Wiltshire Council
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AGENDA

Meeting: Health Select Committee

Place: Committee Rooms A-C, Monkton Park Offices, Chippenham SN15 1ER

Date: Thursday 30 May 2013

Time: **10.30 am**

Please direct any enquiries on this Agenda to Sam Bath, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 718211 or email sam.bath@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225) 713114/713115.

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Membership:

Cllr Chris Caswill
Cllr Christine Crisp
Cllr Mary Douglas
Cllr Peter Hutton
Cllr Bob Jones MBE
Cllr Helena McKeown
Cllr John Noeken
Cllr Jeff Osborn
Cllr Sheila Parker
Cllr Nina Phillips
Cllr Pip Ridout
Cllr Ricky Rogers

Substitutes:

Cllr Pat Aves
Cllr Mary Champion
Cllr Dennis Drewett
Cllr Sue Evans
Cllr Russell Hawker
Cllr Julian Johnson
Cllr Gordon King
Cllr John Knight
Cllr Ian McLennan
Cllr Helen Osborn
Cllr Mark Packard

PART I

Items to be considered whilst the meeting is open to the public

1 **Membership**

2 **Apologies**

3 **Election of Chairman**

To elect a Chairman for the ensuing year.

4 **Election of Vice Chairman**

To elect a Vice Chairman for the ensuing year.

5 **Committee Membership - stakeholders**

The previous Committee included the following non-voting stakeholder representation:

- Advisor on social inclusion for older people (Brian Warwick)
- Wiltshire and Swindon Users' Network (Linda Griffiths or Dorothy Roberts)
- Wiltshire Involvement Network (Phil Matthews) – NOTE: This organisation ceased to exist as at 1 April 2013.

Following the changes to the health and social care system, the Committee may wish to consider stakeholder membership of the Committee. Members are also able to invite appropriate representatives to consider specific activities or projects as they arise.

6 **Minutes of the Previous Meeting** *(Pages 1 - 14)*

To approve and sign the minutes of the meeting held on 14 March 2013.

7 **Declarations of Interest**

To receive any declarations of pecuniary and non-pecuniary interests or dispensations granted by the Standards Committee.

8 **Chairman's announcements**

9 **Public Participation**

The Council welcomes contributions from members of the public.

Statements

If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to

3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named above for any further clarification.

Questions

To receive any questions from members of the public or members of the Council received in accordance with the constitution. Those wishing to ask questions are required to give notice of any such questions in writing to the officer named above no later than **5pm** on **Wednesday 22 May 2013**. Please contact the officer named on the first page of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

10 **Mid Staffordshire NHS Foundation Trust Public Enquiry (Francis Report)**

The final report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, chaired by Robert Francis QC, was published on 6 February 2013. The report considered the evidence of over 250 witnesses, over a million pages of documentary evidence and put forward 290 recommendations.

Whilst the report attributed accountability for the failures at Stafford Hospital to the Trust Board, it also pointed to the systematic failure of a wide range of national and local bodies to respond to the concerns raised about patient care. The report says,

> *'…that at every level there was a failure to communicate known concerns adequately to others and to take sufficient action to protect patients' safety and wellbeing from the risks arising from those concerns*.'

Chapter 6 of the report relates to patient and public involvement and scrutiny. The inquiry took evidence from councillors and senior officers with responsibility for health scrutiny in Staffordshire. The report goes into some detail in its observations and a number of the recommendations made relate directly to overview and scrutiny.

Members are asked to note that it is intended to bring a report to the next meeting of the Committee, which will look specifically at the implications for overview and scrutiny arising from the Francis Report. The report will set out the key messages arising from the Francis Report and consider the relevant recommendations to enable the Committee to identify any areas for development for health overview and scrutiny in Wiltshire.

11 **Royal United Hospital - Inspection Update** *(Pages 15 - 44)*

Members may have seen reports in the local media and be aware that the Care Quality Commission (CQC) made an unannounced inspection at the Royal United Hospital (RUH) in February 2013.

The CQC looked at two different parts of the hospital, the older people's wards and the day surgery unit. It found that the RUH was not meeting the required standard in the following four categories:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Records.

The CQC has provided the following comment.

> *'Following inspection at the RUH Bath in early February the Trust sent an action plan to CQC outlining how the trust intends to achieve compliance with the areas of concern identified in our inspection report . CQC have accepted the action plan and will return to the hospital to check compliance again when the dates in the action plan have passed. The inspection will be unannounced so we are unable to confirm when the inspection will occur.*
>
> *'The inspection in February was a responsive inspection following local information raised with CQC raising concerns about the manner in which patients had been discharged during a period of 'black alert' in January. Upon arrival at the hospital the scope of the inspection was extended to review the care of patients accommodated in 'escalation' areas at the hospital. Shortly after the inspection we were informed that the Trust had stopped using the day surgery unit (DSU) as an escalation area. Due to continued high levels of urgent admissions the trust was unable to maintain that position. We have been in touch with the trust since the inspection and been informed of the immediate actions taken by the trust to ensure care quality and safety had been improved for patients accommodated in the DSU.'*

Both the CQC inspection report and the RUH action plan in response to the report are attached. Members are asked to note these reports. The Committee will be kept informed of developments and a further update provided following the CQC follow-up inspection.

12 **SWAN Advocacy**

Members will recall that Cllr Jane Scott, Leader of the Council, referred to SWAN Advocacy at full Council as the organisation that provides advocacy services on behalf of the Council. SWAN Advocacy is in the process of preparing a funding application for the second stage of a Big Lottery Fund application. This is to fund a specialist dementia advocacy service throughout the county to complement the work undertaken as part of their contract with Wiltshire Council; a successful application will result in over £350,000 over 4 years.

As part of the application, SWAN Advocacy have undertaken consultations with

a range of stakeholders. They would now like to seek the views of the Committee; they would also like to quote the meeting as part of their evidence in the application. Irene Kohler, Chair of SWAN Advocacy, will deliver a presentation and answer members' questions.

13 **Work Programme**

The Overview and Scrutiny Management Committee is due to meet on 23 May, after the publication of this agenda. The Management Committee will consider the recommendations of the previous Council in respect of legacy items for the work programme of this Committee. Should they be accepted, the legacy items for the Health Select Committee will comprise the following topics:

Topic	Notes
Clinical Commissioning Group (CCG) via task group	Review performance of CCG and local groups against priorities in Strategic Plan 2013/2014, including effectiveness of public engagement and mechanisms to deal with conflicts of interest during commissioning.
Transfer to Care via task group	Review proposed protocol, policy documents and project results, and consider any resulting financial challenges.
Avon and Wiltshire Mental Health Partnership (AWP) via task group	Consider review of services to Wiltshire residents
Continence Services via task group	Review of services.
Air Quality (joint with Environment Select Committee) via task group	Review the implementation of the Air Quality strategic objectives and actions plan, and the effectiveness of Council Services working together to ensure that respective service contributions are embedded within service delivery plans. To consider 'cause and effect'.
NHS 111 service via rapid scrutiny	Investigate impact of implementation of 111 service (please see note below*)
Joint Strategic Assessment Adults Safeguarding Annual Report Continuing Health Care Cardiovascular Services	The Committee to receive reports/updates

*NHS 111 service (rapid scrutiny)
At the last meeting of the Committee, concerns were raised about the performance of the NHS 111 service and particularly its impact on the ambulance service. As a result it was agreed that a rapid scrutiny exercise should be conducted into the NHS 111 service but, due to the imminence of the local elections, that it should be added to the legacy items for the Committee. It was subsequently agreed that there was sufficient time to conduct the exercise before the elections. It was then established that the BANES and Wiltshire Clinical Commissioning Groups (CCG) had decided to delay the start of the 24/7 cover for the service and were due to meet to consider a number of options in relation to the provision of the service by Harmoni. It was considered inappropriate to undertake a rapid scrutiny at that time and the Committee wrote to Harmoni urging it to work with the CCG to ensure that it delivers a high level of service for Wiltshire residents and that patient safety is paramount.

The Committee is asked to consider the legacy items and any additional topics, including those arising from the overview and scrutiny induction event on 16 May, for inclusion in the forward work programme.

14 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

15 **Date of Next Meeting**

The next meeting of the Health Select Committee will be on 02 July 2013.

PART II

Items during whose consideration it is recommended that the public should be excluded because of the liklihood that exempt information would be disclosed

NONE

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HEALTH SELECT COMMITTEE

DRAFT MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 14 MARCH 2013 AT GREAT WESTERN AMBULANCE SERVICE OFFICES - JENNER HOUSE, LANGLEY PARK, CHIPPENHAM SN15 1GG.

Present:

Cllr Chuck Berry, Cllr Nigel Carter (Substitute), Cllr Chris Caswill, Cllr Peter Colmer, Cllr Christine Crisp, Cllr Peter Davis, Cllr Peter Hutton, Cllr John Knight, Mr Phil Matthews (WIN), Cllr Nina Phillips, Cllr Bill Roberts, Cllr Judy Rooke (Substitute) and Mr Brian Warwick

44 Apologies

Apologies were received from Cllr Jane Burton, Cllr Desna Allen and Cllr Pip Ridout. Cllr Niger Carter substituted for Cllr Burton and Cllr Judy Rooke substituted for Cllr Allen.

45 Minutes of the Previous Meeting

The Minutes for the meeting held on 17 January 2013 were signed and approved as a correct record.

46 Declarations of Interest

There were no declarations.

47 Chairman's Announcements

The chairman thanked Members and partners for their support over the past year, and particularly Phil Matthews, who was attending his last Committee meeting as chairman of WIN. He welcomed Mike Franklin from the Fire and Rescue Service and thanked the Great Western Ambulance Service (GWAS) for their hospitality at Jenner House.

The chairman had attended an event at the Great Western Hospital organised by NICE, an open day at Chippenham Hospital for the launch of the new X-ray machine and kitchen, and the final public meeting of WIN.

The chairman announced the following appointments: Christine Graves, new chairman of Healthwatch, Iain Tulley, new Chief Executive of the Avon and Wiltshire Mental Health Partnership (AWP), Peter Hill, new Chief Executive of Salisbury Hospital. He confirmed that GWAS had been acquired by the South Western Ambulance Service Foundation Trust (SWASFT).

Item 9 on the agenda was to move to item 7 and item 12 was to move to item 8.

48 **Public Participation**

No questions were received.

49 **Task Group and Rapid Scrutiny Group Reports**

The Committee received reports from Task Groups and Rapid Scrutiny Groups.

CCG Task Group Report

The Committee agreed to the creation of the Task Group at its meeting on 15 November 2012 to consider the effective development of the CCG.

The Task Group report was presented by Cllr Peter Colmer. It was noted that the CCG comprised three local groups: North East Wiltshire (NEW), West Wiltshire, Yatton Keynell and Devizes (WWYKD) and Sarum, covering the Salisbury area.

Resolved:

To endorse the recommendations of the CCG Task Group as follows:

1. The Health Select Committee, within the newly-elected Wiltshire Council, should establish a CCG Task Group to undertake the recommendations below.

2. The Task Group should devise its own Terms of Reference.

3. The Task Group should investigate what progress the CCG makes against the priorities identified in its Strategic Plan 2013/14.

4. The performance of each of the three local groups of the CCG should be monitored, with a review requested from each area within their first year.

5. The Task Group examines what mechanisms the CCG has in place to deal with conflicts of interest that could arise during the commissioning/procurement process.

6. The Task Group considers what arrangements the CCG is making to engage with patients and the public, and what mechanisms are in place to measure and monitor the effectiveness of these.

7. The Health Select Committee considers identifying an individual service, commissioned by the CCG, with a view to establishing a further Task Group to investigate the 'patient pathway' within that service.

Public Health Transition Task Group Report

The Committee agreed to the creation of the Task Group at its meeting on 15 November 2012 to consider the transfer of Public Health from the NHS to the Council.

The Task Group report was presented by Cllr Peter Hutton. He confirmed that the Task Group was satisfied that the transfer was progressing smoothly and, as a result the Task Group should be disbanded.

Resolved:
To endorse the recommendations of the Public Health Transition Task Group as follows:

The Health Select Committee disbands the Public Health Transition Task Group.

That an update report on the transition is presented to the Health Select Committee at its meeting on 14 November 2013.

Transfers to Care Task Group Report

The Committee agreed to the creation of the Task Group at its meeting on 15 November 2012 to consider the systems which allow patients to leave hospital promptly and to go into the care facility of their choice.

The Task Group report was presented by Cllr Nigel Carter.

It was noted by Sue Geary that recommendation 4 in the report made reference to 'the Partnership Group'; this should be more correctly referred to as 'the Steering Group'.

Amendment
Cllr Colmer proposed an amendment to alter the wording of recommendation 4 from "...documents produced by the partnership group" TO "documents produced by the Steering Group". This was seconded by Cllr Nina Phillips and unanimously agreed by the committee.

Resolved:
To endorse the recommendations of the Transfers to Care Task Group, with amendments, as follows:

1. The Health Select Committee, within the newly-elected Wiltshire Council, should establish a Transfer to Care Task Group to undertake the recommendations below.

2. The Task Group should devise its own Terms of Reference.

3. The Task Group meets at the earliest opportunity.

4. The Task Group should review the proposed protocol and policy documents produced by the Steering Group.

5. The Task Group should review the results of the project being undertaken at the RUH. In addition, it should consider the identified reasons for delays, with a view to asking the Health Select Committee to establish a further Task Group to investigate specific causes of delay.

6. The Task Group considers the financial aspects in this area and the challenges they impose on decision making.

Continence Services: Rapid Scrutiny Report

The report was presented by Cllr Carter, who led the Rapid Scrutiny Exercise.

Brian Warwick expressed his concern that the changes to the continence service had been implemented without any consultation with carers. He was keen that carers should have a stronger voice as he did not believe that they were listened to. He had hoped that the rapid scrutiny exercise would have resulted in a faster resolution to the problem.

Cllr Carter endorsed Mr Warwick's views. It was noted that the service was not directly under the control of the Council, the CCG being the lead body, and Cllr Carter was keen to establish how officers were liaising with colleagues in the NHS.

The Chairman stated that Mr Warwick's concerns should also be raised with Cllr Milton as the portfolio holder for this area, who may be able to take this forward more quickly.

It was noted that Medequip had not given evidence to the Rapid Scrutiny. It was queried whether Medequip audited their complaints in any way. It was also queried whether Medequip was adhering to its contract, as it could be that the service specification was too loose.

The Committee acknowledged that monitoring the outcome of service delivery was difficult as there were no indicators other than service users' experiences. It agreed that the current service was inadequate and was not delivering the level

of care required, but also agreed that there was no evidence of underfunding in this area.

Resolved:
To endorse the recommendations of the Rapid Scrutiny Exercise – Continence, as follows:

1. The Health Select Committee, within the newly-elected Wiltshire Council, should establish a Task Group to consider the Continence Service and to undertake the recommendations below.

2. The Task Group consider the assessment/re-assessment process, in particular the nature of it, the criteria involved and timescales around it.

3. The Task Group will investigate the logistics of the service, with reference to Medequip and the options offered, in relation to the requirement for greater flexibility and client choice, and considers the monitoring of performance issues.

4. The Task Group look at patient outcomes and requirements, including availability of appropriate continence products, frequency of supply, buffer stocks and flexibility.

5. The Task Group review the Council's role, responsibilities and authority in continence care under its Health and Wellbeing remit.

6. The Task Group examine the terms and conditions of the Disability Living Allowance and its applications.

Joint Air Quality Task Group Report (joint with Environment Select Committee).

The Air Quality Task Group had originally appeared on the work programme of the Environment Select Committee (ESC). However, it had been agreed by the O & S Management Committee at its meeting on 6 September that it should become a joint Task Group with the Health Select Committee to ensure that both 'cause and effect' of air quality were considered.

Cllr Alan Hill, as chairman of the Task Group, was in attendance to present the report of the joint Air Quality Task Group.

Maggie Rae, Corporate Director, confirmed that operations around air quality have been increased. It was stated that air quality is not a new science. The Council, under its public health duties, has the power to address any serious air quality issues that may arise.

Resolved:

To endorse the recommendations of the joint Air Quality Task Group as follows:

1. Scrutiny of the Air Quality Strategy remains in the Forward Work Plan for the new Council's Overview and Scrutiny function, subject to any comment from the inspector.

2. Oversight of the monitoring regime and the equipment be undertaken to ensure it is fit for purpose

3. The Task Group believes that, whilst Wiltshire Council is not legally obliged to improve air quality, even when it exceeds the Government optimum in a particular location, and there are no sanctions available if we do not, it is incumbent upon us as a responsible Authority to attempt to reduce the exceedances to below recommended levels.

4. That Air Quality Alliances review all the Council, school and business travel plans in their area.

50 **Older People's Accommodation Development Strategy**

In January 2011, Wiltshire Council's Cabinet approved a 10 year development strategy to modernise and improve the way that older people's accommodation is provided. Karen Jones, Senior Project Manager, provided an update on the progress of the Strategy.

It was stated that since the adoption of the strategy, significant progress has been made with advancements to developments within the various community areas. Work was being undertaken on 23 developments across 15 community areas to improve and modernise older people's accommodation. In addition some developments were also being progressed with flexible section 106 agreements. Developments were utilising council land, and were in line with financial projections.

The projected timescales of some developments had been brought forward whilst others have taken longer to come to fruition than was originally anticipated.

The Committee discussed the number of units that were being provided as a result of the developments and it was agreed that development, design and management would be crucial to the success of the Older Peoples Accommodation Development Strategy. It was agreed that the Strategy would be brought to the next meeting for consideration by the Committee.

The location of some developments was discussed and concerns were expressed that more rural sites could result in some older people being isolated. Karen Jones explained that the Strategy was not a one size fits all approach, that some older people wished to continue to live in rural locations, and that

placing some units away from town centres provided greater choice. She also confirmed that the project was well resourced despite the unsurety of funding over a two year cycle.

Resolved:

To note:

1. The implementation progress of the Older People Accommodation Development Strategy.

2. The funding application made to the Department of Health's Care and Support Specialised Housing Fund to assist the delivery of extra care housing.

3. The development and implementation proposals associated with Wiltshire's Extra Care Housing Model.

51 **Joint Strategic Assessment (JSA)**

An update on the JSA was presented by Aimee Stimpson.

It was confirmed that a summary document was being produced for local community areas to provide information on local changes.

It was queried how the JSA reflected the strategic requirements of military personnel in the county, following the announcement by the Secretary of Defence that 4000+ troops would be relocating to Wiltshire. It was confirmed that meetings had been held with military groups to identify the requirements of military groups. It was noted that Wiltshire had been praised by the military for the services and arrangements in place for military personnel in the county.

The Committee questioned the use of the document if it would not be seen by the public. It was confirmed that the JSA would be utilised as a strategic decision making tool, but that could be viewed and scrutinised by the public.

Cllr Chris Caswill acknowledged that there was a brief mention of child poverty in the JSA but believed that more attention should be paid to this important topic. It was noted that changes in government policy surrounding benefits could exacerbate this problem in some of the most vulnerable areas, and that the Council would need to focus attention on this area.

Maggie Rae stated that extensive reports on child poverty in the county had been compiled and that the Council would continue to tackle the issue. It was stated that the issues of relating to child poverty were covered in a number of categories within the JSA.

Brian Warwick noted that the 'issues matrix' within the JSA contained many issues which related to older people, but there was no mention of older people,

per se. He would like to see a greater emphasis on 'active ageing', to enhance quality of life as people age.

Cllr Hutton noted the comments made to ensure that the Committee's views on the JSA were made known at the Cabinet meeting on 19 March 2013.

Resolved:

The Committee noted the production and publication of the JSA 2012-13 report and its supporting documents and endorsed its use in commissioning and strategy.

To review the JSA annually as part of the Committee's ongoing monitoring arrangements.

52 **Avon & Wiltshire Mental Health Partnership (AWP) - Charter House**

Denise Clayton, Avon & Wiltshire Mental Health Partnership (AWP), provided an update to the Committee on the temporary closure of Charter House in Trowbridge.

Ms Clayton stated that, as a facility for persons with advanced stages of dementia, Charter House had recently seen a reduction in its admissions. There had been difficulties recruiting adequately trained staff to provide the level of care that would be expected and the facility has also fallen into a bad state of repair. As a result of all of these factors, it was agreed to suspend any further admissions to Charter House while a review of it is conducted. All patients being treated at Charter House have now been relocated to other centres including;

- Fountain Way (Salisbury);
- The Victoria Centre (Swindon); and,
- Ward 4 at St Martin's Hospital (Bath).

It was noted that some centres were a considerable distance away from Charter House, and therefore were in conflict with the access to care expressed in the JSA and various other strategic documents. Following discussion, it was agreed that access to good quality care in the region would be preferable to less favourable care locally, and that the arrangements were not contrary to strategic practice.

It was confirmed that additional funding had been sourced and passed to care homes and community hospitals in the region to manage increased demand. Ms Clayton stated that the temporary closure of Charter House was part of a wider review into the service across the region which was looking at local requirements for older people.

The Chairman thanked Ms Clayton for the update. It was unfortunate that the Committee had not heard of AWP's plans from them directly. The chairman

expressed the wish to work closely with AWP and hoped that they would bring any future plans to the Committee for early consideration. Ms Clayton confirmed that AWP would be working closely with the Committee and stakeholders.

The Chairman stated that two public meetings were being held by AWP in Wiltshire to invite comments on their plans to refresh their strategic objectives, vision and values. These would be on 18 April at the Town Hall, Devizes between 2-4pm and 6-8pm. Individuals are advised to Contact 0800 694 9990 to reserve a place. For more information and to provide feedback, go to: www.awp.nhs.uk/strategicobjectives.

Resolved:

To note the update provided.

To agree the creation of a Task Group to consider the review being undertaken by AWP on care provision for people with dementia in Wiltshire.

53 **Update from Great Western Ambulance Service (GWAS) Joint Health Overview & Scrutiny Committee**

Cllr Peter Colmer had attended the meeting of the joint Committee on 22 February 2013 and gave a verbal report to the Committee.

GWAS was acquired by the South Western Ambulance Service Foundation Trust (SWASFT) in February 2013.

Service performance is measured against three categories. It was noted that there was a significant deterioration against the 19 minute measure. GWAS agreed this was a cause for concern, commenting their resources were stretched due to lack of ambulances. It was agreed that close monitoring of this issue was required.

Handover times at hospitals were still an issue. It was noted that fines of £1 million had been levied on the PCTs this year. Based on the revised formula, this would equate to £4 million if the same level of performance occurred. There were concerns that one part of the health system was paying large sums to another part of the system. It was suggested that a scrutiny committee could look at 'pathways' associated with the new GP commissioning arrangements.

Following the acquisition of GWAS, their headquarters at Chippenham will close. SWASFT, whose headquarters are in Exeter, prepared a report for the Committee to update them on staffing plans in relation to the former GWAS headquarters.

The joint Committee discussed the future of scrutiny of SWASFT. It was agreed that the chairman of the joint Committee would prepare a paper which will be circulated to individual Health Select Committees for discussion and comment.

It was intended that the full NHS 111 service should go live on 10 March. The Committee was concerned to hear that the implementation of the service to date had resulted in significant problems, with reports of ambulances being despatched to none emergencies.

The Committee was concerned about the possible impact on 'genuine' emergencies if they had to wait for an ambulance which was attending a patient with a minor condition. It was agreed that the Committee should undertake a rapid scrutiny exercise into the 111 Service.

It was confirmed that the future scrutiny of GWAS would now be undertaken as SWASFT and currently SWASFT were in the process of identifying how best to work with Councils across the region to scrutinise services in these areas. The Chairman will be contacting Wiltshire Council in future to discuss these arrangements.

Resolved:

To note the report from SWASFT.

To undertake a rapid scrutiny exercise into the NHS 111 service.

54 **Update on Continuing Healthcare (CHC)**

The Committee received the final report from the CHC Task Group on 12 July 2012 and requested an update report on the action plan at its meeting in January 2013. This was subsequently deferred until March 2013.

Deborah Gray, Deputy Director of Nursing and Patient Safety, NHS Wiltshire and Sue Geary, Head of Performance, Health and Workforce, gave an update on Continuing Healthcare arrangements.

It was stated that the pathway had been improved, although some actions were still to be completed. It was confirmed that the responsibility for CHC now fell to Jacqui Chidgey-Clark, Director of Quality and Patient Safety at Wiltshire CCG.

Resolved:

The Committee noted the update on Continuing Healthcare

To receive an update on the progress of the action plan at the Committee's meeting in September.

55 **Update on cardiovascular services prior to transfer to specialist commissioning**

At the Committee meeting on the 17 January 2013, Wiltshire CCG presented a paper on the national review of vascular services and the implications to the population of Wiltshire. The Committee expressed grave concerns about review and requested an update prior to the service transferring to specialist commissioning.

Beatrix Maynard, Wiltshire CCG, and John Goodall presented the update.
The CCG remained concerned about the proposed service and confirmed that a Steering Group for vascular services for Wiltshire had been set up to ensure a clear and shared understanding of the implications for the population of Wiltshire for each area's network plans for vascular surgery. The first meeting of the steering group was confirmed as April 8 2013.

Resolved:

To note the report.

To receive an update from the CCG on the work of the steering group at its meeting in November 2013.

56 **Emergency Falls Admissions in Salisbury Community Area**

The Wiltshire Falls and Bone Health Strategy 2012-14 and consultation results were presented to the Committee in November 2012. The high rate of emergency admissions from the Salisbury Community Area for falls was questioned. A report exploring the data further was requested.

Zoe Clifford presented the report, detailing the data for the areas in question. It was suggested that the greater number of falls in the south, and in Salisbury in particular, could have been a result of a greater proportion of elderly people.

It was confirmed that the data was tested further, examining demographics (age, gender), types of fall (in care, in public), and comparative data for over 65's in general.

The Committee questioned some of the figures to ascertain the integrity of the data, and agreed with the extensive findings of the report. It was agreed that the data was not representative or inclusive of persons on medication, re-admissions or non reported falls.

The Committee suggested that the report could link in with the Older Peoples Accommodation Strategy, and also with Highways and Town Planning.

Resolved:

To note the report on Emergency Falls Admissions in Salisbury.

57 **Recommendations for O&S Management Committee**

The Committee was required to identify items for inclusion in the legacy report to be submitted to the Overview and Scrutiny Management Committee; the suggested items to form the basis of the Committee's work programme in the new Council.

Resolved:

The following topics to be recommended as legacy items to the O & S Management Committee for possible inclusion in the Overview and Scrutiny work programme in the new Council:

The following Task Groups are re-established:
- **Clinical Commissioning Group**
- **Transfers to care**
- **Joint Air Quality (with Environment)**

Two new Task Groups are formed:
- **Continence Services**
- **Review of Services by AWP**

A rapid scrutiny is undertaken:
- **NHS 111 service**

Update reports are received in respect of:
- **Cardiovascular services (November)**
- **CHC (September)**
- **JSA (annually)**

58 **Partner Organisations Update**

Great Western Hospital (GWH)
The Committee noted the report from the Chief Executive of GWH on key issues relating to GWH and community services across Wiltshire. Kevin McNamara updated the committee and stated that the Trust was pleased to confirm that over £1m will be invested in additional nurses this year with recruitment underway in a number of areas following detailed skill reviews.

Mr McNamara confirmed that GWH would develop action plans against all outcomes of CQC inspections, and that the CQC would return in future to evaluate the concerned areas.

The Committee raised some of the issues detailed in the Francis Report that outlines problems with care quality and, in particular, patient respect. Mr

McNamara confirmed that the new lead nurse at GWH was committed to the values of respect and compassion.

Royal United Hospital Bath NHS Trust (RUH)

Francesca Thompson, Chief Operating Officer, RUH to provide an update.

It was confirmed that RUH had entered a 5 year patient safety arrangement with the Strategic Health Authority. RUH had also bid for and been awarded a hosting arrangement that aims to reduce the mortality rate at the Hospital by 15%.

RUH also hosted the Wiltshire Carers event on March 6 2012, which was a success.

RUH had also recently elected its first Council of Governors. This involved 11 public governors and five staff Governors who will represent the views of members and sit on the Council of Governors with five stakeholder Governors. Nearly 3000 people voted with a turnout of around 32%.

RUH also highlighted its current challenges including the extraordinary demand on emergency care that it was receiving, and the plans to discharge patients within the agreed limits.

The Committee discussed emergency data collection, and noted that reports include a breakdown of admissions to emergencies would be useful.

Healthwatch
Christine Graves, the new Chairman of Healthwatch, provided an update.

Healthwatch will come into effect from 1 April 2013. The remit of Healthwatch would be similar to that of WIN, but had some enhancements.

Healthwatch has a duty to engage with the Health Minister, whilst championing health and social care and its delivery. In addition, Healthwatch Wiltshire will make recommendations to Healthwatch England, and advise the Care Quality Commission to carry out special reviews or investigations into areas of concern. Healthwatch will also act as a signposting service, providing advice and direction to the public on matters of healthcare. It was stated that Healthwatch hoped to build on the legacy of information that WIN had built, and was pleased to inherit its active support.

The Chairman welcomed Healthwatch and Christine Graves to the Committee and stated that it was hoped that the relationship would be as successful as it has been with predecessors WIN. Healthwatch would act as a critical friend, providing a check and balance on Healthcare providers across the region.

The Committee queried how information or concerns would feed into Healthwatch. Information would arrive through various channels, including the Committee, from the public and also via user groups and networks.

It was agreed by both the Committee and Healthwatch that information sharing was crucial to building a successful relationship.

Resolved:

To note the updates provided.

59 **Urgent Items**

There were no urgent items raised at the meeting.

60 **Date of Next Meeting**

30 May 2013

The Officer who has produced these minutes is Samuel Bath, of Democratic Services, direct line (01225) 718211, e-mail samuel.bath@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Royal United Hospital Bath NHS Trust

Directors Offices, Royal United Hospital, Combe Park, Bath, BA1 3NG

Tel: 01225428331

Date of Inspections: 06 February 2013
05 February 2013
04 February 2013

Date of Publication: March 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Royal United Hospital Bath NHS Trust
Overview of the service	Royal United Hospital Bath is an acute hospital on the edge of Bath just over a mile from the centre of the city. The hospital covers a local population numbering around half a million people in Bath and some parts of North East Somerset and Western Wiltshire.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 February 2013, 5 February 2013 and 6 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

This inspection visit was prompted by information that had been shared with us. Concerns were raised about the manner in which some patients had been discharged without adequate information and support. Because of this we took a nurse with us who had expert knowledge in discharge arrangements.

During our inspection we looked at two discrete areas of care at the hospital. These were the older people's wards and the day surgery unit (DSU). We also looked at pharmacy arrangements for providing medication for people to take home on discharge.
We met and talked with many patients during our visit. Where patients were not able to talk with us for various reasons, we spent time observing how care and support was delivered. We saw and were given written evidence from the trust. This included patients' notes, hospital records and recordings of their clinical observations.

We met with consultant medical staff, pharmacists, therapy staff, registered nurses and healthcare assistants. All the staff we met with showed a professional and caring attitude towards their patients. We also met with hospital directors and senior management staff, they explained to us that the hospital had recently been under unprecedented pressure. Inpatient admissions though the emergency department had increased by 13.9% in the current financial year against the previous four year average. This had meant the hospital was using the day surgery unit to accommodate inpatients, when its intended use was for short stays for up to 23 hours.

We found the trust was not ensuring they met all patients' treatment and care needs on the day surgery unit. This was because the day surgery unit was being used as a facility to care for inpatients who would normally be accommodated elsewhere in the hospital. The environment and the care arrangements on this unit were not suited to ensuring inpatients privacy, dignity, health and welfare needs were met. Risks to their care and treatment were not being adequately managed. After our visit we raised concerns with the trust about the impact of this and the accommodation of inpatients on the DSU was stopped.

We found record keeping was not consistently completed, including records of patients' fluid intake and output and completion of the trust's own discharge documentation. Staff were not using the trust's system of documentation to support discharge planning. This meant that the system in place to ensure correct information and support resources were put in place for patients discharge was not always followed. For those patients with more complex needs this created inconvenience and risk for those patients ongoing care elsewhere

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 22 March 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken. Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At this inspection we looked at two different parts of the hospital. These were the older people's wards and the day surgery unit (DSU).

We asked patients and their carers about their experiences of their stay on the DSU and looked at the unit's most recent survey feedback from patients. Overall feedback was negative about the care environment impact on privacy and dignity. Patients described the unit as being "cramped", "too hot", the ward is very stuffy, they are trying to fit in too many patients."

Patients' reported disturbed sleep due to the amount of night time activity on the ward. One patient told us "people are being admitted all the time, both day and night". Staff reported the unsuitability of the care environment to the needs of a patient with a learning difficulty, who would normally be given more one to one attention, but instead had to be left on their own for long periods of time.

Staff and patients told us and we saw there were inadequate bathing facilities for the inpatients accommodated on the DSU. There was just one mixed sex shower for 22 patients which was located in an assisted toilet, which meant there were long waits for patients to shower. Although there were two separate toilets for male and female use, the other two assisted toilets were for mixed sex use. The sinks available in the toilets could not satisfactorily be used for washing as there were no plugs. On one of the days of our visit the shower had become flooded and could not be used at 3pm. The shower head was fixed and one person said they could not use it because of this.

A staff member said "its purpose built for day surgery, it's just not set out for inpatients. The spaces fit three trolleys and so the curtains fit then. If we have beds then the curtains just don't fit."

We saw there were no windows in the women's part of the ward. A patient told us "it's like living on an aircraft all the time." One patient told us "if some one uses the commode on the ward, then we can all smell it. Where is the dignity in that?"

After our visit we raised concerns with the trust about the impact of the day surgery unit care environment on the privacy and dignity of inpatients accommodated on the DSU and this was stopped shortly after our inspection visit.

On the older people's wards we saw that people's privacy and dignity were respected.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection we looked at two discrete areas of care at the hospital. This was the day surgery unit (DSU) and three wards at the hospital designated for the care of older people. We met with staff, including consultant medical staff, therapists and registered nurses. They all showed a professional and caring attitude towards their patients. Senior nurses spoke with us about assessments of risk for older patients, such as risk of falling, pressure ulceration and malnutrition. They told us about the actions they took when people were assessed as being at risk, including care plans and use of monitoring tools such as routine 'comfort rounds' to check on patients welfare needs.

Some patients we met with looked comfortable and told us how helpful staff had been. We saw staff took time to explain to patients how they were going to help them. A patient told us about a recent assessment they had done with an occupational therapist so they could make themselves a cup of tea independently again. Another patient told us they were glad their intra-venous "drip" was now down, so they could "be a bit more active." Others told us they felt their care needs had not been met. One person told us they had not had sufficient drinks, another told us they were not being turned to reduce the risk of skin pressure damage. We saw other patients that had some cognitive impairment who were not having all their needs met.

We visited the DSU on all three days of our inspection and found they cared for both day cases and inpatients on the same ward. A staff member explained to us how the care of inpatients who would normally be cared for elsewhere in the hospital came about and then quickly escalated. "It started as one or two patients, then it just got more and more and more." On 6 February 2013, 21 of the 22 patients cared for on DSU were inpatients and only one was a day surgery patient. We saw inpatients on the DSU stayed for a range of durations, but many patients stayed for more than a few days, some for a week or two weeks. On 5 February 2013 we looked at five patients care pathway in detail. Two of these patients had been on DSU for more than one week, and one for two weeks.

Inpatients were from a range of specialties within the hospital. A member of staff told us this was difficult, as patients were at "all stages" in their treatment. The trust's guidelines for transfers to the unit excluded patients requiring sliding scale insulin and admissions directly from the emergency department. These guidelines were not being followed. A staff member said "at first they didn't send us anyone on the clinical inclusion list, but now they do."

Staff told us they were rushed and didn't have time to carry out all the planned checks on patients. There were no 'comfort rounds', as elsewhere in the hospital to check on patients welfare needs. Patients told us about the impact of this. One person told us at 3.30pm, they had not had a wash all day because staff were too busy and we saw they had dried food on their gown from lunch three hours earlier. Another patient told us they had been "absolutely gasping", as between 5.30am and lunch time staff had not had time to offer them a drink. We were told by staff that this shortage of time sometimes placed patients at risk. For example, we saw an incident report from the hospital where there had not been enough time to check a patient with diabetes blood sugar levels before they were taken to theatre. The patient was documented as behaving "strangely" in the anaesthetic room and when their blood sugar was checked it was at an unsafe level.

Routine systems that were in place on inpatients wards, such as a pharmacy service and equipment supplies were being managed by the DSU staff. This reduced the amount of time they had available for patient care.

Because the unit was organised to care for day patients, there was an inadequate system in place for assessment, planning and evaluation of the care for in patients. We met with five inpatients on the DSU and we were shown their records including electronic records on the computer. Four of these patients were elderly and looked frail. None of the five patients had a risk assessment for pressure ulcers completed in line with guidelines from the National Institute for Health and Clinical Excellence (NICE). Two of these patients told us they were on bed rest. One of these patients told us they did not have their position changed regularly to reduce skin pressure damage. The other patient told us some staff did assist them to change their position, but that this was "variable." Neither of these patients had a care plan about prevention of risk of pressure ulceration or turn charts to show their position in bed had been changed regularly. A third patient looked frail, they were not able to tell us if their position was changed. We looked at this patient's records. These showed two occasions when concerns about tissue damage over pressure points had been documented. The patient did not have a care plan about prevention of pressure ulceration or a turn chart. We spoke with staff, they told us they did not have access to turn charts on the DSU.

We looked at the assessment and care planning for older patients on the DSU and the older people's wards. One of the patients was not able to tell us about where they were or where they normally lived. This person and several other records documented issues relating to "confusion", including records of refusal of care. A cognitive function test called the abbreviated mental test (AMT) had been carried out for these patients. This consisted of questions about orientation, age and recall. A consultant told us if the score was lower than eight out of ten, this triggered another more detailed test.

This included more detailed questions, which led to a decision about the patient's mental capacity assessment to make a range of specific decisions. We saw two of the patients had AMT scores of six out of ten and one had a score of three out of ten. No other mental cognitive tests had been completed for these three patients. This meant no further assessment or care planning had been developed for the risks associated with their confusion.

We met with a patient who had been admitted to the DSU from accident and emergency. The person had visible bruising on them. Their records, including computer records, indicated they had fallen at home. A body map of their bruising had not been completed. On 5 February 2013, they did not have a risk assessment for falling or a care plan to indicate how their risk of falling was to be reduced. They also did not have a mobility assessment or communication assessment.

After our visit we raised concerns with the trust about the impact of the day surgery unit care environment on the care and treatment of inpatients accommodated on the DSU and this was stopped shortly after our inspection visit.

Cooperating with other providers ✖ Action needed

People should get safe and coordinated care when they move between different services

Our judgement

The provider was not meeting this standard.

Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At this inspection we looked specifically at the way the hospital worked to ensure patients care needs would be continued by other care providers after discharge from the hospital. Concerns had been raised with us about the manner in which some patients had been discharged during a period of 'whole community black escalation' (where the hospital was not in a position to provide a service to any further patients and so were urgently discharging existing patients).

The director of nursing told us that during the 'whole community black escalation' patients were discharged in the manner which they would normally have been discharged. The only exception being they had arranged for some patients to see a social worker after discharge, when this would have normally have taken place before discharge.
The trust's policy on discharge states "an initial assessment and plan must be completed within 24 hours of admission…..the patient /carer must agree the discharge plan. This must be documented in the multi disciplinary notes……the discharging nurse from the ward must ensure that the patient and carer receive instructions on care required after leaving hospital…the discharging nurse from the ward, must complete the discharge checklist which is included in the nursing documentation." .

To review discharge arrangements we chose three patients in three different older people's wards. Two were about to be discharged and the other had been discharged the previous day. We spoke with staff, read their records, met with the discharging consultant, spoke with the pharmacist and the staff at the care home to where they were discharged. We also reviewed care records for 13 patients discharged to, among other places, nursing homes during the black escalation and spoke to senior staff at two care homes to where they were discharged and relatives.

In none of these cases had trust's discharge form been completed, as required by the hospital's discharge policy. Copies of discharge summaries written by the medical staff were available in 15 of 16 records where the patient had been discharged. These contained information about diagnosis and treatment. They did not include any key

information about patients' care and treatment needs as covered in the trust's discharge planning form. For example a patient's current continence status and any aids they used, how they were to be assisted to move or if they were able to take their medication independently, or needed support with medications, such as administering eye drops. There was no other documented information provided to receiving homes.

Staff told us they had provided some information verbally. A few patients' records documented discussions between the hospital ward staff and relevant other persons, prior to the patient's discharge. For example one person's records showed the ward had contacted the patient's intermediate care team to discuss their specific needs before they were discharged home. Another patient had clear information about their nursing needs provided at the end of their medical discharge summary. Other discharge summaries we looked at did not include similar information. A patient who had been suffering from infectious diarrhoea and vomiting was discharged to a nursing home. Information about their infection had not been communicated to the nursing home. There was no information in the patient's notes about the decision to discharge in relation to their infection. We talked to ward managers about nursing and care information provided to external providers. They said they would provide such information verbally over the phone or when the provider came to assess the person. They told us such information was not consistently documented.

We contacted two nursing homes to where these patients had been transferred. We did this to check whether appropriate information, dressings and medications had been sent by the hospital. The feedback given to us by these homes included many examples of insufficient information and medication to ensure continuity of care.

Homes had received patients discharged to them of whom they had no previous knowledge. At times, including the 'whole community black escalation', homes were given very little notice. We were told by the nursing homes that medical discharge summaries were usually provided. These contained sufficient information about diagnosis and treatment. Information about nursing and care was largely absent. This meant the homes did not have sufficient information given by the hospital to ensure safe care and patients' needs were met. For example, one patient arrived with anticoagulant injections, but there was no instructions for how this medicine was to be administered. One patient was sent out with insufficient insulin, so they ran out within the first day. Another patient had been returned to his nursing home with a verbal handover by telephone stating that 'care remained the same'. This patient had arrived with unlabelled medication that was not prescribed for them. The nursing home staff described how they had to telephone the hospital ward three times, to ascertain that this medication had been sent with the patient in error and belonged to another patient. This person had been admitted for choking. Their consultant had prescribed the use of a thickening agent for use in drinks to reduce chocking risk. No written information about the need to use the thickening agent, or supplies of the thickening agent had been sent to the home.

Nursing home staff and patients' relatives told us as a result of so insufficient information they had to observe people for a couple of days to determine what their needs were and then write their care plans. We were told staff from the homes contacted the hospital for additional information to care for these patients safely. In one case a discharge summary included brief information about a dressing which was needed. It also stated the patient "preferred a soft diet". The care home did not know if this was preference, or a medical need.

One nursing home told us two families had stated they were "very unhappy" with the discharge arrangements. One patient had a ward meeting where the plan for discharge

was made and agreed with the family, physiotherapists and other care workers. This plan was then not followed. When they visited their relative they found that there had been no discharge information provided by the hospital. The patient, who was over 80, had to tell the nursing home staff what medications were needed and the type of care they required. One of their essential medicines had not been sent to the nursing home with their discharge medication.

We looked at the care records file of a patient recently discharged from Coombe ward. This person had been tested twice on the AMT with scores of zero and seven respectively. Although the second score was lower than eight out of ten, the more detailed cognitive test had not been carried out. The patient relatives could not be contacted and they had been discharged home to the care of a neighbour who had the key to their home. This meant the staff could not be fully assured this person's discharge to their home was safe.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We concentrated at looking at older patients records at this inspection. We looked at 21 patients' records to see if there was sufficient information to allow staff to care for them safely. In connection with most of these records we spoke with a range of staff, including nursing, medical and management staff. This was to check we had reviewed all relevant sources of information, including the electronic record system.

The trust's health records management policy stated "any information that is stored, produced or recorded for patients must be printed and added to the paper held record." The health record content policy states "details of any assessments and reviews undertaken must be recorded to provide clear evidence of arrangements made for future and ongoing care". During the inspection we found there were three methods of recording patient's information, these were the electronic computer records, paper files and information recorded on whiteboards in the ward area. Staff were not clear about the appropriate route to record information.

We saw some patients' records included some detailed information about their current assessments and responses to treatment. These included actions taken when a patient was acutely unwell. Records showed evidence of appropriate checking of patient's medical conditions, such as blood tests. Documentation showed staff regularly reviewed a range of information about patients' responses to treatments.

We found patients' records omitted other information in relation to their care and treatment. This could have put patients at risk of unsafe or inappropriate care. The lack of certain records also meant it was not possible to monitor or evaluate all standards of care and treatment.

Assessments were carried out using standard forms but relevant individual information had not been included. For example one patient we met with told us they were not able to lie on one of their sides. They did not have any assessment about this and we could not see a section where such information could be documented on the trust's standard documentation.

In the majority of the records we reviewed we found there were no plans of care to show how staff were to meet people's care and treatment needs. This included care plans to reduce a patient's risk of falls, pressure ulceration and malnutrition. We saw one patient's records documented occasions when they had experienced incontinence. We saw requests had been made for urine samples to check for infection. The patient did not have a care plan about how their continence was to be managed, for example by supporting them in going to the toilet more regularly and offering additional fluids.

We asked staff how they planned care. They told us they used a white board to track actions which needed to be taken. This whiteboard was behind the main nurses' station. It showed the name of the patients together with lists and coloured dots to indicate progress towards their discharge. Staff told us they had a handover at the beginning of each shift about patients' care and treatment needs, but this did not form a permanent record. On some wards, each patient had a whiteboard above their bed to provide staff with key information, such as about support the patient needed with moving. These were wiped down and so were not a permanent record to facilitate evaluation of care and treatment.

Where patients had fluid balance charts, in many cases these were not completed. Fluid charts did not evidence patients were given regular drinks, so charts could not be used to monitor or evaluate care provided. For example, one patient's records documented they were confirmed as having Norovirus. This virus causes vomiting and diarrhoea and in older people puts them at risk of dehydration. The patient's notes documented "fluids encouraged". There was no evidence from the patient's fluid chart records that this was the case. Most of the fluid charts we saw had not been totalled every 24 hours, so they did not show if a person's input and output balanced or were satisfactory for their current needs. We asked staff and managers how they would know if a patient had appropriate level of fluid intake and they were unable to tell us.

Records of changes of position for people at risk of pressure ulceration were variable. Some records, for example comfort round records, were fully completed on some shifts, but not on others, with no records as to why this might be for the patient. We saw some turn charts where records were made by some shifts, for example on night duty, but not others. Again there was no documented rationale for this in the patient's records. We saw in one patient's records that their turn chart had been discontinued, but again there was no reason for this documented in their records.

Some records did not agree. One patient had a record indicating they had a very low mental cognitive test score, but a different record completed on the same date which documented they had capacity to make a certain decision. A patient's standard assessment record changed between 4 February 2013 to 5 February 2013, from stating there might be issues relating to their discharge, to stating there were no such issues. There were no notes in their other records to show what factors had occurred to affect this change in their condition.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained. Regulation 17 (1) (a).
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there. Regulation 9 (1) (a) (b) (i) (ii).
Regulated activity	Regulation

This section is primarily information for the provider

Treatment of disease, disorder or injury	**Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010** **Cooperating with other providers**
	How the regulation was not being met: Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care. Regulation 24 (b) (i).
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records. Regulation 20 (1) (a).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 22 March 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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Appendix C: Action Plan from the CQC unannounced inspection of the RUH (February 2013)

Key findings	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained. ***(Outcome 1 – Minor impact)***	Review DSU admission criteria.	March 2013	Suzanne Wills, Divisional Manager		**Action complete**
	Develop DSU admission criteria for red / black escalation status.	April 2013	Suzanne Wills		
The CQC notes, "the day surgery unit was being used as a facility to care for inpatients who would normally be accommodated elsewhere in the hospital. The environment and the care arrangements on this unit were not suited to ensuring inpatients privacy, dignity, health and welfare needs were met."	Review of DSU patients by duty matron / site manager is documented daily.	March 2013	Sharon Bonson, Assistant Director of Nursing, Surgery		
	Site management team to hold a log of patient safety issues raised and actions taken. Develop process for addressing where patient safety concerns have been raised but not resolved.	April 2013	Janet Wright, Clinical Site Manager		
	DSU staff / clinical site team / on call managers / on call directors to be made clear of DSU function when trust is in red / black escalation (circulate DSU admission criteria and process for addressing patient safety concerns).	April 2013	Suzanne Wills		
	Investigate option of providing an additional shower.	April 2013	Julia Papps, Matron Howard Jones, Director of Facilities		
	Air flow for DSU has been reviewed and found to be fully functional.	March 2013	Howard Jones		**Action complete**

Author: Rob Eliot, Lead for Quality Assurance
Version 2
Date: 15 March 2013

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Key findings	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there. ***(Outcome 4 – Moderate impact)*** Concerns raised in DSU included: • No comfort rounds carried out • Risks assessments for pressure ulcers not completed in line with NICE guidance • No access to turn charts • Care plans for prevention of pressure ulceration not in place • Risk assessments / care plan for falls not completed • Mobility assessment and communication assessment not completed Concerns raised in OPU included: • Patients not able to understand CQC questions were not having all their care needs met • No other mental cognitive tests had been completed for patients with abbreviated mental test (AMT) scores of less than eight. This meant no further assessment or care planning had been developed for the risks associated with their confusion.	Review availability of documentation within DSU. Nursing documentation to be held in folders at the end of the patient's bed to allow easy access for staff (yellow clip boards to indicate if comfort rounds required) Appoint ward clerk for DSU who will be responsible for maintaining a supply of relevant documentation. Develop an overview of documentation that should be completed for inpatients – core and care need specific, in line with record keeping standards. DSU staff to be trained on inpatient millennium record keeping and patient documentation. Shift coordinator to ensure that all patients have had appropriate nursing documentation commenced, including initial and on-going risk assessments. Develop a guideline for AMT (to include requirements for further assessment and care planning)	March 2013 March 2013 April 2013 April 2013 April 2013 April 2013 May 2013	Julia Papps Julia Papps Sarah Fletcher, DSU Senior Sister Anne Plaskitt Jessica Flower, Millennium Change Lead Anne Plaskitt Sarah Fletcher Dr Chris Dyer, Consultant Geriatrician		Completed. DSU have been provided with relevant documentation for inpatients. Interviews to be planned for April 2013. Training log to be maintained. Sue Leathers (Matron) to discuss with Chris Dyer.

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Key findings	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care. ***(Outcome 6 – Moderate impact)*** Concerns identified included: • Nursing and care information to external providers was not consistently documented in the discharge planning form (e.g. continence status, support with medications) • Essential medications not always sent to the nursing home • Unlabelled medicines, or medicines not prescribed for the patient supplied inappropriately	Roll out the use of the transfer of care power form on Millennium to all wards Nursing documentation standards for discharge will be promoted on each ward through: • Poster of discharge documentation standards • Awareness sessions with each ward and sisters meetings • Prompt cards with step by step information for completion of the transfer of care form on Millennium Audit of completion of discharge checklist – to include checking on what information was given to the patient and external providers. This will be carried out by ward staff (5 records per week). Audit on the transfer of care form to be carried out monthly (data can be exported from Millennium). Sections 10 & 11 of Discharge Medicines Policy to be promoted on each ward through: • Poster and prompt cards for key actions • Awareness sessions with each ward and sisters meetings Audit of Discharge Medicines Policy standards Green Review meetings with external providers are held 3 times a week. Ensure that issues around discharges are a standing agenda item and a log kept of identified concerns to raise at site / bed management meetings.	March 2013 April 2013 May 2013 May 2013 May 2013 May 2013 April 2013	Anne Plaskitt Anne Plaskitt, Senior Nurse, Quality Improvement Anne Plaskitt Rob Eliot, Lead for Quality Assurance Ward Sisters Business Intelligence Unit Regina Brophy, Chief Pharmacist Rob Eliot Clare O'Farrell, Divisional Manager		Refer to Transfer of care roll out plan. First awareness sessions are to be held week commencing 11 March 2013. Add audit of the discharge checklist to the monthly global trigger tool harm review (from April 2013, in addition to the weekly ward audits). The results from completed audits will be reviewed at Quality Board. Only in exceptional circumstances should patients be discharged home without their medicines, e.g.OOH discharge of local patient who can collect medicines the following morning.

Appendix C: Action Plan from the CQC unannounced inspection of the RUH (February 2013)

Key findings	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records. ***(Outcome 21 – Moderate impact)*** Health Records Management Policy states, "any information that is stored, produced or recorded for patients must be printed and added to the paper record". Concerns identified included record keeping not being consistently completed for: • Patients' fluid intake and output / fluid balance charts • Discharge planning & checklist • Falls care plan • Pressure Ulceration prevention and turn charts • Malnutrition • Continence • Comfort rounds (completed on some shifts but not others)	Revise Health Records Management Policy to more accurately reflect where documentation should be recorded / filed. Whiteboards are used as a tool for viewing patient status at a glance. Develop a revised comfort and pressure care record. This combines information from the comfort round record, repositioning charts, daily skin check and pressure ulcer care plan. A new hydration record chart is being tested on Parry Ward. This will then be rolled out for use across the Trust. Further promotion on use of the fluid intake and output / fluid balance charts through awareness sessions with each ward and sisters meetings. Review Patient Assessment Record to consider recording whether a fluid balance chart and comfort round is required for each patient Comfort Round compliance is audited through the IHI General Ward Work stream (to include Day Surgery) Audit form to be designed to allow a full patient case note review (this will be undertaken across the Trust on a monthly basis)	April 2013 May 2013 May 2013 May 2013 April 2013 May 2013	Mark Hawkins, Medial Records Manager Anne Plaskitt Anne Plaskitt Natasha Howard, Sister, Parry Ward Anne Plaskitt Nutrition and Hydration Steering Group Anne Plaskitt Anne Plaskitt Rob Eliot Bernie Marden, Chair of Medical Records User Group		Agree changes to policy at next Medical Records User Group / NHSLA documentation steering group. The results from completed audits will be reviewed at Quality Board.

Appendix C: Action Plan from the CQC unannounced inspection of the RUH (February 2013)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress

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