

DRAFT

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RY8
Our reference	INS1-694464234
Location name	Walton Hospital
Provider name	Derbyshire Community Health Services NHS Trust

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:
	<i>The provider had not made suitable arrangements to ensure that patients' dignity was consistently promoted. Regulation 17 (1)(a). Patients were not always provided with appropriate information and support about their care. Regulation 17(2)(b). Patients were not consistently encouraged to express their views and preferences in relation to their care and treatment, Regulation 17(2)(c)(ii)</i>
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
<p>As a result of the two inspections the Trust has been investigating in fine detail Derwent Ward performance and has been acting to drive up the standards in treatment and care. The following actions set out are firstly the generic or wider actions for improvement and then those orientated to the specific areas of non compliance to the regulations. These include the key themes of improving clinical leadership and general management, setting and delivering standards, supporting and maintaining the workforce and their training, promoting patient and family centred care, underpinned by improvement processes such as ward based clinical audit, peer review, and more targeted internal quality inspections. Performance systems are in place and have been enhanced to provide greater transparency and accountability on a more frequent basis.</p> <p>Actions that are set out below are grouped accordingly:</p> <p>1. Clinical Leadership and General Management Actions</p>	

This is an important and urgent set of actions and applies to all regulations.

1.1 Action: Put in place a new interim ward sister, ward manager and hospital matron (started 27/08/13).

Planned Outcome: This team is a specifically chosen, high performing leadership team that is empowered to drive improvement of the ward quickly and effectively. They will remain in post until their primary objectives are achieved.

Measures: appointment of new interim ward management; delivery of their primary objectives to achieve a high quality service and compliance to regulations.

Progress: Completed, the new staff are working to deliver the action plan.

1.2 Action: The substantive management post holders from Derwent Ward will be supported through an intensive development programme and buddying arrangement at other sites within DCHS and are currently supernumerary to the leadership at these sites. The focus of the package will be upon clinical leadership, patient and carer involvement and record keeping, incorporating the principles of *Care And Compassion 6 Cs*.

Planned Outcome: These staff will achieve a level of competence as part of this performance management process before returning to a leadership role

Measures: these are agreed as part of their development programme.

Progress: Staff are undergoing the programme with pending performance outcome.

These actions are fundamental to the significant improvement in the ward and are proportionate action to the failure of the existing management to drive up standards fast and reliably enough. The Trust has fair employment processes and is committed to help any member of staff to improve. The Trust takes its duty to hold staff to account very seriously especially where there is any perceived failure to deliver the essential standards of care.

1.3 Action: Temporary bed capacity reduction from 30 to 20 (commenced 27th August 2013)

Planned Outcome: This reduction in activity and control of case mix is necessary to significantly reduce work load and increase staff to patient ratios in order to achieve urgent staff and system improvements, increasing importantly time to care, learn and embed new practice. Any increase in capacity will be decided in conjunction with the interim ward management team, their senior managers and lead directors.

Measures: daily bed states and measures of activity; staff to patient ratios (adjusted for skill mix and dependency using Hurst methodology)

Progress: Bed reduction has been agreed and will be achieved w/c 2nd September 2013

1.4 Action: Workforce- the new interim ward management will ensure adequate staffing for delivering a high quality service. Forward planning must reduce the requirement for non substantive workforce but where necessary the use of Trust bank staff / approved agency. The new team will also drive through a healthy team approach and begin to address longer standing and ongoing issues of sickness and absence / attendance.

Planned Outcome: the ward will continue to meet the recommended staffing to provide high quality care.

Measures: Trust workforce indicators including skill mix / establishment / Hurst guidance and RCN guidelines.

Progress: Improvements in rotas are already in place. Medium and longer term plans are currently being revised.

2. Setting and Delivering Essential Standards can only be achieved by improving staff awareness of CQC findings and regulations

These apply to all Regulations

2.1 Action: Provide staff feedback via engagement events to all ward staff following the CQC visit, discussing all elements highlighted within the report.

Planned Outcome: Staff are now aware of the findings at both inspections and have engaged with the new management team to improve standards.

Measure: delivery of planned events and staff sign into action plans.

Progress: Completed August 2013

2.2 Action: Ensure there is a positive culture for improvement and maintain this by on-going staff engagement and support (re-commenced by new leadership team). The interim leaders will be accessible and in close contact with staff, modelling behaviours, listening to concerns and maintain momentum.

Planned Outcomes: the staff will demonstrate a positive attitude to caring for patients and work as a team to achieve improvements.

Measure: this will be measured by a number of direct and indirect performance indicators, the emphasis being placed on patient experience such as comments, compliments, concerns, complaints, Friends and Family Test, staff pulse check and staff surveying.

Progress: This has been started and will be ongoing.

2.3 Action: Introduction of new weekly staff meetings where performance can be discussed and their actions to improve care especially those where they have been shown to not meet the regulation. Key patient and family / carer's feedback and incidents will be discussed. (commenced August 2013).

Planned Outcome: by embedding team meetings and service improvement the staff will be informed and better supported to achieve better outcomes for patients.

Measures: delivery and attendance of planned weekly meetings; record of discussions and actions agreed.

Progress: Meetings starting w/c 2nd September

2.4 Action: Confirmation of staff ownership of standards and any actions to improve care will be set out in the ward action plans. This will be achieved through ward and individual staff meetings. Failure to deliver actions will trigger a performance review.

Planned outcome: Staff must know and agree what is expected from them and be responsible and accountable. Staff will be accountable to deliver improvements to achieve high quality care.

Measure: evidence will be collated on a day to day basis that demonstrates staff (team and individuals) will own responsibilities and deliver improvements. There is a register of meetings and actions with staff that provides an oversight to ward quality performance. This is owned by the Matron.

Progress: this has commenced and will be supported by the current action plan and improvement process with regular engagement with ward staff by ward management.

2.5 Action: The ward will proactively collate staff, patient and family members' comments and suggestions for improvements. Staff will share their ideas and joint learning as part of the wider improvement plan for the ward and to other sites where appropriate.

Planned Outcomes: Staff will demonstrate they involve key partners in service improvement placing an importance to the views of patients and their families. Staff will share their learning with other sites / professional groups where appropriate.

Measure: there will be a central record of comments, ideas for improvement with supporting evidence of how they were actioned. Matrons meetings will have an agenda that is specific to service improvement and professional standards.

Progress: this has commenced and will be progressed over the next few months.

Regulation 17 Respecting and involving people who use services

Finding: Patients were not consistently encouraged to express their views and preferences in relation to their care and treatment Regulation 17(2)(c)ii

Involvement with patients, family and carers about care and treatment is a fundamental principle in understanding and delivering patient and family centred care. The Trust has worked with expert organisation Picker Institute to rapidly strengthen systems to support empowering patients and ensuring their voice is heard.

3.1 Actions: Staff are engaged in a work-based development programme led by the Matron and delivered using coaching, mentorship, clinical supervision, and reflective practice. This programme will be pivotal to ensure all ward staff learning needs are orientated to a patient and family centred approach. The new management team will be leading the learning by example, modelling positive, professional behaviours for all staff.

This will support a sustained change to:

- ensure there is clear patient involvement with assessment, planning, implementation and evaluation of care plan
- clear and contemporaneous documentation of patient involvement and understanding throughout this process
- enshrine the principles of inclusion in practice, delivered by involvement from DCHS Healthcare for All and Equality and Diversity Lead There will be a main focus on 'listening' to what the patients, family and carers tell us about our services and 'acting' upon what we hear, in order to re-shape services based on the 'patients voice'

Planned Outcome: staff will understand, have the skills and resources to listen and work to patient preferences and priorities and be able to demonstrate this in care planning outcomes and records.

Measures: delivery of training programme with feedback and evaluation. Separate outcome measures on care planning and documentation will be reviewed.

Progress: this has commenced and is planned for the next 12 weeks before formal review.

3. Patient Pathways and Care Management

3.1 Action: Ensure the daily huddles and weekly JONAH discharge planning places patients' decisions / preferences at the heart of the decision making process.

Planned Outcomes: The outcomes are orientated to patients' decisions / preferences and are recorded appropriately on the electronic JONAH system. Patients, family and carers are informed of progress.

Measures: evidence will be collated in the JONAH system.

Progress: this has commenced. The action will need to be monitored over a period and the system checked for evidence of compliance.

3.2 Action: Patients informed decisions or best interest decisions taken on their behalf meet the requirement of the law especially the Mental Capacity / Health Act. This relates to day to day / smaller but important decision through to decisions about life sustaining treatment.

Planned Outcome: patients are empowered as decision makers or protected when they lack capacity to make decisions.

Measures: case note auditing as part of the wider clinical records auditing process with specific evidence of compliance to the FACE assessment of mental capacity, Deprivation of Liberty and Safeguards, Do Not Attempt Resuscitation Orders.

Progress: this has become an explicit part of the monthly clinical records audit for this team.

Measure: clinical auditing as part of the wider clinical records auditing process.

3.3 Action: Ensure all decisions are communicated clearly with the patient and family/carers/staff in a timely manner and documented with a description of the understanding and involvement in the patients' decision care plan.

Planned Outcome: patients and staff report high levels of satisfaction with communication.

Measure: patient experience feedback including interviews with patients, peer review and internal inspection.

Progress: this is now part of the work base development plan which is ongoing.

3.4 Action: Staff will proactively engage and encourage feedback and views from patients as a

normal part of their interactions with patients whilst on the ward as well as ask their family and carers about the care received. This will include aspects from basic care such as the quality and choice of food or the standard of the accommodation.

Planned Outcome: patients, their families and carers have an active voice to offer positive and negative feedback in real time across the spectrum of care to staff.

Measures: activity coordinators process will lead the process; evidence through patient experience feedback, case note / care records clinical auditing, unannounced ward visits / inspection / peer review, listening to patients and families. There will also be a post discharge survey of willing patients that measures this and the wider patient experience they experienced.

Progress: this is being developed by the Matron for implementation in September 2013.

3.5 Action: Ensure records and care plans reflect the feedback and discussions with patients.

Planned Outcome: By asking and recording these discussions, treatment and care will be more personalised to a patient's needs. By listening and acting on patient feedback staff will understand the 'smallest things make the biggest difference' in relation to patient experience and what matters to them.

Measures: evidence through patient experience feedback, case note / care records clinical auditing by peers, unannounced ward visits / inspection / wider peer review, listening to patients and families.

3.6 Action: Instigate quarterly independent reviews of patients experience of care by listening to patients, their family and carer feedback. This will be supported by the Patient Experience Team and representatives from the local voluntary agencies / lay representatives / Trust members and governors. The Trust will be ensuring we work with Healthwatch in setting this process up, noting their intention for unannounced visits to providers.

Planned Outcome: this will lead to a richer source of information, potential reducing reporting bias, about the quality of service provided.

Measures: quarterly reports on the subjective / qualitative accounts of patients and families experiences.

Progress: to be agreed with governors 3rd September 2013 and then in coordination with external partners.

Care and Compassion

3.7 Actions

Re-emphasise the Trust quality culture and values by the further promotion of the DCHS Way throughout all staff training and awareness sessions, the required standards of care delivery, ward displays and posters.

Provide specific targeted training about Compassion in Practice and the 6 Cs. Agree with staff what the local measures of these 6 Cs will be.

Develop a clinical audit methodology to demonstrate compliance against the *care and compassion* 6Cs, with regular feedback at staff meetings to discuss and correct any variances from agreed standards whilst striving for a sustained change and improvement gain.

Discussions with all ward staff, reinforcing their responsibility, to raise concerns against fellow members of staff where they witness any practice that gives rise to concern, or is not compliant with the above standards. Staff may raise concerns via their line manager, or any of the wider management team, alternatively they may use the DCHS whistle blowing policy.

Perform unannounced inspection and review of the ward by internal expert review teams (quality team, professional / clinical leads and peers) supported by robust quality performance information, clinical audit outcomes, benchmarking.

Planned Outcomes: To deliver a high quality service that can evidence compassion in practice on the ward.

Measures: evidence through patient experience feedback, case note / care records clinical auditing, unannounced ward visits / inspection / peer review, listening to patients and families. More specific measures will be agreed for the 6Cs and these will be subject to clinical auditing the initial proposal are as follows:

I care enough to deliver every day, every shift, every patient...

Care

Safety, always striving to reduce harm

(Measurement- Safety Thermometer, Datix)

Compassion

"What matters to you?"

(Measurement – Friends and Family / Patient Experience indicators)

Communication

Transitions and handovers of care

(Measure Shift - Handovers; Care Planning / Discharge)

Courage

Report incidents and errors (supporting a positive quality culture)

(Measurement Datix and NRLS data set)

Competence

Live Life Long Learning

(Measurement appraisal, staff training rates, staff survey)

Commitment

To be there when it counts, by keeping well, at work and motivated

(Measurement – workforce / attendance)

Progress: planning is under way, early work has commenced through the development work.

Finding: the provider had not made suitable arrangements to ensure that patients dignity was consistently promoted Regulation 17(1)(a)

Promoting and achieving dignity for people with complex physical and mental health problems requires a range of knowledge and skills. It also requires involving patients in their care, a vital part or re-enablement. Supporting them to achieve this is by providing a flexible and responsive team and a safe, clean and private environment.

4.1 Actions: Responding to calls for help

Call bell system upgrade and staff response times

This upgrade provides an audible and a visible alert to staff and patients, a pendant option for those patients that are mobile and may require assistance, an emergency call bell system as a different level of alert.

Inform all staff and the multi-disciplinary team of the priority to answer call bells promptly, supporting patients' privacy and dignity. Matron, and Ward Manager to monitor this practice, providing immediate staff feedback where required.

Complete 24 hour observational study of staff response time to call bell activation, share findings with wider team

Planned outcome: patients' needs will be responded to in a much more effective and timely way.

Measures: completion of system and demonstration of effective installation, direct observation studies of how patients and staff use the system, patient / family and staff experience / feedback.

Progress: Completed (report of the observation study pending).

4.2 Action: Access to equipment for mobility / independence / activities of daily living and

personal hygiene.

Planned Outcome: maintain the high standards shown by the specialist ward therapy staff across the whole ward team.

Measures: direct observation of practice, clinical supervision

Progress: this has been started and is under review from the Matron.

4.3 Actions: Environmental

Upgrades to curtaining in all areas.

Minor decorative and ward furniture / layout changes to promote the healing environment and reduce risk of harm i.e. falls, disorientation / agitation.

Increasing space around beds in bay areas by reducing the bed number in each bay from 6 to 4.

Measures: Credits for Cleaning Audits, PACE and PLACE scores, patient / family and staff feedback

Progress: this is being implemented.

Finding: Patients were not always provided with appropriate information and support about their care. Regulation 17(2)(b).

4.4 Actions: The Patient Experience Team supported by the Communications Team will use the principles of experience based design to organise a session with patients and their families to improve our understanding in relation to what information they would like to see and in what formats focusing initially on:

- 'ward welcome pack' visiting, speaking to key workers e.g. nurse, therapist, sister, doctor
- ward notice boards
- ward team information (with photos), daily staffing and ward manager
- information to support key treatment and care decisions
- advocacy
- giving feedback including how to make a complaint

Planned Outcomes: utilise the findings from this event and work with the communications team to revise and devise a new patient / ward resources.

Measures: post implementation evaluation, patient and family feedback.

Progress: Date planned for October 2013.

4.5 Action: Improve accessibility and visibility of ward management team, walking the ward floor.

Planned Outcomes: patients and family will see and have the opportunity to stop and talk with the Matron, Ward Manager / Sister (which are supernumerary clinical staff). The previous drops in sessions were not well attended. Patients and their family will also see in real time coaching / feedback from these ward leaders to staff.

Measures: direct and indirect patient experience measures and feedback from ward management team.

Progress: this has commenced.

4.6 Actions: Raise awareness and improve general interaction skills amongst all ward (clinical and support) staff, requesting that they proactively engage and communicate with patients, family and carers. Clinical staff will be proactive about offering information to patients and their families on their care, particularly during visiting times rather than waiting for relatives to seek and approach staff themselves.

Inform all staff of their 'meet and greet' role whilst on duty, particularly around visiting times

Implement a 'meet and greet' role as part of the ward clerks duties, and consider better orientation of clerks hours to better support visiting or telephone enquiries.

Planned Outcomes: This action will engender and embed positive, transparent and active communication behaviours between ward staff, patients and any visitor.

Measures: using the array of feedback mechanisms and patient experience indicators.

Progress: this is being driven currently by the Matron supported by planned specific "customer-service" training sessions.

Consistency of information provided

4.7 Actions: Installation of 'a patient status at a glance board', providing quick and easy reference for staff to enable them to inform patients relatives and carers of patients progress within their pathway of care and actions planned.

Staff reminded to use medical notes and care plans to update family and carers of patient's progress to ensure consistency and accuracy of information provided.

Handovers / Transitions / Communication algorithm.

Planned Outcomes: staff will be able to provide consistent and timely information about patients and their care.

Measures: monitor working practice, perform direct observation of practice, feedback from patients and families, the use of Productive Series and Patient Safety tools – Early Warning Scores, Detecting the deteriorating patient, SBAR.

Progress: this is part of the ward work based development plan being implemented.

Who is responsible for the action?

Sally-ann Coope interim Matron

Elaine Price Assistant Director ICBS

**How are you going to ensure that improvements have been made and are sustainable?
What measures are you going to put in place to check this?**

The previous section contained reference to specific measure alongside the actions. In this section we provide more evidence related to the governance arrangements.

Effective Risk Management

Identification

The failure to meet the specific regulations identifies the risk of not providing a high quality service to patients and a subsequent loss of reputation. This risk has been registered on the Trust risk register and been given a risk score of 20 (high). It will remain under active review until the CQC have returned and full compliance achieved.

“Out of Hours”: careful monitoring will take place in more specific times of potential risk including out of hours, at bank holidays or times of demand escalation. We will work with partner organisations to ensure they are aware and follow revised working arrangements on the ward. We will seek feedback too from these partners.

Confirmation of Risk Ownership

The risk owner will be Elaine Price, Assistant Directors ICBS North.

Agreed Process

The overarching risks will be reviewed at every Quality Service Committee supported by objective information on progress against the action plan and other performance information.

This risk will be also reflected in the monthly Board report and briefings. The Board will maintain a grip on this risk.

There will be de-escalation or removal only when a subsequent CQC inspection has

demonstrated compliance. Weekly monitoring achieved by the Strategic Steering Group weekly and senior service managers.

More specific risks / performance issue will be considered in more dedicated committees / groups e.g. Safety or Patient Experience Groups.

Enhanced Internal Audit and Assurance System

Increased surveillance of key quality performance indicators with greater triangulation of risk including the Trust wide measures of harm (safety thermometer); patient experience (including complaints / compliments, feedback and Friend and family test); incidents and serious incidents; workforce (ensuring appropriate levels of staffing and skill mix)

Monitor trends and findings from the independent quarterly reviews, share with staff to agree action required, maintaining staff engagement and involvement in continuous service improvement and required change.

Weekly reviews: ward based reviews by the matron with the staff, strategic oversight by a leadership team.

The action plans describe an extensive review system including Trust unannounced visits supported by Board members, Council of Governors / lay representatives and expert clinical leaders. There will be process peer review and independent inspection and clinical auditing.

Day to day clinical supervision of ward staff and ward / wider risk owners.

Appraisal of ward staff and risk owners using the Trust system (this emphasises not just was the objective achieved but was it achieved the right way with the right behaviours).

Establish and implement a ward based performance framework and regime to monitor against the action plan to demonstrate progress and compliance against the regulations we did not meet.

Provide ongoing timely and constructive feedback to the ward staff, the Ward Management Team, Assistant Director.

Manage any poor performance or non-compliance against the standard via the performance matters toolkit.

Who is responsible?	Sally-ann Coope, Matron Elaine Price, Assistant Director ICBS North
What resources (if any) are needed to implement the change(s) and are these resources available?	
New call bell system funded via the capital programme Ward décor, fixtures / fittings Information resources (patient information / ward notice boards etc) Management resource These have been estimated, agreed and or actually spent.	

Date actions will be completed:	October 2013 (noting there some long term /continuous improvement processes involved).

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Potential impact upon the wider quality of service especially patient experience leading to the loss of confidence in the service provided and damage to Trust / NHS reputation.

Completed by: (please print name(s) in full)	Jo Furley, supported by wider management team
Position(s):	Interim Chief Nurse
Date:	26.8.13

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:
	<i>Patient's nursing records were not being maintained or completed consistently and did not always contain appropriate information in relation to the care and treatment being provided. Regulation 20 (1)(a).</i>
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
<p>Finding: Patient's nursing records were not being maintained or completed consistently and did not always contain appropriate information in relation to the care and treatment being provided. Regulation 20 (1)(a).</p> <p>Please also refer to the previous section of this report that contains actions which are applicable to all the regulations.</p> <p>Specific Actions</p> <p>1.1 Action: Provide specific training on record keeping CQC Outcome 21: records and regulation 20 (1) (a), supported by the Nursing and Midwifery Council documentation standards.</p> <p>Planned Outcome: all staff will achieve required learning and have the skills to meet the regulation and therefore improving care to patients.</p> <p>Measure: attendance and successful completion of training. Applying this learning in practice will be measured through case note / care plan audits. Staff will be coached through in real time by the ward management team with current patients in their case load. Peer review by expert colleagues in the Trust will be organised by the Matron.</p> <p>Progress: attendance at training is being quickly scheduled into rotas. Work based competency is actively supported in the ward development plan in progress.</p> <p>1.2 Action: Support staff through education and clinical supervision to understand the importance of completing accurate, contemporaneous records for specific assessments of safety, clinical treatment and care i.e. fluid balance, weight / nutrition, tissue viability assessment, pressure ulceration prevention and wound management and observations / early warning scores and rounding charts.</p> <p>Planned Outcome: Trust clinical / quality high priority issues relating to clinical treatment and care and the essential documentation will be reliably addressed and this will improve outcomes.</p> <p>Measures: clinical auditing of records for assessments and care plans, patient / ward outcome</p>	

measures for Safety Thermometer. A review of patients care and progress via the care plan at significant times of change or at minimum weekly updates.

1.3 Action: The schedule of formal audits of the Rounding Tool, to embed the process as a positive support to the wider patient care and not just a tick box exercise.

Planned Outcomes: patient rounding will be done regularly and effectively.

Measures /Progress: Rounding audit being completed in August 2013

1.4 Action: Implement of a new non medical documentation system, following successful pilot in 2 sites within DCHS.

Planned Outcome: this will make the burden of paperwork less and support better practice / more accurate and useful documentation.

Measure / Progress: to be rolled out during 2013 to all sites to be supported by evaluation tool.

Who is responsible for the action?	Matron Sally-ann Coope Elaine Price
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**How are you going to ensure that improvements have been made and are sustainable?
What measures are you going to put in place to check this?**

As in the previous section the actions are described with the measures. The same system of governance described in the previous section will support the sustainable delivery of improvements in care and meet the regulations we were found to be non compliant with. Clinical Record Keeping is a Trust priority for this year and together with new (and less burdensome) systems of documentation, close clinical supervision and learning with and from peer review the staff on this ward have a good chance of significant improvement.

Who is responsible?	Sally-ann Coope, Matron Elaine Price, Assistant Director ICBS North
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What resources (if any) are needed to implement the change(s) and are these resources available?

No additional capital resources are required. There is an agreed budget to support the learning and practice development of the ward.

Date actions will be completed:	October 2013
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How will people who use the service(s) be affected by you not meeting this regulation until this date?

Potential impact upon the wider quality of service especially patient safety and experience leading to the loss of confidence in the service provided and damage to Trust / NHS reputation.

Completed by: (please print name(s) in full)	Jo Furley, supported by wider management team
Position(s):	Interim Chief Nurse
Date:	26.8.13



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23 October 2013

Dear Colleague,

Re: Minor Injury Units

Derbyshire Community Health Services NHS Trust (DCHS) commissioned an external review of its Minor Injury Units (MIUs) following the Royal College of Nursing's (RCN) release of its 'standards for caring for neonates, children and young people' report. In that report the RCN recommended that in all urgent care settings, such as a MIU, there should be a registered children's nurse available.

As we continually strive for improvements in the quality of services and outcomes for all of our patients, DCHS invited the Royal College of Paediatricians and Child Health (RCPCH) to review the services we provide in our local nurse-led MIUs. The review resulted in a number of recommendations from the RCPCH, particularly in relation to treating children under one year of age and caring for ill children during the night. One of their recommendations included reducing MIU opening hours to 8am-10pm every day, to guarantee safe and effective services are provided for children and young people overnight.

Providing safe, effective and high quality services is our number one priority. Given the recommendations in the RCPCH report, coupled with the long-term low overnight patient activity we have seen, we are proposing to make the recommended reduction in opening hours from 25th November at Ripley and Whitworth Hospital (Darley Dale) MIUs.

We have discussed the report's recommendations and this proposal at great length with fellow providers and commissioners of urgent care services locally, all of whom agree this would be the best course of action.

These units have seen very low activity overnight, typically between the hours of 10pm and 8am. At Whitworth Hospital, the average number of attendances has been less than 1 and at Ripley the average is just 2. Highly skilled nurses are required to be on duty at all times in our MIUs, and the need for these specialist staff to be available for patients during the day is much greater (when numbers are higher). Furthermore there is a recruitment challenge on a national scale for specialist nursing roles such as these.

In addition to the low overnight activity, a significant number of patients attending our MIUs overnight have to be referred to other providers of urgent healthcare so their condition can be effectively treated. These other providers are normally local accident and emergency



departments or the GP out-of-hours service, Derbyshire Health United. An onward referral, and the obvious delay in treatment this can cause, is not in the best interests of patients.

The longer-term future of urgent care services locally will be subject to a full public consultation led by our local commissioners of health services.

Should you have any questions about these proposals, please do not hesitate to get in touch with me, or with our communications department via: communication@dchs.nhs.uk

Yours sincerely,

William Jones
Director of Operations

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23 October 2013

Dear Colleague,

Re: New and improved arrangements introduced in north Derbyshire

Derbyshire Community Health Services NHS Trust is announcing new and improved arrangements for providing care for patients requiring rehabilitation services in north Derbyshire.

Under the proposals unveiled today:

- An additional ward will be created at Bolsover Hospital, increasing its bed numbers to 40 beds from its current 25.
- Three further beds will be created on Whitworth Hospital's fully refurbished Oker Ward.
- Additional rehab beds will be created in north Derbyshire to provide rehab and therapy support working in partnership with Derbyshire County Council's Social Care teams.
- To support new models of care, our commissioners have also invested £2mn to recruit additional staff to further improve patient care.

The improved arrangements – which have the full support of the local Clinical Commissioning Groups and staff union representatives, will also allow the Trust to close the current Derwent Ward at Walton Hospital, Chesterfield from 18 November. This move is in line with plans to develop services and care closer to patients' own homes.

Arrangements at Derwent Ward have suffered from high staff vacancy and absence rates, with care reliant upon agency staff on a daily basis. Coupled with its outdated patient environment, the current arrangements have been acknowledged to be unsustainable in the long term.

By investing in newer facilities, more modern care arrangements and better ratios of permanent staff to agency nurses, we will be able to improve the quality of care, deliver a better service for patients, invest in our permanent nursing staff and improve our efficiency.

Should you have any questions about these proposals, please do not hesitate to get in touch with me, or with our communications department via: communication@dchs.nhs.uk



Yours sincerely,

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