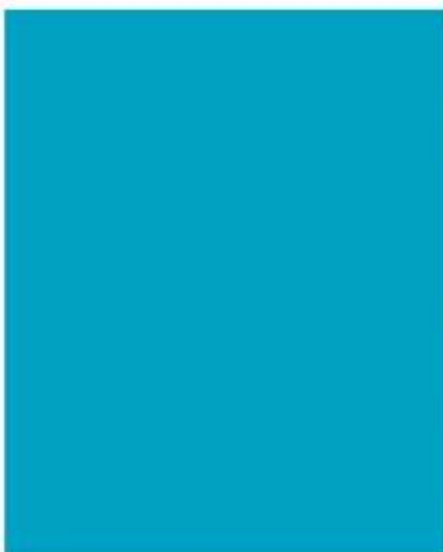
NHS England

Rapid responsive review into the quality of care and treatment provided by Wye Valley NHS Trust



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Rapid responsive review into the quality of care and treatment provided by Wye Valley NHS Trust

Prepared by NHS England, Midlands and East region

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Executive summary

Key findings

The Trust was extremely welcoming to the panel and fully cooperative throughout the visits. The panel was particularly impressed with staff that we met who consistently demonstrated commitment and compassion often in the face of great adversity. The majority of patients and members of the public we met at the listening event spoke very positively about the Trust. Most of the patients we met on the wards looked well cared for and spoke highly of the care they were receiving; we did, however, meet and observe some patients whose care was compromised.

The panel recognised that the Trust faced some difficult challenges given its geographic isolation and the absence of a clear strategy for providing clinically and financially sustainable services into the future. This was clearly causing uncertainty and impacting on staff morale. However, the panel were clear that there were a number of things, which were in the absolute control of the Trust that could be done to immediately improve patient care.

The nature of any such review is to focus on areas that could be improved. However, the panel did find many examples of good practice. These are listed in the detailed findings later in this report. Some of the examples of good practice we found included:

- A robust process for undertaking the quality impact assessments of cost improvement programmes involving the director of nursing and the medical director
- The board had had a workshop with the Dr Foster organisation to explore the issues underlying the higher than anticipated mortality rates
- The trust had recently implemented a 7-day 8am-8pm “physician of the day” rota
- An orthopaedic mortality review in May 2013 recommended the introduction of a fractured neck of femur care bundle and a detailed review of all deaths. There is good senior leadership of this pathway
- The nursing staff were very committed to providing high quality patient care often in spite of major staffing difficulties. The panel wanted to make special mention of the staff on Redbrook ward; we also mention in the report some excellent individual members of staff we met
- The panel, were particularly impressed with the environment, food and patient dignity at Leominster community hospital
- The Safer Nursing Care Tool, the National Early Warning Score (NEWS) and DATIX incident reporting have recently been introduced across the Trust
- 100% of appraisals were complete on the maternity unit and induction packages were excellent

Key findings included:

***Governance and leadership*:**

- There is a disconnect between the quality committee, leadership team and the service unit performance meetings with an ensuing lack of clarity as to ward to board and board to ward assurance
- It is not clear how risks and issues are appropriately escalated within the Trust, nor how the board is assured on the key risks facing the Trust

- There is no clinical and organisational strategy underpinning both the health economy and the Trust resulting in uncertainty and planning blight
- There are concerns over the sustainability and visibility of leadership within the Trust
- There are concerns over the accuracy of the reporting of key performance issues
- The cost improvement programme is unlikely to be delivered leading to enhanced issues on sustainability

Clinical and operational effectiveness:

- There are concerns about management of capacity and flow within the trust from admission to discharge
- Support to clinicians was observed to be poor in several areas
- There are concerns about the quality of care for stroke patients at the Trust
- While there has been improvement in the trust's attention to mortality, there remain weaknesses and inconsistencies in mortality processes and there is a lack of leadership

Patient experience:

- There is no patient experience strategy and the trust is not able to articulate its priorities for patient experience
- There is no clarity on how the board is assured on patient experience or prioritisation plan based on friends and family test (FFT) responses
- There are gaps in assurance in the new complaints process, and the process needs to be embedded at ward level
- There is scope to improve staff engagement in and ward level ownership of improving patient experience
- There is scope for improvement in the way the Trust systematically acts on patient feedback
- Staffing levels clearly have a negative impact on patient experience as reported by some patients in most areas visited
- Serious concerns raised regarding patients' privacy and dignity on day case unit, which would also apply to the Fred Bulmer unit when used as an inpatient escalation area
- Staff reported that they would not want to be treated in certain wards and in escalation areas of the hospital.

Workforce and safety:

- There are shortfalls in the Trust's approach to managing its workforce.
- There is scope to improve processes to further engrain safety or learning culture within the Trust.
- There are serious concerns about the safety of day case unit.
- There are immediate risks regarding insecure access to the theatres.
- Staff reported that training opportunities had been cancelled due to operational pressures, and trust data suggested mandatory training rates are low.
- There is high locum spend, and a lack of middle grade doctors.
- There is no clear standard regarding do not attempt resuscitation (DNAR) orders, and there appeared to be a lack of engagement with patients and relatives about their use.
- Staff working in the community hospitals are isolated and there is insufficient medical cover.
- Staffing in the maternity unit is leading to potentially unsafe practice.

Recommendations

The panel made a number of recommendations grouped under the key lines of enquiry (KLOEs), namely:

- Governance and leadership
- Clinical and operational effectiveness
- Patient experience
- Workforce and safety

Of these, eight recommendations have been made for immediate action, including actions for the immediate safeguarding of patients in the day case unit and theatres. A further 36 recommendations were made that need urgent attention and 31 recommendations were made that require medium term attention. Further details of these recommendations can be seen later on in this report.

It is of great credit to the Trust that from the time of the visit to the drafting of the report that they have already made progress in addressing many of the issues we identified. Wherever possible we have tried to reflect this in the report.

From our findings and recommendations we believe that there are 4 major themes:

- Inadequate medical and nursing staff in some wards and on some sites. Although, these had improved over the last weeks, the panel felt there was a lot more to be done.
- There is significant scope to improve patient flow. This was adversely impacting on patient care; with inappropriate use of escalation areas (particularly the day case unit); a large number of patient moves; and problems in the tracking of patients.
- The governance arrangements including the approach to improving patient experience were complex and disjointed. This resulted in key risks not being effectively escalated and mitigated in the Trust.
- There is scope for the Trust to improve its systems and processes in order to reduce excess mortality.

It is proposed that these 4 themes are used as the main focus for the risk summit.

Introduction

The Arden, Herefordshire and Worcestershire quality surveillance group meetings of 11 April and 16 May 2013 discussed concerns about raised mortality at Wye Valley NHS Trust. It was agreed that a rapid responsive review should be carried out to investigate raised mortality and review the quality of care provided by the Trust.

The scope of the review included Wye Valley's acute services, provided at the County Hospital in Hereford, and community hospital services, provided in Leominster, Bromyard and Ross-on-Wye.

This is the report of the rapid responsive review visit. The visit is the second stage in a three-stage process. The process is described in the terms of reference attached at appendix 1.

Background to Wye Valley NHS Trust

Wye Valley NHS Trust is an integrated care organisation, providing acute and community health care to people in Herefordshire and parts of Wales. The Trust was formed on 1 April 2011, bringing together Hereford Hospitals NHS Trust, NHS Herefordshire Provider Services and Adult Social Care previously provided by Herefordshire Council. Since September 2013, the Trust no longer provides social care services.

The Trust has a small catchment population of around 183,500 for acute services, with an increasingly elderly population (22%) aged 65 years and over. The Trust has an estimated annual turnover of around £160million, and employs around 3000 staff.

Methods of investigation

The two day announced visit took place at Wye Valley NHS Trust on Thursday 10 and Friday 11 October 2013. A further unannounced visit took place on the evening of Thursday 17 October. A variety of methods were used to investigate the identified key lines of enquiry (KLOEs) and enable the panel to consider evidence from multiple sources in making their judgments.

The visit included the following methods of investigation:

Patient and public listening event

A patient listening event was held on 10 October 2013 at 18.00. Approximately 45 patients, carers and members of the public came to the event. The majority of the feedback was very positive, highlighting the professionalism and compassion of staff and their satisfaction with the quality of care received. However, some people raised concerns about care at Hereford County Hospital. These included staff being too busy to be as attentive as patients would have liked; patients being moved around wards several times; delays in accessing scans; a poor environment on the day case unit; concern about the future of the hospital; and a decline in public engagement following withdrawal from the Foundation Trust pipeline, due to the wind-down of membership groups.

Interviews

17 interviews took place with key members of the executive team, non-executive directors and selected members of staff based on the KLOEs during the visit. See appendix 3 for details.

Focus groups

Focus groups provided an opportunity to talk to staff groups to ask what they felt is good about patient care and what needs improving. They enabled staff to speak up if they felt there was a barrier preventing them from providing good quality care to patients and what actions the Trust might need to consider to improve services. See appendix 4 for details of the seven focus groups held.

Observations

Observations of clinical areas enabled the panel to see the Trust during day-to-day operations. These allowed the panel to talk to a range of staff and observe clinical care and handover processes. The panel also talked to current patients, and their relatives. See appendix 5 for details of the areas observed.

Review of documentation

A number of documents were made available to the panellists by the Trust. While the documents were not all reviewed in detail, they were available to panellists to validate findings. See appendix 7 for details of the documents made available to the panel.

Concurrent CQC inspection

A team of three CQC inspectors visited the Trust at the same time as the RRR panel to investigate whether there were any regulatory breaches evident on the Hereford County Hospital site. The RRR panel has shared its findings and drafts of its report with CQC, and the CQC inspectors joined the RRR panel’s discussions during the visit. The CQC will produce its own report, and it is expected that the CQC report and this report will be published at the same time.

Key findings from the review

Based on the data gathered and analysed in advance of the rapid responsive review visit, the panel reviewed four key lines of enquiry in the following areas: governance and leadership; clinical and operational effectiveness; patient experience; and workforce and safety. The review's findings are presented here under these four headings. The list of KLOEs can be found at appendix 2.

Governance and leadership

Overview

Examples of good practice were identified in the following areas:

- The recent appointment process of clinical directors against new person specifications was considered robust
- There was a good process for quality impact assessments with director of nursing (DoN) and medical director (MD) rejecting some schemes, although arrangements for post-implementation monitoring are less robust
- Staff generally knew about the three new service delivery units and the locally held governance meetings
- On the children's ward, staff articulated good links to local and national networks
- Staff in A&E thought that the chair and non-executive directors (NEDs) were visible in the department
- Regular meetings held between DoN and heads of nursing and sisters/charge nurses
- Board workshops, e.g. the board held a two hour workshop around mortality to which Dr Foster were invited
- We met some excellent clinical directors who were keen to drive improvements in patient care

The following areas of outstanding concern were identified:

- There is a disconnect between the quality committee, leadership team and the service unit performance meetings with an ensuing lack of clarity as to ward to board and board to ward assurance
- It is not clear how risks and issues are appropriately escalated within the Trust, nor how the board is assured on the key risks facing the trust
- There is no clinical and organisational strategy underpinning both the health economy and the Trust resulting in uncertainty and planning blight
- There are concerns over the sustainability and visibility of leadership within the Trust
- There are concerns over the accuracy of the reporting of key performance issues
- The cost improvement programme is unlikely to be delivered leading to enhanced issues on sustainability

Detailed findings

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – immediate, urgent or medium
There is a disconnect between the quality committee, leadership team and the service unit performance meetings with an ensuing lack of clarity as to ward to board and board to ward assurance • The MD does not routinely attend the service unit performance meetings which receives the risk concerns from service units; the DoN does attend. • The three service unit leads do not routinely attend the quality committee.	The Trust has told us that it has commenced a review of its governance arrangements and that this is due to be completed by the end of November.	Ensure all current risks are reviewed and discussed at the service unit governance meetings with all significant risks discussed at the quality committee. This committee should include attendance by representatives of the three service unit governance groups to ensure timely escalation. Review the terms of reference, membership and attendance of the quality committee. The Trust should consider the MD attending service unit performance meetings.	Urgent Urgent Medium
It is not clear how risks and issues are appropriately escalated within the trust, nor how the board is assured on the key risks facing the trust • There is no clear reporting process from service units to the quality committee by attendance of chairs or in minutes.	The Trust told us that the risk register is regularly reviewed by the Leadership team and the Board	Recurring items on the risk register must be re-evaluated regularly and rated objectively against alternatives	Urgent

• Staff reported to the panel that concerns on low levels of staffing had been reported in Ross-on-Wye community hospital but it had taken a year for this to be addressed. (The Trust management, however, disputes this). • Twelve committees report to the leadership team, many of which have a quality and safety focus; this in turn does not report to the board. • The terms of reference of the quality committee includes oversight of safeguarding adults and children yet the child safeguarding committee reports to the leadership team. • High level risks, e.g. the day case unit being used as inpatient escalation areas, are not being risk assessed by operational and clinical staff and there is no escalation process in place. • There was a lack of clarity throughout the organisation as to who had board responsibility for quality and safety. • The non-executive directors were unable to explain to the panel some of the key issues facing the Trust. They were unable to articulate the mortality reduction plan; why it had taken so long to implement care bundles; and the top three priorities for improving quality.	The Trust told us that they intend to undertake a review of the systematic and attitudinal obstacles to escalation	Staff must be encouraged to report risks and receive feedback on how their concerns will be addressed. The Trust should undertake a root and branch review of the governance arrangements which ensures that appropriate risks are properly escalated through to the Board. The Trust should provide clarity to the organisation on where Board level responsibility for mortality reduction and for clinical quality rests. NEDs must hold the executive team to account to ensure action plans are implemented in a timely fashion	Immediate Urgent Immediate Medium
There is no clinical and organisational strategy underpinning both the health economy and the trust resulting in uncertainty and planning blight • The quality strategy is poorly focussed and it is not clear how progress on implementation is monitored. • There is no clinical strategy	The CCG is due to develop a clinical commissioning strategy by the end of December. WVT will then seek to set out its own strategic	Update, publish and communicate a clear prioritised quality strategy triangulated from all sources of quality information. This should include a clear	Urgent

	direction.	implementation plan. While the lack of a clear clinical strategy cannot explain or excuse poor quality care or care which does not follow current good practice, the CCG must make its intentions regarding future configuration of services clear.	 Medium
There are concerns over the sustainability and visibility of leadership within the Trust • On their visit to Ross-on-Wye community hospital, staff reported that executive director visits were rare. • Lack of visibility of the executive team in clinical areas at the Hereford site was a concern for senior clinical staff. • The chief executive and HR director are interim appointments.	We saw evidence that executive walk arounds undertaken at the County Hospital and Community Hospitals were reported to the Board. The Trust reported a series of visits to Community Hospitals by members of the Executive team were planned. The Trust reported that they are currently recruiting substantively to the	The executive team and NEDS must be visible across all sites and not just at Hereford Hospital.	Medium

	CEO and Director of HR positions.		
There are concerns over the accuracy of the reporting of key performance issues • Mixed sex accommodation (MSA) breaches were observed in the day case unit (see KLOE 3) • There were no reported deteriorating patient incidents and in practice examples were seen of the national early warning system not being followed (see KLOE 4) • The panel did not find evidence of clear reporting processes for pressure ulcers.	The Trust reported that they have put in place processes to address MSA breaches and that weekly reports are produced to the CCG.	The Trust board and CCG should seek assurance that mixed sex wards are being reported according to national definitions. The Trust should develop a programme for the promotion of reporting, staff education programmes and clinical audit. All grade 3 and 4 pressure ulcers to be reported as SIRIs.	Urgent Medium Immediate
The cost improvement programme is unlikely to be delivered leading to enhanced issues on sustainability • The director of finance stated that, from the £8.8m cost improvement programme (CIP) agreed by the board, they had full confidence in plans to deliver £6.9m, of which £5.1m is recurrent. • The Trust board had assumed £9.7m of support from the TDA; as yet this was not agreed.	None	The Trust should continue to assess what the impact of any underachievement of recurrent CIPs in 2013/14 will have on their CIP for 2014/15 and continue to discuss this with the TDA and CCG.	Medium

Clinical and operational effectiveness

Overview

Examples of good practice were identified in the following areas:

- The recent implementation of a 7-day 8am-8pm “physician of the day” rota
- The Trust has developed eight care bundles
- The Trust has more than 96% compliance with the WHO checklist
- Improvements have been made in the understanding of mortality including the peer review of each case by a consultant not directly involved in the patient’s management and the implementation of a mortality checklist
- An orthopaedic mortality review in May 2013 recommended the introduction of a fractured neck of femur (#NOF) care bundle and a detailed review of all #NOF deaths. There is good senior leadership of this pathway, which is a key mortality outlier.
- Consultants report a greater focus from the board on quality in the last 6-8 months
- The Trust has invested in pressure ulcer equipment
- Post incident debriefs are held following any unusual clinical events in A&E
- Good attendance was observed at a daily bed management meeting where attention was given to weekend planning and ensuring that patients to be discharged were to be identified by 4pm
- The temporary relocation of the critical care unit to Arrow ward had been well managed

The following areas of outstanding concern were identified:

- There are concerns about management of capacity and flow within the trust from admission to discharge
- Support to clinicians was observed to be poor in several areas
- There are concerns about the quality of care for stroke patients at the Trust
- While there has been improvement in the trust’s attention to mortality, there remain weaknesses and inconsistencies in mortality processes and there is a lack of leadership

Detailed findings

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – immediate, urgent or medium
There are concerns about the management of capacity and flow within the Trust from admission to discharge. • Clinicians expressed concern over the lack of bed capacity, use of escalation and poor management of patient flow through the trust. The review team observed significant issues with the operation of the day-case unit and A&E. Concerns were expressed that senior staff are being used to continually fire-fight flow issues to the detriment of clinical leadership. • A&E has a capacity of 120 but was routinely dealing with up to 170 patients per day. Clinicians talked of low morale and lack of trainees at middle grade level (see KLOE 4). There is no area for ambulatory assessment and although clinical decision unit protocols are now available for a number of conditions, these are delivered in a medical assessment unit (MAU) environment. • The Frome ward is a designated acute admissions/short stay unit but currently functions as a hybrid of short stay unit and general medical ward with of 98% patients coming through A&E (including GP referrals). • The site manager takes calls for GP referrals, therefore opportunities to discuss potential referrals with a consultant are missed. Junior doctors only find out about these accepted	Two virtual wards starting in October 2013. A business case has been accepted for the recruitment of 3 emergency assessment unit (EAU) physicians and the trust is pursuing their recruitment ECIST visited the trust on 16 October The Trust stated plans are being developed to effect an internal redesign of the department. The Board has also approved a scheme to develop a Clinical Assessment Unit which will divert GP referrals from the Emergency Department and will help identify patients for ambulatory assessment The Trust stated that a	Within existing constraints the A&E department requires redesign to enhance patient flow Provision should be made for ambulatory assessment The Trust should consider extending the critical care outreach team (CCOT) out of hours. The Trust should analyse day case unit capacity and demand and agree the bed base. The surgical bed base needs to be benchmarked and a capacity and demand tool agreed and applied. The Trust should review use of the PAS to allow creation of accurate patient lists that junior	Medium Urgent Medium Urgent Urgent Urgent

patients after receiving a call from A&E. • The day case unit is being used as an escalation ward, thus affecting the start time for theatre (only 18% of theatre lists start on time) and the bedding of patients following endoscopy and surgery. This also has significant impact on patient experience and safety (see KLOEs 3 and 4). Other areas such as the Fred Bulmer unit were also used for escalation. Although we did not see these areas in use, we did not consider the Fred Bulmer unit a suitable inpatient environment. • The inpatient surgical wards have allocated medical beds which can lead to pathway difficulties and increased length of stay. • There are significant issues with the tracking of patients throughout the acute hospital. The PAS (patient administration system) can only be accessed by ward clerks and does not necessarily give an up to date picture, hence wards keep their own lists and patients can get “lost in the system”. In addition, the A&E ‘Symphony’ system does not directly interface with the PAS. • Handovers are not always consultant-led. Maternity handovers are consultant-led but information is not monitored or shared at a higher level. • Junior doctors are concerned by the lack of cover out of hours and especially at weekends. There is no critical care outreach cover at night and doctors often have to make crash calls to the ITU registrar. • Discharge processes are inefficient: pharmacy	programme of training is being put in place for a range of staff to ensure that timely PAS entries are made throughout the 24 hour period. The Trust is also introducing a real-time bed board which will enforce the real time use of PAS The Trust stated that a comprehensive review of discharge systems and processes has taken place using as a template the 10 steps to successful discharge. The question of amending the drug TTO process will be included in further stages of that review The Trust stated that they had recently taken steps to put additional staff in place. A supplementary FY2 has been employed in Medicine on Saturdays and Sundays 10.00 am to 9.00 pm. They are also trialling the use of an additional registrar at nights and weekends.	doctors can access. The Trust should consider amending the TTO process so that draft TTOs can be sent to pharmacy prior to EDS sign off. The Trust should conduct a review of current hospital at night arrangements Consultant job plans should be reviewed to facilitate daily consultant ward rounds (see KLOE 4).	 Medium Urgent Urgent

have to wait for electronic discharge summary (EDS) sign off before issuing TTOs. This means that patients identified for discharge in the morning may not be discharged until late afternoon. • Delays in transfers to community services also delay discharge. Social services issues are causing discharge delays. • The consultant physicians are not providing daily patient reviews of inpatients. Junior doctors described two consultant ward rounds a week as typical on medical wards. While the new physician of the day model for on call is welcome, a focus is needed on providing daily consultant led review of inpatients to improve quality and reduce length of stay.	The Trust stated that discharge processes have been subject to comprehensive review and a programme of change in underway. A new team to affect complex discharges has been put into place as part of changed arrangements. The electronic discharge summary and issue of TTOs is an issue which is being reviewed.		
Support for clinicians was observed to be poor in several areas • Delays with diagnostic reporting can have implications for patient care and hospital flow. There is one CT scanner in use at the acute site and clinicians often have to wait 48 hours for both CT and ultrasound, impacting on length of stay. There are two vacancies for radiographers and PACS is reported to be unreliable. • The panel found that phlebotomists will not take blood from patients in side rooms and do not cover the maternity department. Bloods are not covered in handovers thus delaying discharge. Junior doctors often only discover bloods have not been taken late in the day, impacting on length of stay. • Although the Trust has recently implemented care bundles there remains an unclear audit	Bid in place for second CT scanner. The Trust stated that they had undertaken lean optimisation of these imaging modalities and is seeking to appoint Radiologists to vacant posts. Periodically mobile MRI and CT are used to supplement machine capacity. Outsourcing weekend work is planned. The Trust stated that additional phlebotomists have been employed to	The Trust should work to ensure that optimal use is made of CT, ultrasound and MRI in hours, and at weekends. The Trust should undertake a review of phlebotomy to ensure that optimal use is made of this service.	Medium Urgent

strategy, lack of training and patchy implementation in some areas. For example, the sepsis bundle has not been implemented consistently across all hospitals or in a timely manner, and audit is currently restricted to admission and not more widely throughout the Trust.	address the issues identified. In addition a new business case will be presented to the Trust Executive Team to effect a permanent uplift to the service.		
There are concerns over the quality of care for stroke patients at the Trust • The Trust deals with hyperacute and acute stroke but sees a relatively low number (less than 400) of stroke patients per annum. The Trust has attempted to create a stroke network with other Trusts but this has not thus far been successful. • There are only two stroke consultants at the Trust and thrombolysis is mostly carried out by medical specialist registrars (SpRs), rather than British Association of Stroke Physicians (BASP) accredited stroke specialists, who told the panel they felt insufficiently trained and supported to do this. • The stroke team will only see patients after thrombolysis is carried out. • There is no early supported discharge. Patients requiring rehabilitation are often sent to Hillside, but up to 50% of stroke patients sent to Hillside return to the acute site due to medical complications as a consequence of inadequate medical input. • There is no emergency stroke outreach team (ESOT), to review patients on other wards who have a stroke, or support thrombolysis in A&E. This puts further pressure on the medical SpR,	Discussions are underway to establish a joint service with Worcester Acute Hospitals NHS Trust (WAHT). The Trust are clear that unless a clinically and financially sustainable solution can be found, they would not want to continue providing hyperacute stroke services The Trust have stated that a telemedicine link with the Bristol network is being put in place	The Trust should ensure improved medical input into the Hillside site The Trust should create an emergency stroke outreach team. The Trust should explore the possibility of telemedicine through a stroke network, to provide stroke physician decision making for thrombolysis out of hours The Trust should explore the possibility of a network approach to providing weekend stroke unit ward rounds and weekend TIA clinics.	Urgent Medium Medium Urgent

and may reduce proportion of patients who are thrombolysed, in part explaining the low thrombolysis rates. • There is no current stroke network to allow potential for telemedicine for thrombolysis out of hours, weekend TIA clinics and weekend stroke consultant ward rounds on the hyperacute and acute stroke units. • There is no current provision of a weekend Doppler service to support a high risk TIA clinic at weekends.			
While there has been improvement in the trust's attention to mortality, there remain weaknesses and inconsistencies in mortality improvement processes and there is a lack of leadership • Despite a rising HMSR over some years the mortality and morbidity review processes lack leadership and are inconsistently developed across specialities, teams and wards. • While we identified some good practice, this appeared to be taking place within specialties and did not appear to be shared across the organisation. • There is no ward level view of mortality. There is little evidence of mortality analysis at ward or speciality level. For example, the respiratory team do not meet to review mortality. • The majority of staff interviewed considered that there were external explanations for high mortality such as an aging population and late admissions from primary care. This, along with the acceptance that frequent patient moves made it difficult to pinpoint causes suggests that staff are reluctant to own issues of mortality.	Roll-out of care bundles and of the national early warning system (NEWS), although these are not being used consistently and to full effect. Trust has carried out mortality reviews recently, and is receiving detailed mortality reports from Dr Foster (see KLOE 1 good practice)	The Trust should develop an overarching plan for mortality reduction which should be taken to the board.	Urgent

• Actions plans resulting from mortality reviews did not always refer to clinical change (see KLOE 4) • Junior doctors and other clinical staff asked were only aware of some areas where mortality was outlying.			

Patient experience

Overview

Examples of good practice were identified in the following areas and examples of positive patient feedback:

- Patients commented that staff were very committed, friendly and caring: “Nothing is too much trouble for the staff!”
- Timeliness to be seen in some departments, e.g. patients on Wye ward said they received prompt treatment once seen, after wait in busy emergency department
- The panel who undertook the unannounced visit were particularly impressed by the positive attitude of staff on Redbrook ward despite extremely low levels of staff
- Specific services, ophthalmology, cancer, maternity described by some patients as excellent
- At Leominster community hospital: having the model of 1 GP allocated to do the weeks’ visits works well
- At Leominster community hospital: patients’ call bells are within easy reach and the panel felt the environment, food and dignity were excellent
- On Wye ward: there were positive statements from some patients concerning quality of nursing care, privacy and dignity.
- Hillside Intermediate Care Centre: very good feedback from all patients, very pleasant atmosphere, staff well liked, patients are fully aware of their care plan and are very happy with their carers involvement
- Patients spoken to were generally very pleased with the level of communication they receive about their care or treatment: “Everything fully explained”
- One ward manager was working with a clinical nurse specialist to plan the elective admission for an adult patient with learning disability the following week, including enabling the parents to stay over.

The following areas of outstanding concern were identified:

- There is no patient experience strategy and the trust is not able to articulate its priorities for patient experience
- There is no clarity on how the board is assured on patient experience or prioritisation plan based on friends and family test (FFT) responses
- There are gaps in assurance in the new complaints process, and the process needs to be embedded at ward level
- There is scope to improve staff engagement in and ward level ownership of improving patient experience
- There is scope for improvement in the way the Trust systematically acts on patient feedback
- Staffing levels clearly have a negative impact on patient experience as reported by some patients in most areas visited
- Serious concerns raised regarding patients’ privacy and dignity on day case unit, which would also apply to the Fred Bulmer unit when used as an inpatient escalation area
- Staff reported that they would not want to be treated in certain wards and in escalation areas of the hospital.

Detailed findings

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – immediate, urgent or medium
There is no patient experience strategy and the trust is not able to articulate its priorities for patient experience • There is no patient experience committee. • There is no reporting mechanism in place, which would solely focus on patient experience. • There is a lack of triangulation of patient experience data e.g. national survey results with FFT and hospital surveys. • There is no clarity on how patient experience is linked to corporate and clinical strategies.	The Trust have stated that they intend to have a strategy in place to improve patient experience by December The Trust have put in place a rolling ward audit programme using volunteers to ask specific questions of patients	The Trust should develop and implement a written patient and carer experience strategy. This should include the appropriate systems and processes to ensure proper reporting through to the Board. The Trust should develop a process to engage ward managers and staff in owning their patient experience data and subsequent action plans for improvement.	Urgent Medium
There is no clarity on how the board is assured on patient experience or a prioritisation plan based on FFT responses • Patient stories are taken to board meetings, but patients and carers do not attend to present their stories personally. • Patient experience/complaints are reported to board in a very brief format without the level of detail and triangulation which would	The Trust have stated that they will start a programme of patients taking their stories to the Board on 31 October 2013 The quality committee receives a quarterly patient experience report,	The Trust should consider developing a programme of patients and carers taking their own stories to the Trust Board. The Trust could improve its quarterly patient experience report by	Urgent Medium

highlight areas of concern. • From the evidence reviewed it does not appear that the board is given enough details to understand the substance of complaints. The section on complaints in the board reports briefly states numbers and response times, no key themes are identified and action plans agreed/implemented. There is little mention of complaints in the annual report. The monthly reporting has not taken into account the recommendations in the Francis report.	which includes themes across wards or service unit and summaries of most 'red-rated' complaints.	triangulating complaints and concerns with claims and incidents. In line with Francis report recommendations the Board should receive excerpts from patient complaints.	
There are gaps in assurance in the new complaints process, and the process needs to be embedded at ward level • The Trust has ratified and started to implement its revised management of complaints, concerns, comments and compliments policy in October 2013. The policy and the complaints log do not clearly describe the criteria as to how the complaints are assigned to a grade of severity (green, amber, red). • We found that the new complaints policy was not well embedded at ward level, and ward-based staff, including sisters, did not have awareness of complaints that had taken place on their wards, and resulting action plans. • There are gaps in assurance in the complaints process, including in the development and monitoring of action plans at the completion of the complaints cycle. • Where complaint letters are sent to the chief		The Trust should ensure that it has appropriate processes in place so the trust board is sighted on all aspects of complaints including PALS queries, formal enquiries, low, moderate and high risk complaint numbers. Ensure that the policy is clear on responsibility for ensuring complaints action plans are completed . The action plans should include the names of implementation leads, time-frames and be followed up to ensure that the cycle is fully completed.	Medium Urgent

executive, the acknowledgement letters are not signed on behalf of the chief executive. We recognise that the chief executive may not be able to sign every letter, e.g. due to annual leave; however, we would expect all letters to be signed on his behalf.		The trust should ensure that ward-level staff are aware of the themes and actions of complaints for their ward. The trust should consider whether all complaint letters, including acknowledgements, should be signed by or signed on behalf of the chief executive.	Urgent Medium
There is scope to improve staff engagement and ward level ownership of improving patient experience • Ward level staff were not able to articulate the Trust's priorities for patient experience and are not aware of ward level performance of patient experience. • There was a lack of knowledge of and engagement with FFT. Ward managers did not know their wards results and had to go to the poster at the ward entrance to find the result. • Hospedia enables patients to undertake seven surveys, but staff aren't clear which one includes the FFT and Hospedia is not available on every ward. • Staff can't access real time results or, if they can, they don't know how.	The Trust have stated that FFT response and score is included in the ward nursing metrics.	The Trust should consider implementing a half day rolling programme for staff, including mandatory reporting so staff can better understand patient experience and the ways to measure it. The Trust should ensure staff have access to real time data or weekly reporting of FFT by ward.	Medium Medium
There is scope for improvement in the way that the Trust systematically acts on patient feedback	The Trust state that they have retained a stakeholder group, which	Appropriate reporting and a board to ward approach should be incorporated	Medium

• There is a lack of understanding of key themes and there is no trust-wide initiative. • Due to a lack of planned/coordinated activities, ward level staff are not engaged in actions to improve patient experience. • A ward level action plan template was developed, but it is not populated with sufficient detail (no deadlines/no agreed actions). Ward managers could not provide a patient experience action plan. • Noise at night still appears to be an issue on the wards and not fully addressed (although the Trust implemented a noise charter in 2012). • Frome ward, bay D and Monnow ward toilets: patients complained that paper is some distance from the toilet, this also causes a risk of falls. • Leadon ward: a severely physically disabled patient's carer raised concerns about the trust's approach to dealing with patients with a disability. • Trust membership meetings have been discontinued following the decision that the trust is not currently in the FT pipeline. Patients attending the focus groups felt this was a very important communication interface between the trust and patients. • Patients would welcome more regular direct communication from the trust to patients regarding the future of the hospital, rather than being reliant on information gathered from the media.	is active and engaged in the "Future's programme".	into a patient experience strategy. Ward managers need further encouragement to feel empowered to improve the patient environment or pathway based on patient feedback.	 Urgent
Staffing levels clearly have a negative impact on		See KLOE 4	

patient experience as reported by some patients in most areas visited • Staff are often pulled to cover contingency/escalation areas, as demonstrated by the Leadon ward roster for September. This leaves the home ward to become underestablished and supported by agency or bank staff. • There is no trust-wide electronic patient record, leading to a lot of paperwork and taking away big proportion of clinical time. • The huge number of patient moves has a significant impact on patient experience and also impacts on outcomes. • Some patients stated that they had a lack of support with eating. A patient on the stroke ward reported choosing finger food as staff were too busy to help her cut up her meals. • Incomplete medical notes cause delays in speciality assessments, diagnostic tests and TTOs. • Patients at the listening event described staff as too busy to give their full attention to patients, particularly in A&E		recommendations for workforce	
Serious concerns raised regarding patients' privacy and dignity on day case unit, which would also apply to the Fred Bulmer unit when used as an inpatient escalation area • Trust is declaring compliance with mixed-sex accommodation requirements and not reporting any breaches; however, the day case unit is not adherent to best practice guidance. • We observed female and male patients	The Trust state that the following interim safeguards have been put in place Escalation areas may only be brought into use with the express approval of the Director on call, the Chief Operating Officer or	The Trust should develop an action plan to ensure compliance with mixed sex accommodation requirements	Urgent

bedded opposite one another. • We also observed a male patient being escorted through the female bay by a member of staff. • Changing rooms are open and used by both male and female patients and the layout of the recovery area is not suitable to ensure privacy and dignity. • We had privacy/dignity concerns in relation to the nursing handover, as there is no space off the unit and sound travelled easily.	the CEO. For the day case unit specifically, the following steps were taken immediately after the Review panel gave their initial oral report: • Immediate removal trolleys 1-3 on male side to prevent patients looking into female side. • Maximum of 12 inpatients on beds in Day Case Unit. In addition, no inpatients within the first three beds on male side. • Complete risk assessment to include mixed sex issues, patient experience, infection control and patient flow. • Identify and circulate patient pathways to and from Theatre to prevent passing through an area occupied by the opposite gender. • Review use of day surgery recovery area (recliners) and how to maintain privacy and		

	dignity. A review was undertaken with the CCG on 15/10/13 concerning the reporting of gender separation and an approach agreed.		
Staff reported that they would not want to be treated in certain wards and in escalation areas of the hospital • Some of the older wards were described as "Nissan huts" and "should be bulldozed down". • When staff were asked if they would be happy to be treated in the hospital, none of them said an unconditional yes, all said only in certain areas. They would definitely not want to come via A&E and risk being cared for in an escalation area.	A series of listening events have been planned from November 2013 onwards to enhance the dialogue between senior management and the workforce.	The Trust should develop processes to capture staff feedback and better involve staff in developing and implementing a patient experience strategy.	Medium

Workforce and safety

<u>Overview</u>

Examples of good practice were identified in the following areas:

- The Safer Nursing Care Tool, the National Early Warning Score (NEWS) and DATIX incident reporting have recently been introduced across the Trust.
- We met excellent staff across the Trust, who demonstrated commitment and compassion. Marilyn Hamon, the receptionist on the Macmillan Renton unit, demonstrated particular compassion. Suzie Hicks, sister on the day case unit, showed outstanding commitment and we were impressed with her efforts to do the very best in a difficult situation. Seng Weo, service unit director in theatres, was very engaging and absolutely knew the challenge ahead.
- We met two lead nurses in paediatrics and outpatients (Fiona Blackwell and Rachel Lowe) who had very innovative ideas to improve their departments and were keen to share their learning and experience across service units.
- Sharon Wood, sister on the orthopaedic unit, confirmed that following high numbers of falls, the ward had cohorted high risk fallers and the incidence of patient falls had reduced.
- The new Head of Quality and Safety, Rachel Dunne, has introduced a new process for the service unit governance groups, including single improvement plans incorporating all actions resulting from complaints, concerns and incidents.
- Junior doctors felt well supported and able to raise concerns; we were provided examples of concerns being acted on.
- 100% of appraisals were complete on the maternity unit and induction packages were excellent.

The following areas of outstanding concern were identified:

- There are shortfalls in the Trust's approach to managing its workforce.
- There is scope to improve processes to further engrain safety or learning culture within the Trust.
- There are serious concerns about the safety of day case unit.
- There are immediate risks regarding insecure access to the theatres.
- Staff reported that training opportunities had been cancelled due to operational pressures, and trust data suggested mandatory training rates are low.
- There is high locum spend, and a lack of middle grade doctors.
- There is no clear standard regarding do not attempt resuscitation (DNAR) orders, and there appeared to be a lack of engagement with patients and relatives about their use.
- Staff working in the community hospitals are isolated and there is insufficient medical cover.
- Staffing in the maternity unit is leading to potentially unsafe practice.

Detailed findings

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – immediate, urgent

			or medium
There are shortfalls in the Trust's approach to managing its workforce • The Trust has difficulties recruiting due to its geographical location. • Nursing and medical staffing across the sites is underestablished and vacancy rates were relatively high. • The director of nursing establishment review recommendations would still not bring the trust into line with national guidance for ratios of registered:unregistered and registered nurses to patients. A limited number of recommendations were supported by the Board. • Due to the staffing levels and patient acuity, we were told that staff are doing additional hours for which they are not getting paid and are unable to take time back; this is dependent on the good will of staff. • The head of nursing advised in relation to staffing on the stroke ward that an external advisory group report recommendation was to increase establishment by 12 WTE registered nurses, this has not been implemented. There has been an increase in staffing but still provides a 50:50 ratio of registered to unregistered nurses on a shift by shift basis. • There was a lack of clarity about the high nurse agency and bank spend, which was out of proportion for the bed numbers and did	The Trust has stated that a nursing review is currently being undertaken and the report is due to be presented to the Board on 31 October 2013. At present this includes all inpatient adult areas with full costing and the year to date impact. A further plan for speciality areas will be completed within the next 3 months. The Trust stated that they are considering the amalgamation of stroke services into a single site. A business case will be produced by December 2013. The Trust stated that interviews for the HR Director position are due to take place on 1November. The Trust stated that agreed job plans now stand at 30% following the introduction of a new job	There needs to be a full nursing and midwifery establishment review undertaken by ward with recommendations based on national guidance and taking into account previous external review recommendations. The review should contain full costings and yeat-to-date (YTD) impact. Trust should address the very low level of agreed job plans to ensure value for money and clinical activity which supports the Trusts goals. The Trust should investigate the reasons for both high sickness and high agency and bank spend, and report on this to the quality and safety committee.	Medium Urgent Medium

not correlate with vacancy figures; it was unclear how they related to acuity. • Junior doctor cover, especially by medical registers, was particularly low at nights and during weekends. • Appraisal rate is consistently low, although there has been a recent increase. It appeared that it is not being given sufficient priority due to competing pressures. One ward manager reported that she had 30 staff and had only been able to undertake 7 appraisals year to date and she could not book staff on statutory training as the sessions were fully booked until March. • The consultant job planning rate was very low (20%). The NEDs were aware of this but could not articulate an action plan. • The HR director is interim and HR has been outsourced until recently. • There are relatively high sickness rates, particularly among doctors, which are not understood.	planning policy and, from 1 October 2013, a new clinical management structure. Job plans in all specialities were reviewed on a team basis in 2012/13 as part of the cost improvement programme. The outcomes were not necessarily agreed and so were not placed on Zircadian.		
There is scope to improve processes to further engrain a safety or learning culture within the Trust • Staff were not able to articulate any safety themes or programmes and there was no evidence of sharing learning across directorates and across professional groups • Many staff reported that they were unaware of the outcomes of investigations into incidents, complaints and claims, and that there are no shared learning events or other mechanisms to disseminate lessons.	DATIX has recently been rolled out to support incident reporting, and we understand that training is being rolled out. As noted in the good practice above, Rachel Dunne has brought together single improvement plans for each service unit.	The Trust should initiate and run the Manchester Patient Safety Framework and facilitation system. The Trust should initiate systems for identifying deteriorating patients that are not recognised and responded to in a timely fashion, including reviewing unplanned	Urgent Urgent

• Some staff viewed incident reporting as a 'task', rather than a tool as part of an improvement methodology, and we were concerned that not all incidents are reported. • In particular there was no evidence of reporting 'failure to rescue/ deterioration not recognised' serious incidents, yet the panel did encounter patients who had deteriorated and the critical care team did talk about unplanned admissions to HDU/ITU from the wards. • Reviewing meeting minutes, a number of internal reviews and incident investigations, we found little evidence of change of clinical practice resulting from incidents or of themes and lessons being discussed in trust-wide fora. • Ward sisters reported that service unit action plans and dashboards are not filtering down to them. • There did not appear to be systematic opportunities for multi-disciplinary learning from events. • The majority of staff we spoke to could not articulate the trust's quality strategy or any quality priorities. • There was very limited information displayed on the wards showing performance against key quality indicators. • An internal review of SIRI investigations highlighted that these were not of sufficient quality and actions were not robust enough to reduce risk; it also found that actions are not always completed. This was supported	The Trust has stated that the Director of Nursing and Quality has instructed HDU and ITU to complete incident forms for unplanned admissions. Auditing of cardiac arrests already happens and a report went to Quality Committee on the 24 October 2013. Currently patient safety walk rounds are used to audit NEWS, the effectiveness of this will be reviewed. Further training concerning NEWS is planned.	admissions to HDU/ITU, auditing NEWS and cardiac arrests. Themes and learning from complaints, incidents and claims should be discussed as a standing item at ward meetings, service unit governance groups and senior nursing meetings. A sharing the learning report should be shared with the board and cascaded; the board should monitor implementation. A sharing the learning trustwide safety programme for all professional groups should be initiated. Ward based staff should be able to access real time data against nursing and quality metrics.	 Urgent Medium Medium Medium

by other evidence we saw of actions being incomplete. • Staff reported a lack of training on DATIX prior to introduction of the new system.			
There are serious concerns about safety of the day case unit • The unit has been in use as an escalation ward relatively consistently for the past two years and regularly has 20 inpatients; however, staffing does not take account of this and staff report being pulled from the wards to cover escalation areas. • There were 2 cases of patients who were acutely unwell and should have been on an acute ward rather than on the day case unit and who then deteriorated. We saw evidence of a medium early warning score not being acted upon for several hours. • The standard operating procedure for the unit does not identify types of patients who were appropriate for the unit or exclusions that the staff were aware of, including junior doctors. • Beds are too close to one another breaching infection control standards. • We saw patients bedded where signage indicated the space was only suitable for trolleys. • Use of the day case unit as an escalation ward for inpatients means that beds are not available for endoscopy patients in recovery. • A number of incident reports made by theatre staff in the past three months highlight that patients are also often held for long periods (up to 5 hours) in post-operative recovery, as	The Trust recognises in its risk register that use of the day case unit breaches CQC standards; however, this risk was opened in April 2011 and remains at a risk rating of 20 with gaps in both assurance and controls. The Trust state that they have now removed beds in order to achieve infection control standards.	The escalation area should be staffed appropriately for the number of inpatients regularly on the day case unit. This would also mean that there is no need to backfill the wards with agency staff. The standard operating procedure must be reviewed including vital sign parameters and NEWS scoring of the types of patients who are suitable for the unit and those who should be excluded. The Trust should remove beds or increase the space between them to meet infection control standards. The Trust should make provision of ringfenced beds for endoscopy patients a priority, and	Immediate Urgent Immediate Urgent

the day case unit is in use as an escalation area and ward beds are not available. • During the window between our announced and unannounced visits, we became aware of a never event reported on the day case unit involving a drug error.		reflect this in its work to analyse the capacity of the day case unit as recommended under KLOE 2.	
There are immediate risks regarding insecure access to the theatres. • Access from the day case unit and intensive care unit is not controlled by swipe card. • Staff recounted how they had found a patient using his mobile phone in theatres as he had been unable to get a signal in the day case unit .	The Trust confirmed it had contacted a contractor to put in swipe card entry, and we saw evidence of this work underway on our unannounced visit.	The Trust must ensure theatres are secure and only accessible via swipe card.	Immediate
Staff reported that training opportunities had been cancelled due to operational pressures, and trust data suggested mandatory training rates are low • Staff reported that training opportunities have been cancelled due to operational pressures. • The Trust was unable to provide detailed information regarding training uptake, and we understood it has been unable to report fully to the board on training uptake since July. • Information provided on mandatory level 1 safeguarding training showed uptake between 50-60% over the past four months. We understand, but were not able to confirm, that safeguarding training levels for medical staff are below this. • Junior doctors told us that induction training is variable in quality. Those that arrive in August receive a good induction, but those arriving at other times in the year receive	The Trust is introducing a new system to track training, linked to the electronic staff record. The Trust has stated that there are 2 mandatory trainers within the organisation who have reviewed the number of courses/places required over the next 5 months. The Trust has stated that all doctors in training undertake adult safeguarding mandatory training as part of the deanery induction e-learning package.	The Trust should ensure that training opportunities are only postponed, and not cancelled, due to operational pressures. The Trust should develop an action plan to increase training rates, and the HR director and medical director should work together to improve uptake of mandatory safeguarding training among medical staff. The Trust board report on training should contain a breakdown of each professional groups and	Urgent Medium Medium

limited induction, particularly training on and access to IT systems.		their compliance to mandatory training requirements and appraisal. The Trust should ensure that comprehensive induction is provided to all new starters.	 Urgent
There is high locum spend, and a lack of middle grade doctors • Consultants we spoke to did not feel that the trust was attractive to new doctors, and that many of the middle grade doctors working in the trust were inexperienced. • We heard from staff that there is very limited medical cover, e.g. one registrar covering A&E, obstetrics and gynaecology, and no critical care outreach team at night. One junior doctor described being expected to perform thrombolysis without training; several said that the registrar did not always come when called. • Junior doctors reported that the numbers of locums at night impacted on the quality of handovers. • Staff in A&E and obstetrics reported a particular lack of middle grade doctors; there is also a lack of FY2 cover in obstetrics.	The Trust has previously attempted overseas recruitment for obstetrics.	The Trust will need to work with the local education and training board on developing joint posts e.g ITU/ ED / acute medical specialities or a joint post as a medical patient safety lead with ITU. The Trust could consider the development of ED majors nurse practitioner posts as part of the ED middle grade rota and paid for out of medical monies.	Medium Medium
There is no clear standard regarding do not attempt resuscitation (DNAR) orders, and there appeared to be a lack of engagement with patients and relatives about their use. • The end of life care pathway provided by the	The Trust state that the Palliative Care Team has been asked to review the end of life care pathway.	The Trust should review its end of life care pathway and supporting processes, taking account of both the acute and	Urgent

trust is dated August 2011 and has not been updated to reflect the withdrawal of the Liverpool Care Pathway. • There is no trust standard for DNAR; audits of DNAR do not appear to be all encompassing, and it is unclear how audits can take place without a clear standard. • DNAR forms viewed on wards (Frome, Wye) did not include patient and relative engagement. • Junior doctors told us that registrars complete DNARs for the consultants to sign. Forms are not signed off at earliest opportunity by the consultant and nursing staff are not always aware that documentation is not completed appropriately. • Staff reported that DNARs were not routinely reviewed by GPs in the community hospitals. We saw one example of a DNAR form completed by a middle grade doctor in August, which was still outstanding a consultant signature on 10 October.	The Trust state that the internal auditors have been asked to review Trust wide DNAR on the 4 November 2013. Following this audit the standard will be reviewed, amended and re-audited. The Trust state that a weekly report is planned for publication which will include performance on VTE assessment, Dementia assessment, WHO checklist compliance, NEWS spot checks and DNAR compliance which will identify responsible consultants in November 2013. The Trust state that the Medical Director has been required to undertake comprehensive review of DNAR practice and put in place remedial actions as soon as possible.	community sites. The trust should ensure that individual responsibilities within the pathway are clearly communicated to staff. The Trust should agree a standard for DNAR, against which audit may be undertaken.	 Medium
Staff working in the community hospitals are isolated and there is insufficient medical cover • Staff in the community hospitals reported that	The Trust intend to use the Community Hospitals for the patients with higher	The Trust should ensure its communications and governance mechanisms	Medium

they receive no communication about SIs, complaints, learning or organisational improvement. • Electronic systems are not consistent across the acute and community sites, and clinical improvements rolled out at the county hospital are not always rolled out to the community hospitals. • We heard that both occupancy levels and acuity of patients in the community hospitals is increasing, and staff are frustrated that their requests for increased staffing are not always listened to. • There is no multi-disciplinary team collaborative discussion with acute consultants and GPs for community hospital patients, and no handover. GPs reported that they usually 'found' new patients at the hospital on their next visit. • Nursing staff told us that GPs only review those patients about whom they have raised concerns; there are not full medical ward rounds on the community hospital sites. • At Bromyard Community Hospital, registered nurses, with no training/competence in non-medical prescribing or patient groups directions, on receipt of abnormal INR results were altering warfarin doses on the prescription charts following verbal order from the GPs, which the GPs then countersigned on the their following visits. (The Trust subsequently stated that this practice ceased 2 months ago) • We heard concerns from a GP that a new	acuity and to improve throughput. The Trust is in the process of changing the medical cover and reviewing the out-of-hours arrangements. (They state that they have served notice on the GP practices).	are inclusive of community hospital based staff. The Trust should consider joint posts across the acute and community sites to improve links; we heard a good example of this already taking place in paediatrics. The Trust should urgently review medical cover at its community hospitals, including out-of-hours. The Trust should introduce a medical or multi-disciplinary team handover from the County Hospital to the GPs taking patients at the community hospitals. The Trust should check that the practice of registered nurses altering warfarin prescriptions on receipt of INR results has ceased. INR results should be reviewed or received one day earlier in preparation for the GP visit.	 Medium Urgent Urgent Urgent

contract may lead to a reduction in medical cover at the community hospitals. • Staff at Bromyard hospital advised that when patients deteriorate out-of-hours, nurses call PRIMECARE who triage the call and call back. It can take up to 6 hours for a doctor to see the patient, or nurses may have to call 999, particularly if the patient deteriorates while waiting for a GP to arrive.			
Staffing in the maternity unit is leading to potentially unsafe practice • There is a lack of middle grade and FY2 doctors in obstetrics. • The current midwife:birth ratio is 1:34, well above the national recommended standard; with vacancies and maternity leave, the effective ratio is 1:36. • We found evidence of band 3 midwifery support workers assisting in theatre. • The skill mix on the delivery suite is compromised as most of the band 6 midwives are on maternity leave and a third of the workforce is in the community. • The caesarean section rate is high, at 36%. • Most shifts are down 2-3 midwives, and agency midwives are on every day. • There was very limited evidence of strategic workforce planning taking place within maternity.	The Trust has attempted to recruit the agency midwives who work regularly in the unit, with no success, and has attempted to recruit medical staff overseas. 12.5 hour shifts will be introduced in November, which may attract staff from further afield. The Royal College of Obstetricians and Gynaecologists is due to undertake a visit to the unit.	The Trust should develop a strategic approach to workforce planning in the maternity unit. The Trust should consider temporary measures to improve the midwife:birth ratio, including bringing community midwives into the hospital, asking specialist midwives to do some clinical days and remodelling community and home visits. The Trust should review how it provides safe and appropriate support to caesarean sections. We recommend the Head of Midwifery considers service models in use in other trusts, and potential	Medium Urgent Immediate Medium

		use of the productive series.	

Next steps

A risk summit will be held on 5 November. This will be chaired by the Regional Director (Midlands and East) of NHS England. Attendees will include representatives from:

- NHS England regional and area teams
- Wye Valley NHS Trust
- NHS Herefordshire Clinical Commissioning Group
- The Care Quality Commission
- The NHS Trust Development Authority
- Health Education West Midlands
- Nursing and Midwifery Council
- General Medical Council
- Herefordshire Health Watch
- Herefordshire Health and Wellbeing Board
- Pawys Teaching Health Board

The outcome of the risk summit will be to agree an action plan to address the urgent recommendations and the support requirements to deliver this plan.

The Trust will then have 15 working days to develop an action plan to address the other recommendations in the report, which should be submitted to the panel chair and risk summit chair for agreement. Oversight and monitoring of the actions by commissioners and regulators will be agreed at the risk summit

Appendices

Appendix 1: Terms of reference
The rapid response review was designed to investigate raised mortality ratios at Wye Valley NHS Trust, as discussed at the Arden, Herefordshire and Worcestershire quality surveillance group meetings of 11 April and 16 May 2013.

The purpose of the review is to seek to:
- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at this Trust; and
- Identify:
  i) whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken;
  ii) any additional external support that should be made available to these Trusts to help them improve; and,
  iii) any areas that may require regulatory action in order to protect patients.

The scope of the review will be Wye Valley's acute services, provided at the County Hospital in Hereford, and community hospital services, provided in Leominster, Bromyard and Ross-on-Wye.

Methodology behind the review
The review will follow the methodology of the recent Keogh reviews into the care and treatment provided at 14 hospital trusts. It will follow a three stage process:

Stage 1: **Information gathering**: NHS England will gather and analyse a range of information and data available within the NHS to develop key lines of enquiry.

Stage 2: **Rapid Responsive Review**: A team of experienced clinicians, patients, managers and regulators (CQC) will visit the trust to observe the hospital in action. This will involve walking the wards and interviewing patients, trainees, staff and the senior executive team. The review team will then meet to discuss and share their opinions before producing a report. Should the review team identify any serious concerns about the quality of care and treatment being provided to patients that they believe requires rapid action or intervention, the Chief Executive of the Trust and the relevant regulator(s) will be notified immediately.

Stage 3: **Risk Summit**: A further risk summit will be held, chaired by NHS England Regional Director (Midlands and East) or a nominated deputy, to share the findings of the rapid responsive review alongside other hard and soft intelligence. Risk summit participants will make judgements about the quality of care being provided and agree any necessary mitigating actions, including offers of support to the trust.

Review membership
The rapid responsive review will be chaired by NHS England Regional Chief Nurse (Midlands and East), and the review team will include representatives of the Care Quality Commission, Clinical Commissioning Group and NHS England area team. The review team will recruit

experienced clinical members and a lay member from outside of the area, and will be supported by senior managers from NHS England. Careful consideration will be given to any potential or actual conflict of interest.

Membership of the risk summit will be in line with National Quality Board guidance for risk summit attendance and will include senior representatives of

- NHS England regional and area teams
- Lead commissioning clinical commissioning group
- Care Quality Commission
- NHS Trust Development Authority
- Local Education and Training Board
- General Medical Council
- Nursing and Midwifery Council
- Wye Valley NHS Trust.

Accountability / Reporting

The actions and recommendations will be monitored by Herefordshire Clinical Commissioning Group and other organisations participating in the risk summit, as agreed by the risk summit chair, with progress made reported to the Regional QSG.

Appendix 2: Key lines of enquiry

Area of focus	KLOE
Governance and leadership	1. Can the Trust clearly articulate its governance processes for assuring the quality of treatment of care?
Clinical and operational effectiveness	2. What governance arrangements does the Trust have to monitor clinical and operational performance data at a senior level, including mortality data and clinical effectiveness?
Patient experience	3. How does the Trust review patient experience data and engage with patients to seek views about their experience?
Workforce and safety	4. How does the Trust approach workforce planning to ensure patient safety is managed effectively?

Appendix 3: List of interviews

Interviewee	Date held
Derek Smith, Chief Executive	10 October 2013
Mark Curtis, Chair	10 October 2013
Dr Peter Wilson, Medical Director	10 & 11October 2013
Michelle Clarke, Director of Nursing and Quality	10 & 11 October 2013
Neil Doverty, Chief Operating Officer	10 & 11 October 2013
Sara Coleman, Non-executive director and chair of the quality committee	10 October 2013
Maxine Chong, Head of Midwifery	10 October 2013
Ken Hutchinson, Interim Director of HR	10 October 2013
Sara Coleman, Simone Rennie, Frank Myers, Christine Maclean and Mark Woller, Non-executive directors	10 October 2013
Paul Deneen, HealthWatch Chair	11 October 2013
Howard Oddy, Director of Finance	11 October 2013
Andy Parker, Business Manager – Elective Care Service Unit	11 October 2013
Rachel Dunne, Head of Quality and Safety	11 October 2013
Dr Alner, Associate Medical Director	11 October 2013
Steph Cholmondley, Patient Experience Manager, and Alison Joyce, Acting Complaints Manager	11 October 2013
Lucy Simcock, Risk Manager	11 October 2013
Dr Alison Johnson, consultant microbiologist	11 October 2013

Appendix 4: List of focus groups

Focus group	Focus group attendees	Date held
Doctors	c20 doctors and surgeons from a range of acute specialties, including obstetrics, paediatrics, anaesthetics, general surgery and stroke.	10 October 2013
Sisters / Matrons	c20 sisters, heads of nursing and other senior nurses from across most wards and services at the county hospital and Hillside intermediate care centre	10 October 2013
Staff – all	c25 staff, including radiographers, therapists, dieticians, midwives, service managers and administrators	10 October 2013
Junior doctors	13 junior doctors, including GP trainees, FY1s and registrars, representing paediatrics, obstetrics, general surgery and medicine	11 October 2013
Trainee nurses	c25 trainee nurses and midwives, largely from the acute hospital wards	11 October 2013
Staff nurses	c12 staff nurses, including medical and surgical wards, critical care, children's, day case and endoscopy	11 October 2013
Patients and public	c45 people joined a public listening event. Most were recent patients at Hereford County Hospital; some had experience of the community services; and a small number represented organisations, including patient user groups, charities, HealthWatch and the local council.	10 October 2013

Appendix 5: List of areas observed

Area observed	Date(s) observed
Arrow ward	10 & 17 October
Bromyard community hospital	10 October
Children’s	10 October
Day case unit	10, 11 & 17 October
Emergency department	10,11 & 17 October
Frome ward (Acute admissions unit)	10,11 & 17 October
Hillside intermediate care centre	10 October
Leadon ward	10 & 17 October
Leominster community hospital	10 October
Lugg ward	10 October
Maternity department	10, 11 & 17 October
Redbrook ward	10 & 17 October
Ross-on-Wye community hospital	10 October
Teme ward	10 October
Theatres	11 & 17 October
Wye ward	10 & 11 October
Fred Bulmer unit	11 October
Intensive care unit	11 & 17 October
Macmillan Renton Unit	11 October
Monnow ward	11 & 17 October
Outpatients – dermatology	11 October

Appendix 6: List of panel members

Panel role	Name, role
Chair	Ruth May, Regional Chief Nurse, NHS England
Senior Regional Support	Gareth Jones, Regional Head of Strategy, NHS England
Senior Regional Support	Shelley Bewsher, Regional Quality Assurance Manager, NHS England
Doctor	Paul Molyneux, Consultant Neurologist, West Suffolk Hospital NHS Foundation Trust
Doctor	Mike Lambert, Consultant in Emergency Medicine, Norfolk and Norwich University Hospital NHS Foundation Trust and Honorary Senior Lecturer at Norwich Medical School
Board Nurse	Nancy Fontaine, Director of Nursing and Quality, The Princess Alexandra Hospital NHS Trust
Board Nurse	Angela Thompson, Director of Nursing, Patient Experience and Infection Prevention and Control, East and North Hertfordshire NHS Trust
Operational Nurse	Matthew Sandham. Head of Nursing for Surgical Services, Milton Keynes Hospital NHS Foundation Trust
Midwifery Specialist	Katherine Hawes, Local Supervising Midwife (East of England), NHS England
Lay representative	Leon Pollock, Lay Adviser, advising Health Education West Midlands and the Care Quality Commission
TDA representative	Jane Palin, Quality Manager, NHS Trust Development Authority
CQC representative	Deb Holland, Compliance Manager, Care Quality Commission
CCG representative	David Farnsworth, Executive Nurse, NHS Herefordshire Clinical Commissioning Group
CCG representative	Ian Tait, GP governing body lead for quality, NHS Herefordshire Clinical Commissioning Group
Area team representative	Sue Doheny, Director of Nursing (Arden, Herefordshire and Worcestershire), NHS England
Area team representative	Martin Lee, Medical Director (Arden, Herefordshire and Worcestershire), NHS England
Area team representative	Chris Day, Patient Safety and Quality Manager (Arden, Herefordshire and Worcestershire), NHS England
Area team representative	Vikki Tweddle, Assistant Director of Nursing (Arden, Herefordshire and Worcestershire), NHS England
Powys Health Board representative	Andrew Evans, Locality General Manager, Powys Health Board
PMO support	Patrick Kite, Operations and Delivery Manager (Midlands and East), NHS England
PMO support	Erika Polgar, Development, Support and Intervention Manager (Midlands and East), NHS England
PMO support	Jessica Seed, Development, Support and Intervention Manager (Midlands and East), NHS England

Appendix 7: List of documents reviewed

- Board member and executive team biographies
- Rapid response review summary presentation
- Summary of inpatient wards, including bed number
- Quality of care and treatment review process presentation
- Quality and safety strategy 2012-2016
- Board assurance framework reports (May-September 2013)
- Annual clinical audit report 2012/13
- Clinical audit programme 2013/14
- Cost improvement plan summary and monitoring
- Joint review of deaths within 30 days of discharge report, December 2012
- Joint review of deaths occurring on day of admission, March 2013
- Audit of mortality of patients admitted with hip fractures, May 2013
- Francis inquiry update to trust board, may 2013
- Internal audit recommendation tracker
- CQC inspection report for Hereford Hospital, January 2013
- CQC review of compliance for Hereford Hospital, May 2012
- CQC review of compliance for Leominster community hospital, August 2012
- West Midlands quality review of care of adults with long term conditions and care of children and young people with diabetes
- Service unit structure
- Executive team structure
- Peter Wilson, Medical Director, CV
- Committee structure
- Public trust board minutes and reports, March, May, July and September 2013
- Private trust board minutes and reports, April, May, June, July, August and September 2013
- Redacted quality committee minutes and reports, March 2013 and April 2013 (redactions not marked)
- Mortality review group terms of reference, June 2013
- Mortality review group papers, April 2013 and May 2013
- Key performance indicators, 2012/13
- Business plan for 2013/14 and key performance indicators
- CQC mortality outlier alert response reports, December 2011 and April 2012
- Notes of meeting between Stan Silverman and Peter Wilson, April 2013
- Note of local providers
- Letter to area team, evidence of trust mortality reduction
- Clinical directors structure chart, updated October 2013
- Quality impact assessments
- Quality accounts 2012/13
- Quality committee terms of reference
- Quality committee papers, July, August and September 2013
- Mortality review group papers, June, July, August and September 2013
- Francis inquiry self-assessment and action plan
- Keogh review self-assessment and action plan
- Maternity review self-assessment and action plan
- Trustwide review of all SIRI improvement plans from 1 April 2012-31 July 2013
- Report of learning from complaints
- Quality governance assurance framework self-assessment
- Reports of ward walk arounds
- KPMG-led audits of CQC compliance, IT, RTT, workforce and HR and corporate governance
- External case review for SIRI 2013/9420 (intrapartum stillbirth)
- Nursing/midwifery/health visiting action plan 2012-2016

- Six Cs action plan
- End of life care pathway
- Complaints log (current, open cases)
- Management of complaints, concerns, comments and compliments policy
- Complaints annual report 2012/13
- Whistleblowing policy
- Capacity escalation plan
- Discharge policy for adults and discharge care plan
- Skill mix review of inpatient areas, September 2013
- Job plans for elective care service unit, urgent care service unit and paediatrics
- Physician of the day role
- Ward rotas (3 months) for all wards
- LSA reports
- Charitable funds committee papers, May and September 2013
- Audit committee papers, July and September 2013
- Leadership team agenda and minutes, July-September 2013
- Remuneration committee papers, May-September 2013
- Feedback from NHS safeguarding peer reviewer, 4 October 2013 (provided by CCG)
- File note of TDA Deputy Medical Director visit, 1 October 2013 (provided by NHS TDA)
- Urgent care recovery plan, September 2013 (provided by CCG)
- Maternity escalation guidelines
- Maternity establishment WTE
- 4 weeks' rosters for maternity services
- 11 SIRI reports for maternity (12 months)
- Supervisor of midwives investigations
- Patient experience report, August 2013
- Sample complaints reponses
- First audit of care bundles implementation, October 2013
- Stroke project working group papers
- Standard operating procedures for the day case unit
- Letters from patients and members of the public unable to attend listening event
- Quality performance dashboard, 2012/13
- Director of Nursing and Senior Nurse meeting agenda and minutes, (12 December 2012, 16 January, 13 February, 20 March, 8 May, 12 June and 24 July 2013)
- Pressure ulcer summit meeting notes, 9 August 2013
- Letter to Senior District Nurse re increase in pressure ulcers within neighbourhood teams, 27 August 2013
- Pressure ulcer dashboards, as shared with sisters, August 2013
- Presentation on safety thermometer (not dated, forum unclear)
- Care Closer to Home and Urgent Care Service Unit governance meeting action plans, 15 August and 12 September 2013
- WHO Surgical safety checklist policy, August 2013
- WHO surgical safety checklist templates, current and proposed
- Cataract and maternity specific WHO surgical safety checklists
- 43 incident reports from theatres, including: 17 relating to at least 133 patients being held in recovery, often mixed sex, as no beds available on wards; 5 relating to theatre only being notified post-operatively that patients were MRSA positive or had C difficile; 12 relating to non-compliance with the WHO checklist; and a further 9 incidents reports from theatres including errors in notes, faulty equipment and harassment (dated 2 August – 10 October 2013)
- Health and safety inspection report and action log for theatres, 19 June 2013
- Theatre establishment operational monitoring (not dated)
- Weekly theatre reports, 29 September, 6 October 2013
- Theatre activity and capacity, April 2011-September 2013

- Care bundles for: community acquired pneumonia care bundle; acute kidney injury; sepsis; hip fracture; hyperglycaemia; upper GI bleed
- Service unit performance dashboards and improvement plans (all units), August 2013
- National cancer waiting times system report for breast symptom two week wait, May 2013
- Ward meeting minutes for Wye and Monnow wards and day case unit, July-October 2013
- Mandatory training figures, and breakdown of safeguarding level 1 training uptake (current)
- Pressure ulcer and safeguarding training registers
- SSKIN care bundle and waterlow audits, Bromyard, Arrow and Frome
- Herefordshire CCG report on assurance visit to day case and Fred Bulmer units, September 2013
- Quality committee minutes, 20 June, 18 July, 22 August 2013
- Quality strategy update on year one, report to quality committee, 22 August 2013
- Trust total performance dashboard, month 4, 2013/14
- Quality and safety overview report to quality committee, 18 July, 22 August, 19 September 2013
- Trust risk register, 10 October 2013
- Risk management and assurance procedure, February 2012
- Risk management and assurance strategy, March 2013
- 2013/14 financial plan
- Service unit governance meeting terms of reference for integrated family health services and care closer to home and urgent care
- Letter from maternity business unit to Chief Executive, 21 June 2011
- Letter from midwifery supervisory team to Director of Nursing re birth to midwife ratio, 9 November 2011
- Maternity workforce review, June 2008
- Midwifery staffing/birth ratio update to operational board, 18 June 2010
- Community midwife induction pack
- 2x Caesarean section operative notes, dated 1 and 10 October 2013