to their individual needs and to avoid any undue distress.
- Staff knew how to access interpreting services. The trust had Polish interpreters who also managed the whole of the interpreting requests. The trust used the local diversity team to provide face to face interpreting for appointments where complex clinical information was being discussed. The trust also used telephone interpreting and Deaf Direct when required.

- Hearing loop facilities were available throughout the hospital.

Dementia

- The dementia lead reported that the trust had trained 30 individuals as dementia champions at the time of inspection, and were planning to increase numbers of dementia-trained staff across all areas as staffing levels permitted.
- The dementia team had a dedicated email address, which was available on the intranet, which enabled staff to access them directly and seek support or advice regarding patients.
- The trust did not have an electronic system in place to identify patients living with dementia. Although we were told this was being implemented in spring 2017. Patients living with dementia were identified on the ward and patient name boards by the use of a forget-me-not flower symbol. Permission was sought from relatives prior to completing this. The use of the symbol-enabled staff to identify patients who had a dementia diagnosis and ensured additional care and support were available.
- All patients living with dementia were assessed using the standard trust documentation and the “9 things about me” checklist. This was completed in conjunction with the patient’s carer and/or next of kin to enable staff to gain insight and provide quality person-centred care.
- Patients were assessed following the guidance of the safeguarding policies. This included a mental capacity assessment and if appropriate a Deprivation of Liberty Safeguard (DoLS) referral.
- Person centred-care was planned post assessment. A suitable location on the ward environment was identified, when required, which provided increased visibility to mitigate the risk of absconding and/or falls. Additional staffing were provided as required based on the needs of the patients.
- Gilwern assessment unit was not identified as a dementia ward, however, this had been taken into consideration when planning the environment. The unit had been decorated with photographs of “old Hereford” which were used to help with patients reminiscing. Additional facilities included flooring that was sprung to reduced sound and risk of harm if patients fell, colour coded bays and wide corridors to allow assisted mobility. Memory boxes were available for relatives to place personal items and memory aids for patients with a history of dementia, and twiddle mittens provided as patient activities.

- The trust informed us they had admitted 1,980 patients living with dementia in 2015/16 and had 74 inpatients living with dementia at any one time. This was however, based on a snapshot of admission to the inpatients' services.

Access and flow

- Bed occupancy rates for the trust were higher than the England average for five of the six quarters between quarter two (2014/15) and quarter three (2015/16). The first quarter of 2016/17 the bed occupancy at the hospital was 95%. For 2015/16 the bed occupancy was 94%, this was worse than the national average (88.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of a hospital.
- The emergency department was not meeting standards in terms of the amount of time patients spent in the department and waited for treatment. In every month from April 2015 to March 2016, the trust scored worse than the 95% Department of Health target for patients being seen within four hours of arriving in emergency department. Percentages at the hospital ranged from a low of 84% in March 2016 to a high of 91% in June 2015, and averaged 89% for the whole period.
- The amount of patients waiting four to twelve hours from the decision to admit until being admitted was consistently worse than the England average, with no patients waiting over 12 hours for admission between April 2015 and April 2016, with the exception of February 2016. This meant that patients could not access services in a timely way.
- Patients were unable to access the majority of outpatient services in a timely way for initial assessments, diagnoses and/or treatment. There were long waiting lists for the majority of specialities including gastroenterology, dermatology, neurology and ear, nose and throat. This remained a challenged since the September 2015 inspection. However, the trust had put a system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
- The trust did not consistently meet all cancer targets for referral to treatment times.
- Whilst the trust had reviewed 42,000 open patient pathways they still had approximately 28,000 open pathways to review. This meant there was a risk that the trust did not have full oversight of the risk to patients on open pathways.
- Between June 2015 and May 2016, the overall referral to treatment indicators within 18 weeks for admitted surgery patients was worse than the England average (80%), with 61%

of referred patients treated within 18 weeks of referral. For general surgery, 49% (373) of patients were not treated within 18 weeks; in ENT, 53% (332) of patients were not treated within 18 weeks. Of the patients requiring ophthalmology surgery, 72% (1353) of patients were not treated within 18 weeks. For trauma and orthopaedic surgery, 50% (1030) of patients were not treated within 18 weeks.

- The percentage of patients that had cancelled operations was worse than the England average of 5%, at 28%. On average 20% of patients' cancelled operations were not then treated within 28 days as per NHS England standard.
- There had been 22 cancellations of on the day of surgery for the 12 month period ending March 2016, due to lack of the intensive care unit beds in 2015/16. This was significantly worse than the previous year, when six patients had their surgery cancelled on the day. The surgical division were aware of this and were trying to forward plan operations better to prevent on the day cancellations.
- Delays in accessing beds in hospital were resulting in mixed sex occupancy breaches on the intensive care unit each month. There were 27 instances of mixed sex occupancy reported on the unit from January to June 2016.
- The admission, access, appointments, transfers and discharges (AAATD) incidents showed 100 patients were affected for April 2016 in comparison to 60 patients reported in April 2015. The main three AAATD categories were:
  - Delay in transfer to a ward with the majority of patients waiting in recovery to return to a ward.
  - Unexpected readmission/re-attendance. This was mainly for babies less than 10 days old for weight loss or mothers readmitted to the maternity ward for raised blood pressure or possible infection.
  - Failure in the referral process. Although no particular areas or themes were identified these included incorrect referrals from outside organisations and patients being brought up to the wards from the emergency department without notification.
- The average length of stay at trust level was better than the England average for elective care but worse than the England average for non-elective admissions.

Learning from complaints and concerns

- The complaints policy was appropriate and within date. Although it needed amending to reflect the change to divisions within the trust.

Summary of findings

- Systems and processes were in place to provide advice to patients and relatives on how to make a complaint. Information and leaflets about the complaints process were displayed across the trust. Complaints could be raised in a variety of ways; in person, verbally, in writing and electronically.
- From April 2015 to March 2016, the trust received 260 formal complaints. The number of complaints received by the trust varied from month to month but had increased from April 2015 to March 2016, from 13 to 25. Surgery received the highest percentage of complaints (30%) followed by medicine (29%) and the emergency department (18%). Most complaints received were in relation to clinical treatment (23%), quality and safety of care (12%) and values and behaviour of staff (11%).
- For 2015/16, 59% of all complaints received were upheld or partially upheld with 28% of complaints not upheld. 8% of complaints were still ongoing whilst 4% were withdrawn.
- The patient experience team were responsible for managing complaints and overseen by the head of quality and safety. Complaints were discussed directly with the director of nursing and actions taken if necessary.
- On receipt of a complaint, it was logged and an email was sent to the relevant divisional governance lead. The complaint was then allocated to the divisional lead (nurse or medic) for investigation. If the complaint spanned across divisions, the division with the significant element of the complaint lead the investigation. The patient experience team maintained a tracker of all complaints received.
- An acknowledgement letter was sent to the complainant within three working days. Where the complainant provided a contact phone number the complainant would be contacted via telephone. This was to ensure they had clear understanding of the exact elements of the complaint, the type of response required and how they would like the complaint taken forward. The complainant would be offered a face to face meeting with the investigating officer, relevant members of staff (if appropriate) and the patient experience manager or a member of their team. Face to face meetings with a complainant were seen as the way forward in effective complaint management. Face to face meetings were noted in the complaints that we reviewed and the patient experience manager felt it had reduced the number of complaints that needed to be reopened following the sending of the complaint response.
- Response letters were written by the divisional lead and sent to the chief executive officer (CEO) for final sign off. We were told that complaint responses were challenged by the CEO where

Summary of findings

appropriate. All response letters invited the complainant to contact the trust if they are unhappy with the response and contact details of the Parliamentary Health Service Ombudsmen were also provided.

- All complaints that were upheld, or had elements upheld had an action plan written. The action plan was incorporated into the divisional improvement plan. The patient experience team did a random one out of 10 check to ensure actions were completed. If shared learning was identified the learning was included in the CEO monthly brief or if learning was urgent a memo was sent to all staff. In order to provide assurance of learning members of the patient experience team and the divisional governance lead attend the divisional unit monthly governance meetings.
- The trust quality committee received a quarterly patient experience report which provided complaint information.
- The complaints process was under review in order to make it more efficient and effective. The trust were rolling out datix web to ensure all aspects of complaints were recorded and staff investigating the complaint will have access to all upload information. The training was being delivered at the time of our inspection and should enhance complaints management if embedded in practice.
- The patient experience team were located by the reception area in the main hospital entrance. Staff directed patients to the team who supported and advised patients, their families and/or carers with any questions, compliments or concerns. The patient experience team were available Monday to Friday, 8.30am to 4.30pm. Messages could also be left via e-mail or on the 24 hour telephone answer machine service.

Are services at this trust well-led?

Requires improvement

We rated the hospital as requires improvement for being well-led. For specific information please refer to the report for Hereford Hospital.

We found that four of the eight services required improvement. We rated four services as good for being well-led.

- The trust had governance oversight of incident reporting and management. The board assurance framework and corporate risk register identified most of the keys risks.
- The trust implemented a new organisatioanl structure in June 2016 we were unable to assess the sustainability and effectiveness of the restructure as this had not yet been embedded into the trust.

Summary of findings

- The trust had a vision, their mission and their values. However, these were not fully embedded or understood by staff.
- Although the leadership within the organisation were aware of the legal requirements the objectives aligned with Equality and Diversity Standards 2 there was no equality and diversity strategy to reflect these.
- Following the trust being placed into special measures in October 2014, a comprehensive quality improvement plan was developed, which included a number of projects and actions. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.
- We were assured that appropriate steps had been taken to manage the 'Fit and Proper persons' legislation implementation.
- The executive team did regular walkabouts within the hospital and most staff felt the executive team were visible.
- The executive team could demonstrate good understanding of the risks, issues and priorities in human resource management. However, overcoming some of these issues, such as recruitment, remained a significant challenge.

Vision and strategy

- The trust had implemented a new mission, vision and values which included;
  - Vision "To improve the health and well-being of the people we serve in Herefordshire and the surrounding areas".
  - Mission "To provide a quality of care we would want for ourselves, our families, and friends". Which means: "Right care, right place, right time…every time".
  - Values · Compassion · Accountability · Respect · Excellence
- There was a mix of staff that were aware or unaware of the trust vision, mission and values.
- The main commissioners and providers in Herefordshire had formulated a healthcare strategy for the next five years through its "One Herefordshire Programme." The main expected benefits of this programme were:
  - A step change in the way communities behaved when managing illness and reduced demand for services.
  - Care to be localised, where possible, and centralised where necessary.
  - Services to work together and based on the patient's needs.
  - Improved quality, efficiency and effectiveness of service.

  - A more sustainable health and care systems that could meet the demands of its population.
- The trust had implemented a transformation programme alongside the commissioners and providers by redesigning acute and community services following a review and development of a clinical strategy for the trust. Examples of the main themes were to:
  - Optimise services for the older population.
  - Create new roles to replace traditional nursing and medical roles.
  - Increase capacity and availability of diagnostics across seven days.
  - Integrate records with other providers.
- The clinical strategy and transformation programme relied on the development of a partnership with another provider in order to deliver services collaboratively. This was being taken forward across the Herefordshire and Worcestershire footprint.
- The service reported that at the time of inspection there was no divisional strategy in place for medicine. However, there was a strategy for delivering care to surgical patients.
- The trust had a comprehensive quality improvement plan, which included a number of projects and actions. These were divided into projects such as risk management, information governance, reducing harm, estates, stroke services and clinical effectiveness. Each project was then further divided into themes and action plans. We saw that the action plans were reviewed regularly, with monitoring of compliance against targets and details of completed actions. For example, the risk management project included the production of a risk register that reflected the trusts risks accurately, and the completion of patient risk assessments. Both actions were in progress with a new risk register in place, and training plans in place for e learning for staff.

Governance, risk management and quality measurement

- A trust restructure was implemented in June 2016, just prior to the inspection, with three service units reduced to two divisions, medical and surgical. Some areas the restructure hoped to address were to:
  - Develop clinically led services to ensure the triumvirate of medical, nurses and senior management are represented from board to ward.
  - To have clear lines of clinical and corporate governance through the structure.
  - Improve the clinical and operations' responsiveness to variation in demand.

  - Strengthen the relationship between board, executive and those responsible for service provision.
- We were unable to assess the sustainability and effectiveness of the restructure as this had not been embedded into the trust. However, staff across the services felt the reconfiguration was positive and provided more support with key identifiable processes of whom to contact should any issues or concerns arise.
- There was good governance between the executive board and the safeguarding team. Staff were able to explain how issues would be disseminated downwards from the various teams.
- Both the board assurance framework (BAF) and the corporate risk register were reviewed monthly but the trust board. The majority of the organisation's key risks were represented there was some reference to the risks and how they should be managed.
- In March 2016 the trust commissioned the Good Governance Institue (GGI) to review the governance within the trust and make recommendations for improvement. The areas asked to be looked at were: strategy, capability and culture, quality governance process and structures and measurements. The report by the GGI highlighted recommendations some of which included;
  - Trust risks should be managed through the risk register process.
  - Create closer collaborative relationships with and between the board and clinicians as well as with middle managers for example, joint clinical governance meetings.
  - Provide development to staff around the use of data and to consider providing training to staff on how data should be collected, analysed and presented.
- The trust had identified the need for a risk management e-learning training package to be developed and imbedded within the trust. This was incorporated into the quality improvement plan and we saw that discussions with the head of education and development had commenced. However, the quality improvement plan identified the trust was behind with its target in relation to the draft of the risk management/risk assessment training.
- The trust had created a "star chamber" group to review the evidence reports submitted to the quality improvement plan. This was to check and challenge the evidence each project lead presented, to ensure it met the desired objective.

Summary of findings

- The executive team members told us that there were regular challenges within board meetings from board members and non-executive directors. We saw in the minutes of the meetings frequent questions and queries by non-executive directors.
- We reviewed the operational risks which could impact upon the strategic objectives of the trust to improve the quality and safety of care to patients, their carer's and families. Most of the risks had no variances between the review in March and May 2016. However, the risk to women and babies due to the lack of a second obstetric theatre; the risk to patients due to potential delay in patient care by obstetrics and gynaecology registrar between 8.30pm and 8.30am; and the risk to security of women and children within women's and children's services due to lack of a robust security systems had deteriorated. We saw the trust had recognised a new risk within elective care in relation to patient safety due to lack of critical care level two and three capacity to meet emergency requirements.
- The trust had improved its oversight of incident reporting and management with the implementation of the quality and safety group which was overseen by the medical director. The group reviewed all incidents and completed root cause analysis. We saw the minutes were cascaded to the staff teams to identify any learning.
- The quality and safety group conducted safety visits to wards. We reviewed the action plans and observed that although the actions plans had a due date there was no evidence of the outcomes of the actions and/or if the actions had been completed. For example, one of the actions stated the ward sisters should ensure documentation was fully completed with feedback to all staff highlighting the importance of fully completed documentation, such as the correct recording of fluids, incomplete discharge planning and falls care plans.
- The trust had a comprehensive major incident policy and staff were able to tell us where this was located on the trust website. However, it was noted that the trust wide major incident policy was due for review in 2014 and had not been updated since it was published in 2013. According to the intranet, the trust was in the process of updating this policy.

Leadership of the trust

- The majority of the executive team had been stable for 18 months. The exceptions to this was the director of nursing (DoN), where an interim was in post at the time of our

inspection and a substantive DoN was due to start in August 2016; and the workforce director who was interim with interviews for a substantive post holder scheduled. The team were passionate about improvements within the organisation.

- The trust was placed into special measures in October 2014 and remained in special measures following our September 2015 inspection. Following enforcement action by the Care Quality Commission a quality improvement plan had been developed. We were assured there had been effective oversight of this with outcomes and projections monitored weekly. Staff at ward level were aware of the programme and their responsibilities for delivery as necessary.
- The trust had been in receipt of support from an improvement director allocated by NHS Improvement.
- Most staff said the chief executive officer (CEO) was visible and had opened up lines of communication. Staff said they felt the CEO listened to them and supported them in their roles.
- The chief operations officer (COO) and the medical director (MD) conducted a walkabout every Friday afternoon whilst the director of nursing (DoN) and their deputy regularly walked around the emergency department. Staff said they felt supported by the executive team and gave them the opportunity to discuss any issues and get their feedback. However, some staff said they were “fed up” with interim posts within the executive team and felt this did not lead to a “stable” environment.
- Most staff that we spoke with reported to us that they saw their immediate line manager regularly.
- Overall, we were assured that there was good corporate understanding of the risks, issues and priorities in human resource management. However, overcoming some of these issues, such as recruitment, remained a significant challenge.

Culture within the trust

- Results for the 2015 NHS Staff Survey showed 13 positive and seven negative findings. The remainder of findings were within expectation between 2014 and 2015 results significantly improved for three questions and showed no significant change for 18 of the 21 comparable questions. The 2015 response rate and overall engagement scores improved in comparison with 2014 scores.
- The trust performed within expectation for 14 questions in the General Medical Council National Training Scheme Survey. The trust scored worse than expected for Induction.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.

- Staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged.

Fit and Proper Persons

- The Fit and Proper Person Test (FPPT) is established by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which requires that directors of NHS providers are fit and proper to carry out their role. The trust had a fit and proper persons test policy dated August 2015 which covered the requirements of the regulation.
- We looked at the files of all the executive directors and supplementary information. These demonstrated that FPPT was part of the recruitment process and involved a combination of self-declaration and checks. The checks made included a disclosure and barring check, financial checks and references. The non-executive directors had been appointed by either the Appointments Commission or NHS Improvement.

Equalities and Diversity

- The training records showed an inconsistency in the completion of the equality and diversity training. For example, the trust management team showed a compliance level of 45% and the elective care service unit which included nursing and midwifery medical staffing at 67%. This did not meet the trust target of 90%.
- The leadership within the organisation were aware of the legal requirements the objectives aligned with Equality and Diversity Standards 2 (EDS2) but did not have an equality and diversity strategy to reflect these.
- The equality and diversity lead had tested out the board's understanding and feeling around EDS2. The equality lead told us that the trust plan was to mirror the objectives of EDS2 to the trust strategy objectives and develop the strategy through a workforce stream. However, the vision was not robust and no completion date or milestones had been set.
- Staff attending the black and ethnic minority focus group were unaware of any work around equality and diversity in the trust.
- There was no evidence provided regarding completion of a workforce race equality standard indicators.
- There was no evidence in complaints, grievances or employment tribunals to suggest there were any issues that the trust were aware of concerning equality and diversity.

- An equality and diversity policy was in place which made reference to the bullying and harassment policy; both policies were within date. Staff did not express concerns about bullying or harassment to the CQC team during our inspection.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. Using surveys, comment cards and questionnaires to gather information to enable improvement.
- The trust had established a young people's ambassador group. This was run by a group of patients who had used the service or continued to use the service. The group met regularly and were consulted on changes and developments, for example they had been instrumental in the development of the 'Saturday club' which was well established and had been running for over one year. The Saturday club had been set up to provide a comprehensive pre-assessment service for children and young people being admitted for surgery. The ambassadors also told us about their involvement in improving the paediatric emergency department environment and their plans to improve other aspects of care and support on the paediatric ward. The ambassadors felt listened to by hospital staff and were pleased with action taken in response to the issues raised. The ambassadors had an agenda and list of issues they planned to raise with the trust; next on the list was improving food for patients. The ambassadors were currently involved with making a film about transition which would be used nationally across the NHS and this was taking priority; the ambassadors told us they would soon be working their way through agenda items to further improve the service.
- The newly introduced clinic for patients with epilepsy had enlisted the support of a patient with epilepsy; their views had helped the clinic develop so that the needs of patients were met.
- There was trust stakeholder group that provided feedback on trust business plans and patient care improvement plans. The group had representation from patients, carers, staff and commissioners.

Staff engagement

- Results for the 2015 NHS Staff Survey showed 13 positive and seven negative findings. The remainder were within expectation.
- The trust performed within expectation for 14 questions in the General medical Council National Training Scheme Survey. The trust scored worse than expected for induction.

Summary of findings

- Staff were encouraged to complete a "Celebrate the good work you do". We looked at five forms which were completed by three wards, ED and the clinical assessment unit. Staff were asked a number of questions which included "what are you proud of" and "what are your top three risks". There was a current theme regarding the risks which included; staffing levels which also included staff morale, bed availability and effective discharge.

Innovation, improvement and sustainability

- There was a continued focus on the trust mortality which showed a small improvement since the September 2015 inspection. The safety and quality committee met weekly to review all morality cases within the trust.
- The trust had identified several business plans for the year 2016/17 which included an additional 16 bedded Gilwern ward, the procurement of a second CT scanner and an additional ophthalmology unit. We saw all of these had either been implemented or were due to be completed within the next few months. This meant the trust had reviewed its objectives and strategies for the best interest of patients.
- Recruitment was a significant challenge for the trust and there were a number of actions being taken to address this including recruitment of oversea nursing staff. However, the trust felt they were disadvantaged by their geographical location and were considering what other actions could be taken to provide a sustainable recruitment and workforce solution.
- The trust had a financial deficit in 2015/16 of £20,455m against a revenue of £178,045k, at the time of the inspection they had yet to agree a financial control target for 2016/17.
- There was recognition that the organisation given its size and location needed to work differently to provide a sustainable model for delivery of sustainable services to its population. There was work on going to link with partner organisations which was actively progressed by the executive team.
- Through the quality improvement plan the trust and stakeholders were able to review the trust's performance against key issues identified in the inspection report of September 2015. This plan had gone through a number of variations, the most recent being key in understanding the progress the trust was making. However, with the relatively new approach to this and a new organisational structure, we were unable to assess the future projection based on present trends.

Overview of ratings

Our ratings for Hereford Hospital

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

Our ratings for Wye Valley NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust MUST take to improve
Action the hospital MUST take to improve

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

Outstanding practice and areas for improvement

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

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity The regulation was not being met because risks were not always identified and all mitigating actions taken in all areas of the hospital. Effective systems and processes were not in place to improve the quality of services provided, including the quality of the experience of service users in receiving these services. Patients were unable to access surgery, gynaecology and outpatient services in a timely way for initial assessments, diagnoses and/or treatment. Access to services did not consistently meet trust or national targets, and were significantly worse. Times taken to assess and triage patients within the emergency department were not always recorded accurately. Incidents were not always reported or investigated in a timely way, particularly in children and young people's services. Not all risks were identified on the risk register.

This section is primarily information for the provider

Requirement notices

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

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