North Bristol NHS Trust

Southmead Hospital

Quality Report

Southmead Hospital Bristol
Southmead Road
Westbury-on-Trym
Bristol
BS10 5NB

Tel: 0117 950 5050
Website: www.nbt.nhs.uk/our-hospitals/southmead-hospital

Date of inspection visit: 4-7 and 17 November 2014
Date of publication: 11/02/2015

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	**Inadequate**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Critical care	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Services for children and young people	**Good**
End of life care	**Requires improvement**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Southmead Hospital is one of five locations that are registered with the Care Quality Commission and form North Bristol NHS Trust. It is an acute hospital, which provides urgent and emergency services, medical care, surgical care, critical care, maternity and gynaecology, neonatal intensive care, end of life care and outpatients. It also provides specialist services such as neurosciences, renal and plastics/burns to people from across the South West and in some instances nationally or internationally. Inpatients services for children and young people are provided at a neighbouring trust.

In May 2014 the Brunel building on the Southmead Hospital site opened. This was a significant event with the majority of services moving from the 'old' Southmead Hospital and the Frenchay hospital site into this new building.

We carried out a comprehensive inspection because North Bristol NHS Trust had been flagged a medium risk on the Care Quality Commission (CQC) 'Intelligent Monitoring' system, which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. The inspection took place on 4–7 and 17 November 2014.

Overall, this hospital was rated as requiring improvement. We rated it good for being caring and as requiring improvement in safety, effectiveness, being responsive to patients' needs and being well led. There were particular concerns relating to safety and responsiveness in the urgent and emergency services and we judged these aspects as inadequate.

Our key findings were as follows:

Safety

- Safety was good in services for children and young people, but in all other areas it required improvement, and in urgent and emergency services it was judged as inadequate.
- The emergency department regularly and frequently declared a status of red or black escalation. This meant that the department was considered to be "not able to function as normal" and "verging on unsafe for periods of time" or "dangerous for a sustained period of time (more than two hours)" when "normal care was not possible". The department was often overcrowded and patients were not always cared for in the appropriate part of the department.
- Staff were aware of how to report incidents and generally reporting was good, but some teams were not reporting all incidents.
- Feedback following the reporting of incidents was mixed, with staff in most areas stating this was not consistent.
- There were shortfalls in staffing levels across the hospital. Although staffing had been reviewed before the move to the new hospital, the workload in some areas was higher than predicted, including the emergency zone. In areas such as critical care, theatres and the neonatal intensive care unit, staff had been recruited, but there were issues with the skill mix and a high proportion of junior and inexperienced staff.
- Medicines were not appropriately managed with weaknesses in storage and accurate recording of administration.
- There were concerns with the availability of medical records and the use of temporary sets of notes.
- Compliance with the WHO checklist was not consistently achieving the target of 100%. Review of records found issues with documentation.
- The environment was clean and well maintained.

Summary of findings

- The hospital was performing better than the England average for MRSA and since the move to the new building the number of cases of Clostridium difficile had reduced.
- Not all areas were meeting the targets for statutory and mandatory training.

Effective

- Services were found to be effective in critical care, maternity and gynaecology, and children and young people. Improvement was required in urgent and emergency services, medicine, surgery and end of life care.
- In the majority of areas we found care and treatment to be evidence based. There were examples of excellent practice relating to trauma management and the treatment of stroke patients in the emergency department.
- Mortality rates were below (better than) the national average, as measured by the Hospital Standardised Mortality Ratio.
- There was strong multidisciplinary working across the hospital. Working relationships between disciplines were good, with good access to specialist teams and services.
- The hospital was working towards providing seven-day services. The general medical consultants provided seven-day cover, and pharmacy was open for four hours on Saturdays and Sundays. Some cover was provided at weekends by allied healthcare professionals. However special services such as the cancer nurse specialist, diabetes team and palliative care team were only available Monday to Friday.

Caring

- Staff were providing kind and compassionate care and treatment in all services. The majority of patients and relatives we spoke with were complimentary about the care they received.
- The design of the new building, with 75% of beds in single rooms, helped to provide privacy and dignity. However, there were some areas where this was compromised. For example, patients in rooms overlooking the atrium or on the ground floor could be seen by members of the public. While there were curtains that could be drawn to protect patients' privacy, when these were drawn patients could feel very isolated in their room.
- Some patients commented on the isolation they felt in the single rooms. While the trust provided free Wi-Fi, there was no access to televisions or radios.
- Emotional support was available. There was a spiritual area known as 'the Sanctuary' in the atrium of the hospital, which was well utilised.
- When the hospital first opened in May 2014, a number of volunteers known as 'move makers' assisted with the move and directed patients and staff around the building. This had been so successful that their role had continued and they were proactive in providing assistance to patients and relatives.

Responsive

- Services for children and young people were responsive to patients' needs, but all other services required improvement, and the urgent and emergency services were rated as inadequate.
- There were significant issues with the flow of patients into, through and out of the hospital. The four-hour target for patients attending the emergency department to be admitted, discharged or transferred was not being met. There were instances when patients remained on a trolley in the emergency department for over 12 hours. Medical patients could not always be accommodated in medical beds, resulting in medical patients being cared for in beds across all specialities. There were examples of medical patients in non-medical beds not receiving regular review from medical staff. Some patients were discharged home directly from the critical care unit because no ward beds were available for them to transfer to when they no longer required intensive care.
- People who attended the emergency department out of hours and required a Mental Health Act assessment waited too long in the department, often in an inappropriate area, including overnight.

Summary of findings

- Medically fit patients were delayed because of waiting for social care or community health packages; on one day of the inspection 96 patients had their discharge delayed.
- There were concerns with equipment provided by the sterile services department, with equipment not available when required and kits not fit for use. This had led to cancellation of operations, delayed starts to theatre lists and, in one instance, a patient having a longer anaesthetic while issues with the kit were dealt with.
- The national target time was not being met for the 18-week pathway for referral-to-treatment for outpatient services.
- In outpatients services there was a backlog of unreported images (4,642 within the last year). Although actions were being taken to address this, the risk register lacked details of the actions, the timescales and who had overall responsibility.
- There was a large backlog of appointment requests (49,000), although actions had been taken to address this and the number had decreased by 20,000 in the previous three months.

Well led

- Services for children and young people, maternity and gynaecology, and critical care were well led; all other services required improvement.
- Staff were highly motivated and passionate about providing high-quality care. Although the actual move to the new building had been a success, staff now faced a number of challenges, ranging from an excessive number of snagging issues to severe problems with flow and capacity, many expressed frustration with the quality of service they were able to provide.
- The vision for the hospital had focused on the move; the development of a strategy for the future had been paused over the summer and some areas lacked clear direction.
- There were examples of good local leadership by ward managers and department leads; in some areas, leadership beyond this level was less clear.
- All services had governance systems in place. However, some risks that had been highlighted and that were in the process of being actioned had not been recorded on the risk register.

We saw several areas of outstanding practice including:

- The emergency department's performance in relation to stroke treatment was excellent.
- Clinical staff in the emergency department were compassionate and caring; they showed passion, resilience and determination to provide high standards of care in the face of significant challenges.
- Staff in the emergency department worked well as a team. The senior team were strong, highly respected leaders, who motivated and supported their staff.
- There was a high level of dedication among the senior management team in critical care to ensuring the welfare of their staff, patients and one another.
- The emergency department had designed a quiet room, for relatives and friends of the deceased patient. The room was sensitively decorated and had the capacity for up to 12 people. Hot and cold refreshments and a telephone were available for relatives to use. Access to toilet facilities and the viewing room was designed so that the bereaved did not have to enter the emergency department.
- The specialist palliative care team were passionate and committed to providing a high-quality service to patients at Southmead Hospital. The team was highly regarded throughout the trust and were praised for their knowledge, skills and support by everyone we spoke with.
- The participation in research and improvement in clinical outcomes as a result of obstetric skills training.
- In maternity services, there was clear evidence of learning from incidents and improvements which took place as a result.

Summary of findings

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

Importantly, the trust must:

- Improve its performance in relation to the time patients wait to be assessed and the time they remain in the emergency department.
- Improve patient flow through the hospital to ensure that patients arriving at the emergency department by ambulance do not have to queue outside the department because there is no capacity to accommodate them in clinical areas of the emergency zone.
- Work with healthcare partners to ensure people with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained staff to meet their needs.
- Ensure that the seated assessment area is used appropriately for the short-term assessment, diagnosis and treatment of patients who are not expected to be admitted. If patients require a lengthy or overnight stay, they must be accommodated in an appropriately equipped ward that provides same-sex accommodation to ensure their dignity is protected.
- Ensure that nurse staffing levels in the emergency department are urgently reviewed and aligned to match current patient demand, flow and acuity.
- Ensure that temporary staff employed in the emergency department receive appropriate induction to ensure their familiarisation with the department and their competence in the role.
- Enable and facilitate emergency department staff to undertake mandatory and essential clinical training and professional training and development.
- Take action to support emergency department staff, including senior staff, to ensure their psychological wellbeing.
- Ensure there are enough staff with the rights skills and experience to provide safe and quality care to patients at all times.
- Ensure there is capacity in the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and wellbeing. This includes a robust hospital-wide system of bed management.
- Ensure it acts in full accordance with the law as it relates to the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

Summary of findings

- Ensure staff meet the targets for statutory and mandatory training.
- Ensure that more than 50% of the nursing staff in critical care have attained their post-registration qualification in critical care nursing.
- Ensure that equipment required for surgical procedures is available in sufficient quantities so all patients operations can go ahead as planned.
- Ensure all surgical equipment and materials are ready for use.
- Ensure that all medicines are stored safely and appropriately and records relating to administration are accurate.
- Ensure that all incidents are reported and investigated, and that feedback is provided to staff. The specialist palliative care team did not consistently report medication errors.
- Take action to address the problem of the backlog of unreported images.
- Continue to take action on, and monitor, the patient appointment request backlog.

In addition the trust should:

- Continue to participate in local and national audits to benchmark practice and ensure continuous improvement in patient experience and outcomes in the emergency department. In particular, staff should take steps to improve pain management.
- Ensure that appropriate records are maintained for the disposal of controlled drugs in the emergency department, in accordance with the trust's medicines policy. This will reduce the risk of misuse of these medicines.
- Ensure that appropriate records are maintained in the emergency department in respect of emergency medicines and that the medicines trolley is sealed to show that it has not been used. This will ensure that appropriate emergency medicines are always available when needed.
- Ensure that resuscitation equipment in the emergency department is appropriately sited and regularly checked.

Summary of findings

- Review and amend the standing operating procedure for the emergency zone and the standing operating procedure for triage in the emergency zone to accurately reflect current practice.

- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.

- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include customer service training for receptionists, the provision of TVs, appropriate reading material and information about waiting times.

- Ensure that concerns about nurse staffing levels are appropriately documented on the emergency department risk register and escalated for consideration at the directorate and/or trust level, as appropriate.

- Keep under review the emergency department staff skill mix and training to ensure staff are competent to care for children.

- Improve the provision and take up of training for emergency department staff in dementia care, supported by departmental champions and the development of a pathway for dementia care. This is so that the needs of patients with dementia are identified and appropriately met.

- Ensure that the reception staff in the emergency department are receptive to patients arriving and observe those that are waiting to be seen.

- Improve access to cleaning materials on Percy Phillips ward for the cleaning of patient baths.

- Improve access and flow through the maternity service to ensure capacity meets demand.

- Ensure that medical records are available for patient appointments, mortality and morbidity reviews and data recording, and that they are stored securely so that patient confidentially is maintained.

- Ensure that patients are kept informed of the waiting times in clinics.

- Display safety metrics and quality performance information in the clinic waiting areas.

- Ensure that chaperoning is available and that patients are aware of this service.

Summary of findings

- Ensure that information about reporting complaints is clearly displayed and available to patients and visitors to the hospital.
- Continue to develop and improve the centralised booking system with increased staffing and training. This should include reducing the backlog of appointment requests referrals.
- Ensure that information for the benefit of patients, such as translator and interpreter services and chaperoning, is available and visible.
- Review the incidents they are reporting to ensure they represent a full and accurate reflection of the events within the service.
- Improve feedback to staff about incidents they have reported and demonstrate learning and improvements from remedial actions.
- Improve the quality of safety thermometer and patient outcome data and how it collects this data in the critical care unit to ensure the service is able to innovate and improve.
- Ensure staff meet the targets for annual appraisals and performance reviews.
- Ensure that monitor alarms in the critical care unit can be heard or seen at all times.
- Ensure that the critical service develops a set of standard operating procedures to ensure consistency of clinical approach to patients.
- Ensure that the critical care service investigates ways to develop the emotional support offered to patients, their relatives and friends.
- Ensure that the critical care service produces a booklet for patients, their relatives and friends about staying on and visiting the unit.
- Make sure that all wards have the correct consent form in place for staff to use when caring for patients who lack capacity to consent to treatment and surgery.
- Consider improving early identification of patients who could be in the last year or months of their life.

Summary of findings

- Ensure all staff are trained to enable optimal end of life care to be delivered.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	The Emergency Zone was a large, well-designed, modern and well-equipped area. However, patient flow within the Emergency Zone and the hospital was not effective and this presented a serious risk to patients' safety and their overall experience of care and treatment. The Emergency Department (ED) was frequently overcrowded and overwhelmed, which meant patients were not assessed, diagnosed or treated promptly enough. Measures put in place to mitigate risks were not effective and patients regularly queued outside the ED on trolleys because there was no capacity in the department. National standards in respect of assessing patients promptly on arrival and the total time spent in the department were consistently not being met. The average total time spent in ED was significantly worse than the England average. Staff were motivated and caring and patients regularly acknowledged this, but patients' comfort and dignity were compromised because of extended waits in the department. This affected staff morale. Staff frustration was clearly evident, as was their distress. Several staff told us they were "ashamed" of the standard of care they were able to provide. The terms "soul-destroying" and "heart-breaking" were repeatedly voiced to us. Nurse staffing levels were not adequate in the ED to manage the number and acuity of patients who presented and did not allow staff to be released for essential training and professional development. Working conditions were described by senior clinicians as "intolerable". We saw some examples of excellent practice, for example in trauma management and the treatment of stroke patients. The department participated in a range of research, audit and medical education. Treatment of patients with sepsis was poor, although improving, and in most national audits run by the College of Emergency Medicine, performance was below expected standards and the national average. Performance in relation to pain relief was particularly poor, most probably a consequence of patient flow issues. Despite these challenges, staff worked

Summary of findings

cohesively as a team, led and supported by a strong local management team. The ED lead consultant, matron and ward manager were highly respected leaders, described as “inspirational” by several staff. They showed passion and determination to provide high standards of care in the face of significant challenges. However, we were concerned that they were at breaking point. While there was clearly understanding of these challenges at the trust executive level, there remained a feeling that the risks associated with patient flow were not shared by the rest of the hospital.

Medical care

Requires improvement

Patients were treated with compassion and respect. All of the patients we spoke with told us that they were happy with the care provided by staff. Safety in medicine was compromised. We found prescription medicines that were not appropriately stored, shortfalls in staffing numbers for nursing and a patient tracking system that did not adequately assess and prioritise patients effectively. There was no system to accurately track medical outliers in a timely manner (medical patients on non-medical wards) and therefore patients were at risk of delayed or missed medical reviews. There was poor patient flow in the trust and we found medically fit patients across the medicine directorate awaiting social care and community health packages to support their discharge from hospital. The service had undergone a major change with the move to the Brunel building in May 2014. Wards had been reconfigured and sub-specialties joined together. Staff we spoke with told us that ward staff were starting to work together and gain peer support within their new teams.

Surgery

Requires improvement

Surgery services at Southmead Hospital required improvement.
While staff were seen to be caring and compassionate within surgical services, improvement was required in order to make the service safe, effective, responsive and well-led. Incidents were reported and investigated, but not all staff said they had feedback about them. There

Summary of findings

had been seven Never Events within surgery and theatres between April 2013 and September 2014. There was evidence that changes to practice had been made.

There were concerns regarding the Sterile Services Department, with equipment not being fit for use or not available when required. This had led to patients' operations being cancelled and the start of theatre lists had been delayed.

Compliance with the WHO surgical safety checklist did not meet the trust's targets. Senior staff felt some of this was because of recording issues and their IT system.

Wards, theatres and departments were clean. However, not all staff in the theatres area were observed to be following the 'bare below the elbow' policy.

Medicines were not always stored securely. Patients were assessed for risk and were monitored for changes in their condition. Concerns were escalated appropriately.

There was confusion on the surgical wards about who was responsible for reviewing medical outliers. The staff on these wards were not aware of the medical outliers team. However, this was rectified by the trust after our feedback during the inspection.

Some of the patient outcomes were worse than the England average for hip fractures. The proportion of patients who developed pressure ulcers was 4.8% compared with the England average of 3%. The mean total length of stay of 25.8 days was significantly higher than the England average of 19 days.

The standardised relative risk of readmission rate was noted to be higher for both elective cases in urology and plastic surgery. For non-elective cases, the standardised relative risk of readmission rate was higher for general surgery.

Not all patients were reviewed by consultants during their stay because some wards had no set timetable for consultant-led ward rounds or did not know when they were coming. Other wards had daily input from consultants.

The vast majority of feedback we received from patients and relatives identified that the staff were kind and gave compassionate care to patients and

relatives. Most patients and their relatives had a good understanding of the care and treatment they were receiving. Emotional support was provided for patients and staff.

Bed occupancy levels were high and this impacted on patients waiting for elective surgery. Operations were cancelled and operating lists delayed because of the pressures on beds. At times patients had to stay in recovery overnight.

The flow of patients through the hospital was affected by patients who were medically fit to leave hospital having to wait for social care or community health support. Patients also remained in hospital in some specialities for longer than the England average. The trust was not meeting the target for rebooking all cancelled operations within 28 days.

The trust was not meeting the 18-week referral-to-treatment time for trauma and orthopaedics, urology, oral surgery and neurosurgery. The trust did not expect to be meeting the target for the 18-week referral-to-treatment time for urology by the end of the financial year. The trust was continuing to undertake urgent elective orthopaedic spinal surgery and neurosurgery spinal cases but was closed to other spinal cases due to the imbalance between demand and capacity which had resulted in a number of patients waiting over 52 weeks. This was by agreement with NHS England and local commissioners. Systems had been put in place to mitigate clinical risks around the closure.

The surgical directorate had a high number of unresolved complaints. The trust told us they had put in extra resources to address this.

Services were mostly reported as being well-led on wards and in theatres. Although members of the executive team reported they had spent time in the services there was some feedback there was little visibility of the executive management team. Staff told us there were forums and meetings for raising issues, but felt nothing had been done about the issues they raised.

Critical care

Requires improvement

We have judged the overall performance of critical care as requiring improvement. This was because the unit needed to improve safety and

Summary of findings

responsiveness. The effectiveness, caring and leadership of the unit was good. The most pressing issue for the safety of the unit was the lack of skill and experience of such an unusually high proportion of the nursing staff, who were new to the unit and critical care nursing. This was the highest priority for the senior staff team. The new critical care unit was designed to accommodate patients in single rooms, called 'cubicles'. There were challenges because of the lack of high visibility of patients. Staff were adapting their practice to ensure all patients had the appropriate safe level of nursing staff with them at all times, but this was not always working as it should. Staff needed to improve incident reporting and demonstrate learning and improvements to practice arising from incidents. Attributed to the weaknesses in the nursing staff skill mix (although the situation was improving) was the relatively high incidence of patient harm. This included falls, pressure ulcers and patients removing their own medical devices. This had been recognised by the unit, escalated to the trust risk register for attention of the board, and actions were being put in place and monitored. Support from specialist staff in falls and pressure ulcer management was being provided. The clinical effectiveness of the unit was good, as were outcomes for patients. Care and treatment was delivered by trained and experienced medical staff, and patients and relatives spoke highly of the unit and its staff. Essential inputs into patient care such as pain relief, nutrition and hydration were managed well. In terms of staff support, appraisal rates for non-medical staff needed to improve to reach minimum trust standards, and staff needed to be released for professional development and clinical education. The care given by staff was good. Patients, their relatives and their friends told us they were happy with the care provided. Staff were described as "excellent" and "kind, polite and considerate". The consultants and doctors were professional, thoughtful and respectful, as were the other healthcare professionals involved with care. The reception staff were caring and made sure they were aware of the needs of patients and their visitors. The domestic staff greeted patients respectfully. The responsiveness of the unit

Summary of findings

required improvement because the poor flow of patients through the hospital affected the ability of critical care to respond effectively. Too many out-of-hours discharges, delayed discharges and high bed occupancy were not within the control of the unit, but patients requiring intensive care were affected. A high volume of elective surgery had been cancelled because intensive care or high dependency beds were unavailable. The length of stay for patients was much higher than the NHS national average and not optimal for patient social and psychological wellbeing. We have judged the leadership of the service as good. All the senior staff were committed to their patients, their staff and their unit. There was reasonable evidence and data gathered for senior managers in the unit to base decisions on and drive the service forward. There was, however, room for improvement in the way the data was made available or collected. There was an improving programme of audit in the department, although senior staff were relying at times upon some tasks being carried out, such as, for example, checks of resuscitation equipment, without any assurance it was being done.
There was accountability among all staff for driving through actions and improvements and a strong culture of teamwork and commitment in the critical care unit.

Maternity and gynaecology **Requires improvement** 

Overall we found the service required improvement. Within the five domains, we rated safety and responsiveness as requiring improvement. The effective, caring and well-led domains were good. Incidents were reported and there was clear evidence of learning as a result. Learning was shared across the whole service. Staff completed the safety thermometer, which showed results being consistently higher than the England average. Areas were clean and there was good compliance with infection control policies, but there were no instructions for staff or cleaning materials available in the bathrooms on the postnatal ward. Not all medicines were kept securely locked. Some emergency medicines were stored in unlocked boxes that were left unattended. This posed a risk that they could be taken or tampered with. There were specialist midwives

employed for safeguarding, teenage pregnancy and drug and alcohol misuse. These provided support for all staff across both the maternity and gynaecological services. Access to mandatory training was good. In addition there was skills training in both obstetric and gynaecological emergencies. The midwife-to-birth ratio of 1:33.9 was higher (worse) than England average of 1:29. In addition, the average for the provision of one-to-one care in labour in 2013/14 was reported as 85.6%. Staff sickness within the maternity unit was high at 7.7% for midwives and 10.6% for midwifery care assistants, against a trust target of 3.8%. The unit average was 4.8 to 5% across all staff members. The service had identified the need for five elective theatre lists a week; however, they were only funded to provide three. With staff moved from the delivery suite to provide cover, this meant women were at risk if the number and acuity of women on the delivery suite was high. Staffing on Quantock day assessment unit was such that when one midwife was required to accompany a patient for a scan or for transfer to the delivery suite, the area was left with only one midwife. At night with only one midwife on duty, the unit would be left with a midwifery care assistant only. There were 74 hours of dedicated consultant time on the central delivery suite. The Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) suggests this figure should be 168 hours. Staff provided care and treatment that was evidence based and in line with policies and national guidelines. Staff were trained in the management of obstetric emergencies which saw an improvement in patient outcomes. This training was nationally and internationally renowned, with staff leading the research and spread of the training in other countries. As a result of the outcome successes in obstetrics, a similar model of 'skills drills' training was being implemented within gynaecology. Care was delivered with kindness and compassion. Choices were well explained and patient centred, with women having clear choices throughout the service. Women had choice with regards to place of birth and there was good use of specialist midwives and community facilities to provide care closer to teenage and young mothers. There was a single

appointment process in colposcopy and women attending the early pregnancy assessment clinic had good access to services and scans, though at times this meant women had to wait several hours. Gynaecological waiting times were within national targets. The service met two-week cancer targets and also 18-week referral-to-treatment times. Antenatal clinics often ran late, though the frequency of this was not recorded. Bed occupancy was significantly higher than the national average. The postnatal ward was described as “bursting at the seams”, with occupancy in excess of 95%. As a result, women sometimes remained on the delivery suite for longer than they needed. Maternity and gynaecology services were well-led. There was a vision and a strategy, though most staff were not aware of it. There was an awareness of a vision for improved facilities, but not a general awareness of the vision for care. The service had a well-defined and functioning governance structure that oversaw activity, performance, quality, safety and audit. These fed into the trust’s governance processes and there was strong representation of the service at trust level. Action plans devised as a result of incidents, complaints, audits or case reviews were monitored and there was clear evidence of actions taken and learning having occurred. Leaders were visible and participated in the day-to-day running of the service. There was a cohesive approach between medical and midwifery staff. There was a culture of openness and learning and a strong focus on research with national and international engagement and promotion of the research undertaken and the outcomes delivered. The trust had recently featured on a television documentary charting the role of midwives and following women in labour. There were opportunities for professional development and as a result there was succession planning across all services.

Services for children and young people

Good

Neonatal services at Southmead Hospital were rated as good across all five areas. Staff were caring and compassionate and worked in partnership with parents to provide family-centred care. Care was evidence-based and in line with national good practice. Systems were in place for incident reporting and investigation. Incidents were

reported and investigated. Where lessons had been learnt, these were fed back to staff. The unit was clean, there had been no recent issues of cross infection and the staff had achieved 100% in the hand hygiene audits. Medicines were stored appropriately. A double-checking system had been introduced to reduce the number of medication errors. Medication errors had reduced as a result. The NICU had robust safeguarding processes in place and a clear process of referral for staff when concerns were identified. Nurse staffing was funded to establishment, but did not meet the standards set by the British Association of Perinatal Medicine. The parents were extremely complimentary about the staff and the care their babies received. No complaints had been received since before September 2013, but a complaint management system was in place. The NICU had good governance arrangements in place. Staff were aware of these arrangements and how these linked to wider trust committees. The unit was well led by its ward sisters and head of nursing.

End of life care

Requires improvement

The specialist palliative care team were passionate about ensuring patients at the end of their life received high-quality, compassionate care. All staff understood their responsibilities to report incidents, but the specialist palliative care team omitted to report some incidents because of their concern for ward staff. This may have put patients at risk of unsafe care. The specialist palliative care team responded promptly to referrals and requests from colleagues to provide guidance and support for patients who were at the end of their life or required symptom management for complex medical conditions. However, the specialist palliative care team felt symptom management and psychological care needs were not always being met out of hours because they were not able to offer a seven-day service. Patients identified as being in the last days and hours of their life received care that was planned for in advance. Multidisciplinary team meetings were conducted to ensure the needs of patients they were supporting were being met. Improvements were required to identify patients who were potentially in the last year of life to enable early discussions and plans for

Summary of findings

future care. Throughout the trust, all staff we spoke with valued the support, expertise and responsiveness of the specialist palliative care team.

Outpatients and diagnostic imaging — **Requires improvement**

The atrium of the Brunel building, the outpatient waiting areas and the clinics were clean, comfortable and well maintained. The new building had opened in May 2014. We found that a safe environment was maintained. There were problems with the accessibility and availability of medical records for patients attending clinics. There was a trust-wide action in place to address these problems, which were ongoing at the time of our inspection visit. Patients were very positive about the quality of clinical treatment and the professionalism of all the staff. Compassionate care was provided. Staff and volunteers interacted with patients in a friendly manner and treated patients and visitors with dignity and respect. There were shortfalls in the displaying of information for patients. This included information about treatments and conditions, help and support groups and also about how to report complaints. There was also limited information displayed about waiting times in clinics. There was a backlog of unreported images and although actions had been instigated to address this, the risk register lacked details of the actions, the timescales and who had overall responsibility for this. There was also a large backlog of appointment requests, which the trust was addressing. Action had been taken to ensure patients most at risk were prioritised. Not all the services were meeting the national referral-to-treatment targets. There had been problems with appointment booking since the opening of the new centralised call centre. There were some difficulties for patients booking appointments at times and also for some specialities with the booking of urgent appointments. An action plan was in place to address these issues. This included staff recruitment and training. Since opening, the hospital had been developing a centralised outpatients service with a new management

Summary of findings

structure that covered the majority but not all the services being run as outpatient services. There was clear leadership and risk assessments and action plans were in place to address the identified issues.

Requires improvement

Southmead Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Children and young people; End of life care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Southmead Hospital

North Bristol NHS Trust is an acute trust located in Bristol providing hospital and community services to a population of around 900,000 people in Bristol, South Gloucestershire and North Somerset. In addition specialist services such as neurosciences, renal, trauma and plastics/burns are provided to people from across the South West and in some instances nationally or internationally.

In May 2014 the Brunel building on the Southmead Hospital site opened. This was a significant event with the majority of services moving from the 'old' Southmead Hospital and the Frenchay hospital site into this new building.

The inspection team inspected the following eight core services at the Southmead site

- Accident and Emergency
- Medical Care (including older people's care)
- Surgery
- Critical care
- Maternity Services
- Children and young people
- End of life care
- Outpatients

Our inspection team

Our inspection team was led by:

Chair: Andy Welch, Medical Director, Newcastle upon Tyne NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Head of Hospital
Inspections

The team included CQC inspectors and a variety of specialists:

Director of improvement, quality and nursing, associate chief nurse, head of safeguarding, consultants from accident and emergency, anaesthetics, sexual health, obstetrics and paediatrics, a general manager, junior doctor, dermatology nurse, theatre matron, emergency nurse practitioner, resuscitation officer, midwife, critical care nurse, paediatric nurse and a student nurse. The team also included two experts by experience, analysts and an inspection planner.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the two local commissioning groups (CCGs), NHS Trust Development Authority, General Medical Council, Nursing and Midwifery Council and the Royal Colleges.

We held a listening event in Bristol on 3 September 2014, when people shared their views and experiences. Over 35 people attended the events. People who were unable to attend the events shared their experiences by email or telephone.

We carried out an announced inspection on the 4, 5, 6 and 7 November 2014 and an unannounced inspection at Southmead Hospital on 17 November 2014. We held focus groups and drop in sessions with a range of staff in the hospital including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with patients and staff from across most of the hospital. We observed how people were being cared for, talked with carers and or family members and reviewed patients' records of their care and treatment.

Detailed findings

Facts and data about Southmead Hospital

Southmead Hospital has 1024 beds, approximately 7,600 staff who provide healthcare services to the residents of Bristol, South Gloucestershire and North Somerset which has a combined population of around 900,000 people. Specialist services such as neurosciences, renal, trauma and plastics/burns are provided to people from across the South West and in some instances nationally or internationally

In 2013/2014 the trust had over 97,600 inpatient admissions, including day cases, 360,000 outpatients attendances (both new and follow up) and 103,202 attendances at emergency and urgent care.

Bed occupancy for the trust ranged from 91.1% in the third quarter of 2013/2014 to 84.8% in the first quarter of 2014/15. This reduction was due to the move from the previous two hospitals to the new Brunel building on the Southmead site in May 2014 when the amount of elective procedure work was reduced in order to manage the move. The overall occupancy rate was above the England average (85.9%) and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

CQC inspection history

North Bristol NHS Trust has had a total of 11 inspections since registration.

Five of these have been at the "old" Southmead Hospital site. In May 2011 a themed inspection was undertaken specifically looking at dignity and nutrition. The outcomes inspected were met, although there were some areas for improvement identified. In September 2011 during a routine inspection minor concerns were found relating to safeguarding people who use services from abuse, staffing, and failure to inform CQC of notifiable issues. In March 2012 a themed inspection was undertaken specifically looking at termination of pregnancy and the trust was found to be meeting the required standards. In January 2013 a further routine inspection was undertaken and concerns were identified relating to the management of medical records. This was followed up in July 2013 and the trust was found to be meeting the standards required.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided to people across Bristol, South Gloucestershire and North Somerset 24 hours a day, seven days a week in Southmead Hospital's Emergency Zone. Managed by the trust's medical directorate, the Emergency Zone opened in May 2014 following a reconfiguration of urgent and emergency services in North Bristol and the closure of Frenchay Hospital located approximately four miles away. The Emergency Zone aimed to provide a 'one-stop shop' for unplanned care. The service consisted of a number of areas, co-located in the purpose-built Brunel building. These were the Emergency Department (ED), the Acute Assessment Unit (AAU), the Minor Injuries Unit (MIU) and the Seated Assessment Area (SAA). As a major trauma centre and regional specialist centre for burns and plastic surgery, the hospital was served by a helipad. An operations centre provided a central point of access for telephone referrals and all admissions. The ED expected to provide emergency care and treatment to about 103,000 adults with serious and life-threatening emergencies a year. There were six resuscitation cubicles (including one for children) and 14 major cubicles. The MIU provided treatment for illnesses or injuries that were not life-threatening, but still needed prompt treatment. This included minor head injuries or suspected broken bones. There were 11 'see and treat' cubicles in this unit. As a result of reconfiguration, inpatient paediatrics and paediatric trauma services were transferred to the Bristol Royal Hospital for Children, run by University Hospitals Bristol. The paediatric ED at Bristol Royal Hospital for Children was the centre for the treatment of children with major injury or illness. Southmead Hospital provided only a minor injury service for children. The MIU saw about 360 children a month. Seriously injured or unwell children who presented at the department were seen and, if appropriate, transferred to Bristol Royal Hospital for Children. The SAA, also known as Ambulatory Emergency Care, had 16 reclining chairs to accommodate patients who required an urgent specialist opinion, rapid assessment, diagnostic investigations, observation or treatment, but were not expected to require an overnight stay. Patients were referred to this unit by GPs or other community providers through the operations centre. There was a waiting room for 46 seated patients. There was space for patients to queue in the 'crossroads' area of the ED. This space was effectively a corridor, entering the major area, designed as a signposting area where patients would be directed to a ward or the appropriate part of the Emergency Zone. It was not designed as a clinical area for patient care. There was space for two trolleys in the departures area, where patients waiting for admission or waiting for transport would be accommodated. There was a 64-bed Acute Assessment Unit (AAU) for the assessment and stabilisation of acute medical patients for the first 24 hours of their stay. Accommodation was provided in 48 single rooms with en-suite facilities and four four-bed bays. There was a dedicated imaging suite providing CT, plain x-ray and ultrasound. We visited the department over two and a half days, and conducted a further unannounced visit at night. We spoke with about 50 patients and 30 relatives. We spoke with staff, including nurses, doctors, consultants, managers, therapists, support staff and ambulance staff. We observed care and

treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Before and after our inspection, we reviewed performance information about the trust and information from the trust.

Summary of findings

The Emergency Zone was a large, well-designed, modern and well-equipped area. However, patient flow within the Emergency Zone and the hospital was not effective and this presented a serious risk to patients' safety and their overall experience of care and treatment. The ED was frequently overcrowded and overwhelmed, which meant patients were not assessed, diagnosed or treated promptly enough. Measures put in place to mitigate risks were not effective and patients regularly queued outside the ED on trolleys because there was no capacity in the department. National standards in respect of assessing patients promptly on arrival and the total time spent in the department were consistently not being met. The average total time spent in the ED was significantly worse than the England average. Staff were motivated and caring and patients regularly acknowledged this, but patients' comfort and dignity were compromised because of extended waits in the department. This affected staff morale. Staff frustration was clearly evident, as was their distress. Several staff told us they were "ashamed" of the standard of care they were able to provide. The terms "soul-destroying" and "heart-breaking" were repeatedly voiced to us. Nurse staffing levels were not adequate in the ED to manage the number and acuity of patients who presented and did not allow staff to be released for essential training and professional development. Working conditions were described by senior clinicians as "intolerable". We saw some examples of excellent practice, for example in trauma management and the treatment of stroke patients. The department participated in a range of research, audit and medical education. Treatment of patients with sepsis was poor, although improving, and in most national audits run by the College of Emergency Medicine, performance was below expected standards and the national average. Performance in relation to pain relief was particularly poor, most probably a consequence of patient flow issues. Despite these challenges, staff worked cohesively as a team, led and supported by a strong local management team. The ED lead consultant, matron and ward manager were highly respected leaders, described as "inspirational" by several staff. They showed passion and determination to provide high standards of care in

the face of significant challenges. However, we were concerned that they were at breaking point. While there was clearly understanding of these challenges at the trust executive level, there remained a feeling that the risks associated with patient flow were not shared by the rest of the hospital.

Are urgent and emergency services safe?

Inadequate

The ED regularly and frequently declared a status of red or black escalation. This meant that the department was deemed to be "not able to function as normal" and "verging on unsafe for periods of time" or "dangerous for a sustained period of time (more than two hours)" where "normal care was not possible". When we spoke with staff, their overwhelming safety concern was overcrowding, associated with a lack of patient flow, which led to delayed assessment, diagnosis and treatment. All of the staff we spoke with were concerned about the number of undifferentiated, seriously unwell patients queuing outside the ED in the crossroads area and felt it was unsafe. A senior clinician told us "Nobody has died there (crossroads) yet, but for the grace of God." Staff were also concerned that self-presenting patients were often not quickly assessed in order to identify or rule out serious or life-threatening conditions that required prompt attention. Staffing was a concern. The department had been staffed based on anticipated patient demand, profile and acuity, which in reality were not as expected. The department had realigned staffing within budgetary constraints but urgently needed more resources to mitigate the risks of overcrowding in the department. Current measures to mitigate the risks associated with overcrowding were not effective. The 'one up policy', which allowed wards to take an extra patient to alleviate pressure in ED, was not being used to full effect. Assistance from ward staff to ED at times of pressure was not prompt, adequate or consistent. As a consequence, patients waiting at the crossroads were put at risk because there were not sufficient staff to care for them.

Incidents

- A significant number of incidents reported related to delays and associated quality of care.
- The ED reported four serious incidents requiring investigation between May 2014 and November 2014. These were all breaches of a national standard that required that no patient should wait more than 12 hours in the ED. A fifth breach was notified to us following our unannounced night visit. All were subject to a 72-hour management investigation and a root cause analysis (some ongoing). These incidents involved extended

waits for a seriously unwell patient with a learning disability and suspected perforated volvulus, an acutely unwell patient with advanced dementia, an elderly patient suffering from delirium associated with infection, and a patient with end-stage chronic obstructive pulmonary disease/pneumonia who died the following day. Investigations concluded that none of these patients suffered actual harm as a result of their extended stay in the ED, but they highlighted the risks of sub-optimal care and the potential for mistakes to be made at times when the department was under severe pressure.

- The ED declared red or black escalation on 13 out of 14 days from 20 October 2014 to 2 November 2014. According to the definitions outlined in the trust's Full Capacity and Emergency Department Escalation Policy (June 2014), this meant that the department was "regularly unable to function as normal" and was "verging on unsafe for periods of time" or deemed "dangerous for a sustained period of time (more than two hours) and where normal care was not possible".
- We received information from a health professional who had visited the ED in July 2014 that a patient had suffered a respiratory arrest while waiting at the crossroads of ED. We discussed this incident with the clinical lead and the matron. They told us the patient had been moved into the resuscitation area, displacing another patient. This incident was reported at the time, but was not classified as a serious incident because the patient suffered no actual harm.
- The health professional reported that senior ED staff were not happy with the level of undifferentiated ill patients waiting in the corridor (for example, aortic aneurysm, severe liver disease, diabetic ketoacidosis, and melena) and they had warned that "somebody will die".
- We were made aware of two events that occurred in September 2014. On 15 September 2014 a self-presenting patient was taken to the crossroads following triage because there was no capacity in the ED. There were 20 patients already at the crossroads. A nurse in this area reviewed the patient and was concerned. They requested a specialty registrar to arrange an urgent CT head scan, which revealed that the patient had sustained a serious head injury. The staff member who reported the incident commented "the sheer volume of patients in crossroads could have meant that this patient deteriorated unnoticed with a serious head injury". They went on to say that at one point during the shift there were 30 patients in the crossroads with serious conditions including heart conditions, fractured neck of femurs, mental health problems and sepsis. They said "Sheer volume of expected patients arriving by ambulance meant that at times there were two-hour waits for triage."
- The lead consultant told us about an event that occurred in September 2014 (date not provided) when a patient was delayed at the crossroads for two and a half hours before being found to have a high lactate level (a possible indicator for sepsis or septic shock). This was not reported as an incident, although it was clearly a serious concern because it was used as an example of the risks associated with care in the crossroads to the executive team.
- On 31 October 2014 an incident report was completed by the nurse in charge of the night shift. The nurse declared the shift unsafe and detailed a number of events that occurred in a short space of time, while between ten and 12 patients queued at the crossroads and there was no room in resuscitation. These events included a patient with a head injury and traumatic bleed found having a seizure in the waiting room, a child brought in to the waiting room with a head injury and a patient fainting at the crossroads. A patient was moved from resuscitation with thrombolysis treatment ongoing and transferred to a ward. It was reported there was a shortage of porters and nurses to transfer patients to wards.
- There was an awareness of safety in the Emergency Zone; risks were well understood and safety issues were regularly discussed. The matron or ward manager reviewed daily ED escalation sheets and ensured that issues affecting the safety of the department were appropriately escalated and acted on where possible. The department had a designated clinical governance lead who chaired monthly departmental clinical governance meetings. Safety was reviewed at these meetings and included a review of incidents. We were told that all available doctors and nurses were invited to attend these meetings.
- Staff were encouraged to report incidents. They told us approximately four to five incidents were reported a shift. Most of these related to patient flow issues and the

associated risks to patient safety. Staff described a 'no blame' culture in which learning from mistakes was encouraged. They told us, however, that they rarely received feedback about incidents.
- The trust had signed up to a national government-led campaign called 'Sign up to Safety'. A plan had been published detailing how the trust aimed to reduce avoidable harm to patients. One of the pledges made was to improve emergency care in the treatment of sepsis. Audits and education were ongoing in the department to raise awareness. Staff we spoke with knew what to look out for and how to respond to this serious condition.
- Mortality and morbidity reviews took place in clinical governance meetings to review the care of patients who had experienced complications or an unexpected outcome, to share learning and inform future practice.

Cleanliness, infection control and hygiene

- The departments were clean and tidy.
- Hand washing facilities were readily available and we observed staff wash their hands and use hand gel between treating or supporting patients.
- Staff used appropriate protective clothing such as a gloves and aprons, although we observed one staff member taking blood from a patient with only one hand gloved. The 'bare below the elbow' policy was adhered to.
- In a recent hand hygiene audit the ED had achieved 100% compliance.
- There were appropriate arrangements for waste handling and disposal. However, we witnessed unsafe disposal of sharp instruments. We saw used syringes being disposed of in an open bin. We reported this to a staff member who immediately sealed the bin and reported the incident to senior staff. On the same day we observed a full syringe on top of a medicine chart on a notes trolley.
- There were isolation rooms where infectious patients were cared for. The department had developed an Ebola plan for the isolation and treatment of affected or suspected infectious patients.

Environment and equipment

- The department was large, spacious and well laid out. However, overcrowding was regularly an issue, with patients queuing on trolleys or on chairs at the crossroads because of a lack of capacity in the department and the hospital.
- There was a dedicated ambulance entrance, which was designed to ensure patients arriving by ambulance had direct access to the majors and resuscitation areas. At busy times patients had to wait at the crossroads because there was no capacity in the treatment areas.
- The helipad was situated close to the ED and there was good access. There was a helicopter landing policy to ensure the safe arrival and departure of patients and staff.
- There was a large U-shaped resuscitation area, which was well laid out to provide good lines of sight. There were designated bays for trauma, children and stroke care. The area was well equipped and had a dedicated CT scanner.
- An x-ray department was located in the Emergency Zone.
- We checked a range of specialist equipment, including resuscitation equipment. It was clean and in good working order. However, we were concerned that there was no resuscitation trolley in the MIU, given the size of the department. The department used intravenous regional anaesthesia (Bier's block). The College of Emergency Medicine best practice guidelines (March 2014) recommend this procedure should be performed in "an appropriately sited, well-lit and equipped area with resuscitative equipment". The nearest resuscitation trolley was in the adjacent seated assessment area. Records showed this equipment had not been consistently checked on a daily basis, with no checks recorded on 28, 29 October or 1, 2, 3 November 2014.
- We found children's resuscitation equipment had not been consistently checked. There were also out of date blood clotting bottles, which we reported and these were replaced. The department was well stocked with consumable items such as dressings and these were well organised. The fridge used to store blood products was secure and alarmed to ensure the correct temperature was maintained.
- There was a designated room for seeing patients who required a mental health assessment, which had a panic button and had two doors in/out.

- The ED was equipped with pin point alarms linked to a central control room. All staff carried personal alarms. All circulation and waiting areas were covered by CCTV linked to the control room. Security personnel were employed throughout the hospital and could be requested to attend the ED if required. Staff told us they were based in the department on Friday and Saturday nights.

Medicines

- Medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately. The trust's medicines policy stated 'The refrigerator temperature must be monitored and recorded on a daily basis'. This was to make sure they were in the safe range for storing medicines and would be fit to use. Records had been made on 11 of the previous 30 days for one refrigerator. These were all within the safe range. Another refrigerator had no records of the temperature. Staff told us this was because there was an alarm to warn them if the refrigerator was not at the correct temperature. Pharmacy staff were able to periodically review the temperature of the refrigerator. However staff were not following the trust's medicines policy. This increased the risk the medicines could be unsuitable for use.
- Controlled drugs were stored appropriately and suitable records kept. Controlled drugs are medicines that need extra checks and special storage arrangements because of their potential for misuse. However, we saw that appropriate disposal records were not kept when only part of an ampoule for injection had been used for a patient. This did not follow the trust's medicines policy.
- Emergency drugs were accessible and there was evidence that these were regularly checked. We looked at one trolley and saw that there was no seal on the trolley to show that it had not been used. There was a checklist of the medicines contained in the trolley, but no record of their expiry dates. We saw one discrepancy between the contents list and the medicines in the trolley. A nurse we spoke with was not sure why this was. This could increase the risk of this medicine being used inappropriately or of a medicine being missed during the checking process.
- Some medicines were supplied labelled for patients to take home with them. This meant that patients did not have to wait for their medicines. Staff explained how a record of the prescribed medicines was kept in patients' records, so there would be a clear record of the treatment they had been given. However, in one area of the department there was no system in place that would allow staff to check the stocks of these medicines to make sure they had been used appropriately.
- We noted that a doctor had prescribed vitamin K for a patient who had an elevated abnormal INR. (International Normalised Ratio (INR) is a laboratory measurement of how long it takes blood to form a clot and is used to determine the effects of oral anticoagulants on the clotting system). However, the medication had not been given for two hours since it was prescribed. The nurse was unaware of the requirement to administer. When we asked the doctor why they had not instructed the nurse to administer, they said that it was not urgent.

Records

- Patients' registration and triage records were in paper format and included initial assessment, observations and medications. This record would accompany the patient to their destination ward if they were admitted. The main patient record was electronic, which could be accessed throughout the hospital. However we frequently saw staff photocopying records. The only photocopier was based at the crossroads reception. We were told that some staff did not or could not use the electronic records system. A specialty doctor present in the ED during our visit told us they had not been provided with IT access to this system. A healthcare assistant working in the SAA also told us they had not received training to use the electronic records system.
- A paper nursing care record had been developed for documenting risks and the care required to manage these risks. Risks included known allergies, infection control, skin integrity and continence.
- We looked at 12 patients' records over two days in majors and resuscitation. On one day nursing care was well documented and records showed that observations were carried out regularly, comfort rounds were undertaken and medicines were administered as directed. Four records on another day contained little nursing documentation. One patient who had been in the department for three hours had no care recorded. We looked at a further four records during our night visit. These were clear and comprehensive.
- There was a service level agreement in place with the medical records department, detailing the expectation

that medical records would be available for patients attending the Emergency Zone within two hours. Staff in the SAA told us hospital records were rarely available for patients attending clinics.
- Patients' movement through the department were tracked and delays monitored and escalated to senior management by a team of three staff 'running the shift'. There was a lead consultant, nurse in charge and a 'co-pilot' (nursing assistant) who used an electronic patient tracking system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. In the SAA we heard doctors and nurses explaining things to patients simply, checking that patients understood what they were being told and asking permission to undertake an examination or take blood.
- In the ED there were consent forms available for people with parental responsibilities to provide consent on behalf of children and young people, when this was appropriate.
- Most medical and nursing staff had received training in mental capacity. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to provide valid informed consent to care and treatment.
- The ED's risk register highlighted the risk of patients with mental health problems 'absconding' from the department. Staff told us that patients identified as being at high risk would be cared for in majors, where they could be supervised. Staff were not trained to restrain patients, although one described being experienced in "talking people down". They told us if they were not able to manage, security personnel, who had appropriate training, were called to assist.

Safeguarding

- Staff we spoke with in the ED were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was a safeguarding folder and clear guidance to staff on how to manage and report a safeguarding concern. However, training data showed that only 57% of medical staff and 77% of nursing staff had completed either level two or level three child protection training. There was a rolling training programme within the department to address this.
- There was a designated child protection nurse in the ED.
- The ED had evaluated child safeguarding referral rates, which demonstrated they required improvement. This resulted in staff undertaking research and training to improve staff competence referral processes. There had subsequently been a significant increase in the number of vulnerable children being identified and referred to the local authority safeguarding team. The project had been externally peer reviewed by the Royal College of Paediatrics and Child Health.
- There was a team that provided support to people who had been victims of domestic violence or sexual abuse. A nurse in the ED had championed this area of work and had provided staff training to raise awareness of the issues.
- Clinical staff were alerted to frequently attending children because this information was printed on patients' booking-in sheets.

Mandatory training

- Compliance with mandatory training (as at 15 October 2014) was poor (between 50 and 75%). Compliance was particularly poor for blood transfusion, venous thromboembolism, falls, equality and diversity, and waste handling. Consultants were the staff group least up to date with training, with compliance at about 20–30% in most subjects.
- Managers and nursing staff told us that opportunities to undertake training were limited because of operational pressures and many completed mandatory updates online in their own time.
- A nurse staffing review (October 2014) produced by the matron and ward manager stated "over time the training requirements have increased, with a larger mandatory (ED competencies) component. When staffing was remodelled in 2014, no training time was factored into the ED budget. The provision of training since the move to Brunel has been non-existent to the extent that we are no longer compliant in these important areas."
- The review undertaken by the Royal College of Paediatrics and Child Health of proposed arrangements for providing emergency care to children and young people at Southmead Hospital (December 2013)

commented about the lack of funding for continuing professional development for nurses and observed that many staff were undertaking training in paediatrics modules in their own time. The Royal College of Paediatrics and Child Health recommended that a minimum of 25% of the nursing workforce should have completed child-specific training modules. There were concerns that insufficient funding for training would result in increased risk to children attending the department in the future.

Assessing and responding to patient risk

- Patients were not always promptly assessed. The ED was not meeting the standard, which required that patients were assessed within 15 minutes of arrival. Prompt assessment ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- The standard operating procedure for the Emergency Zone (May 2014) described a standardised approach to triage. This was to ensure that patients, however they presented (ambulance, helicopter or self-presenting), were assessed so that they could be directed to the appropriate area of the department to be seen by appropriate clinicians without delay.
- The standard operating procedure for triage in the Emergency Zone (May 2014) stated "Any patient which has been sent to hospital following a discussion between a GP and a specialty take team is an 'expected' patient and is the responsibility of that team. 'Doctor Triage' of these patients will be an acknowledgment of their arrival into the hospital, allowing signposting through to the relevant ward, unless their clinical condition deteriorates during transfer and this necessitates immediate Emergency Department treatment." This did not reflect current practice because expected patients had, by default, become the responsibility of the ED. The procedure had not been reviewed or updated to reflect current practice since the department opened.
- The Emergency Zone's risk register highlighted the risks to patients when they were not able to be received from ambulances into the ED and were unable to receive a timely assessment. The register stated "Patients may have a life-threatening condition that is sub-optimally managed leading to serious harm".
- Patients waiting at the crossroads frequently waited too long to be assessed. On 19 October 2014 the nurse in charge recorded on the ED escalation sheet that there was a wait of two hours for triage, with 15 patients at the crossroads area. On 20 October 2014 the nurse in charge recorded that there was a three-hour wait for assessment. Ten patients were awaiting assessment, mainly in the crossroads area.
- Self-presenting patients were not assessed quickly enough and they were not adequately monitored while they waited. The triage nurse aimed to assess all patients within 15 minutes of their arrival in the department, although staff told us patients frequently waited longer than this. They said it was not unusual for patients to wait an hour for assessment, with the longest delay reported as two and a half hours. On 3 November 2014 the nurse in charge recorded that patients in the MIU were waiting one and a half hours to be triaged and four hours to be seen.
- Self-presenting patients reported to the department's reception desk, which was usually staffed by two receptionists. Details were then sent electronically to the triage nurse based in the department. The triage nurse was able to 'stream out' patients who, in their judgement, had minor complaints and could be seen by 'see and treat' practitioners without triage. However, a triage nurse told us that more patients were streamed out when the department was busy. This suggested the decision was not always being made based on clinical need. Patients were mostly seen in order of arrival, but the triage nurse could prioritise certain patients based on clinical need.
- The receptionists were able to alert the triage nurse or other clinical staff if they were concerned that a patient required prompt attention. There was a tannoy system for this purpose. We witnessed two occasions when the receptionist left the department, leaving the reception desk unstaffed for approximately four minutes, while their colleague was on a break or on an errand. During this time, patients in the waiting room were not being monitored. The receptionists had guidance on alerting clinical staff if a patient showed possible symptoms of Ebola, but had no other guidance on 'red flag' conditions that required urgent attention.

Urgent and emergency services

- On 6 and 7 November 2014 we undertook two periods of observation (30 minutes and 50 minutes) in the waiting room, using a method known as 'short observational framework for inspection'. During both observations the two receptionists on duty did not look at or engage with patients unless they approached the desk, and even then, eye contact was minimal. The triage nurse regularly entered the waiting area to call patients but did not have a full view of the area and some patients sat with their back to the triage room. The triage nurse told us this concerned them. Three other staff entered the area briefly during a period of 30 minutes to collect patients from the waiting room. The observation of patients in this area was therefore unsafe.
- On 6 November 2014 we observed the triage process for two hours and witnessed numerous delays. Apart from one patient who was seen promptly by an extended scope physiotherapist, most patients waited between 30 and 50 minutes. This included a patient complaining of chest pain and palpitations, two children with head injuries and an elderly patient with shortness of breath. The policy for triage in the ED is for patients to be assessed within 15 minutes.
- A significant delay of one hour and 20 minutes was experienced by an elderly patient with Parkinson's disease who had fallen. They had been brought in by ambulance to the crossroads and directed to the waiting room. However, the triage nurse was not informed of their arrival and the patient was effectively forgotten.
- We noted that the triage nurse had started work at 7am and had no break until 3.20pm. They told us this was normal. There was a risk that this staff member may become fatigued and not perform their role effectively.
- A further four patients were streamed to be seen directly (without triage) by the 'see and treat' practitioners. One patient was seen within 38 minutes, while the remaining three were still waiting to be seen at 64, 55 and 45 minutes respectively when we left. One patient who had been streamed to 'see and treat' was triaged after we intervened at 40 minutes because we were concerned that they had a head injury. The triage nurse told us they had misread the card and thought the patient's complaint was a hand injury.
- On 7 November 2014 we observed a patient awaiting triage approach the reception desk, bent over in pain and with one arm over their chest/abdomen. The receptionist agreed to fetch a nurse and gave the patient a vomit bowl and some tissues. The patient, who was unaccompanied, returned to their seat for a further ten minutes during which time they vomited and cried with pain. At this point we intervened and provided assistance. The patient told us "the pain is so bad, I wish I was dead". We summoned a nurse and the patient was taken in a wheelchair to the crossroads, where they received prompt intervention, including pain relief.
- During our night visit self-presenting patients were being triaged within 10 to 30 minutes.
- A flowchart had been produced to allow patients to be received from the ambulance service and to ensure that queuing patients were supervised and monitored. In order to maintain a ratio of one nurse to three patients, nurses and healthcare assistants were moved from other parts of the department to help in crossroads. At times this meant that the nurse in charge took over care of patients in majors in order to release staff. The impact of this was that they were not able to coordinate the shift and manage patient flow effectively.
- Nurses in the ED received briefings at the start of each shift. These included a summary of each patient in the department, any risks and how they were to be managed. Information was also disseminated about audits, incidents and complaints.
- We observed two handovers with medical staff. Again each patient's risks and management plans were discussed. Nurses not involved in patient care were able to attend these briefings.
- The consultant in charge conducted ward rounds every two hours to ensure they had an up-to-date overview of activity and risks in the department.
- There were no children's inpatient facilities at Southmead Hospital and the ambulance service took seriously unwell children to Bristol Royal Hospital for Children. Minor injuries could be treated at Southmead. However, it was not uncommon for seriously unwell children to be brought to the department by their parents. Before the transfer of services from Frenchay to Southmead Hospital, the trust had commissioned the Royal College of Paediatrics and Child Health to undertake a 'health check' of proposed arrangements to ensure that emergency care for children and young people was appropriate and safe. The report from the Royal College of Paediatrics and Child Health said the arrangements for providing a safe and effective service were "sound".

- There were well established and effective arrangements for the safe transfer of children to Bristol Royal Hospital for Children.
- We were concerned about inappropriate use of the SAA, which was sometimes used to accommodate patients who required admission when appropriate beds were not available throughout the hospital. On 28 October 2014 it was reported that a patient on the SAA awaiting admission had received inadequate monitoring or escalation following abnormal test results. They were subsequently admitted to AAU, where they later died. We were told by the trust that, although the incident was originally categorised as a serious incident, following a preliminary investigation this was downgraded and accordingly did not require a 72-hour investigation. However, a management report was required within 28 days. On 29 October 2014 a risk was added to the department's risk register highlighting the risks associated with patients awaiting beds experiencing excessive delays (over six hours, sometimes over 12 hours in the SAA). The entry said patients were judged as at risk of clinical deterioration and delayed treatment.
- We spoke with staff about pressure area care for patients who had extended stays on the SAA. They told us there were no processes or protocols in place to monitor pressure area care for patients, other than to provide a sheet to sit on. In ED we were told that beds were provided for frail, elderly patients who were at risk of pressure damage.
- All patients who presented with mental health problems were initially risk assessed and prioritised by ED staff using a mental health matrix. The risk of mental health patients 'absconding' was on the department's risk register. We were told that patients who were assessed as high risk would be cared for in the majors area, if possible in a cubicle close to the nurses' station where they could be more closely monitored. Registered mental health nurses could be requested to provide one-to-one care if necessary.
- There was detailed guidance contained in the operational policy for the mental health liaison service on the management of patients brought to ED under section 136 of the Mental Health Act by the police. The section 136 'place of safety' (where patients found by police in a public place who they believe to be suffering from a mental disorder and to be in immediate need of care or control could be legally detained) was located on the Southmead Hospital site, although managed by the local mental health trust. Appropriate patients could be transferred there following treatment at the ED.

Nursing staffing

- The nursing workforce for the Emergency Zone was led by the medical directorate head of nursing, supported by two clinical matrons covering the ED and the AAU. Daily matrons' meetings took place within the medical directorate to review staffing and deploy as necessary.
- Staffing levels for the ED were established before the new department opened in May 2014. The department's senior team told us that levels were based on the understanding that expected patients (urgent medical admissions arranged by GPs) would be admitted directly to a ward. In fact, they told us, all such patients were admitted through the ED when there was no bed capacity in the hospital. As a consequence, the department was regularly "gridlocked". It was concluded that activity, acuity and patient flow was not as predicted and a review of staffing was required. We noted that this was not recorded on the department's risk register.
- A business case (staffing review) had been produced in October 2014 by the matron and ward manager, which outlined the impact of overcrowding and the additional staffing required to manage it. The authors of this report both told us that they considered nurse staffing levels to be the second highest risk in the department, with patient flow being the highest risk. The document clearly described the pressures in the department, how these were currently managed and the impact that staffing levels had.
- The department had made necessary adjustments to job roles, deployment and skill mix in order to mitigate known risks. For example, a healthcare assistant ('co-pilot') was employed in majors (but not funded) to support the nurse in charge with general administration duties, allowing the nurse in charge to concentrate on optimising patient flow. Staffing of the crossroads area had been increased to reflect the workload (again unfunded and by moving staff and supplementing the team with temporary staff). Additional nurses were employed in majors to maintain, as far as possible, the ratio of one nurse to three patients and reduce the impact of moving staff to crossroads.

Urgent and emergency services

- Following our visits we were informed that temporary (winter pressures) funding had been granted to increase the nursing staff establishment.
- Nursing staff told us that ED shifts were either under-staffed or, as one described it, “running at the absolute minimum”. There were regularly 12 staff per shift when there should have been 13 or 14. There were a number of unfilled vacancies and five staff on maternity leave. Bank and agency staff were employed where possible to fill gaps, but concerns were expressed about the quality of temporary staff. Staff told us the department tried to use regular bank/agency staff with appropriate transferable skills and tried to deploy them where their skills best fit, moving ED staff to accommodate.
- During our night visit, although the Emergency Zone had a full complement of nursing staff, there were two agency staff deployed and one bank nurse. Senior staff acknowledged that these staff were not as effective as permanent staff. There was no formal process for inducting bank and agency staff. A senior nurse told us “we usually show them around”, but assured us care was taken to ensure that they were deployed in the most appropriate area, according to their skills and experience.
- There were 27 unfilled requests out of 380 requests for registered nurses and 12 unfilled requests out of 56 requests for healthcare assistants during the month of October 2014, which meant the department was on occasions not staffed to minimum safe levels.
- There was not a dedicated paediatric trained workforce in the EZ. The department had seven trained children’s nurses, which would not enable the department to ensure there was always a children’s nurse on duty. The numbers of very sick children attending the department were low because they were taken by ambulance directly to the Bristol Royal Hospital for Children. However the RCPCH Standards for Children and Young People in Emergency Care Settings (2012) identifies that parents will continue to take very sick children to their nearest emergency care setting. For this reason it states that in the absence of registered children’s nurses, the paediatric skills of emergency staff must be enhanced and staff should as a minimum be trained in paediatric life support. We were assured that all nurses were trained in Paediatric Life Skills (PLS) or Advanced Paediatric Life Skills (APLS) but on furthers enquiry we found that a significant proportion of staff had not completed recent training.
- There were staff rotations with Bristol Royal Hospital for Children so staff could gain more experience of nursing sick children. The Royal College of Paediatrics and Child Health review (December 2013) had concluded that the staffing arrangements proposed before the move to Southmead Hospital were compliant with relevant standards. However, they stressed the importance of continuing with nurse education to ensure nurses were competent in diagnosing children and young people. They recommended that a minimum of 25% of the nursing workforce should have completed child-specific training modules and that funding for the training programme (including supplementing staff to allow release of staff to attend) should be identified (see mandatory training). The department told us they were confident they would comply with this recommendation. They told us they were supporting staff to train in PLS, APLS, minor injury and illness in children and the principles of children’s emergency care.
- The trust’s Full Capacity and Escalation Procedure outlined measures to ensure safe levels of staffing in the event that red or black escalation was declared and the ambulance standing operational procedure was activated (meaning that ambulance staff monitoring patients in the crossroads would be released from the hospital and return to their road duties). In these circumstances registered nurses from each directorate in the hospital (who had been identified at the beginning of each shift) were to be deployed in the ED to support ED staff.
- Staff told us this was not effective and assistance from the rest of the hospital was not provided promptly or consistently. The ED had developed a process that anticipated moving staff from within the ED and from other parts of the hospital to ensure that patients in the crossroads were cared for on a three patients to one registered nurse basis. This was rarely achieved. A staff member told us some “borrowed" staff were “more of a hindrance than a help” because they did not have the appropriate skills or experience and they were there under duress.
- On 19 October 2014 the nurse in charge recorded there were 15 patients in crossroads with one registered nurse and two healthcare assistants, one of whom was bank

staff. This meant the trust's internal standard of one registered nurse to three patients in majors cubicles was not provided. On 3 November 2014 the nurse in charge recorded a request for extra additional staff at 2pm when there were 45 patients in ED and the department was felt to be unsafe. At 3pm there were 67 patients in the ED and 12 patients in the crossroads and no assistance had been provided. At 4pm there were 64 patients in the ED and 18 patients in the crossroads and one registered nurse had been provided to assist.

Medical staffing

- There were 10.4 whole-time equivalent consultants and one associate specialist in the ED providing cover seven days a week. In addition there was a consultant permanently on-call for major trauma. Senior medical cover (ST4 or above) was available 24 hours a day, seven days a week.
- There were no consultants with formal subspecialty training in paediatrics, but consultants and middle grade doctors were APLS trained, with some being trained as instructors. A consultant had been designated as the lead consultant for paediatrics and spent time working at the Bristol Royal Hospital for Children.
- There was a high consultant presence in the ED throughout our visit. Junior medical staff felt well supported by consultants.
- Medical staff handovers took place at the beginning of each shift and throughout the day/night.
- The AAU employed 7.6 whole-time equivalent consultant physicians seven days a week, with on-call cover overnight. Surgery, urology and vascular consultants were available on-call.

Major incident awareness and training

- Staff in the ED were well briefed and prepared for a major incident. Before the new department opened all staff had attended a safety orientation and briefing session so they could familiarise themselves with the department, systems and processes. This included fire prevention and evacuation procedures and to practice the major incident protocol.
- There were satisfactory arrangements in place to deal with casualties contaminated with chemical, biological or radiological material and these had recently been updated.
- There were satisfactory arrangements in place to deal with patients who may be infected with Ebola and staff training was ongoing.
- There was a well-equipped major incident store.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Summary

The ED adhered to National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine standards. There was a comprehensive education programme for doctors and nurses, although nurse education was not taking place in a structured or consistent way because staffing levels were not sufficient to allow staff to be released for training. We saw some examples of excellent practice, such as in trauma management and the treatment of stroke patients. The department participated in a range of research and audit. Treatment of patients with sepsis was poor, although improving, and a trust-wide quality improvement programme had been set up to tackle this. Although over time performance against College of Emergency Medicine standards was improving, most standards were not met and performance was worse than the national average. Performance in relation to pain relief was particularly poor, most probably a consequence of patient flow issues.

Evidence-based care and treatment

- The ED provided evidence-based care that complied with national guidelines for the management of a range of conditions, including head injury, chest pain, seizures, procedural sedation, stroke, venous thromboembolism, upper gastrointestinal bleed and anaphylaxis.
- Excellent clinical care was provided for stroke patients. During our visit we observed prompt effective care using the stroke care pathway. The department had been pre-alerted to the arrival of a stroke patient. The duty stroke physician and registrar were summoned and arrived in the ED before the arrival of the patient. They

then accompanied the patient to the CT scanner, interviewing them on the way. Following the scan the team wheeled the patient to the resuscitation area, all the time explaining to the patient what was happening.

- In the treatment of children, the ED used clinical guidelines developed by the Bristol Royal Hospital for Children, which were consistent with NICE guidelines and Royal College of Paediatrics and Child Health standards.
- There was a programme of local audit and research. Projects were allocated to junior medical staff, supported by consultants and reported at clinical governance meetings, where learning and actions were agreed.
- In June 2014 the clinical governance committee reported that the ED had participated in a national audit of seizure management. Results were discussed and actions were documented to make improvements. This included incorporation of learning into junior doctors' induction and reminding nurses by email of the importance of undertaking investigations for patients presenting with a seizure.

Pain relief

- Appropriate pain relief was not being provided consistently. The department aimed to provide prompt, appropriate pain relief to patients within one hour of arrival in the department. An audit of records in the week beginning 27 October 2014 showed performance against this standard was only 28%.
- The department conducted a local audit in August 2014 of performance against College of Emergency Medicine standards for the treatment of fractured neck of femurs (hip fractures). This was in response to poor performance in 2012 and 2013, particularly relating to pain relief. Hip fractures are painful and the administration of pain relief should be a priority in the ED. The audit showed improved performance but results remained far short of College of Emergency Medicine standards. For time to analgesia, the results placed the trust in the lowest quartile of performance when compared with other hospitals nationally. The department did, however, score above the national average for x-ray within two hours and use of fascia iliaca block (nerve block).
- The trust performed poorly in the College of Emergency Medicine renal colic audit 2012, with a pain score recorded for only 48% of patients (the College of Emergency Medicine standard is 100%). In response to the audit, the department amended paperwork to include visual aids in addition to numeric pain scores, with room for re-assessment scores. Poor documentation of repeat pain scores was highlighted to staff through clinical governance meetings and a new renal colic care pathway was introduced. The department planned to re-audit this in December 2014.
- It was recognised that early delivery of analgesia was an area that required improvement in the ED. An audit of pain management in the ED as a whole was planned for December 2014.
- On 4 November 2014 we observed a patient on a trolley in the crossroads area of the ED. The matron told us they had been in the corridor for three hours awaiting assessment by a surgeon. They were clearly in pain and distressed. The following day we requested an investigation of this patient's care from the time they arrived at the ED to the time they were admitted to an inpatient bed. The investigation showed that the patient complained of severe abdominal pain on arrival but was not administered any pain relief until two and a half hours after arrival. Pain scores were not consistently recorded and appropriate opiate-based analgesia was not administered for a further two hours. A senior nurse told us that administering analgesia in the crossroads was difficult because it was not a clinical area, there was no access to oxygen or suction, and there were no medicines stored there.
- On 5 November 2014 we spent time observing care of patients in the crossroads area. We observed three patients receive prompt analgesia, although one of these three did not have their pain re-assessed after one hour.
- On 17 November during our night visit we observed that patients received prompt pain assessment and pain relief.
- In June 2014 a comment made through the friends and Family Test stated "Experience in A&E awful, long wait in excruciating pain without seeing anyone (three hours)."
- In July 2014 a complaint identified that a patient requested pain relief at 10pm and did not receive it until the following morning.

Nutrition and hydration

- A relative told us they had recently accompanied an elderly family member to the ED. The patient waited for seven hours in the crossroads area and was not offered

any food. We asked the staff working in the crossroads how the provision of food and drink was managed in this area. They told us staff undertook tea rounds every two hours as far as possible and if they had time they may provide sandwiches or toast to patients. There was no protocol to ensure that this was consistently the case for patients who had been in the department for more than two hours.

- A complaint received in July 2014 stated that a patient admitted to the Emergency Zone at lunchtime had still not had a drink by 7pm.

Patient outcomes

- The ED performed well in comparison with other trusts in the urgent management of stroke patients.
- The trust had participated in national College of Emergency Medicine audits since 2008 so they could benchmark their practice and performance against best practice and other EDs. Overall their performance was below the national average.
- The trust was not meeting College of Emergency Medicine standards in relation to the treatment of severe sepsis (blood poisoning) and septic shock (audited 2013). Although performance had improved since the last audit, the trust scored in the lower quartile for administration of antibiotics in ED. There was a trust-wide project ongoing to improve the identification and treatment of sepsis. In the ED, documentation had been modified to include criteria and prompts for initiation of 'sepsis six' (a set of interventions to be undertaken in the first hour of sepsis presentation). A sepsis care bundle (a set of evidence-based elements of care) had been developed to be used in ED and a focused teaching session for junior doctors had recently been held on sepsis recognition, antibiotic delivery and sepsis six. In June 2014 positive results were reported following a snapshot audit of management of neutropenic sepsis.
- The ED audited the management of fractured neck of femur based on NICE guidelines in August 2014. For time to analgesia, the results placed North Bristol NHS Trust in the lowest quartile of performance when compared with other hospitals nationally. However, time to x-ray results placed the trust in the upper quartile of performance. Only 60% of patients were admitted within four hours (College of Emergency Medicine standard is 98%), placing the trust in the lowest quartile. The department had an action plan to address the areas of poor performance. Actions included the development of a fractured neck of femur checklist to include a reminder of key areas for improvement. It was intended to re-audit this in six months.
- An audit undertaken in July 2014 of the treatment of patients with non-ST segment elevation myocardial infarction (or unstable angina) according to the ED acute clinical and NICE guidelines showed some improvements in the management of this patient group since the last audit in 2013. In particular there was an improvement in the administration of a beta blocker. However the percentage of patients assessed for the risk of future adverse cardiovascular events had declined significantly and the administration of aspirin and other medicines had also deteriorated slightly since the last audit. An action plan had been developed. Actions included raising awareness of the risk assessment documentation.
- The trust was meeting the standard, which requires the number of patients re-attending the department within seven days to be less than 5%. Performance between April and September 2014 was between 3.5 and 3.7%. However, 6.74% of attendances were unplanned re-attendances in September 2014.
- The ED performed above [MSOffice1] the national average in the 2011 audit of consultant sign off. This measured the percentage of patients presenting at ED in certain high-risk patient groups (adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an ED consultant (or in exceptional circumstances an ST4-7 or a career grade doctor with sufficient experience to be designated to undertake this role by the ED consultant) before discharge.
- The ED performed in the top 5% nationally in relation to organ and tissue donation. Two nurses in the department who had a special interest in this subject had undertaken research and disseminated knowledge and training to their colleagues, some of whom had previously been uncomfortable tackling this subject with bereaved relatives.

Competent staff

- There was a published, structured programme of weekly teaching for junior medical staff, who were expected to attend a minimum of 70% of sessions. Junior medical

staff said they were well supported by consultants. However, we were told by the lead consultant that ad-hoc 'shop floor' teaching had suffered because of operational pressures.

- There was a comprehensive nursing education strategy and a structured education programme linked to appraisal, which had been developed at Frenchay Hospital. The matron told us that this had stalled since May 2014 because staffing levels did not allow for staff to be released. There were a number of nurse educators who previously ran in-house mandatory updates such as resuscitation training, child protection, plastering and suturing. A rolling annual update programme had ensured that staff remained up to date. However, because these educators had no protected time in which to deliver training, it was taking place infrequently and in an unstructured way.
- All nursing staff were encouraged to research and develop areas of interest and act as a source of advice and training for the team. Examples included bereavement, infection control, tissue viability, sepsis and support for homeless people.
- Because of pressures in the service, departmental 'champions' disseminated information and learning in an ad-hoc way, rather than at structured teaching sessions, and often completed work and attended meetings in their own time. There was no dedicated professional development nurse (as would otherwise be the case in most trauma centres or large EDs). A senior nurse was responsible for planning, coordination and delivering in-house training, including induction, but was given only one day a week to deliver this and this was not budgeted for.
- A staffing review produced by the ED matron and ward manager in October 2014 stated "it is imperative that this situation is rectified in order to be compliant with trust mandatory and statutory training requirements, as well as equipping ED staff with the essential clinical skills to undertake their roles".
- The ED scored better than the national average in the 2014 National Training Survey for handover and clinical supervision.
- Non-medical staff were allocated to teams, with every band seven nurse leading a team and responsible for staff supervision. Annual performance appraisal compliance for non-medical staff was approximately 75%, which was below the 85% rolling trust target. Nurse supervision was reported to be ad-hoc. A nurse told us they rarely managed to attend meetings and appraisals took place "over a coffee" in department store.

Multidisciplinary working

- There was good team working in the Emergency Zone. Care was delivered in a coordinated way, with support from specialist teams and services. There was a dedicated diagnostic imaging department in the ED, which consisted of two CT scanners, four plain x-ray rooms and ultrasound facilities.
- There were service level agreements detailing the turnaround times for both diagnostic imaging and pathology services.
- There was a trust-wide Mental Health Liaison Service, which supported the Emergency Zone. The operational policy for the Mental Health Liaison Service (2008) was currently under review. The policy stated that monthly meetings were held; however, we noted that meetings had not taken place between March and October 2014. The trust told us that formal meetings had not taken place because of the hospital move, but that informal, unrecorded meetings had continued. The mental health liaison service attended the daily multidisciplinary review meeting in the SAA to review individual patients.
- There was a Complex Assessment and Liaison Service. Consultant physicians were available on AAU and across the Emergency Zone seven days a week. Supported by advanced nurse practitioners, occupational therapists and physiotherapists, this team actively identified patients who could benefit from their service, with the aim of developing a treatment and rehabilitation plan to avoid admission or shorten length of stay. The NHS Emergency Care Intensive Support Team reported that they judged this service to be under resourced and recommended that some bed space be allocated to the team in AAU to improve effectiveness.

Seven-day services

- There was seven-day senior medical staff presence in the Emergency Zone, including on-site cover 24/7 for major trauma. Medical specialists, including cardiology, gastroenterology, respiratory, haematology and diabetes/endocrinology, were available to review patients in the Emergency Zone, although acute

oncology and palliative care consultants were only available Monday to Friday. Consultants from the Complex Assessment and Liaison Service were available seven days a week; however the Rapid Emergency Assessment Care Team (a team of allied health professionals and nurses who assessed and facilitated discharge for vulnerable patients, such as elderly people living alone) operated Monday to Friday only. Radiology services were available seven days a week.

- The Mental Health Liaison Service supported the Emergency Zone seven days a week, although only until 5pm. This was to be extended to 8pm in the near future. Specialist support for patients presenting with problems associated with drug or alcohol misuse was not available seven days a week.

Are urgent and emergency services caring?

Good

Feedback from patients, relatives and carers was overwhelmingly positive and this was consistent with the feedback the service received in the Friends and Family Test. Negative feedback tended to relate to waiting times and a lack of information about how long patients would have to wait. However, at times of significant delays, we received numerous comments about kind, caring and understanding staff and recognition that they were doing their very best in difficult circumstances.

Compassionate care

- The ED used the Friends and Family Test to capture patient feedback. The score in September 2014 was 51.5, exceeding the target of 46[MSOffice1] . This was based on a response rate of 19.07%, just short of the 20% target.
- We observed staff interacting and caring for patients and relatives. Clinical staff were without exception polite, courteous, sensitive and compassionate. This was consistent with feedback received through the Friends and Family Test. However, reception staff on duty during our daytime visits rarely raised their eyes from their computer screens and showed little empathy or kindness. This was not the case when we visited at night. Although a large number of positive comments were received about clinical staff, the Friends and Family Test for September 2014 included three negative comments about unhelpful or unfriendly reception staff.
- Staff's compassion was evident by the distress they showed at not being able to provide high standards of care to people waiting in the crossroads.

Understanding and involvement of patients and those close to them

- We heard clinicians check information with patients and explain in simple terms what they would like to check, the tests they would like to do and why.
- Staff were aware of the importance of privacy and dignity. We saw them taking care to provide privacy, drawing curtains when examinations and private conversations were taking place. However, it was challenging to maintain privacy and dignity in the crossroads area of the department. We frequently saw patients being examined, having blood taken, cannulas inserted and providing medical histories in the corridor in front of other patients and visitors, some of whom were uncomfortable or distressed to witness this.
- Different staff groups were identifiable by the colour of their uniforms, but this was not clear to patients. Although staff wore name badges, they were not always easily visible. We heard staff introducing themselves to patients and relatives.

Emotional support

- We met with a representative from the trust's pastoral care team who provided spiritual and emotional support to patients, relatives and staff in the Emergency Zone.
- A member of the ED's senior management team told us the department was "passionate" about providing support to bereaved relatives. There was a bereavement team of three staff who provided advice and guidance to other members of staff and coordinated work in this area. Bereaved relatives were 'sign-posted' to external organisations that could offer them support. They were offered a follow-up call approximately four to six weeks after a patient's death to allow them to ask questions and talk about their loss. Sympathy cards were sent on the first year anniversary of a patient's death.

Are urgent and emergency services responsive to people's needs?

Urgent and emergency services

(for example, to feedback?)

Inadequate

The trust was consistently failing to meet core A&E access targets, notably the time to assessment and the time patients spent in the department. Patients, both self-presenting and those brought by ambulance, were frequently forced to queue outside the department at the crossroads because there was no capacity in the department. In September 2014, 15% (200) of patients were held in the crossroads for more than four hours. Patients were uncomfortable and lacked privacy or dignity during this time. Patients who required a Mental Health Act assessment out of hours waited too long in the Emergency Zone and were frequently transferred to the SAA, often for lengthy and/or overnight stays. The department was taking steps to improve this by extending the Mental Health Liaison Service out of hours.

The SAA was being inappropriately used for patients who were awaiting admission and the department was not suitably designed or equipped to accommodate patients for long periods or overnight. Single sex accommodation was not provided.

Service planning and delivery to meet the needs of local people

- A reconfigured ED opened in May 2014 after the closure of Frenchay Hospital. The design of the building and staffing levels were modelled on anticipated activity, acuity, bed base (reduced by 200 beds) and attendance profile. However, after only a few months it was evident that patient flow from the 'front door' of the hospital, within the hospital and the wider local heath community, was not effective, leading to overcrowding and frequent delays in the ED. Contributing factors in this poor performance were building issues, delayed discharges and increased pressure on elective beds.
- The standard operating procedure for the Emergency Zone stated that expected patients (urgent admissions) would be admitted directly to the appropriate ward. In fact we were told that all expected medical patients were admitted through the ED. To put this into context, during one week in October 2014 the average proportion of expected patients' stay, as a percentage of overall majors/resuscitation bed time, was 32.5%. On three days it was over 40%.
- A series of external reviews had taken place of systems and to examine the issues affecting operational effectiveness and patient flow. The most recent visits included the Trust Development Authority and the Emergency Care Intensive Support Team. Recommended actions were being incorporated into the trust's action plan. Priorities were: increasing weekend discharges and bringing forward discharge during the day. It was concluded that the number of patients admitted through the ED was too high. This was mainly related to the limited availability of assessment beds.
- A primary care out-of-hours service was provided on the Southmead Hospital site until 10pm. The ED/MIU could refer patients to be seen there at hourly slots. Although this was a pilot, this was not felt by staff to be adequate, given the number of patients who presented with complaints that could be managed within a primary care setting.
- The reconfiguration of children's urgent and emergency services in Bristol was endorsed by the Royal College of Paediatrics and Child Health, who concluded that the urgent an emergency services for children and young people at Southmead Hospital and the links with the ED at Bristol Royal Hospital for Children provided a safe and appropriate service that met the needs of the local population.
- A business case had been produced to extend the Mental Health Liaison Service in response to an increase in demand and complexity of patients' needs. The business plan highlighted that current provision did not meet the needs of patients requiring mental health support and did not meet quality standards for liaison psychiatry recommended by the Royal College of Psychiatrists.

Access and flow

- The trust was consistently failing to meet the standard that required that 95% of patients were discharged, admitted or transferred within four hours of arrival in ED. In the second quarter of 2014 performance was 83.9%. The average total time spent in ED was significantly worse than the England average: 10% of patients waited longer than six hours in the ED in September 2014.

Urgent and emergency services

- Performance against the standard that requires 95% of patients to be assessed within 15 minutes of arrival (includes brief history, pain and early warning scores), ranged from 51.8% to 63% between May and October 2014.
- Delays in ambulance handovers were a frequent and ongoing problem. Joint work with the ambulance service had led to a reduction in delays over 15 minutes, but delays still occurred too frequently, with over 600 reported in August 2014. The department had two cubicles in majors dedicated to initial assessment, early diagnostics and commencement of treatment, staffed by one registered nurse and one healthcare assistant. It was reported that since the introduction of the initial assessment nurse, and detailed offload work, ambulance targets had improved. However, the trust was not consistently meeting the standard that requires patients' treatment (from a decision-making clinician) to commence within one hour of arrival.
- It was suggested by ED and ambulance staff that the trust was not anticipating escalation and acting soon enough. Senior ED staff told us that support from the wards was not provided promptly or consistently. On 4 November 2014 when we visited the ED, we saw 21 patients queuing in the crossroads area of the department at 5.30pm. The matron told us the ambulance Standing Operational Procedure had been implemented at 2pm and two nurses had been requested at that time but had yet to arrive. There were three nurses deployed in the area along with a number of ambulance staff. The nurse in charge on that shift recorded that two nurses arrived at 6pm but both finished their shift an hour and a half later. Agency nurses booked to work also failed to arrive. The nurse in charge recorded "staffing levels are unacceptable for the number of patients".
- On 21 October 2014 the nurse in charge had recorded on the ED escalation sheet at 8.40am that five patients were being cared for in the crossroads area by one nurse. The ambulance Standing Operational Procedure had been implemented and help had been requested. It was recorded that this help was not provided until midday, when one nurse from a ward arrived. By this time there were 20 patients in the department and 18 patients in the crossroads.
- The department achieved the national target that requires the number of patients who leave the department before being seen (by a clinical decision-maker) should be less than 5% (recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait). Between April and September 2014 the proportion of patients leaving before being seen was between 2.4% and 4.2%.
- The trust performed significantly worse than the England average in respect of the percentage of patients waiting four to 12 hours from decision to admit to admission.
- In the MIU there was a 'see and treat' service, which was seen as crucial in maintaining flow through the department. The department was staffed by emergency nurse practitioners, extended scope physiotherapists and medical staff. Staff told us a treatment nurse was regularly moved from the MIU to the crossroads to assist, thus causing delays in the MIU.
- The Trust Development Authority (the organisation that monitors non-foundation trust status NHS trusts) reported there was poor compliance from specialty teams to review patients within 30 minutes of referral. This meant that patients stayed longer than necessary in the ED. Patients referred by their GP for urgent admission were frequently admitted through the ED rather than being admitted directly to a ward or AAU. This had a direct impact on ambulance handover times and performance against the four-hour target. We were told that ED patients could wait four to five hours to see the relevant specialist.
- We looked at a sample of ED escalation sheets, which documented at regular intervals throughout each 24-hour period events or situations that impacted on patient flow and performance. The time taken for specialities to review patients was an indicator that was regularly monitored. The nurse in charge on each shift highlighted delays on the ED escalation sheet. A sample of these records (19–23 October 2014 and 3–5 November 2014) showed delays were regularly recorded throughout this period. On 2 November 2014 the nurse in charge reported that patients were waiting three and a half hours to be seen by specialists.
- Staff told us the diagnostic imaging service was responsive during the day. However, delays were sometimes experienced out of hours. Radiographers explained that after midnight, there were just two radiographers covering diagnostic imaging for the whole

hospital, with a third on-call. Staff may be called on to provide portable x-rays or to assist in theatres and delays happened if these demands occurred simultaneously .

- There was a service level agreement in place detailing the turnaround times from referral to result. The department aimed to report on plain x-rays in 30 to 60 minutes and CT scans in 60 to 240 minutes. This was monitored on a weekly basis. During October 2014, between 92% and 95% of plain film requests were seen within one hour.
- There were respiratory 'hot clinics', Monday to Friday. Up to six patients a day could attend on an appointment basis, usually within 24 hours of referral. The service was intended to prevent the admission of patients with acute respiratory problems.
- The SAA was not being used effectively or appropriately. Concerns about its ineffective use had been expressed by both the Trust Development Authority and Emergency Care Intensive Support Team. Patients could be referred to the SAA by the ED triage nurse or by their GP through the operations centre. Some staff had reported that the unit was being used as an escalation area at times of pressure. The Emergency Zone's risk register recorded "The seated assessment area is being used as pre-admissions unit".
- During October 2014 between 19 and 32 patients a week spent over 12 hours in the SAA. The proportion of patients admitted from the SAA ranged from 11.7% to 19.9%. On 23 October 2014 the nurse in charge recorded at 6am that patients had been in the SAA waiting for beds since 2pm the previous day.
- The hospital recognised that overcrowding in the ED was a serious risk when there was a high demand for services. A Full Capacity Protocol & Emergency Department Escalation Policy had been developed to mitigate this risk by ensuring that patient flow throughout the hospital was managed. The protocol was based on the principle that the wider hospital took shared ownership of the risks associated with overcrowding and supported the ED to deliver the four-hour target.
- The Full Capacity Protocol described and 'RAG rated' the escalation status of the ED, ranging from green (normal functioning) to black (normal care is not possible and the department is deemed "dangerous"). A series of actions were in place for each escalation status. When the escalation status was declared black, the internal major incident/business continuity mode would be enacted and the full capacity protocol may be activated, allowing additional patients to be allocated to wards. This protocol was known as 'one up'. The 'one up' protocol allowed one extra patient to be allocated to each ward at times of extreme pressure. However, senior ED staff told us that activating this protocol made little difference because wards generally only accepted an additional patient when they had a known discharge. It was reported common practice to transfer an outgoing patient to the ward's treatment room to accommodate the incoming patient on the ward.
- A winter weather fracture plan was in place to be enacted when adverse weather resulted in large numbers of patients attending the ED with limb fractures. In this scenario, additional staff would be requested and a dedicated area should be set up in the hospital's fracture clinic. This had yet to be tested.
- Patient flow throughout the hospital was managed by a team of staff in the operations centre. Regular bed flow meetings were held and attended by all the bed holding specialties. The patient flow policy stressed the importance that specialty beds were allocated to the Emergency Zone when a decision to admit was made in order to sustain optimal patient flow. The policy stated that the operations centre would advise the Emergency Zone of available beds as they became available and the Emergency Zone would be required to allocate and move patients to available beds within 30 minutes. Staff told us this was often difficult to achieve because nursing and portering staff were not always readily available.
- On the third day of our visit, a staff member told us there had been "pressure from management to move patients out quicker to fill 20 beds that had miraculously become available". They told us this presented them with a problem because they did not have sufficient porters or nurses to facilitate this.
- There was detailed guidance on the running of regular and focused ward rounds, both hospital-wide and on AAU. This was to ensure that patients had a daily review of progress, thereby speeding up treatment and ensuring patients are in the most appropriate place, and preparation for discharge. On AAU, board rounds took place at 10am for the multidisciplinary team. The multidisciplinary team included the Complex Assessment and Liaison Service and specialist teams such as oncology. The medical teams were required to

operate continuous review of patients with consultant physicians available on-site from 7.30am until 10pm each day and on-call overnight to ensure that patient flow was maintained. Surgical handover and board rounds were held at 8am each morning.

Meeting people's individual needs

- The ED was adequately signposted from the main entrances, although two patients told us of their difficulty in finding the department at night. There were numerous 'Move Makers' (volunteers) in the main atrium during the day who helpfully directed patients and provided maps. At night we saw no volunteers and we found it difficult to locate the department. A relative told us they had parked in one of the hospital's main car parks and walked the length of the Brunel building with their sick relative, trying to locate the ED. Eventually they were directed by a cleaner. We witnessed one patient arrive in the ED main reception looking for the outpatients department. The receptionist directed them back to department's entrance but did not offer them a map or any helpful advice.
- There was a designated car park for patients attending the Emergency Zone, although staff told us this was not large enough and was usually full by 3pm. Car parking was the subject of many negative comments in the Friends and Family Test. During our night visit on 17 November 2014, adequate spaces were available throughout our visit from 7.30pm to 1am.
- There was a drop-off zone at the entrance to the department, although this was not covered to protect people from inclement weather, as recommended by the Department of Health's 'Health Building Note (HBN) 15-01: Accident & Emergency Departments: planning and design guidance'.
- The department was easily accessible for patients with limited mobility or people who used a wheelchair. Wheelchairs (coin operated), including those suitable for bariatric patients, were available in the department for patients to use. Examination couches could accommodate bariatric patients.
- The waiting area was spacious, clean, light, airy and comfortable. There were male and female toilets and both men and women could access nappy-changing facilities. There was, however, no designated facility for breast-feeding mothers. Receptionist staff told us they would direct people to the toilets or the paediatric waiting area. This did not comply with HBN 15-01 standards.
- There were vending machines in the waiting area, dispensing snacks and cold drinks, and there was a water dispenser. There was a wall-mounted television, although staff told us this had not worked since the department opened. There was little or no appropriate reading material provided.
- Self presenting patients were not provided with information about waiting times for initial assessment (triage) in the department. A receptionist told us that patients frequently asked but were only told what the average length of stay in the department was or how many patients were in front of them in the queue. They told us waiting times and the lack of information about waiting times was the most common complaint they received. They told us they had requested a monitor to display waiting times in the waiting room and they understood that this was to be provided but were frustrated they had waited over five months.
- There was a small area within the main waiting room that had been equipped for children. There was also a designated children's waiting area within the minors' area that was welcoming. It was suitably furnished and equipped for children and not overlooked by waiting adult patients. HBN 15-01 states "The waiting area should be provided to maintain observation by staff". The Royal College of Paediatrics and Child Health review before the department opened described the planned waiting area for children as having an adjacent nurses' station, which it recommended should be staffed at all times to ensure that users (parents and children) could get attention when they were anxious. This was not the case. However, we spoke with one waiting parent who told us they felt there were adequate staff in the vicinity that could be called on for assistance.
- There were separate minors' cubicles for children, including one with a specially designed treatment trolley, the 'daisy bus'. A majors cubicle and a resuscitation bay were also designated as suitable for children, although more frequently used for adults.
- Patient confidentiality was, as far as possible, maintained at reception. Patients were directed to queue at a distance from the reception desk to ensure

that private conversations were not overheard. Patients were not obliged to discuss their complaint with the receptionist and were given the option to tell staff it was personal.

- Patients waiting in the crossroads area were uncomfortable, sometimes cold and their privacy and dignity could not be maintained. On one day of our visit it was a cold and windy day. The corridor from the ambulance entrance had become a 'wind tunnel' and patients and relatives complained of the cold. One patient told us "I have only been waiting ten minutes, but I am really cold already".
- The ED and ambulance staff were clearly unhappy about having to care for frail patients in this area.
- We saw an elderly patient on a trolley in the crossroads area who had received intravenous fluid and the giving set had not been removed, causing backflow of blood. This went unnoticed for half an hour before ambulance personnel switched the giving set off. This indicated that this patient was not being adequately monitored or cared for.
- We were told by a relative of a patient who was approaching the end of their life that their spouse had waited six hours overnight on a trolley at the crossroads in September 2014. They described the ED as "chaotic and overflowing", with "patients sitting on the floor in a poor state". They felt their dignity had been compromised and felt embarrassed for them.
- We were told about an incident in September 2014 when an elderly patient had urinated into a cup because they did not want to bother nurses who were too busy.
- The ED saw between 30 and 50 patients a month who required mental health support. There was a Mental Health Liaison Service located in the Emergency Zone, which provided specialist assessment and advice to patients presenting with mental health problems. The service consisted of six band-seven nurse practitioners (4.4 whole time equivalents) who provided a service from 9am to 5pm, seven days a week. We were told this was to be extended to 8pm in the next three to six months. There was a seconded consultant in Liaison Psychiatry and we were told this position was to be filled permanently.
- Out-of-hours advice and assessment was provided by the local mental health trust. According to staff, this service was not responsive and patients waited too long for psychiatric assessment. The average length of stay for patients presenting with mental health problems was five hours, with the maximum recorded as 17.8 hours. A significant proportion (approximately 75%) of this patient group breached the 4 hour target and we were told that some patients were admitted to avoid a long wait in ED.
- Patients under the age of 18 were referred to the local Child and Adolescent Mental Health Service and were sometimes accommodated overnight in the SAA for a next-day review. Staff did not think this was an appropriate setting if the department was busy.
- All patients who presented with mental health problems were initially risk assessed and prioritised by ED staff using a mental health matrix. Patients who were assessed as moderate or low risk were frequently transferred to the SAA for monitoring and assessment. This frequently entailed an overnight stay. A staff member in SAA told us this was not an appropriate setting if the department was busy. We were told patients who were assessed as high risk were cared for in majors. Additional staff were sometimes employed to provide one-to-one care.
- The operational policy for the Mental Health Liaison Service did not specify the timescales in which the team committed to respond. It was stated that the service would accept referrals up to one and a half hours before the end of their working day.
- Staff had access to a Drug and Alcohol Service and there was a 'proactive outreach worker' who, according to the operational policy for the Mental Health Liaison Service, worked from Monday to Friday during working hours. The designated worker was routinely alerted by ED or mental health liaison staff when patients presented more than once with misuse issues. We were told the worker had been on holiday for nearly three weeks at the time of our visit and their workload had not been picked up by anyone else.
- There was a Rapid Emergency Assessment Care Team based in the Emergency Zone from Monday to Friday. This team, consisting of occupational therapy, physiotherapy and nursing staff, facilitated discharges of vulnerable patients such as older people, people living alone or people with limited mobility. They assessed, for example, people's mobility and equipment needs and made referrals to other services as appropriate to facilitate safe and speedy discharge.

- The ED had not appointed a dementia champion, but staff told us they had access to a trust-wide dementia care specialist. There were no pathways for dementia care. Only 56% of staff (all roles) had received training in dementia care.
- We did not speak with any patients whose first language was not English, but a staff member told us a telephone interpreter service was available.
- The SAA, otherwise known as Ambulatory Emergency Care, was regularly and frequently used as an observation unit (it was frequently referred to as an observation unit or clinical decision unit) for patients who were awaiting beds. A nurse told us that the unit was sometimes used for "breach avoidance", meaning that patients were transferred there to avoid breaching the four-hour target in the ED. An Ambulatory Emergency Care passport had been produced, which outlined appropriate criteria for admission to the unit.
- It was not envisaged that patients would stay overnight, but they frequently did. On the morning of 5 November 2014, we saw three patients had stayed overnight, two of whom had been in the department for more than 12 hours.
- Patients were accommodated fully clothed on reclining chairs, with no sheets, although there was a small supply of cushions and blankets.
- Cubicles were not arranged to ensure single-sex accommodation and did not comply with the standards set out by the Department of Health's Chief Nursing Officer in 2009. Because the area was being used as a Clinical Decision Unit, patients staying longer than six hours were 'admitted' and as such, required single-sex accommodation. There was one toilet for 16 patients and no showering facilities. During our visit, two patients who had stayed overnight in the department told us the department was noisy and they were uncomfortable and tired because they had not been able to sleep. One patient described the chair as "sticky". They also complained they were offered no hot food and that they had no privacy. Staff confirmed that patients were not offered a full menu service. They said they sometimes borrowed meals from a ward, although this was against infection control advice.
- HBN 15-01 describes this type of space as 'chair-centric' and defines it as a "clinical space for patients who need short periods of treatment or observation but do not need to be on a trolley". While this type of space may be suitable for Clinical Decision Units, we judged it was not a suitable space for patients requiring more than a short period of treatment or observation.

Learning from complaints and concerns

- There were Friends and Family Test comment cards available in the reception area, although we noted that pens were not provided. We saw comment cards being given out to patients in the SAA.
- Staff were familiar with the complaints procedure and felt comfortable that they were equipped to deal with complaints, although only senior staff had received training. Several staff described how they would attempt to resolve complaints on the spot and informally, but knew how to escalate to a more formal procedure when necessary. Complaints leaflets were available in the department and staff knew where to locate them.
- A relative complained about their family member's care during our night visit. This was escalated to the nurse in charge, who spoke with them and explained reasons for the delayed care. We spoke with the relative following this. They remained unhappy and told us they had not been informed about the complaints procedure or signposted to the trust's Patient Advice and Liaison Service.
- Complaints and learning from complaints were regularly discussed at clinical governance meetings. However, staff were not able to describe to us any learning or changes that had taken place in response to complaints.

Are urgent and emergency services well-led?

Requires improvement

Staff were highly motivated and passionate about providing high-quality care in the face of significant challenges. Many staff expressed disappointment about the quality of service they were currently able to provide. They worked cohesively as a team, led and supported by a strong and committed local management team. The ED lead consultant, matron and ward manager were highly respected leaders, described as "inspirational" and "outstanding" by staff. However, we were concerned that

they were at breaking point. While there was clearly understanding of these challenges at the trust executive level, there remained a perception that the risks associated with patient flow were not shared by the rest of the hospital. This inevitably led to feelings of isolation, frustration and poor morale.

Vision and strategy for this service

- Staff shared a vision of being an outstanding centre for urgent and emergency care, but were not hopeful that this vision would be achieved while patient flow issues affected their performance. Nurse teams had attended away days where they jointly discussed how they were performing, what they were doing well and how they could improve their service.

Governance, risk management and quality measurement

- There were clear governance systems in place. Managers closely monitored risks to patient safety, both formal incident reports and daily situation reports (escalation sheets), which highlighted issues affecting patient flow and patient safety.
- Monthly clinical governance meetings were held that were open to all staff. There was regular presentation of cases and audits, and incidents and complaints, including any learning arising, were regularly discussed. A summary of the meetings was circulated to all staff. Weekly and monthly performance dashboards were produced that analysed activity, performance and breaches.
- A risk register was maintained for the Emergency Zone. Although concerns about capacity were recorded there was no specific mention of staffing levels highlighting the concerns set out in the staffing business case. There had been discussion within the medical directorate, however senior staff in the ED were unclear about the current status of the business case.
- Working arrangements with partners and third-party providers were not well managed. However, there was evidence of good partnership working with the ambulance service at an operational level, with ambulance and ED staff working cooperatively and showing mutual respect and understanding. But at managerial level, joint meetings were not taking place regularly; frustration was expressed by the ambulance service that there was insufficient focus and attendance from trust managers. A number of management changes within the medical directorate may have impacted on this.
- The trust told us that fortnightly ambulance handover internal project meetings were held with the ambulance service. We noted that only five meetings had taken place since June 2014, however. No meetings had taken place during August or September 2014 because of annual leave and/or operational pressures. Meetings were not minuted. We were told the ED management team had implemented a study of processes that a senior staff nurse had been tasked with. This had yet to be completed and discussed by the project group.
- Out-of-hours mental health assessments were provided by the local mental health trust, Avon and Wiltshire Mental Health Partnership NHS Trust. There was no service level agreement in place to outline the expected performance standards. We saw no evidence that the two parties liaised or formally monitored performance.

Leadership of service

- Staff in the ED told us they were well supported by senior clinical staff. The lead consultant, matron and ward manager were visible, accessible and supportive. Staffing in the department did not allow for regular whole team meetings, but there were numerous informal briefings and communication within the ED was felt to be good. Nursing staff had recently attended team 'away days'.
- A staff member in the Mental Health Liaison Service expressed frustration that although the team was well-led by the ED matron, there was a lack of senior leadership for, and interest in, mental health services at executive level. A business case outlined proposals to provide further resource and management for this service, including the appointment of a substantive consultant psychiatrist and a band eight mental health nurse team leader.
- Staff felt that the move to the new ED had been managed well and they had been given time to orient themselves to the new department, new teams and processes. Since the move, however, morale had suffered because of the issues around patient flow and staffing. A number of experienced staff had left the team because of travel difficulties. Two staff were reported to have left because they felt the patient flow issue and the use of crossroads was intolerable and unsafe.

Urgent and emergency services

- The senior clinicians in the ED were highly motivated, strong and resilient individuals but we were concerned they were at breaking point. Senior staff had written to the executive on two occasions, most recently in September 2014, following a meeting with them. They had outlined their concerns about patient safety. They said that nurses were working in intolerable conditions, in which they feared they were not able to provide optimal care. They described the situation in the department as "untenable and dangerous". At the meeting a number of actions had been agreed to address the issues of concern, including additional staffing resource. However at the inspection some six weeks later similar issues of concern were found and senior staff told us they thought nothing had changed.
- The Chief Nurse, Chief Executive and Medical Director were described as supportive and understanding. However other management support outside of the emergency department was directive and lacked a supportive approach. Concern was expressed that overcrowding in ED was seen as ED's problem and responsibility for managing the risks associated with patient flow were not shared by the rest of the directorate or the hospital.

Culture within the service

- Staff were proud of their team, but were ashamed of the service they were providing in the ED. They were passionate about patient care and distressed that patient experience was not always positive. One staff member told us "we are always saying sorry". The terms "soul-destroying" and "heart-breaking" were frequently used by staff when describing patient flow problems and the crossroads. Some staff were visibly distressed when describing events associated with delays.
- Staff in the ED showed resilience and professionalism, working in challenging circumstances. Staff worked well together in a cohesive team and were clear about what was expected from them.
- There was an open culture in the ED, where mistakes were openly discussed so that learning could take place.
- Students and new staff told us they were well supported and made to feel welcome in the ED team. A junior doctor told us "Take out the crossroads and this would be a great place to work."
- Staff felt valued and supported within their team, but not by the rest of the hospital. One staff described an "us and them" culture.
- Most staff felt able to speak out when they had concerns. Staff were able to access psychological and emotional support. However, some senior staff spoke of bullying behaviour within the directorate. On the last day of our visit we were told about an email communication that had come from a senior member of the directorate. The communication was in relation to bed flow issues within the directorate. Whilst the trust assured us that the email was a genuine attempt to engage senior clinicians in the directorate to balance the pressures in ED, the tone of the email had caused offence. Senior staff told us this tone was not unusual. This was at odds with a culture where staff feel supported and motivated by their seniors.

Public and staff engagement

- Staff did not feel well informed or engaged with the rest of the hospital. A senior nurse told us they felt isolated from the rest of the hospital, with the only link being through emails, which they accessed from home.
- Patients' views were captured and listened to. All patients who were not subsequently admitted were encouraged to take part in the Friends and Family Test. Results were displayed in the Emergency Zone and discussed at governance meetings.

Innovation, improvement and sustainability

- The ED had developed an electronic x-ray discrepancy and reconciliation system. This was used to highlight discrepancies between the requesting clinician's preliminary finding and the results of a radiologist's final reading.
- The ED was developing an E-Resus IT support programme containing clinical guidelines, currently provided in paper format.

Medical care (including older people's care)

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

Information about the service

North Bristol NHS Trust provided inpatient medical services. There were 12 medical wards, a medical day care unit and a renal day case unit within the Brunel building. There were two rehabilitation wards in Elgar House on the Southmead site. There were approximately 474 medical beds. We visited the following day care areas within the Brunel building: medical day care, renal day case and endoscopy. We visited inpatient wards within the Brunel building: 6b (neurology), 7a (neurology and stroke), 8a (renal and flexible capacity beds), 8b (renal), 9a (stroke rehabilitation), 9b (flexible capacity beds), 27a (cardiology, including coronary care unit), 27b (respiratory medicine, including the high dependency unit, infectious disease and haematology), 28a (care of the elderly), 28b (care of the elderly), 32a (gastroenterology, haematology, infectious diseases and flexible capacity beds) and 32b (rheumatology and short stay medicine). We spoke with over 50 members of staff, including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 43 patients and 12 relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Summary of findings

Patients were treated with compassion and respect. All of the patients we spoke with told us that they were happy with the care provided by staff. Safety in medicine was compromised. We found prescription medicines that were not appropriately stored, shortfalls in staffing numbers for nursing and a patient tracking system that did not adequately assess and prioritise patients effectively. There was no system to accurately track medical outliers in a timely manner (medical patients on non-medical wards) and therefore patients were at risk of delayed or missed medical reviews. There was poor patient flow in the trust and we found medically fit patients across the medicine directorate awaiting social care and community health packages to support their discharge from hospital. The service had undergone a major change with the move to the Brunel building in May 2014. Wards had been reconfigured and sub-specialties joined together. Staff we spoke with told us that ward staff were starting to work together and gain peer support within their new teams.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety in medicine was compromised. There had been 47 serious incidents requiring investigation between April 2013 and March 2014 and we saw learning from these. We found prescription medicines on three wards that were not appropriately stored and one medicine fridge that was broken and had not consistently met the recommended temperature for three days. We found three examples of medication that had been given but had not been signed off. This meant that prescription and medicine administration records were not always accurate. We inspected five resuscitation trolleys, two of which did not have daily documented evidence of equipment testing to ensure equipment was fit-for-purpose. Intravenous fluids on three trolleys were not appropriately stored. There was a 'hub system', where an electronic system recorded and tracked the status of medical patients referred from sources such as local GPs, who were waiting to be admitted to medicine. However, the system did not always have the patients' accurate location or Early Warning Score. This meant that medical staff could not adequately assess and prioritise patients effectively, therefore opportunities to prevent or minimise harm could be missed. There was not always the number of planned nurses on duty. We found an example of a patient who required one-to-one care, but not enough staff to provide this. Each ward had a daily 'safety huddle', to highlight safety issues such as patients at risk of falls or pressure ulcers. All staff on the ward were encouraged to attend.

Incidents

- Staff told us they were encouraged to complete incidents reports and most staff told us that they had feedback from the reports.
- Between April 2013 and March 2014, there had been 47 serious incidents requiring investigation. Of these incidents, category-three pressure ulcers accounted for 21 and slips, trips and falls accounted for 11.
- We saw learning from incidents, for example, root course analysis investigation reports were completed for category three or four pressure ulcers. An action plan was in place to prevent pressure ulcers; for instance, staff at the safety briefing were to document all patients with actual and potential pressure damage and each ward was to have a tissue viability link nurse to disseminate relevant information. There had been no category three or four pressure ulcers between April and August 2014.
- Since moving into the Brunel building there had been 16 serious incidents of falls trust-wide compared with six for the same period last year, which was a 300% increase and was highlighted on the risk register. Ten falls were on medical wards and two were medical outliers (medical patients on non-medical wards); two patients had died.
- Root cause analysis had been completed for the falls and learning could be demonstrated. For example, the trust had recently implemented a procedure whereby ward staff could call for an immediate response from the falls team to all serious falls. This meant that patients who had fallen were assessed by specialist clinicians. There were magnetic signs on patient doors to highlight patients at risk of falls and we saw a falls care plan used that prompted cohorting patients to provide 'line of sight' care to prevent falls. There was 66% compliance with mandatory falls training for staff in the medical directorate.
- On the endoscopy unit, alongside completing an incident form, staff were encouraged to document 'mistakes' and 'near-misses' in a book that was kept in the coffee room. Staff members spoke positively of this system. One nurse told us that she worked part time and having the book easily available allowed her to keep in touch with what was happening in the unit and helped her learn.
- There were no mortality and morbidity meetings for the directorate; the trust told us that the process was under review.

Safety thermometer

- NHS Safety Thermometer information showed that Harm-Free care between September 2013 and August 2014 for the medicine directorate was below the trust average of 93.2%. In August 2014 there was a reduction in Harm-Free care in medicine, with an increase in new pressure ulcers, catheter-associated urinary tract infections, venous thromboembolism harm and falls harm. NHS Safety Thermometer results were shared with teams.

- NHS Safety Thermometer information was displayed outside each ward. This included information about falls and new pressure ulcers.
- Each ward had a daily 'safety huddle', to highlight safety issues such as patients at risk of falls or pressure ulcers. All staff on the ward were encouraged to attend.

Cleanliness, infection control and hygiene

- Within the medicine directorate there were eight Staphylococcus aureus (MSSA) incidents reported between September 2013 and August 2014. There were 21 Clostridium difficile incidents reported between May and August 2014. There had been no cases of MRSA reported, meeting NHS England's zero tolerance approach.
- Compliance for infection prevention and control training was at 82% for the directorate.
- We observed staff were 'bare below the elbow', used hand gel between patients and used personal protective equipment. However, we witnessed over a 30-minute period on ward 8a four staff members and five visitors enter the ward unchallenged without washing their hands or using alcohol gel.
- The nurse in charge on the medical day unit told us that they had requested a matron to complete a 'walk around' checklist, to audit safety aspects such as cleanliness, infection control and patient safety. Results showed compliance in all areas; one matron had commented on the checklist: "Excellent team working, uniform policy adherence and feedback from patients".

Environment and equipment

- The wards were well lit, clean and tidy.
- Equipment was clean and functional. Items were labelled with the last service date and some equipment had decontamination status labels that identified when equipment was cleaned.
- We inspected five resuscitation trolleys and saw they were centrally located, clean and that defibrillators had been serviced. We saw a healthcare assistant checking the resuscitation trolley on ward 8a following its use to ensure there was adequate equipment.
- For two out of the five resuscitation trolleys we checked, staff had not documented daily equipment testing (Elgar House, ward 3 and ward 7a) to ensure equipment was fit-for-purpose. Intravenous fluids stored on three trolleys (two in Elgar House and one on ward 9a) were not locked away and therefore not appropriately stored. We reported this to nursing staff.
- We found three open equipment store rooms, two in Elgar House and one outside renal day case. This meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.
- We found out-of-date equipment, including a muscle biopsy needle pack and sterile examination gloves on ward 7a. We reported these to nursing staff, who disposed of the equipment.
- Doctors told us that each ward stored equipment in a way that meant it was not easily accessible and this delayed procedures. For example, they told us that to assemble a lumbar puncture kit was a "nightmare" because they needed to source equipment from three different locations across the hospital from different wards.
- When we visited endoscopy, staff told us that two of the five sterilisers were out of order due to water problems, causing high cost filters to be regularly changed. Incident reports showed that the steriliser had failed six times between May and August 2014. This impacted on service delivery and meant that some patient procedures were delayed or cancelled because of the unavailability of sterilised scopes. One incident report noted that this issue had been raised at trust level with infection control and general managers and was on the trust risk register, however it had not been highlighted on the directorate risk register.
- The trust had conducted waste audits for the Elgar House wards in May 2014, which identified issues regarding waste facilities, such as clinical waste bins. There were associated action plans and during our inspection we found no issues with the waste facilities on these wards. We saw a waste audit calendar with the date of planned audits across the trust. However, only 69% of staff in the medical directorate had complied with mandatory waste handling training.

Medicines

- A pharmacist visited all wards each week day. We saw the pharmacist completed the necessary medicines reconciliation and ensured that patients were taking the correct medications and that records were up to date.

- We saw minutes of the July 2014 medical directorate clinical governance meeting, which highlighted a pharmacy safety alert that drug cupboards were not closed or locked on wards and asked attendees to action this through their teams. However, we found prescription medicines such as intravenous fluids and glyceryl trinitrate (used to treat angina and heart failure) on both wards in Elgar House that were not appropriately stored in locked facilities. We reported this to the nurse in charge and the chief pharmacist. Despite this, when we revisited ward three on our unannounced inspection, there was an open box in the medication area containing medicines such as omeprazole (a drug used in the treatment of dyspepsia and gastro-oesophageal reflux disease). We reported this in our trust-level feedback.
- The medicines refrigerator on Elgar House ward three was not secure because the lock had broken. Temperature records showed that the refrigerator had been slightly below the recommended minimum temperature for storing medicines for the three days before our visit. This meant staff could not be sure the medicines had been stored safely during this time, which could put patients at risk. We reported this to the chief pharmacist.
- We found IV fluids and haemodialysis fluid stored in an unlocked room outside the renal day unit, accessible from a public corridor. We reported this to a nurse who said that the store room was never locked because it was easier for staff to access the fluids. This meant the fluids were not stored securely and were at risk of theft, damage or misuse.
- We looked at the prescription and medicine administration records for 23 patients on five wards (28b, 27b, 25b, Elgar 3 and Elgar 4). If people were allergic to any medicines, this was recorded on their prescription chart. We saw 'Get it on time' stickers on a prescription chart for a patient with Parkinson's disease to highlight the need to administer medication at specific times and we saw evidence that this happened.
- Staff were meant to record when they had given patients their medication and record the reason why a medicine had not been given. However, we found incidents when medication had been given but not been signed for, and when patients had not received their prescribed medication. On ward 28b we found a patient had missed a hydrocortisone injection (hydrocortisone is a synthetic steroid with an anti-inflammatory effect). We reported this to the ward pharmacist. On ward 28b two medicines for a patient had not been signed for the day we visited. The nurse on duty confirmed that they had given the medicine but had not signed the record. This meant that prescription and medicine administration records were not always accurate.
- Doctors told us that they thought the prescription charts could be difficult to read and a nurse told us that an incident had occurred that they attributed to the difficulty in reading the chart. A senior nurse told us that they had been using the chart for a number of years and was familiar with it, but accepted that the chart could be quite challenging for new nurses on the ward. These views on the prescription and medication records were not consistent with staff in other areas of the hospital.
- Medicines trolleys were introduced to the Brunel wards during the week of our inspection. They facilitated the secure transportation of medicines across the ward. One nurse told us the trolleys had made the process of administering medicines more efficient by reducing the time taken to complete the drug round.
- Nursing staff told us there could be a delay in obtaining medicines for patients awaiting discharge from hospital. This was a particular issue when medicines were provided in a medicines compliance aid (a tool used when patients needed extra support with taking their medicines correctly). Therefore, nursing staff would have to try to order these before 10am to aim to get them before patients were discharged. However, if discharge had not been confirmed by 10am, obtaining medications in compliance aids could delay the discharge.

Records

- Most patient care plans were up to date. All healthcare professionals used the medical notes to record patient care.
- There were temporary paper medical notes used on most Brunel wards, which staff told us were later filed into the patient's permanent set of medical notes. Temporary notes were not always in chronological order and not bound together; there was a risk of individual record sheets falling out of the folder. A junior doctor told us that they often spent a significant amount of time putting notes back in chronological order when asked to review a patient. A ward clerk told us that temporary medical notes were not tracked and there

had been occasions when notes had gone missing. We saw incident reports since May 2014 that correlated to missing medical notes and missing prescription drug cards.
- The renal department had electronic patient records, which were shared across all satellite renal clinics. The system recorded the patient's choice of treatment, their treatment plan and, where appropriate, their preferred place of death.

Safeguarding

- Safeguarding training had 79% compliance by staff within the medicine directorate. However, senior clinical staff such as consultants had 61% compliance and nursing sisters had a 55% training compliance rate. This placed patients at risk because there were not enough suitably skilled clinical staff to identify and raise safeguarding alerts.
- Nursing staff were aware of what to do if they had a safeguarding concern.
- We saw a safeguarding alert raised for a patient with learning disabilities whose discharge had been consistently delayed due to inadequate social care packages.

Mandatory training

- Overall there was a 72% compliance with mandatory training for staff in the directorate of medicine. This did not meet the trust's 85% target.
- In October 2014 annual resuscitation training had 75% staff compliance within the medical directorate. In particular, only 50% of consultants in specialist medicine and 64% in acute medicine had been trained. This meant that a significant number of staff had not received any life support training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.
- Bank staff had 100% compliance for all mandatory training, except information governance, pure blood transfusion and dementia training, where they had received no training.

Assessing and responding to patient risk

- We saw clinical risk assessments were completed for each patient. These included assessments for pressure ulcers, nutrition and mobility. However, we found three patients on ward 27b who were waiting for risk assessments 12 hours after being admitted to the ward. Nursing staff told us this was because there were not enough nurses on duty to meet the six-hour target for assessment completion. This meant risk assessments were not always done in a timely manner.
- The trust's September 2014 Early Warning Score and Oxygen Audit showed that 100% of medical notes reviewed on medical wards had documentation to indicate that patients with an Early Warning Score greater or equal to four had been escalated.
- There was a 'hub system', where an electronic system recorded and tracked the status of medical patients referred from sources such as local GPs, who were waiting to be admitted to medicine. Referrals could also be from staff within the trust who had identified deteriorating patients. Patient names were entered into an online clinical information system, which was available on the trust intranet. However, the system was not always updated in a timely manner to reflect the patient's current location. Junior doctors told us that patients who had been referred by GPs were not always updated on the system as having arrived into the hospital, leading to delays in their initial assessment. Furthermore, even though there was a section on the clinical information system allowing entry of an Early Warning Score, we found no evidence of this section being used. A medical registrar told us that because of these issues, it was difficult to prioritise patients; therefore, most patients were treated in chronological order by when they were referred. This meant that medical staff could not adequately assess and prioritise patients.
- Elgar House was located away from the main Brunel building. An Elgar House consultant assessed patients referred from Brunel to ensure Elgar House's facilities could meet the needs of patients. Staff told us that if patients deteriorated during their Elgar House admission, they were transferred back to Brunel to ensure services such as the cardiac arrest team were located nearby. We saw a generic risk assessment for patients who may go into cardiac arrest in Elgar House.
- There were two telemetry rooms on ward 7a. Patients were under 24-hour monitoring by a healthcare assistant located outside the rooms with computer equipment that recognised when a patient seizure may occur. The healthcare assistant told us that there was additional equipment in these patient rooms to ensure prompt response to seizures.

Medical care (including older people's care)

Nursing staffing

- The Deputy Director of Nursing produced a safe nurse staffing assurance report to the trust board every six months. The trust used guidance from the National Quality Board (November 2013), National Institute for Health and Care Excellence (NICE; 'Safe staffing for nursing in adult inpatient wards in acute hospital' (July 2014) and the Shelford Groups Safer Nursing Care Tool (an acuity and dependency tool) to plan the nursing establishment and skill mix. The planned skill mix included supervisory sisters, ward administrators and receptionists, with the intention of releasing nurses to provide patient care. This meant planned staffing was one qualified nurse per eight patients on a day shift and a minimum skill-mix registered nurse and healthcare professional ratio of 60/40.
- The October safe nurse staffing assurance report highlighted the two Elgar House wards did not meet the required registered nurse staffing levels and 11 wards in the trust did not reach the expected skill mix.
- We saw wards that were not staffed as planned. For example, ward 9a was one qualified nurse short for the early and late shift when we visited. They had been given an additional healthcare assistant for the late shift, but this left a shortfall in the ward skill mix.
- When we visited ward 8a, they were a qualified nurse short for the night shift; the manager told us that they had requested a bank nurse to cover the shift, but that they did not know if this would be filled.
- We saw evidence of nurse staffing levels reflecting higher dependency patients on some wards. For example, we saw evidence of a staffing-level review for ward 27b where nursing staff levels had increased due to high-dependency patients, such as patients requiring non-invasive ventilation, to reflect staffing levels recommended by British Thoracic Society staffing guidance. However, during our unannounced inspection at night, we found one patient on Elgar House ward three who required one-to-one care, but nursing staff told us that there was not enough staff to provide this. This put the patient at risk.
- The directorate integrated performance report August 2014 showed that over the last year staff turnover had increased, mainly with qualified nurses and healthcare assistants. There were vacancies for 8.7 whole-time equivalent (WTE) registered nurses and 4.3 WTE healthcare assistants. Although the use of agency staff had reduced from September 2013 to January 2014, the use of bank staff had risen to over 150 WTE staff per month. There were daily matron meetings to review staffing levels. On ward 8a, a flexible capacity ward, we found a lack of permanent staff. For example, a night shift during our inspection had no permanent nursing staff on the ward; instead, they had bank staff. This meant that staff may not be familiar with the ward and the location of equipment.
- Nurses told us that it was difficult to observe all the patients because of the single rooms. The falls lead reported evidence from root cause analysis that showed there were not enough staff able to observe patients, which had contributed to falls, and the report recommended an urgent review of staffing and acuity of patients.
- We saw nursing handover sheets containing information such as presenting complaints, past medical history and plans for discharge.

Medical staffing

- The medical intake of patients was managed by senior consultants supported by junior physicians.
- The medical outlier team of one consultant and two senior house officers cared for medical patients on non-medical wards. When the consultant was not available, the senior house officers depended on the medical registrar on-call for assistance with deteriorating patients. They reported that the lack of senior support had caused delays in patient procedures.
- Ward doctors reported having no verbal hand over from on-call night doctors, which meant that they did not have an overview of the patients when they came on shift. We saw evidence of a patient who had deteriorated overnight and a decision had been taken by the medical registrar to provide palliative care for this patient. However, this decision was not communicated to the day team and the deterioration was only identified on a routine ward round.

Major incident awareness and training

- The trust had a major incident plan and staff were aware of this.
- There was an escalation plan for occasions when the hospital did not have enough patient beds. Ward procedure rooms were used as inpatient rooms and we saw the procedure room escalation policy on the door

for staff to refer to. Staff on ward 28a told us that this happened on a daily basis, whereas staff on ward 7a told us that they had only used their procedure room twice since May 2014.

- There were three flexible medical capacity wards. These were wards that opened during periods of high bed occupancy, to provide additional beds for patients.

Are medical care services effective?

Requires improvement

The trust performed worse than the national average in the Myocardial Ischaemia National Audit Project Audit 2012/2013 and for the Sentinel Stroke National Audit Programme (April to June 2014) and was in the bottom 20% of respondents for 18 out of 21 patient-related questions in the 2013 National Diabetes Inpatient Audit. We saw evidence-based care and treatment within the trust, such as the seven-day transient ischaemic attack service, which reflected NICE stroke guidance (2008). However, we found care and treatment delivered that was not evidence-based. For example, patients did not receive cancer surveillance in accordance with British Society of Gastroenterologist guidelines. This had been identified in the trust risk register and, although an action plan was in place, this had not been completed. Nursing staff, patients and relatives told us that there were not enough staff to assist patients with their meals and this meant that hot meals were sometimes cold by the time staff were available to help. There was evidence of good multidisciplinary working and most services were working towards a seven-day service, but staff reported a lack of financial and staffing resources to achieve this. We found a patient under a Deprivation of Liberty Safeguard, but there was no evidence of this assessment, monitoring or documentation to state what restrictions the patient was under in the patient's medical notes. This meant that there was no plan to care for this patient regarding Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- There was a transient ischaemic attack seven-day service, in line with NICE stroke guidance (2008). Patients who had symptom onset were able to be seen within 24 hours for specialist assessments and investigations.
- There had been a snapshot audit in June 2014 when six out of seven patients admitted with possible neutropenic sepsis received antibiotics within one hour. This met the National Chemotherapy Advisory Group 2009 guidelines.
- There was no robust coordinated colonoscopy screening mechanism for patients at risk of bowel conditions such as colitis or polyps. This meant that patients were at risk of missing screening and could present later with more advanced diseases such as cancer. A trust audit highlighted that patients did not receive cancer surveillance in accordance with British Society of Gastroenterologist guidelines. A plan was in place to set up a database that allowed clinicians to register patients with at-risk conditions for a follow-up colonoscopy. However, the target date for this was January 2013 and it was still not in place.
- In May 2014 the speech and language therapists completed a clinical audit of compliance with the care plan for oro-pharyngeal dysphagia (a swallowing disorder) because of on going concerns relating to compliance with recommendations. Out of 83 patients audited, the care plan was completed and present for 92% of patients (76); the correct fluids consistency had been given to 96% of patients (79); but only 73% of patients (61) were given the correct food texture. This meant that patients were at risk of being given an incorrect textured food, which increased risk of patient harm. An action plan was in place to increase compliance.
- The food texture categories were based on the Dysphagia Diet Food Texture Descriptors March 2012. We were told by a speech and language therapist that the fluid textures were based on Australian guidance. We saw one patient had been prescribed 'naturally thick fluids, for example, full fat milk', but was drinking white coffee and had squash on their table. We asked the nurse caring for the patient if white coffee was categorised as a 'naturally thick fluid', but the nurse was unsure and would check with a speech and language therapist. This put patients at risk of harm because ward staff were not always aware of what fluids were suitable for patients.
- The Joint Advisory Group on Gastrointestinal Endoscopy had found the service on the Southmead site did not meet the accreditation standards framework such as policies, practices and procedures at the previous

assessment in 2010. However, the service on the Frenchay site did meet the accreditation standards framework. Endoscopy services were to be assessed again in December 2014.

- The trust had implemented 'Intentional Rounding', which was a formal checklist used by staff to check patients every hour, for basic care needs such as toileting and hydration. We found this promoted hourly staff to patient contact, and patients told us they liked this. However, we saw that Intentional Rounding was not always recorded on the care plan; for example, on ward 8a there was no documentation for four hours for one patient; and the record for a patient with Parkinson's Disease on ward 27a was missing documentation for 18 hours over a four-day period. We asked nursing staff about this; they reported sometimes rounds were not always documented, but other times they were too busy to complete rounds.
- We found trust policies and guidelines that were out of date on the intranet, such as catheter and venepuncture policies.

Pain relief

- We saw nurses ask patients if they were in pain, identify the location of the pain and deliver pain-relief medication when necessary.

Nutrition and hydration

- There were protected meal times on medical wards.
- Cold snacks were available for patients outside of meal times.
- We saw two organised meal services on wards 28a and 9a, where healthcare assistants and trained volunteers gathered around the food trolley to take meals to patients. We saw staff ask patients if they needed the toilet before meals and encouraged patients to use the hand wipes provided before eating.
- We saw one meal service on ward 8a which took over 30 minutes with two nurses helping; other staff were available to help, but did not take part. There was no leadership to make the meal service efficient or to prepare patients for the meal.
- Catering assistants told us that they used a 'cook chill' system and that patients were able to choose their lunch time and evening meals in the morning for that day. Nursing staff told us that the patients' first choice was not always available and this reduced their nutritional intake because patients could be served a meal they did not like. Nurses told us that when additional patients were on the ward, for example in the procedure room, no extra meals would be provided and the usual food allocation was to be stretched between more patients.
- One nurse in charge told us that there were not enough staff to assist patients with their meals and this meant hot meals were sometimes cold by the time staff were available to help. A nurse on ward 27b told us that they had thrown away hot food that had gone cold because they could not reheat the food. They had to give patients fortified porridge for a main meal instead. Another nurse commented: "We have to choose between feeding our patients and doing our paperwork". One relative of a patient in Elgar House told us that they had found their relative sat in front of a full tray of lunch that had gone cold because they needed help to eat.
- We audited whether patients had a drink within their reach on several wards and found that 86% of patient could reach a drink. For patients who could drink, we found 15 out of 16 patients audited on ward 8a, 14 out of 17 patients ward 7a and 10 patients out of 12 on ward 9a had drinks within reach.

Patient outcomes

- The overall trust score for the Sentinel Stroke National Audit Programme between April to June 2014 was a 'D'; the score relates to 'A' being the best and 'E' being the worst. This had improved from the 2013 audit. The trust performed better than the national average for patients accessing scans within one hour of the clock starting; and for the proportion of patients who spent at least 90% of their stay on the stroke unit. However, the trust was worse than the national average for admitting patients directly to the acute stroke unit within four hours; for having rehabilitation goals agreed within five days of clock start; and for applicable patients having a continence plan within three weeks of clock start. We spoke with a stroke consultant, who told us that there were plans in place to improve results and we saw these were discussed at stroke specialty meetings.
- The trust participated in the National Heart Failure Audit 2012/13 and the Myocardial Ischaemia National Audit Project (MINAP) 2012/13, with data submitted by both of

the previous hospitals at Southmead and Frenchay. Cardiology staff told us that they felt now the service was on one site, with one specialist team, results would improve.

- In the National Heart Failure Audit the trust performed better than the national average for patients receiving an echocardiogram (an echocardiogram creates images of the heart used in the diagnosis and management of patients with suspected or known heart diseases), but worse for other outcomes such as patients having input from a specialist and being referred to a heart failure liaison team on discharge.
- The Myocardial Ischaemia National Audit Project 2012/13 showed the trust performed worse than the national average for non-ST segment elevation myocardial infarction patients being seen by a cardiologist or a member of their team. The trust had not submitted any data for the thrombolytic door to needle time.
- The trust was worse than the England average for 18 out of 21 patient-related questions in the September 2013 National Diabetes Inpatient Audit; results had deteriorated since 2012. Results indicated issues regarding medication errors, lack of foot care and staff awareness of diabetes. The diabetes team told us that there were plans in place to improve results. For example, they planned that the 'Touch the toes test' (a tool designed to assess sensitivity in feet) recommended by Diabetes UK and a foot care pathway, would be part of the medical assessment clerking sheet for patient admissions when the next batch of sheets were printed. This meant that foot care would be assessed on admission and the pathway would direct treatment. However, for inpatients with diabetes who required specialist foot care, there was no podiatry commissioned service.
- Since April 2014, between 40% and 50% of patients achieved their initial estimated discharge date. This had improved since September 2013 and March 2014 when 30 to 40% of patients achieved their initial estimated discharge date.
- The length of stay for elective patients was variable since September 2013. August 2014 data showed length of stay for patients had reduced to 2.17 days, meeting the trust target. The length of stay for non-elective patients was consistently above six days from September 2013 to August 2014; the target was 5.58 days.

Competent staff

- Staff appraisals across the directorate of medicine were above the trust target of 90%.
- Staff told us that they could access study leave to develop the knowledge and skills.
- Nurses told us that the intention was for ward 8a to care for mainly renal patients, but when we visited 32 out of 34 patients were medical. Nursing staff on ward 8a told us that they had had no training to care for the different patient demographics and needs, and that they were concerned about becoming de-skilled in nursing patients with renal problems.
- Diabetes training was available through the clinical induction programme, eLearning on the intranet and for registered nurses there were monthly diabetes training days.

Multidisciplinary working

- The majority of staff reported good multidisciplinary team working. There were good ward links with specialist services and we saw patients being referred to services such as tissue viability, learning disabilities and radiology.
- There were daily board rounds on wards, where multidisciplinary teams would discuss patients' care and treatment.
- The diabetes team delivered a variety of multidisciplinary clinics, had educational and business team meetings, and had a shared base to promote effective multidisciplinary working.
- There was partnership working between Macmillan Cancer Support and the trust's cancer services. For example, the lead cancer nurse told us about clinical nurse specialist posts that had been funded by Macmillan Cancer Support and that the service followed programmes and guidance developed by Macmillan Cancer Support.

Seven-day services

- Consultants and doctors worked across seven days in medicine.
- The pharmacy was open Monday to Friday 9am to 7pm, and on Saturday and Sunday 10am to 2pm. We spoke with a pharmacist who told us that staff often worked longer than planned hours to arrange medication so that patients could be discharged.

- Physiotherapy provided a six-day service for medicine. Saturday working was implemented to facilitate patient discharge. There was an out-of-hours on-call service for urgent patients, for example patients requiring urgent chest physiotherapy.
- Other allied health professionals told us that they had explored providing a seven-day service, but that financial resources were not available to fund the service.
- The cancer clinical nurse specialist service was Monday to Friday 8am to 6pm, but the lead cancer nurse told us that there was an element of flexible working and staff would work outside of these hours to meet patient needs if necessary.
- The diabetes team worked Monday to Friday 8am to 4pm. They told us that they were considering seven-day working, but staffing resources could not facilitate this because of vacancies.
- Medical day care was open Monday to Friday 8 am to 8pm, Saturday and Sunday 9am to 1pm.

Access to information

- There was no system in place for patients admitted with diseases such as cancer or diabetes to be automatically flagged to specialist teams. Patients could be referred by ward staff using the electronic referral system, but this relied on staff identifying relevant patients and making referrals. Specialist teams told us that appropriate patients were not always referred. This meant specialist teams needed to visit wards daily to identify relevant patients or trawl through the patient electronic system to identify patients already known to their services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Compliance for mental capacity and Deprivation of Liberty Safeguard (DoLs) training was 76% in the medicine directorate.
- There was a patient who had been transferred to ward three in Elgar House under DoLs because of a high risk of falls. We asked to see the DoLs documentation but the nurse was unable to locate any evidence of DoLs in the patient's medical notes. We were concerned that there was no evidence of a DoLs assessment, monitoring or documentation to state what restrictions the patient was under. We reported this at trust executive level. We received information after the inspection that it had been determined that patient in fact had mental capacity to make their own decision on this issue and therefore DoLS was not applicable. We were concerned that the staff on the ward were not aware of this.
- We saw the Montreal Cognitive Assessment tool used to assess cognitive impairment. An occupational therapist told us that the staff member who knew the patient the most would aim to complete the tool to promote continuity of care.
- We saw a mental capacity assessment completed by a consultant seven days after it was recommended by a learning disability liaison nurse. This meant that assessments were not always completed in a timely manner. There had been a best interest meeting for the patient to discuss discharge options.

Are medical care services caring?

Good

We saw patients were treated with compassion and respect. All of the patients we spoke with told us they were happy with the care provided by staff. However, some patients had identified that nurses were busy and that this affected the care delivered. We saw staff explaining to patients and their families the treatment and care planned and delivered. Most patients felt that they were given enough information about their condition and treatment and emotional support was offered.

Compassionate care

- Patients were treated with compassion and respect. We saw that patients were asked for consent and spoken with in a respectful way.
- All of the patients we spoke with told us that they were happy with the care provided by staff. Patients told us: "All of the staff are caring", "Staff are very friendly" and "They're well trained and calm in a situation, they work all hours, the patients are important to them". Four patients also commented about staffing levels which they felt affected care delivered, including: "Staff are very busy" and "There are too few nurses and too few healthcare assistants, particularly in terms of help with feeding".
- The directorate of medicine used the Friends and Family Test to capture patient feedback. The last results were

from the previous hospitals at Southmead and Frenchay between April 2013 and April 2014. The trust averaged a 33% response rate, better than the England average, but results showed variable levels of patients stating they would recommend the trust to friends and family.

- We audited if patients could reach their call bell on three wards. We found 11 out of 16 patients audited on ward 8a; 12 out of 17 patients on ward 7a; and eight out of 12 patients on ward 9a were unable to reach their call bell. This meant that 31% of patients were unable to alert staff using the call bell if they needed help.

Understanding and involvement of patients and those close to them

- We saw staff explaining to patients the treatment and care they were delivering. We heard doctors discussing treatment options with patients and asking if they had any questions. For example, a doctor explained to a patient on ward 7a why their medication was being monitored and modified. They reiterated this gently when the patient did not understand, until it was clear that the patient had understood the information.
- The National Inpatient Survey showed that between September 2013 and January 2014, eight out of ten patients felt they were given enough information about their condition and treatment; and seven out of ten felt that they were involved in decisions about their care and treatment.
- We saw evidence of families being involved in patient care and discharge. For example, within the stroke services there were planning meetings involving family members and stroke specialty meetings discussed how communication with patients and their families could improve. One patient in Elgar House commented: "My assessments and care plans have been discussed with my family".
- In the National Cancer Patient Experience Survey 2014 the trust was in the top 20% of trusts for patients' families having the opportunity to talk to a doctor.
- We observed the phone ringing for over five minutes on ward 8a; there was no ward clerk present. Three doctors were stood behind the nursing station during this time; we asked one doctor to answer the phone, who on answering the call referred it to a nurse who was with a patient. The phone call was then put on hold for over 10 minutes. The call was from a patient's relative enquiring about the patient's care. This meant that relatives could not get feedback from staff in a timely manner.

Emotional support

- In the National Cancer Patient Experience Survey 2014, 88% of patients felt they were told sensitively that they had cancer; this put the trust in the top 20% for this question. However, they scored in the bottom 20% of trusts for patients feeling that clinical nurse specialists listened carefully. The trust had an action plan in place to improve cancer patients' experience.
- We saw data that showed the majority of people who visited the National Garden Scheme Macmillan Wellbeing Centre between September and October 2014 wanted to talk to staff about cancer or received counselling support.
- The National Inpatient Survey showed that between September 2013 and January 2014, seven out of 10 patients felt they received enough emotional support from hospital staff. One patient told us "Staff make time for conversations; they're very good".
- Staff told us that they provided emotional peer support for one another and that they could access counselling services provided by the trust if they needed additional support.

Are medical care services responsive?

Requires improvement

There were high levels of bed occupancy and lack of patient flow within the trust. We found medically fit patients across medicine awaiting social care and community health packages. Discharge teams from both local authorities were based within the trust to help facilitate patient discharge. The trust had flow meetings and a daily teleconference between the trust and local organisations that aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge. Further work was required to ensure these aims were achieved. Medical outliers were cared for by a medical outlier team, who had to actively look for medical outliers on each ward as trust tracking systems were not always accurate. They gave us an example of a patient who had missed a medical review for four days and commented that missed patient reviews were not uncommon, which put patients at risk. Patients commented about feeling isolated in single rooms and that

there was a lack of entertainment facilities with the hospital. The National Garden Scheme Macmillan Wellbeing Centre that had recently opened on the Southmead site provided good facilities, advice and support for people, their friends and relatives, living with and beyond a cancer diagnosis.

Service planning and delivery to meet the needs of local people

- The trust took part in a daily teleconference between the trust, University Hospitals Bristol NHS Foundation Trust, the local authorities, the clinical commissioning group, the South Western Ambulance Service NHS Foundation Trust, local community services, including rehabilitation centre and nursing homes. They aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge. Further work was required to ensure these aims were achieved.
- Medical directorate directors told us that they had bi-weekly system flow meetings with the clinical commissioning group to identify issues with flow. Engagement from the local health and social care economy was needed to improve patient flow.
- We observed a trust bed management meeting; these happened three times a day. Immediate decisions were made to manage the bed situation across the trust, including the discussion of medical outliers to ensure they were in the optimum location for care.
- Stroke consultants were contacted by ambulance services if patients who had had a stroke were coming into the hospital. The trust had access to the South West thrombolysis network to provide advice on scans out of hours and emergency consultants and registrars were trained to deliver thrombolysis. This meant that staff could gain access to information to plan service delivery.

Access and flow

- During our inspection the trust's bed occupancy was 92%. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally.
- There were more medical inpatients than there were medical beds. This was managed by using beds on the surgical wards for medical patients. Medical outliers were cared for by a medical outlier team and consultant-led wards rounds happened three times a week, but nursing care varied between medical and surgical nursing staff.
- Daily bed reports highlighted the number of outliers. There were 42 and 37 patient outliers on two days of our inspection. The outlier team told us that they averaged between 15 and 20 medical outlier patients each day. They told us that they had to actively look for medical outliers on each ward because trust tracking systems, such as the mid-day bed managers list, were not always accurate.
- The outlier team gave us an example of one patient who had missed medical reviews for four days because they had not been referred or identified as being a medical outlier. They commented that patients were missed on a weekly basis due patients not being identified or referred.
- There were discharge teams based within the trust to help facilitate discharge, these teams were made up of social care personnel from Bristol and South Gloucestershire Councils and community health care personnel from Bristol Community Health Community Interest Company (supporting Bristol residents) and Sirona Care and Health Community Interest Company (supporting South Gloucestershire residents). The South Gloucestershire local authority social care teams and the South Gloucestershire rehabilitation team employed by Sirona Care and Health Community Interest Company attended ward board rounds to identify and plan for patients requiring rehabilitation care packages in the South Gloucestershire area.
- On one day of our inspection, directors in the medicine directorate told us that 96 patients had delayed discharges.
- When we visited ward 27a we found 12 patients medically fit for discharge awaiting social care packages. Five were under the Bristol, four South Gloucestershire and three North Somerset councils. We found six patients on ward 8a fit for discharge; on ward 7a there were three patients; on ward 9a five patients; and on ward 9b 15 patients medically fit for discharge awaiting social care packages.
- There was no discharge lounge in the trust. Nursing staff told us that patients waiting for discharge were transferred into the day and quiet rooms on the ward to make a bed available for a patient to be admitted.

However, this meant that there were two patients allocated to one bed and if the discharge failed there would not be enough beds on the ward for all the patients.

- In August 2014 the trust was meeting the 31-day referral to treat cancer target. They were achieving the 62-day target of urgent GP referrals except for lung cancer, where they met 80% of patient referrals.
- The response rate for occupational therapy, dietetic and speech and language therapy had improved compared with the 2013/14 data. On average, between April and October 2014, patients were seen within one day by dietetics, speech and language therapy, and occupational therapy for patients who had had a stroke. For other patients occupational therapy response rate was 2.2 days.
- Medical day care was nurse led, with support from the medical team and with a clinical lead for the service. There were 20 chairs plus four single rooms for patients who required urgent treatment such as IV antibiotics but were fit enough to avoid admission. The unit took most patient referrals by GPs, the acute assessment unit and emergency department. They worked as an admission avoidance service and could see most patients on the day of referral.

Meeting people's individual needs

- There was a learning disabilities liaison nurse to facilitate the care of patients with learning disabilities.
- The diabetes team told us they provided open evenings and transition clinics for young people leaving the paediatric service and entering adult services. This meant patients had the opportunity to meet the adult team before their care was transferred to the adult service.
- In Elgar House there was a patient dining room with a radio and board games for patients to use. Nurses told us that they coordinated some activities and a pianist visited twice a week to play to patients, but they felt more volunteers were needed to help deliver patient activities.
- We saw communication books being used for patients on the stroke ward who struggled to communicate verbally.
- The trust had a dementia awareness team and we saw initiatives by the Alzheimer's Society were in place, such as the 'This is me' booklet, memory cafes and flower signs behind patients' beds to identify and meet the needs of patients living with dementia. The team recognised that the current care could be vastly improved and had started the implementation of a dementia improvement plan outlining countless strategies to improve the care provided for patients with dementia.
- Ward 28a had a DVD player in a women's four-bay room for women to gather and have entertainment. However, for other patients there was a lack of activities or entertainment, and eight patients reported feeling isolated. One patient commented: "There is no television, radio or regular access to newspapers; I don't want to bring in my IPad in case it gets lost".
- Inside Beaufort House on the Southmead site there was a National Garden Scheme Macmillan Wellbeing Centre that opened in September 2014. This was the first Macmillan Wellbeing Centre in the city that provided advice and support to people, their friends and relatives, living with and beyond a cancer diagnosis. People could access help with financial support, information about cancer conditions and treatments, details of support groups, and there were plans to offer complementary therapies. Staff told us that they were motivated to make the centre a hub for people living with cancer and they were beginning to audit feedback from people who dropped into the centre or attended the support groups to monitor their effectiveness.
- Patients felt that their privacy and dignity was respected by staff. However, due to the Brunel building's design, patients in rooms overlooking the atrium could be seen by members of the public in the atrium. There were curtains in the rooms to protect patient privacy, but if these were drawn the patients were isolated in their room.

Learning from complaints and concerns

- The medicine directorate received the second highest number of concerns and complaints in 2013/14; these had increased since 2012/13. Themes, lessons learnt and response times to complaints were discussed in the trust's complaints annual report.
- Minutes of clinical governance speciality meetings showed complaints and compliments were on the rolling agenda

Are medical care services well-led?

Medical care (including older people's care)

Requires improvement

The service had undergone a major change with the move to the Brunel building in May 2014. Wards had been reconfigured and sub-specialties joined together. Staff we spoke with told us that ward staff were starting to work together and gain peer support within their new teams. However, some staff felt the trust was financially focused rather than concentrating on quality of care. Safety and quality improvement, clinical cost effectiveness and patient experience were regular themes in directorate and speciality-level clinical governance meetings. Performance and outcome data was reported and monitored via the service performance dashboard. We saw evidence of public and staff engagement with the trust. Although audits were on going and planned within the trust, we found a lack of innovative proactive practice across medicine.

Vision and strategy for this service

- The service had undergone a major change with the move to the Brunel building in May 2014. Wards had been reconfigured and sub-specialties joined together. Staff we spoke with told us that ward staff were starting to work together and gain peer support within their new teams.
- Teams such as the dementia and diabetes teams demonstrated action plans to improve patient care over the next two years.

Governance, risk management and quality measurement

- Minutes of the medical directorate clinical governance monthly meetings showed that there were discussions and actions planned around safety and quality improvements, clinical and cost effectiveness and patient experience. We also saw that each speciality, for example, gastroenterology, had clinical governance meetings to discuss incidents, quality improvements and patient experience.
- We saw minutes of bi-weekly stroke meetings, where each patient thrombolysed was discussed to reflect on practice and identify how the stroke pathway could be improved. Outcomes were reported through the audit committee.
- We saw minutes of the biweekly cancer delivery meeting, where each service's performance was discussed in terms of targets and also regarding service developments such as clinical pathways and electronic databases.
- Medicine had its own risk register that fed into the corporate register, with appropriate risks recognised across medicine. Staff were aware of the risk register and how to raise a risk to be included on the register.
- Performance and outcome data was reported and monitored through the service performance dashboard.

Leadership of service

- All managers told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Medical directorate directors told us that not all service level agreements within medicine were meeting their agreed targets. They recognised that this could delay patient discharge and told us that they had weekly calls with partners to improve target results.
- Medical directorate directors told us that when there were issues with patient flow across the trust they had daily communication with the executive team and felt able to raise issues with the team.
- Staff were aware of their immediate managers, who were described as visible and approachable. Most staff we spoke with felt supported by their managers.
- Ward sisters worked in a supervisory manner. Matrons were visible and staff told us that they often visited the wards and departments.

Culture within the service

- Staff told us that there was an open culture in which mistakes were openly discussed so that learning could take place.
- Some staff, including doctors and nurses, felt the trust was financially focused rather than concentrating on quality of care. They felt that moving into Brunel had made caring for patients more difficult because of the single rooms.
- Staff sickness levels were consistently above the trusts 4% target for the past 12 months. The trust had identified the flexible capacity and care of the elderly wards as areas of concern with long-term sickness cases. The directorate integrated performance report August 2014 stated that case conferences were being organised with human resources and nursing sisters in these areas to progress sickness management.

Medical care (including older people's care)

Public and staff engagement

- We saw minutes that showed a patient representative had attended the endoscopy users group in September 2014, to provide a service user's view at the meeting. However, we saw no evidence of input from this representative on the minutes or changes implemented due to the patient representative being present.
- Patients and visitors were asked to feed back their experiences of care. We saw 'You said, we did' information displayed outside wards. Improvements suggested were being planned, such as increasing patient meal choice.
- Staff were being consulted and felt listened to regarding the ward refurbishments within Elgar House that were ongoing to promote staff engagement with the project.

Innovation, improvement and sustainability

- Specialist teams told us that they had a patient safety collaboration group that aimed to provide nurses with training on topics such as diabetes, falls and tissue viability. However, the half-day training planned was postponed by the Director of Nursing because staffing resources were not sufficient to release staff to complete training at that time.
- All other staff (excluding nursing) told us that they could access study leave to develop knowledge and skills.
- In the trust's quality improvement and audit progress report May–October 2014, there were 29 registered audits on going or planned within the directorate.
- The Learning and Research Building hosted the UK Renal Registry, part of the Renal Association (a not-for-profit organisation registered with the Charity Commission). The UK Renal Registry collects, analyses and reports on data from 71 adult and 13 paediatric renal centres. Data is published annually and used mainly to audit and benchmark quality of care. Nephrology consultants told us that they were involved in the work of the UK Renal Registry and were proud that the site hosted the database.

Surgery

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

Information about the service

Surgery services at North Bristol NHS Trust were provided at Southmead Hospital. The surgical services previously undertaken at the old Southmead Hospital and Frenchay Hospital were moved to this new purpose-built hospital in May 2014.

There were 24 theatres over two floors. Ten theatres on level two were for day surgery and emergency operations. There were 14 theatres on level three for elective surgery. The trust had a new initiative in place with the use of 'medirooms'. These were individual rooms on each theatre floor. There were 72 medirooms between the two floors. Patients were admitted directly into these rooms before surgery at the pre-admission end of the theatre suites and then recovered in medirooms at the recovery end of the theatre suite. Day case patients could be discharged directly from the medirooms. There were no anaesthetic rooms in theatres; patients were anaesthetised in a designated area in each theatre. In the ward areas there were 24 single rooms with en-suite facilities and two four-bed bays.

Surgery at Southmead Hospital included the following specialities: trauma and orthopaedics, neurosurgery, plastics, burns, general surgery, including breast, gastrointestinal, urology and vascular. The trust is the south-west lead for plastics, neurosciences and major trauma and the tertiary centre for renal transplant and treatment. The majority of data in this report relates to the surgical directorate (unless stated otherwise) which includes; burns, plastics, vascular, general, urology, colorectal and upper gastrointestinal.

The trust as a whole had approximately 49,800 admissions between April 2013 and March 2014. Of these, 27% were emergency, 26% were elective and 47% were day cases.

During this inspection, we visited all the surgical wards, both theatre suites and the sterile supplies department. We spoke with 160 staff, including: theatre managers, head of nursing, matrons, ward sisters, consultants, anaesthetists, doctors, junior doctors and nurses. We also talked with ward clerks, housekeepers, healthcare assistants, pharmacy staff, physiotherapists and occupational therapists and members of the hotel services staff. We spoke with 31 patients and seven of their friends and relatives. We observed care and looked at 31 sets of patient records. We reviewed data provided in advance of the inspection. We received feedback from whistle-blowers about areas for us to inspect. We had four comment cards completed during our inspection.

Surgery

Summary of findings

Surgery services at Southmead Hospital required improvement.

While staff were seen to be caring and compassionate within surgical services, improvement was required in order to make the service safe, effective, responsive and well-led.

Incidents were reported and investigated, but not all staff said they had feedback about them. There had been seven Never Events within surgery and theatres between April 2013 and September 2014. There was evidence that changes to practice had been made.

There were concerns regarding the Sterile Services Department, with equipment not being fit for use or not available when required. This had led to patients' operations being cancelled and the start of theatre lists had been delayed.

Compliance with the WHO surgical safety checklist did not meet the trust's targets. Senior staff felt some of this was because of recording issues and their IT system.

Wards, theatres and departments were clean. However, not all staff in the theatres area were observed to be following the 'bare below the elbow' policy.

Medicines were not always stored securely. Patients were assessed for risk and were monitored for changes in their condition. Concerns were escalated appropriately.

Some of the patient outcomes were worse than the England average for hip fractures. The proportion of patients who developed pressure ulcers was 4.8% compared with the England average of 3%. The mean total length of stay of 25.8 days was significantly higher than the England average of 19 days.

The standardised relative risk of readmission rate was noted to be higher for both elective cases in urology and plastic surgery. For non-elective cases, the standardised relative risk of readmission rate was higher for general surgery.

Not all patients were reviewed by consultants during their stay because some wards had no set timetable for consultant-led ward rounds or did not know when they were coming. Other wards had daily input from consultants.

The vast majority of feedback we received from patients and relatives identified that the staff were kind and gave compassionate care to patients and relatives. Most patients and their relatives had a good understanding of the care and treatment they were receiving. Emotional support was provided for patients and staff.

Bed occupancy levels were high and this impacted on patients waiting for elective surgery. Operations were cancelled and operating lists delayed because of the pressures on beds. At times patients had to stay in recovery overnight.

The flow of patients through the hospital was affected by patients who were medically fit to leave hospital having to wait for social care support. Patients also remained in hospital in some specialities for longer than the England average. The trust was not meeting the target for rebooking all cancelled operations within 28 days. The trust was not meeting the 18-week referral-to-treatment time for trauma and orthopaedics, urology, oral surgery and neurosurgery. The trust did not expect to be meeting the target for the 18-week referral-to-treatment time for urology by the end of the financial year. The trust was continuing to undertake urgent elective orthopaedic spinal surgery and neurosurgery spinal cases but was closed to other spinal cases due to the imbalance between demand and capacity which had resulted in a number of patients waiting over 52 weeks. This was by agreement with NHS England and local commissioners. Systems had been put in place to mitigate clinical risks around the closure.

The surgical directorate had a high number of unresolved complaints. The trust told us they had put in extra resources to address this.

Although members of the executive team reported they had spent time in the services there was some feedback there was little visibility of the executive management team. Staff told us there were forums and meetings for raising issues, but felt nothing had been done about the issues they raised.

Surgery

Are surgery services safe?

Requires improvement

Safety at Southmead hospital requires improvement. Incidents were reported and investigated. However, not all staff received feedback about them. There had been seven Never Events within surgery and theatres April 2013 and September 2014. There was evidence that changes to practice had been made.

There were concerns regarding the Sterile Services Department, with equipment not being fit for use or not available when required. This had led to patients' operations being cancelled and the start of theatre lists had been delayed. Compliance with the WHO surgical safety checklist did not meet the trust's targets. Wards, theatres and departments were clean. Not all staff observed in the theatres area were bare below the elbow. Medicines were not always stored securely. Patients were assessed for risk and were monitored for changes in their condition. Concerns were escalated appropriately. There was confusion on the surgical wards about who was responsible for reviewing medical outliers.

Incidents

- Staff knew how to report incidents and said they were active in reporting all incidents.
- Staff told us that they did not always receive feedback after reporting incidents. One member of staff told us they did not have any valuable feedback about the loss of medication to take home on a ward. The only feedback they received was "it had been looked into and everything was fine". They said they were aware of staff not completing incident forms because they did not receive any useful learning.
- The ward sister and matron received reports of all incidents within their area and these were monitored through their ward key indicators or dashboards. Within the surgical directotate during August 2014 there were 45 patient safety incidents reported and the categories were pressure sores, staffing levels, medication errors and falls. In theatres, which included the medirooms, they had 11 incidents in August 2014. These included issues with equipment (missing or not working) and staffing levels.
- The trust had reported seven Never Events between April 2013 and September 2014. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. All incidents had been thoroughly investigated. Minutes of meetings, for example, core clinical services governance meetings, risk groups and risk safety meetings demonstrated that Never Events had been discussed, areas for improvement identified and actions put in place.
- Learning and changes to practice following Never Events was shared with all staff through a newsletter. We saw copies of the newsletter, which confirmed this. We were told these were e-mailed to all staff and placed in staff areas. However, some staff in theatre were not aware of the newsletters.
- Staff who had been involved in Never Events told us there was support for them, both formally and informally.
- A senior member of staff from the surgical directorate told us about how learning from a Never Event had changed practice in relation to removal of skin lesions. This included the use of photographs taken of the lesion that was to be removed. There had been a further Never Event similar to this one and further suggestions had been made to change their practice, this included clear identification on the photograph of where the lesion was situated on the patient.
- Within the surgical directorate there were a total of 30 incidents reported to the Strategic Executive Information System (STEIS) between July 2013 and July 2014. Ten were categorised as pressure ulcers, five were slips/trips/falls, three were healthcare-acquired infections, two were surgical errors, two outpatients appointment delays and eight were stated as being 'remaining'. Included in the eight remaining were delayed diagnosis, unexpected deaths and equipment failure.
- We were told of an incident on the renal ward where the ice machine used to produce ice to store kidneys awaiting transplant was switched off. This meant that ice was not available when required. Ice was obtained from an alternative source and an incident form was completed.
- Serious incidents in the surgical directorate were discussed at the surgical services directorate

management board meetings for quality. We saw actions were documented in the minutes of the meeting and the member of staff responsible for these was named.

- The ward sister and matron received reports of all incidents within their area and these were monitored through their ward key indicators or dashboards. Within the surgical directorate during the month of August 2014 there were 45 patient safety incidents reported and the categories were pressure sores, staffing levels, medication errors and falls. In theatres, which included the medirooms, they had 11 incidents for August 2014. These included issues with equipment (missing or not working) and staffing levels .
- When there were issues with a set of instruments from Sterile Services Department, theatre staff would complete a non-conformance form. However, there was no evidence that these were returned in a timely way to enable any practice or process issues to be addressed. For example, we reviewed forms that had arrived in Sterile Services Department with incident dates three weeks previously. The non-conformance reporting did not link to the trust's central incident reporting, which affected how themes were collated, lessons learnt, actions taken and issues escalated. However we noted that the trust manages non-conformances with BSI standards and these were reviewed at the Theatres Board. Any themes were identified and actions taken to mitigate any further reoccurrence.

Safety thermometer

- Each surgical ward had a noticeboard outside the ward that included audits related to infection control and venous thromboembolism (VTE) assessments. We visited all the surgical wards and only one ward did not meet the 100% assessment level for VTE. On the 'White Board' on each ward, it was noted which patients had a VTE assessment and two patient notes seen included a paper assessment of VTE as part of the patient's assessment.

Cleanliness, infection control and hygiene

- The theatre and medirooms were clean. Weekly audits were undertaken that included any actions needed to address areas that were not up to the required standard. The plastic and burns ward had a cleaning audit undertaken during one of our inspection days. Their average score was 99.5% compliance with cleanliness; the trust required that all wards exceeded 98%.
- Daily recording forms were completed when medirooms were cleaned. Green stickers were placed on the doors to the medirooms to help staff identify which rooms had been cleaned.
- Patients told us that they found the wards, bathrooms and toilets to be clean. Our observations confirmed this.
- There was a cleaning rota to inform the public of the cleaning standard. Some cleaning staff told us the cleaning expectations were unrealistic and unachievable. This was because of the geographical layout of the wards, the poor communication between nurses and cleaning staff and the lack of supervision of cleaning staff to ensure a good standard was achieved. Cleaning staff also raised concerns that cleaning products were not effective enough to provide the standard expected.
- Surgical equipment was tracked and traced. We saw records of this in patients' notes. This was important in case any issues were identified with patient or the equipment after surgery and they needed to be followed up.
- We observed staff in the theatres area wearing surgical 'scrubs'. The majority of staff were bare below the elbows. However, we did see one registrar and other medical staff wearing watches and an anaesthetist wearing a metal bracelet. We reported this to the matron for theatres.
- Staff confirmed that MRSA screening was undertaken preoperatively for all elective theatre patients. We saw recorded on the white board (where all admissions to the medirooms were recorded) when staff had concerns about the MRSA status of a patient.
- The directorate integrated performance report for core clinical services (which included theatres) from September 2013 to August 2014 stated they had no cases of MRSA in the 48 hours post operatively or Clostridium difficile. The trust provided us with monthly data about the MRSA screening results for elective patients from November 2013 to October 2014. They exceeded their target of 95% of patients being screened for MRSA for each month. For non-elective patients in the same timescale, they met their target of 90% for the first six months and were just under this target for the remaining six months.
- The single rooms allowed for barrier nursing. When this was in place, we saw signs alerting staff and visitors and personal protective equipment was available outside the room.

- Wards had hand-gel dispensers located at the ward entrances and hand-washing facilities; signs encouraged staff and visitors to use them. However, during our unannounced inspection we noted there were no dispensers of alcohol hand gel in the medirooms area on the emergency theatre floor. This was an infection-control risk.
- On the plastic and burns ward we observed staff asking visitors and other staff when they entered the ward if they had washed their hands or used the hand gel.
- The noticeboard outside each ward included infection control rates and hand-wash audits; most were seen to score highly.
- Within surgical directorate the trust target for 85% of staff having completed mandatory training in infection control had not been achieved. Records showed that 82.6% of staff within the surgical directorate had completed training in infection control was and in theatres, 77.9% of staff had completed infection control training Senior staff on the wards and in theatre told us it was the role of the band six or band seven sisters or charge nurses to follow this up with individual staff members.

Environment and equipment

- Some staff told us they were finding it difficult to view all the patients in the medirooms. Staff told us they needed to view all patients to make sure they were safe after theatre, for example maintaining their own airway.
- Some staff in the theatre area raised concerns that the doors were too heavy and that the automatic opening did not always work. We saw on the theatre directorates risk register that theatre doors had been highlighted because there had been 31 injuries and four RIDDOR's (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). The North Bristol NHS Trust theatre newsletter dated October 2014 stated that the theatres management team had set up a technical group to drive actions around a number of snagging issues and doors were highlighted in this.
- We received information of concern that contained photographs of emergency equipment in theatre that was obstructed by other equipment and that showed the defibrillator was not plugged in. They also showed that emergency airway equipment was missing. Equipment in the corridors during theatre days was seen to be obstructing theatre doors. Sockets that were broken were also being used. We were also told that the equipment needed to manage a patient with a difficult airway was separated from the batteries and chargers needed during an emergency situation. During the inspection we saw that the two resuscitation trolleys were checked daily including the defibrillator, with records to confirm this.
- Equipment was stored in designated bay areas in the corridors in theatres.
- The defibrillator machines were checked daily on all the surgical wards. All equipment was maintained and recorded on logs so that the next service date was flagged up.
- There were issues with the service provided by the Sterile Services Department and the equipment it supplied. This ranged from equipment not being available, delays in sterilising equipment quickly enough, and faulty and broken equipment kits. From 13 May 2014 to 21 October 2014, there were 27 incidents recorded when operations were delayed or cancelled because of issues with equipment. We saw an incident report in June 2014 of when a patient who was a relatively high anaesthetic risk had their operation extended by an hour because of a lack of availability of sterile instruments.
- During October 2014 information from the non-conformance forms showed that 25 sets of instruments were reported as contaminated.
- The sterilising of equipment was done off-site. Staff ordered all the sets for patients' surgery the day before, but these were not always delivered in time. They also had a number of sets for various specialities for emergency cases.
- Two consultants told us all theatre packs were opened and checked before patients were sent for because they had no confidence they would contain the correct equipment. This resulted in patient delays, increased costs to the trust and cancellations of patients' surgery because of lack of time.
- During our unannounced inspection we visited theatres. We looked at four equipment stores. In three of them there were a number of surgical sets that were not stored correctly. This was not the recognised storage for Sterile Services Department sets and, because of the amount of other equipment in the stores, they were not easy to access. None of the staff we spoke with were sure why they were there, but thought they might be for emergencies.

- We saw on one ward that a patient with a learning disability and complex mobility and health needs was receiving care. The specialist equipment was available.
- There was a procedure room on each ward. The trust had agreed the use of these rooms as an extra room when required to increase bed capacity. The rooms did not have a toilet or a call bell. A small hand bell was provided to summon assistance if needed. In one instance we saw care being provided with the door open sufficiently to see a naked patient being cared for. Staff rectified this immediately when it was pointed out to them. A ward sister told us they did not like using the procedure rooms for patients because there was no call bell or windows in the door, which made it hard to observe the patient. We saw that in each ward a social space, a day room, was available for patients. However, these rooms and all other single rooms did not have access to a working television or radio for entertainment, orientation or distraction. Wi-Fi, although available free of charge, was not available in all areas of the wards.
- Staff in theatre told us they had equipment available for bariatric patients in the medirooms areas. This included specialist mattresses and beds. We were told they were requested for elective patients in advance and they were able to access this equipment for patients admitted as an emergency.
- The wards had hoists that could lift patients weighing up to 55 stone.
- We were told by staff that the location of some equipment they used was a long distance from the wards. For example, the renal transplant unit needed ice to store kidneys for transplant, but this was stored on the critical care unit. The wheelchair store was outside the emergency department and was a long distance from the wards.
- The portering staff from theatre told us when they were new they shadowed experienced colleagues. They had training in moving and handling and health and safety. They felt they needed more training in heavy lifting and using the trolleys.

Medicines

- We looked at the resuscitation trolleys available on six wards. The medicines were available in sealed boxes ready for use and were all seen to be in date. The drugs trolleys had to be checked daily and this included checking the drug box was there. Records showed this was not consistently done. Routine auditing of these checks had not taken place and so action was not taken to address this shortfall. The staff on one ward told us they only checked their trolley once a month if it was sealed. However, if it had been used, they would then check and re-stock as required.
- Staff told us that there was some delay in dispensing medication to take home on discharge. This was often caused by the need for special dosette boxes, which need extra time to be made up, or delays in prescriptions being written.
- The hospital used a comprehensive prescription and medication administration record chart for patients, which helped the safe administration of medicines.
- Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines. We looked at the prescription and medicine administration records for seven patients on two wards. Appropriate arrangements were in place for recording the administration of medicines. If people were allergic to any medicines, this was recorded on their prescription chart. Most of these records were clear and staff had recorded when they had given patients their medicines and recorded a reason if a medicine had not been given. This meant people were receiving their medicines as prescribed. However, one patient had been prescribed two medicines to be given 'when required' for a particular medical condition. This patient had a plan for the care of this condition, but this did not include any information for staff about how they should use the two medicines. This increased the risk that the patient may not receive the most appropriate treatment.
- We looked at the arrangements for storing medicines on one ward and three areas of theatre. Most medicines were stored safely and securely. However, on one ward some intravenous fluids were not locked away and could be accessible to unauthorised people. We saw controlled drugs were stored and managed appropriately. There was evidence these were regularly checked. Emergency medicines were available for use and there was evidence that these were regularly checked.
- Suitable storage was available for medicines requiring refrigeration. The trust's medicines policy stated 'The refrigerator temperature must be monitored and recorded on a daily basis'. This was to make sure they were in the safe range for storing medicines and would

be fit to use. One medicines refrigerator we saw in theatre had no records of the daily temperature. Staff were not sure whose responsibility it was to check the temperature. This meant that the trust could not be sure these medicines had been stored at the correct temperature and would be safe to use. During our unannounced inspection we saw the medication fridge in the recovery area on level-two emergency floor was locked and we saw evidence of the temperature being checked.

- We spoke with the specialist renal pharmacist and were told that they were included in multidisciplinary meetings and "this had a massive impact on the prioritising of our work". They were included in changes of treatment to ensure patient safety and best interests meetings, and felt well integrated in the renal team. They monitored missed doses of medication and took any learning action needed. They also supported the patient's right to self-medicate when possible, but found this challenging in such an acute speciality.
- We saw on the renal ward that the treatment room was being used for procedures and was not locked. Ampules of lignocaine were accessible on the side and in an unlocked cupboard. This was unsafe because visitors to the ward and patients could access this room. We observed during our inspection on the plastics and burns ward a strip of medication was left out on the nursing station. This was reported to the sister of the ward because this was unsafe since it was by the main entrance to the ward, which meant visitors could have had access to the medication.
- The dashboard results for the plastics and burns ward showed they scored 4% for missed medication doses in August 2014 and none in September 2014. They also scored 5% for medicine reconciliation for September 2014. The trust target for this was 5%.
- During the unannounced inspection we observed in the medirooms recovery area on level two a small box that was overflowing with medicines. These were left unsecured and unattended on the side beneath one of the drug cupboards, which was behind a nurses' station. There were 11 medicines in total, including propofol, noradrenaline, adrenalin and haloperidol. All of these medicines needed to be used under medical supervision. The nurse we spoke with told us these drugs were removed from the cupboard by staff and were there for use in any emergency. There was no standard operating procedure or protocol in place for leaving this medication unsecured. We had received some information before our inspection that that the medication keys were often left unattended. During our unannounced inspection of the level-two emergency theatre suite, we observed keys were stored securely with members of staff.

Records

- Medical records were stored in secure trolleys at the nurses' stations within all wards. Nursing records were held at the bed end and some on the computer system. Medical records accompanied patients to and from theatre. We spoke with a ward clerk who told us they never had any problems with obtaining patient notes. They were usually able to obtain notes the next day after requesting them and the notes tracking system worked well.
- Records were comprehensive and included the details of admission, risk assessments, treatment plans and records of therapies provided. If medical photographs had been taken, consent to the photographs had been given. Preoperative records were seen and this included completed preoperative assessment forms.
- An inter-hospital transfer form was completed when patients were transferred from ward to ward and we saw examples of these in patients' records.
- We observed that important letters were missing from four of the six patient notes for patients who were due for theatre that morning. One of the ward clerks was able to obtain copies, but this delayed the start of the theatre list because the registrar needed to see all patients before surgery.
- A senior member of the mediroom staff told us that records were being stored in lockers for safety until a more secure way of storing them could be found. They also said they encouraged all staff to place notes back in the lockers after using them so they could be found when the patient was transferred to theatre.
- During our unannounced inspection we found patient notes were stored at the reception desk area on level-two emergency theatre suite. We found about 20 sets of patients' notes behind the desk but that were accessible because the door was unlocked. Confidential waste was stored in a box under the desk, which could have been removed.
- A trust confidential waste bin was provided adjacent to the reception area.

Surgery

Surgical Safety

- We observed use of the WHO surgical safety checklist in all theatres. This process was recommended by the National Patient Safety Agency to be used for every patient undergoing any surgical procedure and involves a number of safety checks designed to ensure that staff avoid errors. While we observed the process being completed effectively and in line with trust policy and best practice, when we randomly reviewed three sets of patient notes during our unannounced inspection, we found none of the three WHO checklists were completed correctly. Compliance with the WHO checklists was subject to audit. The theatres dashboard showed the weekly audit rates from 7 September 2014 until 26 October 2014. This was running at 90% to 96%. The target was 100%. The trust board papers for quality and patient safety dated September 2014 reported that compliance for September was 92% and for the year to date compliance was at 91.3%. This was below their planned improvement trajectory of 95%. Actions were recorded to include removing cancelled patients from the figures. This was monitored by the theatres programme board.
- We observed equipment being checked in theatre before the operation started and swab counts being completed. During our unannounced visit we spoke with two anaesthetic nursing team leaders to discuss the WHO checklist. They told us the unit was "all over that" and "really good at it".

Safeguarding

- For the surgical directorate, 83.9% of staff had undertaken safeguarding training. In theatres, 87.7% of all staff had completed safeguarding training. The trust required at least 85% of staff to be up-to-date with training at all times.
- Staff told us they were aware of the policy and procedures for safeguarding and who the safeguarding lead for the trust was. Staff gave us examples when they would make a safeguarding referral, for example, a patient admitted with pressure ulcers from a care home that were not documented or a patient looking unkempt on admission might indicate they couldn't look after themselves.
- Minutes of the surgical services directorate management board meetings for quality demonstrated that safeguarding incidents had been discussed.

Mandatory training

- In the surgical directorate, 75% of all staff had completed fire training, 81.7% health and safety training and 74.6% moving and handling training. For theatres, 69% had completed fire training, 81.5% health and safety training and 77.9% moving and handling training. The trust target was 85%. The senior sisters for the medirooms said that all staff had received specific fire training as part of their induction to working in this area. However some staff had not completed the trust mandatory fire training which was in addition to the local induction training.

Assessing and responding to patient risk

- Patients for elective surgery attended a pre-operative assessment clinic and during this time all the required tests were undertaken, such as MRSA screening and any blood tests. At these clinics any medical or social needs were identified as well as whether the patient needed to be admitted to a ward before their surgery, rather than to the medirooms, for example, if a patient had been taking warfarin they would need to have tests, on the ward, prior to surgery.
- We observed patients being seen by the anaesthetist and surgeon/registrar before their surgery.
- The trust used Early Warning Scores to monitor deteriorating patients. This included the risk of sepsis in patients, which would need urgent treatment. A doctor explained that once a deteriorating patient had been identified with a score of four and above, a request for medical review was made within 15 minutes. A report also had to be completed when a score of four or more was seen so that there was a clear audit trail of actions taken. Access to antibiotics was available for urgent treatment on wards.
- On admission, patients had an assessment for the risk of venous thrombosis. Evidence of the actions taken where risks were identified was recorded. For example, we saw patients had been prescribed anticoagulants or anti-embolism stockings. We observed patients wearing anti-embolism stockings.
- Assessments were undertaken in relation to falls, pressure ulcer risk and nutritional screening. These were completed in all the patient records we examined and some had been reviewed.
- Staff on the renal unit told us that patient procedures were cancelled if clinical risks were not acceptable.

Surgery

- On the first day of our inspection, five wards each had between one and nine medical outliers. These were patients who did not have any surgical treatment needs but had been admitted for medical care. These patients had been placed on the surgical wards to relieve medical ward capacity issues. These patients were mostly assessed to be medically fit for discharge but were waiting for care packages in the community. Their medical care was being provided by either a medical outlier's doctor or by a doctor from a medical ward who would visit the surgical ward each day. We found that no consistent practice was in place for each ward to know who was providing the consultant medical care for these patients. Staff were not all aware of the dedicated outliers medical team and we heard from staff that in two instances patients had not seen a doctor for an extended period of time. One patient had not been seen for four days and the second patient was not seen for nine days. This lack of clarity placed those patients at risk. The trust took action to inform staff of the role of the dedicated outliers medical team immediately after feedback during the inspection.
- Staff told us that some patients for trauma and orthopaedics were admitted directly from the emergency department to their ward and this often took place when the trust was under 'black alert'. Black alert was when the trust had great pressures on their beds and a high number of admissions from the emergency department. These patients usually had not been reviewed by a trauma and orthopaedic doctor to make sure they were under the correct speciality. Doctors we spoke with felt this was unsafe and patients had been placed at risk. They felt the situation had improved recently and the last occasion was two weeks before our inspection when a patient was not reviewed by doctors for a number of days.
- Wards were aware of elective patients transferred to them from the medirooms. The twilight or evening doctor on-call was given a list of patients from the medirooms which they had to input onto a spreadsheet so they were aware of all patients and what wards they were on.

Nursing staffing

- Ward noticeboards included staffing levels achieved for both day and night shifts. These levels varied and showed that levels were between 91% and 100% staffing.
- Staffing levels were mostly one trained nurse and one healthcare assistant to eight patients, but staff confirmed this varied and could be adjusted to cover sickness levels and any increased dependency of patient need. Some wards had lower nurse staffing levels overnight. Staff told us this had been raised by the night staff as a challenge because they were very busy. We saw staff being moved from one ward to another to cover sickness. Staff told us that this would sometimes cause a shortage in staff skills in specific surgical areas. They felt patients were safe, but this was an added pressure on suitably experienced staff to ensure surgical needs were met.
- Staff told us that one of the highest pressures they felt related to managing beds and the movement of patients to enable appropriate admissions. Recruitment in theatres was up to the required establishment numbers, but a number of these were newly qualified staff, therefore the skill mix of experienced to new staff was of concern. The trust recognised this and had practice development roles to support the newly qualified staff. Some staff told us there were times when they felt staffing levels were unsafe for patients, for example, when left alone with no other medical or nursing support to transfer seriously ill or ventilated patients to the critical care unit.
- Some staff told us that staff morale was low in the theatres area.
- The matron explained that before the move to the new Southmead Hospital they undertook a review of the staffing levels using the NHS Benchmarking Network. This resulted in the trust investing extra money for additional staffing.
- Most of the operating department practitioners in theatre were agency staff. We spoke to one, who told us they had been working there for about 18 months and felt they had a good team approach to work and they enjoyed working at Southmead Hospital. Training for operating department practitioners had been stopped a few years ago, this was now starting again, with the first course planned for January 2015, which was hoped would help with recruiting a more permanent workforce.
- The surgical directorate as a whole had used 9.8% agency staff for nursing and 19.8% agency staff for healthcare assistants for July 2014. Theatres had the highest turnover of staff at 15% and the highest sickness rate of 8%.

Surgery

Surgical staffing

- The majority of theatre lists we observed were consultant led. We observed a registrar preparing to undertake a list of what were mostly local anaesthetic operations.
- Staff on some wards, including the rehabilitation ward, did not feel there was a visible consultant presence and access to middle-grade doctors; they felt they were at the bottom of the priority list. There were delays in discharges because of waiting for medicines to take home to be prescribed and notes to be written up to confirm the patients were medically fit for discharge. Only junior F1 and F2 doctors undertook ward rounds and because there were limited nursing staff, a nurse did not attend the ward rounds. The doctors did not consistently feed back to the nurses, who had to look in patients' notes to identify any changes in treatment.

Major incident awareness and training

- Staff were aware of the trust-wide major incident policy. All those we asked knew where to obtain information relating to their role in a major incident. Staff in theatres told us how they would move patients to clear the emergency theatres ready for possible transfers of patients from the major incident. They also told us that senior staff would be contacted at home so they could come to the hospital to direct their own staff groups.

Are surgery services effective?

Requires improvement

In order to be effective, surgical services at Southmead Hospital require improvement. Performance in national audits varied. In the hip fracture audit for 2013/14, the trust was above the national average for the number of patients receiving surgery within 48 hours and for having a review from a senior geriatrician within 72 hours of admission, but performed less well in the number of patients developing pressure ulcers and the length of stay was significantly longer than the England average. The standardised relative risk of readmission rate was noted to be higher for elective cases in urology and plastic surgery. For non-elective cases, the standardised relative risk of readmission rate was higher for general surgery. Not all patients were reviewed by consultants during their stay because some wards had no set timetable for consultant-led ward rounds or did not know when they were coming. Other wards had daily input from consultants.

Evidence-based care and treatment

- The trust participated in national audits, including for surgical-site infection (NICE), hip fractures (the National Hip Fracture Database) and for the national bowel cancer audit.
- Performance in national audits produced varied results. Results from the bowel cancer audit were good and clinical results were above the England average. For example, all patients (100%) were discussed at multidisciplinary meetings, 98.8% were seen by the clinical nurse specialist (England average 87.7%) and 93.4% of CT scans were reported (England average 87.7%). In the hip fracture audit 2013, all patients (100%) were given a falls assessment. The trust fell below the England average rate of patients admitted to orthopaedic care within four hours (17.5% against the England average of 51.6%). The trust also performed above the national average for surgery within 36 hours and pre-operative assessment by a geriatrician, but performed less well for being admitted to orthopaedic care within four hours, for patients developing a pressure ulcer, bone health medication assessment and mean length of acute stay.
- We examined the surgical-site infection rates for the trust. Between April 2014 and June 2014, 134 patients had hip surgery and there were three reported surgical-site infections (2.2%). Between July 2013 and June 2014, 815 patients had hip surgery and there were 20 reported surgical-site infections (2.5%). For all hospitals in the last five years, 233,105 patients had hip surgery and there were 2,766 surgical-site infections (1.2%). The data available indicated the trust had a higher infection rate than the national average. For knee surgery we found between April 2014 and June 2014 that 109 patients had knee surgery and there were six reported surgical-site infections (5.5%). Between July 2013 and June 2014, 616 patients had knee surgery and there were 26 reported surgical-site infections (4.2%). The trust investigated all of the surgical site infections relating to hip and knee surgery and found that the majority were either reported by the patient or in the community and were therefore not a confirmed diagnosis. There was a very low rate of re-admission to

the hospital because of infection following these procedures. In addition the complexity of orthopaedic work from this tertiary referral centre included joints that were known to be infected, which was likely to increase infection rates. For spinal surgery between April 2014 and June 2014, 83 patients had spinal surgery and there was one reported surgical-site infection (1.2%). Between July 2013 and June 2014, 200 patients had spinal surgery and there were two reported surgical-site infections (1.0%). For all hospitals, in the last five years, 39,548 patients had spinal surgery and there were 694 surgical-site infections (1.8%). The data available indicated the trust had a lower infection rate than the national average.

- Enhanced recovery pathways were in place for patients who were undergoing or who had an elective hip or knee replacement and colorectal and urology surgical patients. Patients attended a teaching session several weeks before their surgery and were given a walking stick to practice with at home. A physiotherapist told us they felt the enhanced recovery pathway had fallen "by the wayside" since they had moved to the new hospital. They also felt ward staff awareness had been lost and they essentially had to start again from scratch.

Pain relief

- Care records showed that pain assessments were undertaken and the level of pain relief was monitored to ensure an appropriate level of effectiveness. We spoke with two patients about their pain control; one was taking oral medication and the other was using patient-controlled analgesia. Both felt their pain was well controlled and that staff checked with them frequently to see how they were progressing.
- Staff told us there was a dedicated pain team in the hospital who would come and review patients with chronic or acute pain that was not being managed.

Nutrition and hydration

- We were told patients were offered water up to two hours before surgery in the majority of cases. Some orthopaedic patients were also offered a special carbohydrate drink two hours before surgery. This was also being trialled for burns patients. One patient told us they had been nil by mouth overnight until 5pm. This was because they were told they would be first on the operation list, but were delayed. They also said they only had two slices of toast to eat between Tuesday morning and Thursday morning.
- Each patient was assessed on admission to identify any specific nutrition and hydration needs. This was recorded in the patient's notes and for easy access for staff on the white board on each ward. One patient had been assessed as requiring encouragement with diet.
- Food and fluid charts were in place. One patient had food charts in place because they had been assessed as requiring encouragement. We looked at seven days of these charts. We found that out of the seven days, four days had information missing for some meals and nothing had been written to indicate if the patient had refused meals. This would not have provided staff with a clear picture of this patient's dietary input.
- We had a mixed response to food provision. Some patients felt the food was very good and others felt it wasn't. One patient told us the ward provided them with soup if they couldn't eat what was on the menu. One housekeeper told us the ward they worked on purchased soup out of ward funds for patients. One patient had feedback about their concerns about access to food out of hours. The response confirmed that soup and sandwiches could be provided.
- Some staff felt the food provision was unfair. For example, the first patient had the full choice of five mains and five puddings, but the last patient had to have what was left. This was because the staff would start serving foods at one end of the ward and by the time they reached the other end all choice had gone. Specialist diets could be catered for, for example Halal or gluten free.

Competent staff

- We visited the orthopaedic rehabilitation ward and found that the staff working there were moved between the orthopaedic rehabilitation ward and the stroke rehabilitation ward, because the wards were connected. They also cared for medical outliers and therefore needed to be skilled in three areas. While some skills were transferable, some areas such as the stroke pathways and orthopaedic rehabilitation pathways were specific. This meant that staff skills did not always match the patients they were supporting. Staff said that they were not provided with the support to access the skills they needed. There were only two orthopaedic

trained staff available on the ward to cover day and night shifts and staff were not specifically medically trained to deal with outliers. At times the medical outliers could be acutely unwell.

- We spoke with some newly qualified staff nurses. They told us they felt well supported on their ward. One had been supernumerary for two weeks and worked with more experienced staff.
- Staff in theatre told us they were not able to attend training because of the lack of staff, so they could not update their skills or knowledge. They had concerns about the skill mix; for example, junior and newly qualified staff were not able to be adequately supervised. This was because of the workload and lack of experienced staff. Senior staff in theatres and on one of the wards told us they were due to meet their target for all appraisals to be completed by the end of November 2014.
- A senior house officer had been employed for the urology wards for two months to help manage the increase in pressure and high level of ward work. This had given the trainees extra time for learning and to attend theatre.
- Senior staff in theatres and on the wards were due to meet their target for all appraisals to be completed by the end of November 2014.

Multidisciplinary working

- We spoke with two occupational therapists who felt there was good multidisciplinary working. We observed an occupational therapist in the medirooms with a patient and they told us they worked well with the theatre staff.
- For patients with specialist needs, records showed a multidisciplinary team approach to care.

Seven-day services

- There was physiotherapy cover at the weekends. Patients on the enhanced pathway (for elective hip and knee operations) and patients, who the nursing staff had not been able to mobilise, were all seen by a physiotherapist at weekends.
- Not all consultants did ward rounds. For example, we were told that on the urology ward consultants had no official ward round and would appear on the ward and see one or two patients. The plastics and burns ward had daily consultant input, including out of hours, because they were the tertiary centre for the south west.
- On the trauma and orthopaedic wards the doctors we spoke with told us there were no set times for ward rounds. One doctor told us their consultant did a ward round about twice a week. Other doctors we spoke with also said consultant ward rounds were not set on scheduled days. This was also confirmed by the nursing staff on these wards. The emergency theatre was staffed for 24 hours a day, seven days a week. The renal ward where transplant patients were treated had ward rounds every day, including weekends and bank holidays. A junior doctor and specialist registrar were present on the ward at all times. Renal transplant patients were overseen by the renal medical team with input from the consultant renal surgeons. Staff on the neurosurgery ward said they had daily ward rounds with a specialist registrar and consultants saw patients post operation.
- There was access to out-of-hours pharmacy and imaging.

Access to information

- We saw inter hospital transfer forms for when patients were transferred to other wards. We observed handovers between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief, how the operation and recovery time went.
- We spoke with a discharge nurse who told us they were involved with a patient on one of the surgical wards because they had complex needs. They told us about how they liaised with social care professionals and the family of this patient to help make sure they were discharged safely and all parties were aware of the patient's care needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained appropriately for patients who were able to make decisions about their care or treatment. However, processes were not always followed appropriately for patients who lacked capacity to consent to care or treatment.
- Staff in the theatre showed us the four consent forms they had in place. We found the consent forms for people who had capacity to make decisions were fully completed and signed by the doctor and patient, and risks were documented. However, this was not always the case for those who lacked capacity to make decisions about their care.

Surgery

- On one of the surgical wards we found a consent form was in place for a patient who lacked capacity to consent. We found this had been signed in their best interest by the doctors. It mentioned it was potentially life-threatening if the surgery did not go ahead. The patient was admitted six days before the surgery was to take place. There was no capacity assessment for this patient in relation to the decision to consent for surgery. The ward sister told us the consent form covered this. However, the safeguarding lead for the trust told us there was a more up-to-date consent form and that the one used was out of date: it did not reflect the correct wording to define capacity, and capacity assessments within the form were not compliant with law. The patient had a capacity assessment in relation to their future plans for discharge in place, which was undertaken by a social worker. However, this did not assess whether the patient had capacity to make a decision about the surgical procedure.
- Data relating to staff training indicated that out of 507 staff in the surgical directorate, 386 had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- None of the surgical wards had any patients subject to a Deprivation of Liberty Safeguard during our inspection.
- We received two examples of when patients with capacity to consent had refused or were reluctant to accept care. In one case a family member intervened and provided support and in the other the care was provided despite the patient's objections. This patient had complained to the senior staff about this. They had not had a formal response to their complaint when we spoke with them.

Are surgery services caring?

Good

Surgical services at the Southmead Hospital were caring. The overwhelming majority of feedback from patients, relatives and carers received during the inspection was very positive. They said that staff were kind and gave compassionate care to patients and relatives. This does not negate the validity of the less positive experiences that individuals have reported to the team. Most patients and their relatives had a good understanding of the care and treatment they were receiving. Emotional support was provided.

Compassionate care

- The majority of patients (29 out of 31 patients we spoke with) told us the standard of care they received was "excellent", "so caring" and "amazing". However this does not negate the validity of the less positive experiences reported to us. These included patients feeling lonely in the single rooms and two patients who did not feel they were always treated with compassion.
- Results from the Friends and Family tests were positive. Each ward had their results on their dashboards. The plastics and burns ward was one of the top achievers for response rate in August 2014. They had a response rate of 70% and the majority of responses were that patients were "extremely likely" or "likely" to recommend the ward to family and friends.
- The occupational therapists said they felt the single rooms provided patients with privacy and allowed them plenty of space to work with patients.

Understanding and involvement of patients and those close to them

- Each ward noticeboard included comments from patients and actions taken in the format of "you said… we did…". For example, one ward had patient feedback that they felt isolated and unaware of the time of day. The trust responded "We have bought clocks for each room and the bays".
- Patients confirmed they were involved in the decision making for their treatment. Seven relatives we spoke with also said they were kept up to date with information about their relatives who were receiving treatment. However, one relative felt that none of the care was "joined up".
- We saw examples of the involvement of people close to the patient. For example, for one patient, who was used to the support of a home carer, the hospital enabled a carer to stay on the ward 24 hours a day.

Emotional support

- We visited 'The Sanctuary', a spiritual area available to patients and relatives. We were told that because of the

location of this facility, its use by patients, relatives and staff had greatly increased. Specific requests for spiritual support could be made through the pastoral services and the hospital switchboard.
- Information was available, though not always displayed on the wards, about various support networks or groups that patients could access.
- Staff had access to counselling services provided by the trust after incidents or Never Events.
- Staff provided patients with emotional support, especially after major trauma that resulted in life-changing injuries. Staff said they tried to spend time with patients when they were able to, and talk with them.

Are surgery services responsive?

Requires improvement

Surgical services requires improvement at Southmead Hospital in order to provide a responsive service. Bed occupancy levels were high and this impacted on patients waiting for elective surgery. Operations were cancelled and operating lists delayed because of the pressures on beds. Patients at times had to stay in recovery overnight. The flow of patients through the hospital was affected by patients who were medically fit to leave hospital having to wait for social care support. Patients also remained in hospital in some specialities for longer than the England average. The trust was not meeting the target for rebooking all cancelled operations within 28 days. The trust was not meeting the 18-week referral-to-treatment time for trauma and orthopaedics, urology, oral surgery and neurosurgery. The trust did not expect to be meeting the target for the 18-week referral-to-treatment time for urology by the end of the financial year. The trust was continuing to undertake urgent elective orthopaedic spinal surgery and neurosurgery spinal cases but was closed to other spinal cases due to the imbalance between demand an capacity which had resulted in a number of patients waiting over 52 weeks. This was by agreement with NHS England and local commissioners. Systems had been put in place to mitigate clinical risks around the closure. The surgical directorate had a high number of unresolved complaints. The trust told us they had put in extra resources to address this. Staff had access to translators.

Service planning and delivery to meet the needs of local people

- Delays occurred in operating theatres when the hospital first opened because of issues with the environment. This meant operations were cancelled and patients had to be rebooked. Not all were rebooked within the required timescale of 28 days. Access and flow because of demand for beds had also resulted in cancelled operations. The new medirooms were designed to give patients privacy while recovering from surgery.

Access and flow

- The flow of patients through the hospital was affected by delays in patient discharge to the community. Staff told us this was often caused by patients having to wait for care home placements or care packages in the community. The site bed managers assessed the availability of beds every day within the surgical wards.
- We observed the recovery area on the elective theatre suite in the afternoon of our second day of inspection. There were patients who were delayed in being transferred. Four patients were waiting for beds on the wards and the critical care unit. One day case patient was waiting for refreshments. Staff told us they felt compromised by having to decide between looking after patients waiting for beds and those coming out of theatre.
- We spoke with a patient flow manager who explained about medical outliers on the surgical unit. They told us they tried to make sure patients' elective surgery was not cancelled because of bed issues and it was their role to make sure medical outliers on the surgical unit had an expected discharge time of within one to two days. This was not always met.
- The trust was meeting its 18-week referral-to-treatment time for general surgery, plastic surgery, cardiothoracic surgery and thoracic medicine. It was not meeting these standards for trauma and orthopaedics, urology, oral surgery and neurosurgery. The trust would not be compliant with 18-week referral-to-treatment time for urology by the end of the financial year.
- The trust's integrated performance report for October 2014 stated that, at the end of July 2014, overall 169 patients were waiting for longer than 52 weeks. Of these, 165 were patients waiting for spinal surgery, one for urology and three for orthopaedics. The trust was continuing to undertake urgent elective orthopaedic spinal surgery and neurosurgery spinal cases but was

closed to other spinal cases due to the imbalance between demand an capacity which had resulted in a number of patients waiting over 52 weeks. This was by agreement with NHS England and local commissioners. Systems had been put in place to mitigate clinical risks around the closure.

- Between April 2014 and June 2014, 31 patients had their operations cancelled and they were not treated within 28 days. The trust's integrated performance report for October 2014, using data from September 2014, stated 113 patients had their operations cancelled on the day of surgery. Of these, 53 (47%) were in orthopaedics. Pressure on beds continued to be the main reason for this, causing 53% of all cancellations. Eleven patients did not have their operation rescheduled within 28 days. This included four in general surgery and three in plastic surgery. The cancellations were caused by constraints in capacity and the need to book more clinically urgent patients. No urgent patients had their operations cancelled for a second time.
- The trust average length of stay for patients on elective pathways for trauma and orthopaedics, neurosurgery and urology was higher than the England average by a day. For non-elective patients the trust average length of stay in trauma and orthopaedics was five days more than the England average. However, non-elective neurosurgery was two days less than the England average.
- We asked the trust for details of the length of stay of patients on the interventional radiology suite overnight. They told us 89 patients had an overnight stay, eight patients more than one night and three patients had three or more nights. This was between 1 June 2014 and 31 October 2014.
- One patient told us they had been booked in as an elective patient to stay on the ward. They were also told they would be first on the list. This did not happen and they did not go to theatre until 5pm. They were not told the reason for their delay.
- We looked at discharge planning and reviewed three sets of notes for planned discharges. The notes identified the decision process for discharge and how the patients and their family had been included in the process. There was input from the multidisciplinary team, including social workers and staff in the community, to ensure discharge home was safe.

Meeting people's individual needs

- Patients had access to translation facilities if English was not their first language. This was accessed through the switchboard and interpreters were available for most languages and for those patients needing the assistance of sign language.
- Staff told us specialist diets could be catered for, such as Halal, Kosher and gluten free. However, they said vegan/vegetarians were not accommodated for in the same way. For example, on one of the days of our inspection only four portions of vegan/vegetarian was available. Staff said they tried to keep this for patients who were vegan or vegetarian. If they had more than four patients who were vegan/vegetarian or other patients requested it, there would not be enough food to go around. Staff often had to negotiate with other wards for any leftover suitable food.
- Eight patients told us the response time to getting their call bells answered was slow. Other patients complained to us that at night the call bell system was very loud and was keeping them awake.
- The occupational therapists said they felt the single rooms provided patients with privacy and allowed them plenty of space to work with patients.

Learning from complaints and concerns

- Information was available to patients on how to make a complaint. Each ward had a leaflet available at the main nurses' station, which explained how to raise a concern, complaint or compliment. The leaflet detailed the process for patients to follow and what to do if they were unhappy with the outcome.
- An example of a complaint was passed to us to follow-up and we found that feedback had not been provided to the patient or ward staff. The trust was asked to review this complaint to ensure a conclusion was reached.
- There was a backlog of complaints in the surgery. In October 2014 the surgical directorate had 66 outstanding complaints, as detailed in their surgical directorate clinical governance meeting. Seventeen had plans to be resolved imminently, leaving 49 active complaints; 23 of these were overdue. The main trends for all surgical specialities were: operations cancelled because of: lack of beds, patient notes not being available and availability of equipment. Other issues included the wards being short staffed.

- Extra resources were being made available to respond to these complaints.

Are surgery services well-led?

Requires improvement

Surgical services at Southmead Hospital require improvement in order to be well-led.

Much of the focus for surgery had been on the move to the new building and managing the issues that had arisen as a result of the move. The vision and strategy for the next few years had yet to be fully developed.

Matrons and sisters were visible in the theatres and wards, and in the wards staff reported being well-led. However, in theatres staff expressed some concern with leadership, but some feedback indicated that there was little visibility of the executive management team.

There were forums and meetings in place for raising issues, but staff felt nothing had been done about the issues they raised. There were ongoing issues with the Central Sterile Services Department and equipment, which continued to risk affecting patient safety and the cancellation of operations.

Vision and strategy for this service

- Over the last year the strategy of the trust and surgical directorate had been focused on the successful move into the new building and the new ways of working that were associated with this. The vision and strategy for the next few years had yet to be fully developed. However, there were plans, strategies and tragetories in place which were focused on improving the responsiveness of the service.

Governance, risk management and quality measurement

- Dashboards on each ward enabled the staff to monitor their areas. One ward sister told us they investigated any areas that fell short of the trust's set targets.
- Up-to-date service performance for equipment was monitored by the department's key performance reports, which were produced and reviewed monthly at the department's service heads meeting and were fed back to the medical devices management groups for review.
- The concerns raised about the Central Sterile Services Department and equipment for theatres had been an ongoing issue for a while. This had resulted in cancelled operations and surgeons operating without the correct equipment. This had been recorded on the risk register for surgery and actions were in place to help address it.
- The surgical services directorate had monthly management board meetings for quality and we saw minutes of these meetings. There were specialty meetings, for example, urology. They discussed quality issues that included staffing (both medical and nursing) and waiting times. Significant risks and issues arising were escalated through the monthly surgical services directorate governance meetings to monthly executive board meetings.
- The senior nursing staff in theatre had governance meetings and we saw copies of their minutes.

Leadership of service

- Staff told us that at ward level they felt well-led. Although staff spoke highly of the chief executive, they were unsure how to access the wider board team.
- Staff in theatres felt the local management team were visible, but they felt there was a lack of leadership with staff deviating from standard practice and in some cases standard operating procedures were not in place. For example, where medication was not being stored securely, for the ease of staff access. They felt the executive team did not engage well with staff and were not visible and had not accepted the difficulties with the lack of available beds.
- The staff on one of the surgical wards felt the management above ward level were responsive to change. For example, they put in a proposal for an extra nurse and this was agreed to.

Culture within the service

- Some staff in theatres felt there was a lack of appreciation of their work and they also spoke of bullying and pressure to get the work done. They also told us they felt their line managers did not respond to their concerns or even acknowledge them. Other staff felt able to speak to their ward sister or matron if they had any concerns.
- We spoke with two clinicians from theatre who felt no actions had been taken regarding the issue with the Central Sterile Services Department. They said forums and meetings for raising issues were in place, but felt nothing had been done.

Surgery

Public and staff engagement

- The trust was in line with the England average on indicators in the inpatient survey. Patients were able to give their feedback through the Friends and Family Test. We saw results of these outside the wards, which were mainly positive. They also included comments from patients.
- In the staff survey the trust was in the bottom 30% for three indicators, two of which they had corrected. These were health and safety and equality training. The trust was in the top 20% for two indicators, including appraisals.
- Four staff told us about the "Friday Five" e-mail from the CEO, which they read. Staff told us the move to the new building was very hard work, but most felt the environment was improved. However, they did raise concerns about the distances to walk around the new hospital.

Innovation, improvement and sustainability

- The matrons, clinical directors and senior nurses had plans for the future for theatres and the surgical directorate. The focus at this time was dealing with the priorities of meeting targets for patients who had their operation cancelled. The ongoing issue with the Central Sterile Services Department and equipment was also affecting this and needed to be addressed quickly. Once these had been addressed, their long-terms plans could be implemented.

Critical care

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

Information about the service

The Southmead Hospital intensive care unit (ICU) is at Gate 37 of the newly built Brunel building. The unit comprises of four separate patient areas called 'pods'. Each pod can accommodate 12 patients, all in individual cubicles. The cubicles have solid walls at the sides with windows with integral blinds between adjoining cubicles. At the time of our visit, the unit could accommodate up to a maximum of 38 patients. Four of the cubicles were not yet open for their intended purpose (to provide isolation) because of issues with ventilation, but were available as 'normal' cubicles. The remaining 10-bed capacity was not being opened until the unit had enough skilled and experienced staff (nursing and allied health professionals) to provide safe care to all 48 patients. The ICU in the Brunel building started admitting patients in mid-May 2014. The first patients were transferred from the trust's previous ICUs in the old Southmead and Frenchay Hospitals. The data and information in this report therefore covers a period of around six months. The case mix programme data from the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS ICUs nationally) was available for just over 200 patients admitted from 14 May 2014 to 30 June 2014. The latest information covering the three months July to September 2014 was not yet released by ICNARC. When we visited ICU, the unit was established to care for up to 17 intensive care patients (described as 'level three') and 21 high-dependency patients (level two). This number could be flexible to accommodate more acutely unwell patients and in the week before our inspection, there were 22 level-three patients on the unit at one point. During this inspection, we visited the ICU in the late afternoon of Tuesday 4 November for a short tour of the unit, and for two and half days during daytime hours from Wednesday 5 to Friday 7 November 2014. We visited the unit again on an unannounced inspection on the evening of Monday 17 November 2014. We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades. We met the unit Matrons (a job-share between two part-time matrons), the consultant director for critical care and lead consultant for governance for the unit. We spoke with physiotherapists, including the unit lead, the lead pharmacist for ICU, the domestic staff, receptionists and the specialist nurses for organ donation. We met one of the dieticians and a speech and language therapist. We met with patients who were able to talk with us, and their friends and relatives. We observed care and looked at records and data.

Critical care

Summary of findings

We have judged the overall performance of critical care as requiring improvement. This was because the unit needed to improve safety and responsiveness. The effectiveness, caring and leadership of the unit was good. The most pressing issue for the safety of the unit was the lack of skill and experience of such an unusually high proportion of the nursing staff, who were new to the unit and critical care nursing. This was the highest priority for the senior staff team. The new critical care unit was designed to accommodate patients in single rooms, called 'cubicles'. There were challenges because of the lack of high visibility of patients. Staff were adapting their practice to ensure all patients had the appropriate safe level of nursing staff with them at all times, but this was not always working as it should. Staff needed to improve incident reporting and demonstrate learning and improvements to practice arising from incidents. Attributed to the weaknesses in the nursing staff skill mix (although the situation was improving) was the relatively high incidence of patient harm. This included falls, pressure ulcers and patients removing their own medical devices. This had been recognised by the unit, escalated to the trust risk register for attention of the board, and actions were being put in place and monitored. Support from specialist staff in falls and pressure ulcer management was being provided. The clinical effectiveness of the unit was good, as were outcomes for patients. Care and treatment was delivered by trained and experienced medical staff, and patients and relatives spoke highly of the unit and its staff. Essential inputs into patient care such as pain relief, nutrition and hydration were managed well. In terms of staff support, appraisal rates for non-medical staff needed to improve to reach minimum trust standards, and staff needed to be released for professional development and clinical education. The care given by staff was good. Patients, their relatives and their friends told us they were happy with the care provided. Staff were described as "excellent" and "kind, polite and considerate". The consultants and doctors were professional, thoughtful and respectful, as were the other healthcare professionals involved with care. The reception staff were caring and made sure they were aware of the needs of patients and their visitors.

The domestic staff greeted patients respectfully. The responsiveness of the unit required improvement because the poor flow of patients through the hospital affected the ability of critical care to respond effectively. Too many out-of-hours discharges, delayed discharges and high bed occupancy affected patients requiring intensive care. A high volume of elective surgery had been cancelled because intensive care or high dependency beds were unavailable. The length of stay for patients was much higher than the NHS national average and not optimal for patient social and psychological wellbeing. We have judged the leadership of the service as good. All the senior staff were committed to their patients, their staff and their unit. There was reasonable evidence and data gathered for senior managers in the unit to base decisions on and drive the service forward. There was, however, room for improvement in the way the data was made available or collected. There was an improving programme of audit in the department, although senior staff were relying at times upon some tasks being carried out, such as, for example, checks of resuscitation equipment, without any assurance it was being done.

There was accountability among all staff for driving through actions and improvements and a strong culture of teamwork and commitment in the critical care unit.

Critical care

Are critical care services safe?

Requires improvement

We have judged the safety of the unit as requiring improvement. Most of the areas of concern were because staff needed to become accustomed to the new environment; the inexperienced skill mix of staff; and lack of supernumerary pod leaders. Attributed to the weaknesses in the nursing staff skill mix (although the situation was improving) was the high incidence of patient harm. This included falls, pressure ulcers and patients removing their own medical devices. This had been recognised by the unit, escalated to the trust risk register for attention of the board, and actions were being put in place and monitored. Support from specialist staff in falls and pressure ulcer management was being provided. Staff were adapting their practice to ensure all patients had the appropriate safe level of nursing staff with them at all times, but this was not always working as it should. This was often because of the number of new nursing staff working on shifts needing support and mentoring, and depended on if there were enough experienced nursing staff on the shifts. Staff were open and honest in their reporting of incidents, but evidence showed not all incidents were being reported. This was partly because some staff were not experienced enough to recognise those incidents that should be reported and did not have sufficient time to complete incident forms. The nursing team had undertaken some trend analysis of incidents, but there was a lack of formal feedback following reporting and investigation of incidents to the risk management team. Patient records were completed well and the risks for deteriorating patients were well managed on the unit. Medicines were generally safely managed, but storage of IV fluids required improvement. The unit was mostly clean. There had been significant problems with staff retention and performance in housekeeping, but this was improving.

Incidents

- Staff were open and honest about incidents they reported. However, staff may not have been reporting all the incidents that occurred. This was partly because some staff were not sufficiently experienced to recognise a reportable incident and they did not always have time to complete incident forms. We reviewed the ICU incident reports within the trust-wide incident reporting system from 1 September 2013 to 31 August 2014. Incidents included medication errors, patients being admitted with pressure ulcers, patients removing medical devices and catering failures or no staff to serve food. Given the rise in falls and pressure ulcers reported to us, we saw very few of these incidents reported. The bed pressures, failures to admit or late discharges on the unit were also not reported as incidents.
- Staff were not getting adequate feedback from incidents. This included nursing staff and physiotherapists. Incidents were reported electronically and were reviewed by local managers and the clinical risk team in the clinical governance directorate, Feedback was expected, however staff described feedback as infrequent and pretty rare. Staff said they did not have a sense of any particular trends in incidents, apart from those discussed at staff safety briefings or staff meetings, such as removal of medical devices, falls and pressure ulcers.
- Patient mortality and morbidity was reviewed and discussed at unit level on a monthly basis. Minutes of the meetings were recorded and distributed. Any actions or learning points arising were allocated to a member of the team to take forward. However, there had been issues at the new hospital site with patient notes not being available in many services. This had included notes of critical care patients required for review for mortality and morbidity meetings. This problem had been escalated to the trust risk register because it related to critical care. Staff reported in early November 2014 that 12 of the 18 sets of notes requested for review had been unavailable. Two sets of notes had also been unavailable before the data from them had been provided to the Intensive Care National Research and Audit Centre (ICNARC) for analysis and comparison.
- Action plans were developed in the unit for serious incidents. One of the recognised more serious incident trends in the department was the increase in the removal of medical devices by patients. This included feeding tubes, tracheostomy tubes, central venous catheters and arterial lines. This had been investigated and an action plan developed by the lead nurses. All staff on the unit recognised this problem had escalated since the move to a unit with single cubicles, and the ratio of new and inexperienced nursing staff. Other identified problems were with faulty window/door blinds causing obstruction to visibility; a change in the patient group/acuity and more neurological patients at

risk of agitation; and central computer screens to monitor patients not being used as intended. These areas were being addressed with various solutions and trials of different equipment. This situation had resulted in staff being set deadlines to achieve competencies and more support for preceptorships. Standard operating procedures were being drawn up for single-room working and dates had been set for review of all the actions.

- There was a health and safety newsletter circulated to staff in September 2014. This highlighted the costs of slips, trips and falls, and reminded staff how to limit these for both patients and staff. There was a two-minute risk assessment for scoring patients against their potential for violence and aggression (although not what to do with the results). The newsletter described the classification of pressure ulcers, and gave advice on handling difficult telephone calls and how to report accidents resulting in injury and get assistance from occupational health.

Safety thermometer

- The unit was experiencing a high level of falls. This had been recognised and was escalated to the trust risk register. The unit had developed an action plan and recognised a number of areas of concern that we also observed or noted from evidence. These included: of 203 nursing staff, 120 were still to complete falls training; of the 22 consultants, only three had completed falls training; the new cubicle environment, coupled with the ratio of new nursing staff was presenting problems with patient visibility; outdated assessment documentation was being used; and ICU was not using the trust-wide post-falls action plan. The action plans to address these areas were appropriate, but the timelines for achieving them were not stated and only review dates were recorded. For example, the action plan that addressed the use of incorrect documentation was to be reviewed only in October 2015.
- Since the unit opened, the incidence of lower category (less harmful) pressure ulcers was increasing, although those in the higher category (more harmful) had fallen. In the year 2013/14 there were 38 category one and two pressure ulcers, and six category three and four. In the six months from April to September 2014, there had been 52 category one and two pressure ulcers, but only one category four (no category three). This rise had been escalated to the trust risk register and an action plan produced. The identified problems were from a lack of specialist pressure-relieving mattresses for all patients; low levels of staff training; inconsistent documentation in relation to skin integrity; and no protocols in use for limiting risks from patients sitting in chairs for too long. There was also not full compliance with training in skin care. As at mid November 2014, 66% of the 176 staff required to undertake training had completed it (and this had been following a drive to get this training completed). This situation was partly because of the number of new nursing staff arriving on the unit in the last few months. Staff were reminded of the need to complete 'skin bundle' (care plans to direct nursing staff to safely manage skin integrity) training and ensure patient records were complete. New measures included the tissue viability nurses putting together a new training package; the number of tissue viability link nurses being increased; and all pressure ulcers were now reviewed between tissue viability nurses and the unit's senior nursing staff.
- There was a high incidence of patients unsafely removing medical devices. Although no comparative data has been published, information from other critical care units indicates this happens from time to time, but not frequently. In this unit in October 2014, 42 patients had removed 67 medical devices (tubes, tracheostomies, venous catheters and lines). This situation had been escalated to the risk register and various actions were being put in place or tested.
- The information provided to us by the trust in terms of patient harm did not present an accurate picture. We asked for evidence of the frequency and number of patient harms. We were supplied with evidence from the trust stating falls in the new unit from May to October 2014 had been zero. However, this was information captured on one day each month (published NHS Situational Reporting data) and if there was no fall in the previous 72 hours to the reporting day, 'zero' data was returned. However, in a unit where most patients were critically ill (or expected to be, although some were fit for discharge from critical care), there were around two falls a month on average and there had been four in both August and September 2014. This data was also used to report on venous thromboembolism and pressure ulcers incidence, and also did not give the full picture, as we saw from more local evidence on the unit.

Critical care

Cleanliness, infection control and hygiene

- ICNARC data from 14 May to 30 June 2014 showed there were some healthcare-associated infections acquired on the unit. ICNARC data reported the patient acquired MRSA on the unit in just below 4% per 100 admissions, although no infections were acquired within blood. For other NHS units, the average level of unit-acquired infections per 100 admissions (non-blood) were just slightly above zero. The safety data displayed on the ward reported there had been no MRSA on the unit for 649 days, so there was a lack of clarity about what this figure actually described in relation to MRSA. There had been no cases of Clostridium difficile since the unit opened.
- The internal hand-hygiene audits had shown unacceptable results over recent months with compliance of 63%, 84% and 80%. The Matrons told us performance was now improving and in the week of our visit it had been 100%. We were told staff were now getting better and more confident in challenging unacceptable practice. There was, however, no audit data collected for the use of personal protective equipment, although we observed good use of gloves and aprons, for example.
- In the majority of the unit, cubicles and equipment used were clean and free from dust. There was, however, some light dust in one of the cubicles marked as clean, specifically under the bed and on the bed frame, and on the tops of the pendants. There was light dust in the central areas behind computers and other equipment. We found two of the four drip stands on one pod had sticky residues on the upright bar. Housekeepers and members of the nursing team cleaned all the equipment in a cubicle when a patient was discharged. The domestic team then cleaned the floors, windows, bathroom facilities, sinks and bed frames. Three of the domestic staff we spoke with said the cleaning products had recently been changed and they were not as good as the previous products.
- Most of the storage areas were well managed to allow effective cleaning. There was, however, some litter under the storage units in the locked IV fluid storage cupboard. The waste-handling area appeared to have not been swept for some time because there was debris and litter on the floor.
- Some design features or solutions made effective cleaning less easy. There had been an issue with the safety of electrical cabling below the central work stations, which was being damaged by metal clinical procedure trolleys being placed under the units (where they were designed to go). Metal strips had been placed under the work stations on the floor to prevent the metal trolleys knocking the covers off the cables. But the metal strips were described as 'dust collectors' and had sharp edges. This had been escalated as a serious safety risk on the risk register.
- There was a shortage of domestic staff and this had been a problem for the unit since opening. There were domestic staff working on the unit each day we visited who were cleaning most areas carefully and meticulously. Some new staff had only recently been employed and were learning the job after training and induction. There were now three staff in post from the four positions funded. Two staff were new and one had returned from long-term absence. There was coverage from domestic staff from 7am to 10pm, but no cover overnight. There was a 24-hour rapid response team in the hospital, although none of the staff we met on our visit had experience of using this service.
- Cleaning standards were checked on a regular basis by the manager of the domestic staff. Nursing staff said the infection control team also reviewed cleaning on the unit. We reviewed the cleaning audit data. We were unable to fully understand the audits and the subsequent scoring. For example, on 1 September 2014, there were 42 'failures' identified by the auditor in pods A and B. However, on the unit 13-week review report, the unit scored 95%. On 9 September 2014, units C and D were audited with only three areas of 'failure'. However, on the score sheet the unit scored 100%. The audit from 10 October 2014 had 32 'failures' in pods A and B but it was unclear how this had been reported on the summary review. The 13-week review report had a score of 100% for pods A and B, but this was dated 13 October 2014 when there did not appear to have been an audit undertaken.
- Patient questionnaires provided evidence of infection prevention and control measures being visible. A questionnaire returned by 53 patients from July to September 2014 had the following results:
  - The ICU team wore aprons and gloves and cleaned their hands before delivering care – 85% of patients agreed or agreed strongly. One patient disagreed and two disagreed strongly. There were, however, no actions recorded in the appropriate section of the report to address these concerns.

- The unit was clean and tidy – 98% of patients agreed or agreed strongly. No patients disagreed.

Environment and equipment

- The unit was built to a high specification. Each patient had a large bed space and separation from other patients, limiting the risk of the transmission of hospital-acquired infections. There was a unit policy of keeping all doors and blinds open when the patient was not receiving intimate care. This was in order to improve the visibility of patients for staff. Each cubicle had an electric bed, although not all had pressure-relieving mattresses because of a shortage. There were appropriate high-backed chairs in each cubicle for patient use. Each cubicle had a toilet and sink for patient use, although this was not en suite, but had a moveable screen. Cubicles also had hand-wash sinks for staff use. Each had soap and paper towels. Each cubicle was expected to have sanitizer gel attached to the end of the bed but we saw a few were missing.
- There was a risk of equipment alarms not being audible. The cubicles had not been tested to ensure the monitor alarms could be easily heard on the unit when the door to a cubicle was closed. We observed one patient who was in a cubicle with the doors closed. This was a ventilated patient (level three) and at the time of our observation no nurse was supporting the patient, although they arrived shortly afterwards. There were no staff in the adjoining cubicle. We asked staff if the monitor alarms could be heard by other staff with the doors closed, and no staff present in the adjoining cubicle. They told us they were not aware of testing being carried out as to whether the monitor alarms could be heard, but with the windows and doors being double-glazed, this was unlikely.
- Patient hoist equipment was of a high standard. The unit had been fitted with ceiling-mounted electric hoisting equipment in each cubicle. Nurses and physiotherapy staff told us of the improvements for both patients and staff in terms of safe manual handling since the installation of this system. The unit had access to beds to accommodate bariatric beds patients when required.
- The unit had sufficient ventilators for patients requiring mechanical invasive or non-invasive ventilation. There were 58 ventilators available and a further five portable electric ventilators. The ventilators and other essential equipment were checked by nursing staff at each handover session. At the time of our visit the ventilators had not been secured to the overhead ceiling-mounted pendants because the pendant was not yet suitable for this purpose. So there were some wires trailing to the electrical sockets, although these were not in the working area. The ventilators were all registered with the biomedical engineering team and records showed they had been serviced, as required, in the last 12 months.
- The unit had sufficient monitors and hemofiltration (renal replacement therapy) equipment. Two of the pods had all new monitors and the other two had monitors transferred from the previous intensive care units. All equipment was on service contracts and managed by the hospital's team of clinical engineers. If equipment had to be removed for repair, it was replaced from the equipment library.
- The unit had appropriate emergency equipment. Each pod had a defibrillator and resuscitation trolley with the specified equipment. Each pod also had a difficult airway trolley with four different sets of kit, depending on the nature of the treatment required. Each resuscitation trolley was to be checked each day by the nursing staff and the difficult airways trolleys were to be checked by the doctors. Checklists were provided for staff to sign when the checks had taken place. We saw there were a number of gaps in the daily checks, and in the first five days of November 2014, two days had already been missed. This included both checks by nurses and doctors. There was also some confusion about what document the doctors signed to indicate the checks and this was not consistent across different pods. We brought this to the attention of the matron and lead consultant. This was dealt with before we ended our visit, and all checks were done consistently. When we returned to the unit unannounced, we found the checklists on three of the four pods we visited were fully completed with the exception, however, of the last two days of checks by the doctors for the difficult airway trolley in pod D.
- Equipment had been serviced and maintained in accordance with the manufacturers' guidance. We were provided with a list of almost 1,100 pieces of kit on the trust's medical equipment list used in the critical care unit. The list showed the serial number of the piece and its description. As at 17 November 2014, all the equipment was recorded as having had planned

maintenance servicing. The list showed when the equipment service was next due, the intervals between services and the risk rating (the importance) of the equipment.

Medicines

- The hospital used a specific prescription and medication administration record chart for patients in the ITU, which helped the safe administration of medicines. Medicine interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines. We looked at three examples of patients' prescription and medicine administration records. Appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. The records showed people were getting their medicines as they had been prescribed.
- Medicines, including those requiring cool storage, were mostly stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. Controlled drugs were stored and managed appropriately. Emergency medicines were available for use and there was evidence these were regularly checked. There were some IV fluids on the unit in open portable trolleys with trays, which were standard storage arrangements within the hospital. These fluids were not placed out of direct sight and there was a risk they could be tampered with. When we visited the unit on our unannounced visit, there were three IV fluids on the top of one of the trolleys (two of which were potassium-based solutions), which was not their designated storage area. On our unannounced visit we saw a large quantity of a medicine prescribed for a specific patient on a work surface in a plastic transparent bag. We were told this medicine had been placed there because it needed to be returned to the pharmacy. There was a pharmacy-return bag next to the medicines, but they had not been placed there. The pharmacist would not be attending the unit until the following morning and there was no system in place to hold these medicines securely until they were collected. The value of these medicines was close to £2,000.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. A specialist pharmacist visited the unit every weekday and attended daily ward rounds to provide support with prescribing and use of medicines. Patients had access to medicines when they needed them and the visit of the pharmacist helped to ensure medicines were used safely. However, we were told when the specialist pharmacist was not available a more basic supply service was provided to the unit.

Records

- Those patient records we reviewed were generally completed well. This included nursing, medical and allied health professional notes. Each patient had standard daily, hourly or periodical observations, as required. These were well recorded. There was documentation around the insertion of medical devices and when they were due for changing. Dates and times of any investigations were recorded. The daily checklists, including the resuscitation checks (airways, breathing, circulation, disability and exposure) were recorded, as well as equipment and IV fluids.
- Standard care plans were used. Most were well completed. This included line management, skin care bundles, catheters and ventilator care bundles. In some of the records we found some gaps and were not always able to see how changes in risk assessments had led to changes in the care plans.
- The hospital had standardised handover documentation when a patient came into critical care or was discharged to a ward. This included risks of patient harm such as pressure ulcers, falls, infection status and mental state. Those we saw for patients admitted to critical care were relatively well completed, although some of the information was greater than the limited space on the form allowed.

Safeguarding

- Most staff had been trained and understood how to recognise and respond in order to safeguard vulnerable people. Mandatory training was delivered and most staff were up to date with their knowledge. The trust required at least 85% of staff to be up to date with training at all times. This made an allowance for staff on long-term sick leave or maternity leave. The nursing staff had exceeded the 85% target for both safeguarding and child protection training. However, one of the four staff described as 'officer' had no training record for safeguarding. All the six clerical staff were fully up to date with both courses. Of the 22 consultants on the unit rota, the majority had completed their safeguarding training. The nurses in charge of the unit knew who to contact within the hospital for both adult and child

safeguarding. Staff were clear about their responsibilities to report abuse, as well as how to do so. We discussed a recent safeguarding referral and met with the trust lead for adult safeguarding during a meeting to discuss a specific relevant case. Staff demonstrated good practice and a safe approach with multidisciplinary input, including from social services, to all referrals.

- The unit had been assessed for risks to patients and staff from violence and aggression. The one area the unit did not comply with was the presence of a panic alarm button, and no comments had been made as to why this was not considered a requirement or had not been installed.

Mandatory training

- Staff training was meeting trust targets in some subjects, but not in others. Among the nursing staff of all grades, training in conflict resolution and safeguarding were the only ones among 16 subjects where over 85% of staff were compliant. Those subjects where none of the nursing staff grades had over 85% compliance with training were falls, venous thromboembolism, pure blood transfusion, food hygiene, waste handling and information governance. There was some confusion around information governance because very few staff were compliant with this course. Although it was on the list of mandatory training, it appeared to be unavailable to staff to complete. In most other subjects, including manual handling, child protection, infection control, resuscitation and mental capacity, nursing staff were slightly below the 85% target. The reason for nursing staff not meeting targets was mainly because of a high number of new band five nurses who had not yet completed their induction and training period. Most of the consultant training was up to date. Falls training, according to the trust training register, was completed by only three of the 22 consultants currently working in the unit, but a session on falls had recently been delivered to around half of the current consultant cohort. This had yet to be updated in the trust training register.
- Other staff training had variable compliance. The unit pharmacist was compliant with all mandatory and statutory training. The dedicated physiotherapists and dieticians were either compliant with almost all the mandatory and statutory training or had achieved over 85% compliance. The only areas for update were resuscitation training for the dieticians, because this was listed as required, but none of the four dedicated staff had completed it. As with the other staff on the unit, the falls training was poorly completed with only two of the 10 dedicated physiotherapists and dieticians having completed it, and this was in 2011/12. Equality and diversity training was also only completed by four of the 10 staff.

Nursing staffing

- Nursing staffing levels were established in terms of physical numbers of staff. But the skills and experience of the nursing team required improvement to ensure a safe and quality service was delivered. At the time of our visit the Matrons said they had now recruited and were employing enough nursing and healthcare staff to meet the Faculty of Intensive Care Medicine Core Standards safe levels for the 38 beds. This included provision of one-to-one nursing care for the most critically ill patients (level three) who required advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. There was provision for one nurse for two level-two patients who required more detailed observation or intervention, including support for a single failing organ system, post-operative care, or were stepping down from level-three care. However, this position had been achieved by employing 75 whole-time equivalent new nursing staff since January 2014. Of the new nursing staff, the proportion of band-five nurses was 60% of that cohort. Nine staff were newly qualified nurses, three staff came from an overseas recruitment drive, and 11 were transferred from the neurological high-dependency unit (patients needing this speciality were now admitted to the general ICU). Only eight of the 75 new staff had previous ICU experience. We examined the position on one pod at random on 5 November 2014. There were five level-three patients (requiring five nurses) and four level-two patients (requiring two nurses). There were seven nurses on duty as required to look after these patients, but no supernumerary nurse acting as clinical coordinator.
- Due to the high proportion of new and inexperienced nursing staff, the unit did not yet have the right levels of skills and experience to provide safe care at all times. This was combined with the environment of the new unit and staff gaining knowledge and experience of how the unit was designed and functioned. As a result, the

unit was limiting the number of beds open on the unit. At the time of our visit, the staffing levels were sufficient to staff up to 42 beds, but the senior management of the unit had recognised how many of these staff required mentoring or training, and had taken the decision not to allow these staff to work without supervision until they were ready to do so. All the staff we spoke with, including eight nursing staff, five consultants, two physiotherapists, and three domestics said staff felt under pressure. Concerns included:
  - Working with different staff and not providing a consistency of mentoring and patient care.
  - Poor retention of staff because of work pressures.
  - New nurses who had no critical care experience not getting the support they needed at all times.
- There was inadequate supernumerary clinical cover from nursing staff. The unit had one supernumerary sister who worked weekdays to support the quality and safety agenda. There were two other supernumerary sisters on each shift covering two pods each. The Faculty of Intensive Care Medicine (FICM) Core Standards for Intensive Care Units (the Core Standards) recommended a total of four supernumerary registered nurses for units with 31–40 beds (no nurse covering more than 10 beds). The unit was therefore short of one supernumerary nurse in the daytime shift. The Core Standards also required units to assess the number of supernumerary nurses needed depending on the size and layout of the unit. The service had not addressed this recommendation from the FICM, considering the potential for risks from the use of separate cubicles for all patients and the risks from reduced visibility.
- To ensure pods (usually nine or 10 beds in use) were supervised, sisters or charge nurses were responsible for a pod on each shift. However, we were unsure of the effectiveness of this. We observed and talked to two of the shift leaders on different days. Each had two patients to look after and both felt they were not able to provide enough support to other staff. The lack of visibility of other patients made this harder for supervisory nursing staff. A number of nursing staff also said the shifts could make them feel isolated, particularly if they were supporting a patient with one-to-one care. They said they were not used to being unable to see other staff and other patients.
- There was use of agency and bank nursing staff, although this had reduced. The last data we were provided with was for September 2014, when the use of agency nursing staff was just over 3%, having dropped from 8% in June and July 2014. The unit therefore did not breach the Faculty of Intensive Care Medicine Core Standards for safe levels of the use of agency nursing staff, which stated the unit should not be staffed by more than 20% of agency nurses at any time. The Matron said the unit had not needed to resort to this level of agency nursing staff on any shifts since the unit opened.
- A number of patients and relatives said the area of most concern in relation to nursing staff was not seeing the same nurse very often. Patients and relatives said this did not mean the care was variable, but they often did not know the nurse and had to become acquainted with a lot of different staff. The Matron said this was a concern that had been recognised.
- Sickness levels among nursing staff were in line with NHS hospital levels of around 5% as an average from May to October 2014.
- Band-three healthcare support workers were trained to level three in a relevant national vocational qualification and were rostered to care for those patients who were fit for discharge, but a bed had not been made available on wards for them to move.
- The turnover rate of staff was relatively high, which was not reducing the problems of adding more new recruits to the nursing team. Of the 75 new staff, 11 had resigned. The turnover of staff on average from May to August 2014 was 13.5%, although there were signs that from October to December 2014 (with staff working their notice) this was slowing down.

Medical staffing

- The ICU was consultant-led. There were two consultant-led ward rounds each day, morning and evening, including weekends, led by the consultant on duty for the pod. Both were formally documented, including handover information for the oncoming shift. There was input to the ward rounds from unit-based staff, including trainee doctors. The nursing input to ward rounds was seen by the consultants as sometimes good, but not consistently present. Other allied healthcare professionals were asked to attend when required. The consultant cover followed the recommendations of the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (the Core Standards). There were 22 consultant anaesthetists

working in rotation in the ICU and on-call. All 22 were intensivists (consultants trained in advanced critical care) and Fellows of the Faculty of Intensive Care Medicine.

- There was good dedication to the unit to ensure consistent and mature skills and experience. There were two intensivists working full time on the unit, and four working one week in five. Eleven consultants worked one week in six and four worked one week in eight. The other consultant, who was also a medical director for the trust, worked shifts at weekends and nights. There was a minimum of 15 programmed activities of consultant time committed to the ICU each week.
- There was full coverage from consultants. ICU consultants were on duty from 7.30am to midnight, seven days a week, with on-call cover from within the group of consultants after midnight to 7.30am. When consultants were on-call, their cover was dedicated to ICU and not extended elsewhere in the hospital. In daytime hours, the consultant covering ICU did not have other clinical commitments.
- There was a good consultant to patient ratio. There was one consultant on duty in the unit for nine to 10 beds (which was significantly better than the Core Standards recommended ratio of one consultant to 15 beds).
- There were 16 trainee doctors on rotation in the department. There was a foundation year one trainee doctor on the unit four days a week. There were at least one or two advanced intensive care medicine trainee doctors who would work one night in six and one weekend on-call alongside the consultants. There was, however, usually only one registrar with advanced airway skills and three non-advanced airway-skilled trainees per shirt. Each trainee would be responsible for a pod on the night shift. If the more experienced registrar was called to assist one of the other trainees, there were times when their pod could be left without a supervising doctor.
- Trainee doctors were well supported, but their numbers were low. There was a reduced level of trainee input from the medical trainee deanery and the placement of medical trainees to the unit was currently limited in number and experience. The number of trainees had dropped of late, and there were now only 15 clinical fellows working in the unit. Of these, three quarters were not trained in advanced airway management. In the August 2014 intake, 14 out of 15 had not been in an intensive care unit before.

Allied health professional staffing

- The unit did not meet the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (the Core Standards) for pharmacy staffing levels. The unit had a dedicated specialist clinical pharmacist, as required, and cover for periods when they were unavailable. However, there was no other pharmacist cover. The Core Standards state there should be 0.1 whole-time equivalent (WTE) 8a grade specialist clinical pharmacists for each level-three bed and for every two level-two bed. The unit had 17 funded level-three beds (although had 22 patients at level-three the week before our visit) and the remainder were levels one or two. If 17 patients were level three and 21 were level two, this would equate to pharmacy cover of 2.75 WTE. The Consultant Director of critical care said one band-seven pharmacist had, however, recently joined.
- The unit did not meet the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (the Core Standards) for physiotherapy staffing levels. The suggested levels of physiotherapy staff in the Core Standards are one WTE physiotherapist for four beds, regardless of patient acuity. The unit was at least one WTE physiotherapist short, and this did not take account of cover provided to over 150 surgical patients and the neurological high-dependency unit. There were, at the time of our visit, no plans for additional recruitment to the physiotherapy team.

Major incident awareness and training

- The trust had major incident plans and procedures. There was a flowchart to follow in the event of an internal critical incident or event, or external major incident alert. This described the duties of various staff in the hospital and external to it, such as the ambulance service and NHS England's local area team. The document provided by the ICU staff had not, however, been updated since the move to the new hospital because the nominated control centre was Frenchay Hospital (now closed).
- There had been major incident simulation exercises. The hospital arranged some desk-top exercises to simulate major incidents and critical care staff had been represented with these each year. The consultant director for ICU and one of the lead intensivists had recently been involved in major incident training. The feedback to staff from these events had, however, been limited.

- There was a standard operating procedure to follow in the event of a major incident. This included procedures relating to staff, premises, processes and providers, and what functions of these were critical or essential in an incident or emergency. The document was, however, only partially completed. The matrons were not fully aware of the standard operating procedures and told us the action cards relating to the role of critical care needed updating.
- There was no regular evacuation drill on the unit. The most recent fire inspection checklist had identified this. No action plan had been developed for this on the most recent checklist or the one before that.

Are critical care services effective?

The clinical effectiveness of the unit was good. Care and treatment was delivered by trained and experienced medical staff and committed nurses. The team included allied health professionals such as physiotherapists, dieticians and speech and language therapists. The service followed national guidelines, practice and directives, although standard operating procedures had yet to be fully developed and implemented. Multidisciplinary team work was excellent, and there was input into patient care from many disciplines. The unit was recording consistently low death rates. The mortality figures also demonstrated there was a lower than expected death rate among patients who had been discharged from critical care. Essential inputs into patient care such as pain relief, nutrition and hydration were managed well. There was strong commitment to organ donation and both the clinical lead and specialist nursing team had raised awareness and increased the success of transplants made available. In terms of staff support, appraisal rates for non-medical staff needed to improve to reach minimum trust standards, and staff needed to be released for professional development and clinical education. This included post-registration qualifications in critical care for nursing staff. There were appropriate processes in place to identify and manage people at risk of abuse and staff were well trained. Consent to care and treatment was provided in line with legislation and guidance. However, there was a framework in place around the use of restraint and how it related to the Deprivation of Liberty Safeguards that did not meet the provisions of the Mental Capacity Act 2008.

Evidence-based care and treatment

- The unit participated in and led on organ-donation work for the trust. The trust had a clinical lead for organ donation, supported by specialist nurses for organ donation who were employed by NHS Blood and Transplant (NHSBT) and based at the hospital. The trust was part of the UK National Organ Donation programme and followed NICE guideline CG135: Organ donation for transplantation. In 2013/14 there had been 22 donors from the hospital who had donated to 54 patients which was the same as the UK national average, and an improvement from 2012/13. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. Involvement of specialist nurses had improved in 2013/14, but was below the national average. The latest unreleased report did, however, show significant improvements in this area. The trust was now committed to working towards the NHSBT 2020 strategy, which was to achieve world-class performance in organ donation by 2020.
- The unit had yet to develop a full set of standard operating procedures, although they were being written. There were no written standard operating procedures, for example, for the criteria for booking ICU beds for elective operations, contingency arrangements, single-cubicle working and admission criteria. There was an agreement that elective operations were booked in the electronic diary, but a number of staff told us this did not always work as expected and there was at least one elective surgery patient not booked into ICU in advance on most days.
- On admission, the physiotherapy team used the recognised Chelsea Critical Care Physical Assessment tool to determine a patient's treatment. It was used to set goals for patients and staff to work towards. The assessment was repeated when a patient's condition changed and formed part of the decision for a patient's discharge from the unit. Patients were treated in accordance with NICE guideline CG83: Rehabilitation after a critical illness.
- The age range of admitted patients was similar to the national average (Source: ICNARC). As with national averages, patients admitted to the unit were predominantly aged in the range 60 to 89 years.
- The unit had an acute respiratory distress syndrome net ventilation protocol. This was observed to be in line with evidenced-based appropriate protocols.

- The average length of stay on the unit was higher than the national average. It is recognised as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. The higher than average length of stay was predominantly for ventilated patients, patients admitted with severe sepsis, emergency surgical admission patients, and patients admitted with trauma, perforation or rupture. The average length of stay for all admissions was seven days, compared with the national average of just over four days. The longer stay was compounded by the lack of ward beds for patients ready for discharge and this can be seen in the high delayed discharge figures.

Pain relief

- There was a consistent approach to pain management. The unit used local protocols for analgesic pain relief, which were overseen by the pain team.
- Pain relief was mostly well managed. Patients we were able to speak with said they had been asked regularly by staff if they were in any pain. People's relatives and friends mostly confirmed patients were checked for any pain, and staff responded promptly to complaints of pain. Two relatives said they were not aware of the patient being asked frequently about pain, and one said "this depends on the nurse as some are better than others". Nursing staff said, and we observed on two occasions, patients who were awake were regularly checked for pain. Pain scores were documented in patient records, using recognised techniques and measures.

Nutrition and hydration

- Nutrition and hydration were effective. Patient records we reviewed were well completed and safe protocols followed. Fluid intake and output was measured, recorded and analysed for appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were prescribed and used for patients who needed them.
- The unit had support from dieticians on weekdays and Saturdays. A dietician was attached to each pod. Nurses said patients were provided with naso-gastric tubes within six hours of admission when a dietician was present. Patients provided with total parenteral nutrition feeding (nutrients supplied through a central line) were supported by a dietician. If a dietician was not on duty (that is out of hours), patients were stabilised until a dietician was on duty. There was, however, no naso-gastric feeding protocol for the unit to follow out of hours. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units required there to be guidelines in place for initiating nutrition support out of hours (ideally designed by the lead ICU dietician). There was no evidence to suggest this was not being done safely and effectively, but there was no protocol either easily available or known about by nursing staff. The education team had just purchased a medical manikin to enable more staff to more quickly achieve their naso-gastric tube insertion competencies.
- The unit had specialist input into dietetics and nutrition. Nutrition care plans were being rolled-out for all patients to identify patients who need supplements. The unit now had a separate ordering process with the kitchens each day to ensure patients' diets were suitable to their changing needs. There was now a wider selection of breakfast options. There was a recently acquired set of sit-on scales to weigh patients and the overhead hoists also had the facility to weigh patients.
- For patients able to take their own fluids, drinks were available on bedside tables and within reach of patients. Unconscious patients had their circulatory volumes continuously monitored by nursing staff through central venous pressure lines.
- A number of patients said they did not enjoy the food. They told us they had experienced limited choice and one patient said they were aware there had not been enough for all patients on one occasion.

Patient outcomes

- The unit collected data to determine patient outcomes with recognised indicators. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC). Participation in a national programme was a recommendation of the Core Standards for Intensive Care Units. Participation provided the unit with data benchmarked against similar units. The data returned was adjusted for the health of the patient on admission to allow the quality of the clinical care provided to come through the results.
- Death-rate ratios were good and below anticipated levels, although there was limited ICNARC data for comparison because the unit had only opened in May 2014. The latest ICNARC Case Mix Programme data covered 14 May to 30 June 2014 and was for 202

patients. Over this time period, the majority of bed occupancy was between 23 and 31 beds as the new unit opened more beds. Unit mortality ratios were below national levels. ICNARC and APACHE II measures of mortality (2013 measures) reported deaths below that of the expected rates. The unit had lower mortality rates than similar units with similar admission levels. Post-unit hospital deaths were low. These were patients who died before ultimate discharge from hospital, excluding those discharged from palliative care. The rate of post-unit deaths in the ICNARC period was 2% against a national average of 7%. Previous ICNARC data for the ICU in the old Southmead Hospital, which had many of the same medical team, also demonstrated low death-rates for the unit and these had consistently fallen over time.

- There was an acceptable rate of patients needing readmission to the unit. The early readmissions to the unit (those readmitted within 48 hours of discharge) for the ICNARC period were just below 2%, which was in line with the national average. The late readmissions (those readmitted later than 48 hours after discharge but within the same hospital stay) was just under 1%, which was below the national average of 3%. In October 2014 there had been just one readmission to the unit.

Competent staff

- Medical staff were evaluated for their competence. The consultants we met said the revalidation programme was well underway. This was a new initiative of the General Medical Council, where doctors were required to demonstrate their competence in a five-year cycle. The consultant director for the unit had just successfully completed their revalidation programme for the current cycle.
- Patient questionnaires provided good evidence of competent medical staff. A questionnaire returned by 53 patients from July to September 2014 had the following result:
  - I was confident in the doctors' ability to provide care – 96% of patients agreed or agreed strongly. No patients disagreed.
- There were insufficient nursing staff with post-registration awards in critical care nursing. Because such a high proportion of the nursing workforce in the service were newly recruited, and most of them did not have a critical care background (and some were newly qualified nurses), less than 50% of nurses had post-registration awards in critical care nursing. Of the 168 nursing staff on the trust training register, in October 2014 only 65 had received some level of critical care training, and some had completed only a single module. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (the Core Standards) recommended a minimum of 50% of nursing staff with this award. At the time of our visit there were no nursing staff registered to train for this award. The Matrons and clinical nurse education team were working to identify and place staff on a university scheme in 2015 onwards. However, senior ICU staff told us there was also no funding available for critical care courses.
- Appraisals for staff were below trust targets. Records as at 24 October 2014 showed 63 (39%) of 162 staff had been appraised by their manager. Of these 162 staff, around 75 were new starters on the unit and most still had to be appraised or were due an appraisal. This list, however, did not appear to be complete, because the current list indicated that 203 staff worked in critical care.
- The Matrons were supported by a sister who was supernumerary to clinical work at all times. This sister had lead roles as recommended by the Core Standards. This included quality and safety, staff sickness, human resources, patient experience and staff development. This was a developing strategy and some aspects of the work were currently a higher priority because of the volume of new staff on the nursing team.
- There was a team of clinical nurse educators. The unit had one band-seven nurse, two band-six nurses and one band-five nurse covering a total of 3.8 whole-time equivalent posts. With the exception of one of these staff, the other clinical nurse educators were rostered into the nursing staff rotas, although this met the guidance of the Core Standards. The nurse education programme in the unit was being developed. At the present time, the educators said it was difficult to release staff for training because of safety issues in relation to staffing numbers. Also, if the unit was less busy, nursing staff were moved to other wards to help out, and time for training, mentoring or development was not captured. A new intranet resource was being developed for critical care staff and workbooks and resources could be downloaded and followed when this was fully operational.
- New staff we met on our visit said they felt well supported, although this was sometimes hard for

experienced staff when the unit was busy. New staff were intended to be supernumerary to the regular staff team for their first month. We met some more experienced new staff, however, who had received only four and five shifts of supernumerary induction. The Core Standards recommend all new staff have a period of supernumerary induction and for experienced staff this would depend on the type and length of previous experience. The more experienced nursing staff said the shorter periods of supernumerary induction were satisfactory. As much as was possible, new and inexperienced nursing staff were allocated across the pods to work alongside experienced staff. Each new member of the nursing staff was given a mentor to work with (although one recently appointed member of staff did not know who their mentor was). The practice nurse educators endeavoured to match new nursing staff with the rotas of their mentors. This could, however, mean some new staff ended up working nights in their first month. The clinical nurse educators told us not all mentoring nursing staff had undertaken mentorship courses.

- There was more to be done in terms of staff development when the unit staffing had more experience and stability. However, the service was currently supporting two of the band-three healthcare support workers to train as assistant practitioners. This involved attending college for a foundation degree one day a week and included ICU competencies training. Study days were provided.

Multidisciplinary working

- There was strong multidisciplinary teamwork within critical care. Physiotherapists, pharmacists, speech and language therapists, microbiologists and dieticians visited the unit regularly. Consultants told us there was a good response from most other specialist teams in the hospital. The neurological surgery team had a regular ward round with consultants and were a consistent presence. The hospital's physicians were not, however, as involved as might be optimal, particularly with patients admitted from the emergency department. There were multidisciplinary team meetings held regularly for long-term patients to discuss realistic goals and action plans. These meetings would be joined by a clinical psychiatrist if appropriate and also included occupational therapists and speech and language therapists, alongside regular unit staff.
- There were consultant-led ward rounds in each of the four pods in the morning and evening attended by the consultant, trainee doctors and nursing staff. The critical care pharmacist would attend one of the ward rounds and then review other patients with the consultants of the other pods as necessary.
- The microbiologist attended the unit each weekday for a formal ward round with the consultants when they reviewed all patients. Any test results on cultures were usually returned by midday the following day. The microbiologist gave advice on treatment of infections and antibiotic prescribing.
- There was regular input from the speech and language therapy team. The consultant director told us they were "very accessible" and "their role is increasing".
- There was a physiotherapist team on the unit, led by a two senior respiratory physiotherapists. The physiotherapy team also covered surgical patients in the hospital, but attended the unit every day, and there was always a member of the team in attendance.
- The critical care team did not extend to an outreach team, as recommended by the Faculty of Intensive Care Medicine Core Standards. This had been highlighted on the trust risk register and a business case for establishing this team was being put together by the matrons.

Seven-day services

- There was mostly good cover from the allied health professionals across the week. Physiotherapists were on-call when not present on the unit. All staff on-call were able to attend the unit within 45 minutes, or, if not, would stay on-site. Although there was always a physiotherapist on-call, they may not always be experienced critical care physiotherapists. On weekends, when the physiotherapists worked Saturday and Sunday from 8am to 5pm, they would prioritise respiratory patients. There was no physiotherapy service scheduled for rehabilitation patients. One of the joint lead-physiotherapists we met said they would provide a service to prioritised rehabilitation patients if time permitted.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition

and hydration, and performing tests were made by the medical and nursing teams. If decisions on more fundamental issues were needed, staff would hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. These would take place with those people who could speak for the patient to hear all the views and opinions on the treatment options. Such discussions were documented in the notes reviewed.

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled. One of the patients we met told us staff had spent time explaining everything that had happened to them since arriving on the unit when at that time they were unconscious. We saw good recording of consent, where patients were able to provide it, recorded in patient notes.
- Staff were using the guidance of the Mental Capacity Act 2005 when assessing if a patient was being or could be deprived of their liberty. The flowchart for deciding if a deprivation of liberty might be taking place followed the provisions of the Mental Capacity Act 2005 as it related to decision-making and capacity to consent. However, the unit and the safeguarding adult lead had been given advice around when to make Deprivation of Liberty Safeguards (DoLS) applications that did not meet the provisions of the legislation. The guidance was in relation to the use of restraint. The guidance stated a DoLS application should be made if a patient had been restrained for seven days. However, the legal position is that an application for a DoLS licence should be made as soon as a patient was assessed as being deprived of their liberty in circumstances deemed outside of normal medical care and treatment. The unit staff had recognised this with one patient who was being sedated for their own safety and the safety of others, and a DoLS application had been made, although not when this was initially assessed, due to the misleading external advice, as it had been interpreted. The flowchart used by the staff to make decisions around use of DoLS in situations of restraint also did not include the need to involve those people who could speak for the patient. This approach would be because the patient had been judged as not having the mental capacity at the time to make a valid decision themselves. There was no other guidance in relation to the safe or correct use of DoLS in other circumstances that might arise.

Are critical care services caring?

Good

The care given by staff was good. Patients, their relatives and their friends told us they were happy with the care provided. Staff were described as “excellent” and “kind, polite and considerate”. Patients were treated with respect and dignity. Patients and relatives were given the information they wanted to have, and staff handled bad news or difficult messages with compassion and understanding. The care we observed from the nursing staff was confident, kind and gentle. There was some psychological support available for patients on the unit, but there were few of the latest innovations in patient support such as patient diaries, follow-up clinic visits, reorientation visits for discharged patients, or memorial services for bereaved families or friends.

Compassionate care

- Patients and relatives we met spoke highly of the service they received. A patient said of care: “they have been really kind” and a relative said: “you cannot fault the staff, they are terrific”. Two patients we spoke with about the night time said the unit was quiet at night and they were able to rest. The lights were dimmed and one patient said “they don’t switch them up either at the crack of dawn, which is great”. We arrived on the unit one morning at 7.30am and saw the lights on the pod we walked past were still dimmed and the pod was quiet and peaceful. When we checked the unit at 10pm on our unannounced visit, each pod had dimmed lights and were quiet and peaceful.
- Patient privacy and dignity was maintained. A relative said the nursing and medical staff were “very thoughtful” with matters relating to privacy and dignity. A patient said “they close the doors when they want to do something, even if that’s just talk with me or my family”. The environment of the new unit meant each patient had their own cubicle, which could be screened from outside and from adjoining rooms with integral blinds. The ward rounds with staff from different

disciplines were done with doors opened, but with a screen placed around the door to the cubicle, to ensure other staff knew where these staff were at all times and they could be alerted to any emergencies.

- The unit was sensitive to patients' and relatives' needs. There were set times for visiting hours to allow patients to rest and staff to undertake ward rounds and observations. However, nursing staff said they would accommodate visitors as much as possible at all times. Relatives confirmed they were respectful of visiting times but staff had been accommodating when a relative or patient was anxious, or when they were first admitted to the unit. Relatives and friends said staff explained when they needed to support the patient and would ask the relative to step outside for a short time. They said the staff told them why this was necessary.
- The care we observed from the nursing, medical staff and allied health professionals was kind, patient and delivered with sensitivity. Nurses talked quietly with patients and reassured them continually. All staff introduced themselves to patients and their visitors. We observed nurses talking to patients and explaining what care they were delivering, even if the patient was not conscious.
- There was cover in daytime hours from a team of receptionists and a ward administrator. There were five receptionists working on the team who were worked in the waiting area at the entrance to the unit. They made sure they were kept informed of all patients admitted to the unit and any important or useful information about visitors coming to the unit. This included checking with medical or nursing staff about permitting visitors to come onto the unit, and whether it was appropriate. They also ensured they were informed if any patients were assessed as approaching the end of their life, or had died, so they could handle visitors (who may or may not know this) with the appropriate compassion.
- Patient questionnaires provided good evidence of compassionate care. Evidence from questionnaires returned by 53 patients from July to September 2014 was positive, demonstrating patients were treated with privacy and dignity, felt safe and well cared for, and consultants were polite and made them feel at ease.

Understanding and involvement of patients and those close to them

- Patients who we were able to talk with said they were involved with their care and decisions taken when they were able to be. Patients knew about their condition, tests and treatment considered. We observed staff giving good explanations of what was happening and including relatives where possible. Staff told us they would make sure any visitors were identified and only gave information to them if they were entitled to have it, or the patient was able to give permission.
- Those patients who were able to provided informed consent to care and treatment. Any changes to treatment or decisions were discussed with those patients who were able to consent. Patients said they were able to ask questions about the risks and benefits of any proposed treatment.
- Patients and relatives said staff asked appropriate questions about the patient to get to know them. This included, for example, what the patient wanted to be called, if they had any specific interests, if they had children or pets, and what foods and drinks they preferred.
- Friends and relatives of patients said they were kept informed and involved with decisions when needed. Relatives we met said they were updated about the patient on each visit to the unit, even if they were very frequent visitors. Relatives said they were asked to comment on treatment and able to ask questions about the risks, benefits and alternatives.
- Patient confidentiality was respected. When we were on the unit we did not overhear information about patients that other patients or visitors could easily hear. Patients and visitors said they had not overheard or seen confidential information about other patients. They said conversations with doctors, nurses or other staff either took place in areas away from patients, or with the doors closed and/or voices lowered.
- Patient questionnaires provided good evidence of patient understanding and involvement. For example, patients agreeing they received good information about their care and treatment in a way they could understand.
- There was a 'You said, we did' noticeboard in the main corridor. This reported on comments from patients, relatives or other visitors about what improvements could be made to the unit. One comment had been around the provision of a child-friendly area in the waiting room, and the poster showed this had been heard and an area had been provided in the waiting area. Another was around the difficulty in getting through on the telephone. There were now reception

staff in the unit from 8am to 8pm. There were telephones in patients' rooms. Relatives and other visitors were told not to be concerned if the telephone was not answered in the room at any time, because this was likely to be for good reasons around patient priorities.

Emotional support

- There was psychological support available on-site and staff from that service would visit patients on request. A number of staff said they were aware of this, but thought they perhaps did not identify patients for whom this would help soon or often enough. The charity Headway, which specialised in head injuries, could be asked for advice, or representatives would visit or be put in touch with patients and families.
- There was currently no formal assessment for patient depression. Long stays in ICUs have indicated patients may get depressed, anxious or have other mental health issues for which they might need additional support.
- The unit did not extend its emotional support to follow-up clinics, reorientation for former patients, patient diaries or memorial services for families of patients who had died on the unit. There were aspirations among staff to look at improved emotional support for patients in the unit, but also those discharged and the families of survivors or those who had died.

Are critical care services responsive?

Requires improvement

The responsiveness of the unit required improvement because the poor flow of patients through the hospital affected the ability of critical care to respond effectively. Too many out-of-hours discharges, delayed discharges and high bed occupancy affected patients requiring intensive care. A high volume of elective surgery had been cancelled because of unavailability of intensive care or high-dependency beds. The length of stay for patients was much higher than the NHS national average and not optimal for patient social and psychological wellbeing. Most patients, their relatives, friends and other visitors were impressed with the physical environment in the new unit. They commented on the privacy and dignity enjoyed in the private cubicles, the calm white décor and the quiet environment. However, some patients commented on the isolation they felt when they were feeling better.

Service planning and delivery to meet the needs of local people

- The problems with access and flow were increased by the unit not being open to its design capacity. The unit had opened in May 2014 and increased beds incrementally and safely with 38 beds open at the time of inspection. This was a decision taken by the leadership of the unit and the hospital trust to ensure care and treatment was provided in line with the resources available.
- There was no system-based process for bed management or overall management and control. Staff in critical care were using information from computer diaries for elective patient bookings, but also paper-based information, and messages and requests from phone calls. The unit's bed-state was not communicated electronically, because there was no system for this, so clinical site managers were required to attend handover meetings in the early morning to understand the situation facing the unit that day. The hospital also had no outreach team, so there was no clear line of communication for possible admissions into the unit of patients deteriorating on the wards.
- There was no unit-designed information leaflet specifically about critical care. The information on the internet was more about the hospital than the unit. The matron accepted this was an area that needed to be improved, especially because of the environment, the amount of equipment and monitors, and facilities patients and relatives could expect.

Meeting people's individual needs

- Patients were treated as individuals. Staff told us they had used translation services for both patients and relatives when English was not spoken or not easily understood. Resources were also available for communication with patients in British Sign Language. There were communication boards for patients with tracheostomies to write messages or point at symbols and images.

- The standard patient discharge form included a section for staff to complete for when a patient had learning disabilities. When this was completed, staff also had to complete a safeguarding alerts form to ensure the hospital team were aware of the patient's move.

Access and flow

- The discharge of patients from the unit was sometimes not done at the optimal time. Studies have shown discharge at night can increase the risk of mortality, disorientate and cause stress to patients, and be detrimental to the handover of the patient. Intensive Care National Audit and Research Centre (ICNARC) data (14 May to 30 June 2014) for discharges made out of hours (between 10pm and 7am) placed the unit worse than the national levels for night-time discharge for similar units. Slightly less than 15% (approximately 30 patients) of all discharges took place at night (against a national average of around 8%). Raw data for October 2014 showed there were 12 discharges made at night. This suggests the rate of night discharges was reducing because this would have been against a higher admissions rate than the ICNARC data (more beds were now open).
- Similar to many critical care units in England, there was a high level of delayed discharge. Over 80% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. Four hours is the indicator used for comparison with other units and set by the Intensive Care National Audit and Research Centre (ICNARC). It is used to demonstrate the ability, or otherwise, to move patients out of critical care in a timely way. Raw data (not yet submitted to ICNARC) from October 2014 showed 39 patients had delayed discharges. Four of these patients were delayed by five days or more. Although patients remained well cared for in ICU when they were medically fit to be discharged elsewhere, the unit was not the best place for them. This was recognised by staff. The unit could also be a difficult place for visitors. A number of visitors we met said they found the equipment and monitors unsettling. One said "it can be a bit scary" and another said "it's keeping [the patient] alive but you don't feel safe sometimes with getting too close in case you mess something up". The relative said staff had tried to make them feel comfortable with interacting with the patient, but they remained nervous. They said they had felt more confident on the ward, although that was unrelated to the care, but there was a "less tense atmosphere".
- The length of stay for patients was above the national average for all types of admission to the unit. This included elective and emergency surgical patients, ventilated patients and those admitted with severe sepsis. Staff told us this was mainly because of delays in discharge when waiting for a bed for the patient on a ward.
- Some patients were discharged to their home from the unit because there had been no ward bed available and they had recovered satisfactorily. Since the unit opened in May 2014, there had been 44 patients discharged home from critical care because of a lack of available ward beds. Eight patients were discharged directly home in October 2014. This was a relatively high figure, with most critical care units rarely discharging patients directly to their home without first transferring to a ward. There were delays with some patients who were able to be discharged from the hospital, but who were waiting for community care. Because it was supposed to be a rare event, there was no discharge area within ICU for patients being discharged home. Patients and their relatives used the quiet rooms at the end of each ward to wait for medicines they needed to take home, or other things they required.
- Occupancy levels on the unit were high. The NHS snapshot of the unit (called NHS Sit Reps) taken on the last Thursday of each month (for this unit from May to September 2014) showed the unit was full on each day. The unit was a major trauma centre in the South West of England and one of the biggest receivers of patients transferred from other units for clinical reasons, such as neurological or renal patients. In the ICNARC data from 14 May to 30 June 2014, 13% of admissions were patients transferred into the unit. This was above the average for similar units of around 2%. The unit also took 2% of patients who were non-clinical transfers into the unit; they were admitted to the unit because of no bed capacity in another hospital unit. Patients were not often transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist cardiothoracic care. Non-clinical transfers in the ICNARC data period were 1% of patient admissions; the national average for similar units was 0.4%.

- In June 2014, six patients were transferred out (5% of admissions) and in July 2014, nine patients were transferred out (6% of admissions). However, the unit admitted 17 patients from other hospitals in the same time period. This was significantly higher than the national average for NHS units.
- There was a significantly high rate of 'urgent operations' cancelled because of a lack of an available bed in ICU. Although there was no data collected to support the staff view, staff said when operations were cancelled, there were always patients in the unit who were fit to discharge. This was the case on the three days when we visited the unit and when we specifically reviewed this with staff at the early morning handover meeting. In the four months from June to September 2014, inclusive, there had been 104 cancelled operations, with three cancelled for the second time (or more). This was an average of 26 operations per month, against the average for NHS units of a similar size bed capacity of just under two per month.
- There was a low rate of patients discharged from the unit too early onto wards (that is when they were not quite well enough) to make way for new admissions. In the ICNARC data from 14 May to 30 June 2014 this was just over 1%, which was below the average for similar units and all other NHS units.

Learning from complaints and concerns

- Complaints were investigated and reviewed. There were very few complaints made to ICU in relation to care and treatment. However, two serious complaints had been received since the unit was opened in May 2014. We reviewed these, the investigation into them and the responses made. The responses were in clear non-medical language. Apologies were made when appropriate. The complaints were investigated on the unit and action plans were produced and circulated. The actions were appropriate to demonstrate the staff had learned from what went wrong in these situations. Preventative measures were being implemented to prevent reoccurrences. Relevant skilled and experienced staff were consulted and attending the unit more frequently. We saw discussion of these two incidents reported and discussed at staff meetings.
- The unit had the trust's Concerns, Complaints and Compliments leaflet on prominent display in the reception area. This described how to correspond with the trust, which could be by letter, email, telephone or fax, or in person, and who could complain. The process for raising complaints and their confidentiality were described. The planned response time to a complaint was within 25 days and complainants were advised what to do if they were not satisfied with the response. There were, however, no instructions on how to obtain the complaints procedure in a different language or format.

Are critical care services well-led?

Good

We judged the leadership of the service as good. All the senior staff were committed to their patients, their staff and their unit. There was reasonable evidence and data gathered for senior managers in the unit to base decisions on and drive the service forward. There was, however, room for improvement in the way the data was made available or collected. There was an improving programme of audit, although some reliance placed on tasks being carried out, such as safety checks, without consistent assurance this was the case. There was accountability among all staff for driving through actions and improvements and a strong culture of teamwork and commitment in the critical care unit. Patients, relatives and staff were involved in feedback about care and treatment. A member of the patient panel sat in on the weekly unit governance meeting.

Vision and strategy for this service

- The management team of the matrons, sisters, consultant director and the lead intensivists were committed to their patients, staff and the service. One of the current top priorities was to reach a high level of staff retention. It had been recognised this would be achieved by a good staff training and development regime, and this was being driven forward.
- The unit had a 'mission statement' around health and safety that had recently been developed. This was based on education, communication and raising awareness of health and safety among staff.
- All staff we met were committed to high quality, compassionate and safe care. There was a vision and strategy for the service, both in the short and longer term. The first priorities for the management team were to establish and maintain a skilled and experienced nursing team, and have all the available beds open and

safely staffed. The future strategy also included offering training and development opportunities to all staff, and particularly for the development of band-five nurses. Another element of the strategy for the unit was to allocate teams of staff to certain pods to provide continuity and teamwork.

Governance, risk management and quality measurement

- There was a consultant-led daily safety briefing within each pod each day. This included staff stating if controlled drugs and emergency equipment had been checked. We found emergency equipment had not been checked on some days before our visit, so this part of the safety brief was not working effectively. Other patient risks, harms or medical status were identified, such as patients admitted with pressure ulcers (and if a referral to the tissue viability nurse had been made); patients who had suffered from a fall (and if appropriate documentation been completed); patients who had central venous access devices fitted (and if any had blood-stream infections); patients who were MRSA-positive; patients who were agitated or confused; patients who were being restrained; or patients who met the criteria for organ donation (and if the organ donation staff were made aware). The bed status of the pod was recorded along with whether the pod was able to admit an emergency patient to a fully-staffed level-three bed.
- The unit recognised, understood and reported its risks. The risk register was used trust-wide and defined by the service concerned. The critical care service had identified those areas where it saw risks. There was a health and safety folder where the current open risks were listed and the detail behind them printed. Risks scored at the higher end of the scale included:
  - Inadequate (but improving) skill mix of the nursing staff team, where a high proportion were new in post.
  - The unavailability of beds on the critical care unit for new admissions because of an inability to effectively discharge patients who no longer needed to remain in critical care to wards. This was identified as long ago as April 2013.
  - The unavailability of the isolation rooms because of ventilation and pressure-differential issues.
- Some of the actions agreed had been put in place, such as committing to two beds being kept free for emergency admissions (although these were quickly used each day), and beds for elective or urgent operations being booked in advance (although there were still some surprises on a regular basis when this was not being done).
- The unit had regular unit meetings each Monday afternoon. Around 15 to 25 staff generally attended. This included one of the hospital's volunteers or 'Move Makers'. The agenda covered standing items including risks, safeguarding, complaints, Intensive Care National Audit and Research Centre (ICNARC) data, such as length of stay, delayed discharges, early readmissions and night time discharges, incidents, and any other business. Minutes were produced from these meetings, which we reviewed. Actions were agreed and an 'action calendar' produced to follow their progress, delivery and completion. Staff were made responsible and accountable for the delivery of action plans. The main items from the local governance meetings were reported to the core clinical services clinical governance meeting held every two months.
- The service was improving communication through the department. There was a 'message of the week', where one topic was highlighted to staff through emails and on communication boards. This had included messages on skin integrity checks and documentation.
- The unit had a calendar for routine performance and effectiveness audits. This process was relatively new because of the recent establishment of the service. The current audit list included transfusions, nutrition (start of enteral feeding and review of constipation), use of sedation and incidence of sepsis. The current problem for the unit was with data availability, which, with paper-based systems, made data hard or time-consuming to capture. A clinical audit meeting was held on the unit monthly. This included a review of ICNARC data when the new report was made available, reviews of ward quality assurance reports and special items, such as reports from the speech and language therapist.
- The unit undertook departmental health and safety audits. These were extensive audits designed for all aspects of the hospital, and the department therefore examined those areas appropriate for critical care. We reviewed the assessment from July 2014. There was an associated action plan for those things considered to have not met the audit requirements and that were not about to be addressed or already being dealt with. This

had been updated in October 2014 and completed items reported on. Anything not addressed was highlighted with the reasons for non-completion and moved to the new action plan.
- The unit participated in the collection and submission of performance and quality measures. The unit contributed data to ICNARC database for England, Wales and Northern Ireland. This was done regularly by a trained member of staff submitting the coded data, but also on a daily more localised level. At the 7.30am handover meeting, the lead consultant collected data from staff on patients who had breached some of the ICNARC quality measures. This included patients discharged at night, delayed discharges and any early readmissions.
- As recommended by the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units, the unit was part of a local critical care network.
- Staff were included in the running of the unit. There were various staff meetings on clinical and administrative matters.
- The risks to staff were acknowledged, assessed and actions developed. A 'stress risk assessment' had been carried out by one of the senior nurses involving "numerous staff". Potential risks had been identified by staff (such as staff not coping with demands of the job; staff being subjected to unacceptable behaviours; the organisation not engaging with staff). Suggested ways of containing or controlling the risks had been described in the report. This included recruitment, staff getting their breaks, agreeing sensible deadlines, team building and greater involvement of staff. Most of the actions coming from the report had been implemented, but staff were realistic about the time it would take for some to become embedded in the new service.

Leadership of the service

- The nursing leadership of the service was strong. The matron position was a job-share. The two Matrons had recognised the need for a cohesive approach to the role and worked together each Monday. The other four weekdays and the on-call rota were split between them. They said they were well supported by the directorate general manager and the director of nursing. Both were visible on the unit and available to staff. The Matrons said they were encouraged to have a strong voice and raise awareness of their unit with the nursing management. The consultants we spoke with had a high regard and respect for the Matrons and nursing team.
- The consultant leadership of the service, led by the consultant director and experienced intensivists, was strong and committed. The unit had made good progress on governance and presentation of reliable and meaningful indicators of quality care.
- There was a good working relationship between staff on the unit. The senior team of doctors and nurses all told us they had a close working relationship and strong commitment to the service.
- Nursing staff, physiotherapy team leaders and other allied health professionals were well supported and well respected by their own teams and on the unit.

Culture within the service

- Staff said they were encouraged to raise concerns. Those staff we spoke with said they did not feel they were blamed when things went wrong and were subsequently not discouraged from speaking up. The nurses mentoring new staff and the clinical nurse educators were focused on getting the new staff up to speed as quickly as possible. Safe and quality care was encouraged, as we observed, and we saw gentle but firm education or support when a member of staff was either not confident or could improve their practice.
- A strong culture of teamwork and commitment was spoken about among staff in the critical care unit. All the staff we spoke with said the strength of the unit was the commitment to the unit, the patients and each other. Staff were aware the turnover on the new unit had been high, and there were a few more of the nursing staff moving on. However, staff said they were hopeful but confident the unit would settle down in the near future. Patients and relatives also commented on the positive nature of the staff they met.
- Trainee doctors were well supported on the unit. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.

Public and staff engagement

- There were regular unit meetings. All staff were invited and encouraged to attend the regular Monday afternoon unit meetings, but were required to review

patient and unit priorities before deciding to attend. We were told there was good attendance, but not often from the junior nurses or the physiotherapists because of work pressures.

- The public had been involved in the consultation for the new hospital, which had led to the unit being designed and built with all private patient cubicles. Because of the nature of critical care there was no general public involvement with how the service was otherwise run, but patients and their relatives were asked to comment on the care provided. An inpatient questionnaire was in use and results were collated and presented to staff. We looked at the results for the three months from July to September 2014, which had been compiled into a report (the results of which are discussed elsewhere in this report). Fifty-three questionnaires were returned. Charts were produced to visually display the responses, although we did not see this report displayed in the unit or on the internet.
- A patient representative attended the unit meeting. This was a representative from the patient panel. They were not able to attend every meeting, but came to many. Staff said they appreciated this input and a different way of looking at the unit – that is, from the patient's viewpoint.

Innovation, improvement and sustainability

- The matrons, clinical director, lead intensivists and senior nurses had many plans for the future of the unit. The focus at this time was dealing with the priorities around safer staffing, training and development, and risks and incidence of patient harms. There were valid and informed objectives around quality and safety for both nursing and medical staff. Once the unit had settled down, the matrons and medical staff said they would look at long-terms goals for safety and quality. These would be worked into professional development and key performance indicators for individual staff and the unit as a whole.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecological services for North Bristol NHS Trust were located on the main Southmead site. While the majority of services had moved to the new Brunel building, maternity and gynaecological services remained in the older buildings, unconnected to the main site. The trust provided services to the local community in Bristol, North Somerset and South Gloucestershire.

General gynaecological services were provided as well as early pregnancy, antenatal, induction of labour and postnatal care. The unit comprised a 15-bed gynaecological ward (Cotswold), which had the capacity to increase to 19 beds. There was an antenatal clinic and early pregnancy assessment centre in one building. The main maternity building included Quantock Day Assessment Unit, which had seven couches; a 14-bed antenatal ward (Quantock); the Central Delivery Suite comprising of ten birthing rooms (one of which had a birthing pool and one the bereavement suite, and two high-dependency rooms); and a 35-bed postnatal ward (Percy Phillips Ward) containing transitional care beds. In addition there was a midwife led unit comprising four birthing rooms with two birthing pools and seven post natal beds on Mendip ward. The theatre suite adjacent to both Cotswold Ward and Central Delivery Suite comprised four operating theatres; two for gynaecology and two dedicated obstetric theatres. Obstetric and specialist clinics were run by obstetricians and other specialist consultants (for example, a diabetologist and anaesthetists). Antenatal clinics were held Monday to Friday at Southmead Hospital. Clinics were also held in various settings across the community including Cossham Birth Centre, health centres and community clinics. Between 1 April 2013 and 31 March 2014, there were 5,932 births across the whole of the trust. During the inspection we spoke with 47 members of staff, one relative and 18 patients, and reviewed seven sets of medical records.

Maternity and gynaecology

Summary of findings

Overall we found the service required improvement. Within the five domains, we rated safety and responsiveness as requiring improvement. The effective, caring and well-led domains were good. Incidents were reported and there was clear evidence of learning as a result. Learning was shared across the whole service. Staff completed the safety thermometer, which showed results being consistently higher than the England average. Areas were clean and there was good compliance with infection control policies, but there were no instructions for staff or cleaning materials available in the bathrooms on the postnatal ward. Not all medicines were kept securely locked. Some emergency medicines were stored in unlocked boxes that were left unattended. This posed a risk that they could be taken or tampered with. There were specialist midwives employed for safeguarding, teenage pregnancy and drug and alcohol misuse. These provided support for all staff across both the maternity and gynaecological services. Access to mandatory training was good. In addition there was skills training in both obstetric and gynaecological emergencies. The maternity dashboard for September 2014 reported the midwife-to-birth ratio of 1:33.9, higher (worse) than England average of 1:29. In addition, the average for the provision of one-to-one care in labour in 2013/14 was reported as 85.6%. Staff sickness within the maternity unit was high at 7.7% for midwives and 10.6% for midwifery care assistants, against a trust target of 3.8%. Unit average was 4.8 to 5% across all staff members. The service had identified the need for five elective theatre lists a week; however, they were only funded to provide three. With staff moved from the delivery suite to provide cover, this meant women were at risk if the number and acuity of women on the delivery suite was high. Staffing on Quantock day assessment unit was such that when one midwife was required to accompany a patient for a scan or for transfer to the delivery suite, the area was left with only one midwife. At night with only one midwife on duty, the unit would be left with a midwifery care assistant only. There were 74 hours of dedicated consultant time on the central delivery suite. The Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) suggests this figure should be 168 hours. Staff provided care and treatment that was evidence based and in line with policies and national guidelines. Staff were trained in the management of obstetric emergencies which saw an improvement in patient outcomes. This training was nationally and internationally renowned, with staff leading the research and spread of the training in other countries. As a result of the outcome successes in obstetrics, a similar model of 'skills drills' training was being implemented within gynaecology. Care was delivered with kindness and compassion. Choices were well explained and patient centred, with women having clear choices throughout the service. Women had choice with regards to place of birth and there was good use of specialist midwives and community facilities to provide care closer to teenage and young mothers. There was a single appointment process in colposcopy and women attending the early pregnancy assessment clinic had good access to services and scans, though at times this meant women had to wait several hours. Gynaecological waiting times were within national targets. The service met two-week cancer targets and also 18-week referral-to-treatment times. Antenatal clinics often ran late, though the frequency of this was not recorded. Bed occupancy was significantly higher than the national average. The postnatal ward was described as "bursting at the seams", with occupancy in excess of 95%. As a result, women sometimes remained on the delivery suite for longer than they needed. Maternity and gynaecology services were well-led. There was a vision and a strategy, though most staff were not aware of it. There was an awareness of a vision for improved facilities, but not a general awareness of the vision for care. The service had a well-defined and functioning governance structure that oversaw activity, performance, quality, safety and audit. These fed into the trust's governance processes and there was strong representation of the service at trust level. Action plans devised as a result of incidents, complaints, audits or case reviews were monitored and there was clear evidence of actions taken and learning having occurred. Leaders were visible and participated in the day-to-day running of the service. There was a cohesive approach between medical and midwifery staff. There was a culture of openness and learning and a strong focus on research with national and international engagement and promotion of the

Maternity and gynaecology

research undertaken and the outcomes delivered. The trust had recently featured on a television documentary charting the role of midwives and following women in labour. There were opportunities for professional development and as a result there was succession planning across all services.

Are maternity and gynaecology services safe?

Requires improvement

The service requires improvement. Incidents were reported and there was clear evidence of learning as a result. Learning was shared across the whole service in various ways, from newsletters and emails to safety briefings and team meetings. Staff completed the safety thermometer, which showed results being consistently higher than the England average.

Areas were clean and there was good compliance with infection control policies; however, there were no instructions for staff or cleaning materials available in the bathrooms on the postnatal ward.

There was CCTV, staff had access using swipe cards and there were security staff on duty from 7.30am to 8pm. Entrances were locked and at night access was only through the reception on the central delivery suite.

Not all medicines were kept securely locked. Some emergency medicines were stored in unlocked boxes, which were left unattended. This posed a risk that they could be taken or tampered with. Health records were well maintained and accessible and were subject to annual audit.

Risk assessments were undertaken and plans of care made. Specialist midwives were employed for safeguarding, teenage pregnancy and drug and alcohol misuse. They provided support for all staff across both the maternity and gynaecological services.

Access to mandatory training was good. In addition skills training was available in both obstetric and gynaecological emergencies. The midwife-to-birth ratio of 1:33.9 was higher (worse) than the recommended ratio of 1:28. In addition one-to-one care in labour during 2013/14 was reported as 85.6%. Staff sickness within the maternity unit was high at 7.7% for midwives and 10.6% for midwifery care assistants, against a trust target of 3.8%. Unit average was 4.8 to 5% across all staff members. Return-to-work interviews were conducted and staff could be referred to occupational health if desired.

Maternity and gynaecology

The service had identified the need for five elective theatre lists a week, but they were only funded to provide three. Unfunded elective theatre cover was provided from the midwifery staffing and obstetric and anaesthetic cover two days per week. Obstetric and anaesthetic cover was also taken from the delivery suite rota. This meant women were at risk if the number and acuity of women on the delivery suite was high. The recovery area was staffed by only one staff member. At times staff members were also moved from the recovery area to the theatre to scrub. On occasions midwifery care assistants took over the recovery role. We saw this occur because there was no other staff member available with 'scrub nurse' skills to be in theatre during one of the unfunded 'elective' caesarean section lists. Staffing on Quantock Day Assessment Unit was such that when one midwife was required to accompany a patient for a scan or for transfer to the delivery suite, the area was left with only one midwife. At night with only one midwife on duty the unit would be left with a midwifery assistant only. Quantock Day Assessment and Quantock ward were run as one staff team. Whilst this ensured a minimum of two midwives were on duty at all times with a minimum of one MCA, the second midwife was not in the immediate area. There were 74 hours of dedicated consultant time on the central delivery suite. The Royal College of Obstetricians and Gynaecologists Safer Childbirth (2007) suggests this figure should be 168 hours.

Incidents

- All staff reported incidents using the trust's electronic incident reporting system. This was easily accessible through the trust's main intranet site. Staff said there was a good culture of incident reporting within the maternity service, with approximately 100 reported each month, ranging in severity from near misses upwards.
- Staff told us they all knew how to report incidents and had done so in the past. They described the feedback received and were able to tell us of changes made as a result of clinical incidents. There were maternity-specific triggers for the reporting of incidents such as failed forceps deliveries, third-degree tears and postpartum haemorrhages. These 'trigger lists' were easily accessible and identified incidents that were subject to continuous audit, for example, shoulder dystocia (difficulty in delivering the shoulders of a baby) and those that had the potential to be serious adverse incidents. The list made clear it was not exhaustive and, if in doubt, incident forms should be completed.
- Details of all incidents reported were received by the matron with responsibility for that area. They reviewed incidents and investigations carried out. Within the gynaecological services, incident reports were reviewed by the ward manager and overseen by the head of nursing and deputy director of midwifery, who had nursing responsibility for Cotswold ward. Decisions on whether an incident was serious enough to warrant a comprehensive root cause analysis was made at the maternity risk forum. Incidents were mainly investigated internally, though at times clinicians from other trusts were commissioned to undertake a root cause analysis investigation in order to test objectivity. Following investigation and action planning, any overdue actions were highlighted. This ensured that actions were completed. The maternity and gynaecological services had reported five serious incidents requiring investigation between October 2013 and September 2014. These were incidents described as the most serious. Staff told us they were aware of what would constitute a serious incident requiring investigation.
- Every postpartum haemorrhage over 2,000ml was reviewed at a multidisciplinary postpartum haemorrhage forum. Learning from the forum resulted in changes to practice. For example, a colour chart had been devised to support the estimation of blood loss in water and the use of fresh frozen plasma had increased as a result of recommendations from this group.
- Root cause analysis was always undertaken following a hysterectomy within the maternity unit. We reviewed the notes of a woman who had experienced a large blood loss and subsequent hysterectomy and saw this had been reported as a clinical incident. Notes had been photocopied and the process of case review and investigation had begun.
- All incidents were reviewed by the risk midwife who reviewed scoring and presented a risk report for the monthly Maternity Risk Forum. This fed into the Women's Health and Neonatal Medicine Clinical Governance Group, which reported to the Directorate wide Overarching Clinical Governance group which in turn reports to the trust governance and risk committees..
- Learning from incidents occurred through one-to-one feedback with individual members of staff, group emails, departmental newsletters (the Risks Hotspots and Now What?), safety briefings and team meetings.

The service had developed 'SharePoint' accessible through the intranet. This was a central repository for all information and was widely used and praised by medical and midwifery staff as a means of accessing up-to-date information, policies and protocols, changes and learning. One staff member described it as a "fabulous resource"; another said "everything is on SharePoint".

- We saw evidence of learning as a result of incidents. For example, a 'back to basics' campaign had occurred, with the production of posters reminding staff of the steps to take in basic care. These could be seen around the central delivery suite and staff spoke of learning that had arisen following review of an obstetric emergency.

Safety thermometer

- Incidences of new venous thromboembolisms, urinary catheter and urinary tract infections were reported using the Safety Thermometer system. The trust rates for these were consistently better than the England average. Results were on noticeboards for staff and members of the public to see.

Cleanliness, infection control and hygiene

- All areas were visibly clean. Staff were seen cleaning equipment after use and there were 'I am clean' stickers in use on some items to indicate an item was ready to be used again.
- Cleaning rotas were seen on the walls and cleaning audits had taken place. When the Brunel building had opened, staff such as cleaners and dedicated porters had been centralised. This meant there was often a different cleaner or porter covering the wards and departments. Following concerns raised and weekly meetings with the facilities management team, the service now had its own dedicated team. As a result, staff felt standards had improved. The audit for October 2014 was published on the wall for staff and visitors to the central delivery suite and wards to see. Compliance with cleaning standards and protocols was seen to be good. For example, hand hygiene rates for the month of October were 98% and cleanliness 100%. Percy Phillips ward reported 100% compliance with hand hygiene and 97.3% compliance with cleanliness for October 2014.
- We looked at two bathrooms on Percy Phillips ward. While both appeared visibly clean, there were no instructions for staff or cleaning materials available to ensure the bath was cleaned between each use. In both bathrooms we saw cardboard containers used to collect urine samples. These had been used and were left on the top of the peddle bins rather than being disposed of appropriately.
- Antibacterial hand disinfectant was available at the entrances to the unit, within each birthing and examination room and on each ward. Staff were seen to be 'bare below the elbows', in accordance with the trust's infection control policy, and were observed washing their hands before and after carrying out patient care. We saw signs advising how to wash hands correctly and to 'Fling your bling' and remove all jewellery.
- Aprons and gloves were readily available and we saw staff using them when carrying out the specific duties for which they were required.

Environment and equipment

- Entry to and exit from the maternity unit and Cotswold ward was controlled by swipe card access for staff. Patients and visitors attending wards and departments were greeted by security staff, who were present seven days a week, from 7.30am to 8.00pm. Visitors were given badges and the area was subject to CCTV monitoring. Doors were locked outside of that time and access controlled through the receptionist on the delivery suite, who was present 24 hours a day.
- There was an abduction policy easily accessible, which detailed the actions to be taken in the event of a baby being taken. Babies were not tagged and mothers were advised to take them with them whenever they left their bedspace, for example, to have a bath.
- The antenatal clinic was very cramped, having been built for a unit carrying out 4,000 births a year. At the time of our inspection the unit was undertaking just under 6,000 births a year, but the clinic had not increased in size accordingly.
- Staff told us that a business case was being evaluated to look at the option of either a full refurbishment of the existing premises or a new building to be co-located with the Brunel building, which would allow greater space and improved facilities in which to deliver services.
- There were two obstetric theatres and a dedicated recovery room. The recovery room was initially meant for two patients, but was being used for three women

during their recovery phase. This meant it was cramped when at full capacity. Obstetric theatres were next to the gynaecology theatre, which also had a separate recovery area.

- Emergency resuscitation equipment was available for both mothers and babies. However, the process for checking the equipment to ensure that it was fit for purpose was not always adhered to or effective. We saw emergency equipment in most places was checked and this had been documented daily to demonstrate checks had been carried out. However, we noted the resuscitation trolley in the antenatal clinic had not been checked daily as per hospital protocol. Emergency equipment contained in easy-to-access boxes within areas such as Percy Phillips ward and the Quantock day assessment unit were also checked. These were approximately once a week, although there was indication within the documentation to indicate this was the appropriate checking regime. We saw the defibrillator pads were out of date on one machine. We highlighted this to a member of staff and these were changed.
- The trust held an inventory of all electronic medical equipment. Staff from that department contacted wards when equipment was due to be checked. All pieces of equipment we checked, including foetal heart rate monitors, pumps for the administration of medicines and defibrillators, had been checked and date marked.

Medicines

- Medicines were kept securely stored in locked cupboards. There were, however, some exceptions when this was not the case. We saw unsealed emergency boxes for various obstetric emergencies located in the Quantock Day Assessment Unit and on Percy Phillips ward. These were unlocked and left unattended while staff were busy providing patient care behind curtains. We saw these contained ampules of emergency drugs. This meant there was a risk these could be taken or tampered with.
- When medicines required storage at a low temperature, they were stored within a specific medicines fridge. Temperatures were checked and recorded daily, although there was no evidence of action taken if the maximum temperature had been recorded outside of the appropriate temperature range.
- Staff were observed undertaking a medication round. They were wearing a tabard indicating what they were doing and requesting that they were not disturbed, to reduce the incidences of interruptions and the subsequent risk of error.
- Nitrous oxide for pain relief was piped into the birthing rooms. While air for use on resuscitaires (trolleys for the resuscitation of a baby at birth) was provided by portable cylinder, we saw there was a good supply. A business case had been developed to request the addition of piped air to each delivery room.
- We spoke with one woman about the medication she had received. She said staff always administered it on time. We saw this had been reflected in the notes.
- Medication incidents were reported and all were investigated. Within the maternity service, this was usually undertaken by the individual practitioner's supervisor of midwives. On Cotswold ward, this was undertaken by the ward manager.
- Common medicines for discharge were securely stored on the wards. Staff recorded stock levels and when these were dispensed. We saw these were subject to regular audit by the pharmacy department.

Records

- Medical records for gynaecological patients were retrieved from the trust's medical records store.
- Women carried their own pregnancy-related care notes in the form of hand-held records supplied from booking with community midwives. These accompanied the women when they came to the maternity unit or for examinations with their community midwives.
- Previous medical records were obtained in the antenatal period to allow staff to look at the woman's history and review the details of any previous deliveries. The notes were held securely in the antenatal clinic. These were easily accessed in office hours (Monday to Friday, between 9am and 5pm). When a woman reached 36 weeks of pregnancy, notes were placed into metal trolleys and taken to the central delivery suite for ease of access out of hours. However, if a woman presented in an emergency situation earlier in the pregnancy, staff were required to retrieve the full medical records from the antenatal clinic, a separate building adjacent to the main maternity building.
- Women were given the child health records for their babies on discharge.

- We reviewed seven sets of medical records, all of which were clear to follow and logically laid out, making the access to relevant information easy for staff providing care. They contained risk assessments and plans of care. We saw the use of antenatal and intrapartum fetal heart monitor stickers in use, which provided prompts to midwives for when to refer for a medical opinion. We saw these had been correctly filled in. Observation charts and fluid charts were completed accurately and drug charts contained all relevant information, including the patient's allergies.
- All midwives had an annual supervisory review, which included an audit of their record keeping. One per cent of all records were audited annually by a designated person nominated by the maternity audit team. Audit findings were presented to the Obstetrics and Gynaecology Audit Presentation meeting.

Safeguarding

- All staff were required to undertake safeguarding training as part of the trust's mandatory training. Attendance was good at 90% and above the trust target of 80%.
- There were systems in place to identify vulnerable women. Midwives completed a Request For Help form whenever there were safeguarding concerns. These included instructions on how to access support if there was felt to be an immediate risk of significant harm. Once completed, these were sent to the child protection midwives using a central email inbox. This ensured they were received in the event of sickness or annual leave; response to these was described as good.
- The trust employed a teenage pregnancy specialist midwife, a drug and alcohol specialist and safeguarding midwives. They undertook daily ward rounds, identifying women with concerns and providing advice and support to midwives. They provided advice and support to the Cotswold ward as well as the maternity unit, who had seen an increase in safeguarding concerns and vulnerable women.
- Midwives attended case conferences and a Multi-Agency Risk Assessment Conference (MARAC) as part of a coordinated community response to domestic abuse and safeguarding concerns. Training on MARAC and Domestic Abuse, Stalking and Honour-Based Violence Risk Identification was included in the mandatory training programme.
- All cases of female genital mutilation had safeguarding referrals to the local authority made during pregnancy.
- There were trust-wide guidelines for the care of women with female genital mutilation, mental health problems, teenagers, substance misuse and alcohol dependency, complex social factors, and prisoners from HMP Eastwood Park (which was located near to the unit).

Mandatory training

- Access to mandatory training was good. Staff were able to request attendance on set days. However, if they had not booked onto training by the mid-point of the year, training days were allocated to them to ensure all staff were updated annually. Staff who failed to attend were followed up with their manager and through midwifery supervision. Failure to complete trust mandatory training meant staff would not be able to obtain the annual incremental salary increase.
- There were dedicated practice development midwives for the trust who monitored attendance and organised training sessions. Staff said access to training was good. Midwives attended the trust's mandatory training as well as obstetric emergency skills training known as PROMPT (PRactical Obstetric Multi-Professional Training –an evidence-based multi-professional training package for obstetric emergencies) and neonatal and adult resuscitation training.
- Additional emergency skills training could be accessed if recognised through appraisals and supervision sessions.

Assessing and responding to patient risk

- Medical staff, midwives and midwifery care assistants undertook annual training in obstetric and neonatal emergencies. In addition, half-day training sessions were run regularly at the Cossham Birth Centre and included paramedics from the local ambulance service as well as community midwives.
- On the gynaecological ward, staff completed the Early Warning Score. In the case of midwifery and obstetrics, staff completed the Modified Early Obstetric Warning Score system to record observations. For care in labour, this was incorporated into the partogram, a chart designed to monitor observations and progress in labour. When required, staff completed observations on babies and recorded these on the Neonatal Early Warning Score forms. These indicated actions for staff to

undertake in the event of a concern or deviation in observation from what was normal. Staff we spoke with were able to describe at what point concerns would be escalated to the medical staff.

- Pregnant women with clinical complications or those who were 12 days beyond their due date had their labour medically induced under consultant-led care. Inductions of labour took place on Quantock ward. However, staff told us and we saw from incident reports that at times these were postponed because of lack of capacity within the unit, of either beds or midwives to provide care. At times we saw women had their induction started in line with policy but second and subsequent dose administrations were delayed. We spoke with one woman who had been admitted the previous day for induction of labour. This had not begun because of a lack of staff to manage the acuity of patients on the delivery suite. The woman described being fully informed but felt there was a lack of staff to provide the necessary care. Staff told us this could also be the case for women who had prolonged rupture of membranes but had not gone into labour. This increased the risk of infection and meant women and their babies often required antibiotics. This could increase the length of stay in the postnatal period. Women were advised of the need for induction because of a clinical risk. However, inconsistent advice was then given if the induction was delayed.
- On the central delivery suite, staff practised 'fresh eyes' every two hours. This meant the fetal heart was reviewed by someone other than the midwife who was providing care to the woman, and ensured concerns with progress or the fetal heart were less likely to be overlooked.
- Staff had easy access to emergency trolleys and boxes containing all the essential equipment in the event of an obstetric emergency. This included a 'latex-free' trolley containing all equipment required to provide care for someone with a latex allergy. However, these were not secured safely, so could be tampered with or missing equipment.
- Staff used the Situation, Background, Assessment, Recommendation communication tool when handing over or discussing concerns. This ensured communication was effective and clear as to what was required. The use of this tool was, however, not always documented.
- Each birthing room with a pool was equipped with evacuation equipment to allow for safe evacuation from the pool in the event of an emergency. Staff were well practised in the use of the equipment and procedures to follow.
- Two rooms on the central delivery suite had been converted to provide high-dependency care. These rooms were staffed by midwives from within the central delivery suite numbers who had undertaken additional training.
- The elective caesarean section list on Thursdays was often used for complex cases, for example cases when a large haemorrhage may be anticipated. Staff on these days were always trained in the use of the cell salvage equipment. There were insufficient staff trained to carry out this role at all times. This was identified and was on the directorate risk register. This identified the need to train more staff, but indicated this could not occur without additional resources. This meant patients were at risk if they declined administration of blood products in the event of a life-threatening haemorrhage.
- Staff received a verbal handover when taking over care. Handover on Percy Phillips ward for staff working a short day (i.e. those not on a 12-hour shift) was only for the women each member of staff was assigned to look after. This meant staff did not know about all patients and this was felt by staff to be a concern, particularly in times of emergency.
- Cotswold ward had developed an admissions criteria tool for any non-gynaecological patient being transferred to the ward. Staff told us this was strictly adhered to. Staff on Cotswold ward reported having difficulties accessing the correct medical team for patients who were from a different surgical speciality. They reported having to make several phone calls because it was not always clear who should review the patient. This posed a risk if the patient deteriorated.
- One senior midwife had been identified to work on Cotswold ward to act as a 'fresh pair of eyes'
- When possible, women requiring emergency gynaecological surgery had their procedures 'slotted in' among the elective list. Out of hours, the gynaecological theatre did not operate. Instead urgent cases that could not remain overnight were transported by ambulance to the Brunel building for surgery. We saw that at times this

had been raised as a clinical incident because of the length of time taken to transfer. In extreme emergencies, Brunel theatre staff would attend and 'man' the gynaecological theatre.

Midwifery staffing

- The maternity dashboard for September 2014 reported the Midwife to birth ratio for as 1:33.9 across all areas which is higher (worse) than the England average of 1:29.
- Staff completed the Birthrate Plus intrapartum acuity tool, which demonstrated when staffing met acuity and when there was a shortfall in staffing. Statistics provided for the week beginning 6 October 2014 showed acuity was met 81% of the time, with a shortfall 19% of the time. The tool reported a shortfall in midwifery staffing by at least one midwife for 3% of the time (shown as a high risk) and for less than one midwife for 16% of the time (shown as a medium risk).
- As a result of undertaking the Birthrate Plus intrapartum acuity tool, staff had been able to demonstrate a need for additional midwives. This had shown that during July 2014 there had been a shortfall of at least one midwife (therefore deemed high risk) to meet demand 68% of the time. This had resulted in the recruitment of an additional ten midwives. These midwives were in post at the time of inspection and were just concluding their period of time working in a supernumerary capacity. Staff reported this as having made a difference to the workload and number of midwives on the unit. While the midwives had been recruited, this was in addition to the recognised and funded midwifery establishment. Staff told us a further 20 midwives would be required in order to improve the midwife-to-birth ratio to 1:29. There were no plans to undertake this additional recruitment.
- Recruitment was not described as being difficult. Staff felt the unit had a high profile because of its research and nationally recognised patient outcomes, and had a good reputation. Staff told us there had been over 100 applicants for the ten posts recently recruited into. Students were actively employed and there was a low vacancy rate as a result – reported as 0% for midwives and one whole time equivalent vacancy in midwifery care assistants on the central delivery suite.
- Community midwives carried a caseload of one midwife to 98 to 100 women and provided a homebirth service. The midwife first on-call for home births was not given any other duties, ensuring their availability to support the woman in labour. There was always a second on-call midwife for home births who also attended.
- Staff sickness within the maternity unit was high. At the time of our inspection, sickness rates on the central delivery suite were 7.7% for midwives and 10.6% for midwifery care assistants, against a trust target of 3.8%. The unit's average was 4.8 to 5% across all staff members. Return-to-work interviews were conducted and staff could be referred to occupational health if desired.
- One-to-one care in labour was provided for between 82.1% and 92.2% of the time, trust-wide. The average for 2013/14 was reported as 85.6%. These figures included Cossham Birth Centre, which had an average during 2013/14 of 97.1%, and the Mendip Birth Centre, which averaged 76.7% during that time. This meant that at times women were not provided with dedicated one-to-one midwifery care in labour. Staff told us the midwifery care assistants had received additional 'in house' training to allow them to assist the midwife, undertake roles such as observations and venepuncture, and thereby free midwifery time for midwifery tasks.
- Established and funded staffing levels for the central delivery suite were eight midwives plus one senior midwife acting as coordinator on day shifts and nine midwives plus one senior midwife coordinator on night shifts. On one of the days we visited the hospital we saw these numbers had not been met. Instead there were six midwives plus one senior midwife acting as coordinator in the morning, seven plus one coordinator on the afternoon shift and eight plus one coordinator on the night shift.
- Expected and actual staffing levels were not on display on the central delivery suite. Staff explained they felt this would cause alarm to women if they saw the actual number of midwives on duty fell short.
- Additional midwife support could be sought in a variety of ways. Midwives could be called to work on the delivery suite from the wards and birth centre. Hospital on call midwives could be called to support the delivery suite out of hours for a maximum of four hours. An on-call system also operated at night from 8pm to 8am, among 'unit' staff. Staff were required to volunteer for a minimum number of three on-call shifts a year. The on call community midwife could be called to support the

transfer of women from Cossham to delivery suite at Southmead. In addition, there was a supervisor of midwives on-call, but this was only for advice and support.

- Some midwives, midwifery care assistants and operating department practitioners were trained to scrub in theatres. The service had identified the need for five elective theatre lists a week, but they were only funded to provide three. Funded elective theatre lists had additional staffing for that purpose – dedicated obstetric, anaesthetic and scrub cover provided and a midwife allocated to take the baby. In the event of emergency caesarean sections, scrub nurse cover was required to be found from staff on the central delivery suite. This meant reviewing staff skills and removing a midwifery care assistant or midwife to scrub if anyone with those skills was on duty. In the event of that not being possible, emergency scrub cover was requested from the Brunel building. Unfunded elective theatre cover was provided from within the midwifery staffing numbers for the central delivery suite on a day-by-day basis. This meant women were at risk if the number and acuity of women on the delivery suite was high.
- The Association of Anaesthetists of Great Britain and Ireland guidance states that no fewer than two staff (of whom at least one must be a registered practitioner) should be present when there is a patient in a Post Anaesthetic Care Unit (recovery area) if the patient does not fulfil the criteria for discharge to the ward. Staff we spoke with told us this did not occur, with recovery staffed by only one staff member. At times staff members were also moved from the recovery area to the theatre to scrub. On occasions midwifery care assistants took over the recovery role. We saw this occur because there was no other staff member available with 'scrub nurse' skills to be in theatre during one of the unfunded 'elective' caesarean section lists.
- Two midwives staffed the Quantock day assessment unit, with one healthcare assistant. This unit was open 24 hours a day. At night the number of midwives on duty fell to one. During our visit this area was very busy. At times all beds and couches were full and women were waiting to be seen in the waiting room. Staff told us women could have a three-hour wait to be seen, but this was not reported as a clinical incident. On occasion, one of the midwives was required to accompany women to have a scan in the antenatal clinic or during transfer to the delivery suite. This left the area with only one midwife for a short period of time or without a midwife if the labour ward transfer occurred at night. A proposal had been presented to staff to provide an additional midwife in the day assessment unit at night. However, this would not be an additional midwife overall but would be provided by moving one of the delivery suite midwives to that area.
- Percy Phillips, the postnatal ward, had 35 beds (and babies accompanying their mothers) and was supposed to be staffed by four midwives and three maternity care assistants. At times there were only three midwives on duty per shift. Midwives were seen to prioritise care well, but the need to prioritise could at times cause delay in discharging women and their babies who were a lower clinical risk. The ward had one neonatal nurse on duty to provide support to babies receiving transitional care. The ward manager was supervisory. At times they undertook clinical roles to support staff.
- While staff within the maternity unit were described very positively, patients we spoke with mentioned delays in answering call bells if staff were busy. Staff were described as "go[ing] the extra mile" despite this.
- Maternity staff told us they used to have a system for recording additional hours worked, but this had been abandoned because "nothing happens".
- When additional beds were opened on Cotswold ward, taking the ward from 15 to 19 beds, additional staffing was supplied.

Medical staffing

- Consultants were employed with a variety of specialist interest, such as recurrent miscarriage, colposcopy and urogynaecology. They had been enabled to change job plans to allow personal development and clinical use of skills, for example, some consultants only undertook gynaecology, others only obstetrics.
- Following the identification of risks, changes were made to the on-call rota for obstetrics and gynaecology. These were now separate, ensuring adequate registrar and junior doctor cover over both specialities out of hours.
- Junior medical staff were described as happy and well supported. Staff described the location of the coffee room on the central delivery suite as the centre of information and communication. The GMC survey of doctors in training in 2013 showed responses from

trainees in obstetrics and gynaecology as being better than other trusts for 'Access to educational resources'. The 2014 survey showed all indicators were similar to other trusts.

- ·Staff described the main concerns within medical staffing as the unfunded elective caesarean section list that ran on Tuesdays and Fridays. Staff said there was nearly always an extra registrar to perform the lists, but as well as midwifery staffing, anaesthetic cover was also taken from the delivery suite. This meant there could be a delay for women in labour requesting an epidural for pain relief and if an emergency occurred, a risk to women in labour while a second anaesthetist and theatre team were identified.
- Because of the lack of funding for two of the five elective caesarean section lists, procedures were often carried out by the registrar. These operations were usually been triaged to be identified as those at lowest risk of a complication.
- The consultant obstetricians carried out a 'hot week' when they were present on the central delivery suite every weekday between 8am and 5pm. The consultant on call then took over. At weekends consultants were present within the unit between 8am and 2pm, providing a total of 74 hours a week dedicated consultant cover. The risk register identified this as a medium-level risk, identifying the need for 168 hours of consultant presence to meet the recommendations of the Royal College of Obstetricians and Gynaecologists' Safer Childbirth (2007). The risk register indicated an additional consultant had been recruited in September 2014, but this had not had great effect on the dedicated consultant cover on the delivery suite. Other than review of all new consultant appointments, there were no actions identified to meet this shortfall. Consultants undertook a one in 10 rota, and could expect to be called in every night they were on-call.
- Medical staff did not review all antenatal inpatients daily. Antenatal patients were only admitted in the event of a complication. One antenatal patient told us that while the midwives were excellent, she would have preferred to have seen the doctor daily.
- Junior medical staff described the services as being good places to learn, despite the steep learning curve they felt they were experiencing. Placement at Southmead was regarded positively within their rotation. Junior medical staff told us they had good access to training and support, consultant colleagues were approachable and they were kept informed of changes and what was happening through regular emails and newsletters.

Major incident awareness and training

- Staff were aware of processes to follow in the event of a major incident. The trust-wide major incident policy was available to all staff on the intranet.

Are maternity and gynaecology services effective?

Good

Staff provided care and treatment that was evidence based and in line with policies and guidelines developed by the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists' guidelines Safer Childbirth (2007). There was a multidisciplinary approach to the development of clinical pathways and good multidisciplinary working. Patient outcomes were monitored and recorded on a dashboard. Staff were trained in the management of obstetric emergencies, which saw an improvement in patient outcomes with regards to the management of brachial plexus injury and a reduction in babies born with low Apgar scores (a simple and replicable scoring method to quickly and summarily assess the health of newborn babies immediately after birth). This training was nationally and internationally renowned, with staff leading the research and spread of the training in other countries. As a result of the outcome successes in obstetrics, a similar model of 'skills drills' training was being implemented within gynaecology. The normal birth rate was 60.7% and so was lower than the national average of 61.7%. While caesarean section rates were similar to national rates at 26% to 30%, the induction of labour rate at 29.4% was higher than the national average of 23.3%. Staff received good training and support, though there was no formal return-to-work support after long periods of absence such as maternity leave.

Evidence-based care and treatment

- Policies and guidelines were developed in line with both NICE and Royal College of Obstetricians and Gynaecologists' guidelines Safer Childbirth (2007). All trust and specialist policies were easily available on the

trust intranet site. Staff we spoke with said this was easy to access and use. We observed its use by a member of staff, who was able to quickly access the policy they required.

- Clinical pathways were developed collaboratively with the multi-professional way to ensure agreement and common practice. This meant there were no differences in care approaches between consultants.
- The Early Pregnancy Assessment Clinic closely followed NICE guideline CG154: Ectopic pregnancy and miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage. Women using the maternity services were receiving care in line with NICE quality standards 22 (which related to routine antenatal care) and 37 (for postnatal care).
- Policies were subject to audit; the results were presented back to staff. For example, we saw an audit of 18 to 20+6 week anomaly scanning, which showed a quality screening test complying with the NHS Foetal Anomaly Screening Programme being performed and a re-audit of completion of Modified Early Obstetric Warning Score charts that demonstrated improvement. We saw actions had been identified and further auditing planned.
- Within the CQC intelligent monitoring programme, the trust had been identified as being outside of the normal range for the number of women with regards to puerperal sepsis. As a result, we saw its management was now incorporated into mandatory study days, which also covered the use of Modified Early Obstetric Warning Score, attended by the full multidisciplinary team.

Pain relief

- Women had access to a variety of methods of pain relief including: transcutaneous electronic nerve stimulation, nitrous oxide and water-birth facilities, with a birth pool in two birthing rooms on the Mendip Birth Unit and one on the Central Delivery Suite. In addition, women had access to intramuscular analgesia and epidurals in labour. Post-operative analgesia was provided by patient-controlled analgesia both in the maternity unit and on Cotswold ward. Staff told us that while there was 24-hour access to an anaesthetist, at times epidurals were delayed because of clinical workload and insufficient midwives to provide one-to-one care, because safety was always the priority. Epidurals could also be delayed if anaesthetists were called to the obstetric theatre.
- We spoke to one woman who had delivered by caesarean section. She described receiving good pain relief in a timely manner.

Nutrition and hydration

- The trust employed an infant feeding coordinator, who provided support to women and trained midwives and maternity care assistants in aspects of breastfeeding and bottle-feeding. All midwives and maternity care assistants attended this.
- The trust had level-three UNICEF Baby Friendly Initiative status.

Access to information

- ·There was good access to information for women. The trust had an informative website that also contained hyperlinks to various support groups. Information leaflets were available in different languages. These were given at booking to explain choices to women and contained details such as transfer times if the woman chose delivery at Cossham Birth Centre or at home. Information leaflets were available to women receiving gynaecological care.

Patient outcomes

- Patient outcomes were monitored and recorded on a performance dashboard. All staff were actively encouraged to gather data and monitor outcomes. The trust was leading on a dashboard redesign with agreed performance parameters, to be used across the south west region. Although not yet fully in operation, the dashboard was running alongside the existing performance dashboard. Once fully functioning, it would allow trusts to review each other's data and benchmark their own performance, and would be accessible to all midwives and medical staff on the trust intranet.
- Data only needed to be entered onto the overall IT system once, before being automatically exported onto the dashboard. This meant staff did not have to duplicate work.
- In addition to the dashboard, staff from the unit had developed obstetric skills training known as PROMPT. This was nationally and internationally renowned and was being rolled out throughout all units in Scotland at

the time of the inspection. Data since the inception of the skills drills training showed a considerable improvement in patient safety outcomes when compared nationally. For example, Brachilaal plexus injuries following shoulder dystocia at delivery normally occurs in three per 10,000 deliveries. The unit had been pioneering training and collecting data for a number of years and there had been no instances brachilaal plexus injuries across the maternity service in 24,000 deliveries.

- The percentage of babies born at term with low Apgar scores had also significantly improved. This is a simple and replicable scoring method to quickly and summarily assess the health of newborn babies immediately after birth. Babies are given a scoring of between 0 and 10 at one minute after birth and five minutes after birth. The lower the scoring at five minutes of age, the greater the risk of neurological damage. Since the training had been developed, the rate of low Apgar scores in the unit had fallen to 0.41% in comparison with a rate of 1.2% in the south west region.
- Following the development and roll out of skills drills training, clinical negligence cases had reduced. The trust now contributed more to the national clinical negligence scheme than was paid out.
- Continuous audits were undertaken for decision to delivery times for caesarean sections. When times breached standards, they were investigated.
- The normal birth rate of 60.7% was lower than the national average of 61.7%. While caesarean section rates were similar to national rates at 26% to 30%, the induction of labour rate at 29.4% was higher than the national average of 23.3%. Staff we spoke with felt the increase in inductions was attributed to changes in national guidelines on the management of reduced foetal movements.
- There was a clinic for women for whom vaginal birth after a caesarean section was an option. This was designed to encourage women not to automatically elect for a second caesarean section but to be risk assessed and consider other options.
- Foetal heart traces and 'interesting cases' were reviewed at weekly meetings, which allowed discussion and learning. Learning from these cases was shared at team meetings, during safety briefings, in newsletters and bulletins and also informed the development of future training.
- Women were encouraged to complete the Friends and Family Test. Overall, response rates were lower than the England average, with the exception of responses for the antenatal period.
- The CQC Survey of Women's Experiences of Maternity Services 2013 showed the trust to be performing about the same as other trusts.
- Safeguarding audits were undertaken reviewing the numbers of concerns raised and the number of cases awaiting decisions.
- Babies underwent hearing screening tests. This was subject to regular audit and demonstrated 98% compliance. Follow-up screening occurred within the community.
- Audits were taken across gynaecology services, for example colposcopy and hysteroscopy. Staff told us the audit into hysteroscopy care showed high patient satisfaction and a low conversion rate to a general anaesthetic.
- The continued development of staff skills, competence and knowledge was seen to be central to the improvement of patient outcomes and formed the cornerstone of the skills drills (PROMPT).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records reviewed showed discussions with the woman and verbal consent obtained before procedures such as internal examinations.
- We saw reasons for procedures explained and consent forms completed and signed by women before surgical interventions. These were then stored securely within the hospital notes.
- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed and submitted to the Department of Health as required. However, there was no audit to ensure submission had occurred.
- While signed consent was not required for the disposal of foetal remains, guidance states women should be offered a choice of how to manage the remains, and as such the conversation should be recorded. Notes reviewed showed clear written consent was obtained indicating the woman's choice of disposal.
- Staff we spoke with had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. During the inspection there were no patients subject to a Deprivation of Liberty application.

Maternity and gynaecology

Competent staff

- All midwives and students were assigned a supervisor of midwives. A supervisor of midwives is a midwife who, qualified for at least three years, has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council (NMC) 2012). They are someone to whom midwives go for advice, guidance and support, and they monitor care by meeting with each midwife annually (rule 9, NMC, 2012), auditing the midwives' record keeping and investigating any reports of problems or concerns in practice. All midwives we spoke with had received an annual supervisory review. The trust's supervisor of midwives-to-midwives ratio was 1:17, slightly worse than the recommended ratio, which was 1:15. However, there were midwives in training to fulfil this role, which would bring the ratio down to 1:15. There were plans to train one new member of staff each year.
- Newly qualified midwives had a period of preceptorship for between one year and 18 months. During this time they were assigned a preceptor (mentor) and were required to complete additional competencies. We spoke to one newly qualified midwife who said they felt well supported to take on the role of a qualified midwife. They were undertaking a task they had not had to undertake previously, but said they felt confident to do so, knowing "I can always ask". In addition, the practice development midwives had moved offices to be co-located on the delivery suite. This allowed them greater access to be able to support midwives and to work with newly qualified midwives. In addition, the practice development midwives ran 'hot spot' weeks identifying new guidance. These were produced in a variety of ways such as posters, display boards and for inclusion in safety briefings.
- We spoke to two staff members who had recently returned from absence of almost a year while on maternity leave. One had undertaken two shifts when they were supernumerary, in order to allow them time to settle back into the work area and follow-up changes that had occurred during their absence. The second staff member had not received this and had returned to work in an area that they were unfamiliar with. This meant there was a risk that changes implemented during their absence would not be identified.
- As well as attendance at trust mandatory training, specific training existed for midwives and midwifery care assistants. This included breastfeeding support, foetal heart trace interpretation and obstetric emergency drills, known as PROMPT, which had been developed by the trust. Attendance at training was monitored and if staff failed to attend they were not eligible for incremental pay rises. Compliance was good, with approximately 92% of staff having completed trust mandatory training and emergency skills drills. This figure was slightly lower for medical staff, at 85%.
- Community midwives were encouraged to undertake orientation shifts to familiarise themselves with other work areas such as the birth centres. Orientation through all areas, however, was not mandatory. We saw most staff described as 'core' and were therefore allocated to one working area. This meant there was a risk midwives did not maintain skills in all areas in which they may be requested to work in an emergency.
- Every three months, nursing or midwifery staff were rotated to work for six months in the Early Pregnancy Assessment Centre. This overlap ensured there were never junior staff on without more experienced staff for support. Junior medical staff were encouraged to attend the Early Pregnancy Assessment Centre for support and training, although this was not formalised or monitored.
- Skills drills training based on the model used in midwifery had been adopted and rolled out onto Cotswold ward.
- Additional training was available to staff at all levels. For example, we heard of a member of administration staff undertaking coaching and management courses.

Multidisciplinary working

- There was a good culture of multidisciplinary working. The advanced nurse practitioner for the Early Pregnancy Assessment Centre worked with the emergency department, community midwives and the fertility unit to ensure appropriate referral criteria were in place.
- Obstetricians and neonatologists were seen discussing cases. There were joint antenatal clinics for women with diabetes or renal disorders, ensuring appropriate clinical expertise throughout their pregnancy.
- We spoke with an intensive care consultant, who described good working relationships with obstetricians whenever there was need for a woman to access intensive care.
- Physiotherapy and urogynaecological services provided support to women who had received a third- or fourth-degree perineal tear in labour.

Maternity and gynaecology

- Urogynaecological care was provided in conjunction with the urology department in the Brunel building. There was good multidisciplinary working and multidisciplinary team meetings for difficult cases.
- Staff had worked with the ambulance service to improve the management of women being brought in to the gynaecological ward. There was a protocol in place that allowed direct admission, thus avoiding admission into the emergency department.

- **Seven-day services**
- The antenatal clinic ran Monday to Friday. There were no routine screening appointments at weekends.
- The Early Pregnancy Assessment Centre ran Monday to Friday. One weekend out of four a clinic was held on Cotswold ward with a sonographer present. Women attending were seen by a junior doctor.
- There was no routine access to allied health professionals at weekends, and the pharmacy department operated on reduced hours.

Are maternity and gynaecology services caring?

Good

We rated the maternity and gynaecological services as good for caring. Care was delivered with kindness and compassion. Choices were well explained and patient-centred, with women having clear choices throughout the service.

Compassionate care

- We saw staff treat women with kindness and compassion. One woman we spoke with said “they are lovely, very helpful. I can’t thank them enough”. Another said “it’s been amazing, they [Staff] are so attentive”. Another said “I needed help to tandem feed [twins] and the midwife was amazing”. However, one woman receiving antenatal care described feeling rushed by staff who were rushed themselves.
- In the CQC maternity service survey for 2013, women were asked about their care at the hospital. The trust scored about the same as other trusts. the trust collected data for the Friends and Family scoring. Participation rates were low and were combined with the overall scores for Cossham Hospital.
- We spoke with the chaplain, who described how foetal remains were managed sensitively. The bereavement forum had been set up to monitor all aspects of bereavement management.

Understanding and involvement of patients and those close to them

- Women attending the Early Pregnancy Assessment Centre had their choices explained fully to them. We saw how staff ensured women had a good understanding of their options.
- Women were fully involved in decisions regarding place of birth. Options were discussed at booking and this was supported with an information leaflet, meaning women had information to take away and discuss with their partners.
- Women for whom antenatal screening had raised significant concerns were given time and space to consider their decisions. Partners were involved in these processes in accordance with the women’s wishes.

Emotional support

- Specialist midwives were available to provide addition support. While the trust did not employ a perinatal mental health midwife, there were plans to develop this role in the near future. Mental health guidelines and a care pathway existed for the care of women who had mental health disorders, including previous puerperal psychosis, and mental health screening was undertaken in pregnancy.
- We spoke with the chaplain, who described having an “exceptional relationship” with the midwives. The chaplain had come to provide additional support to a woman who had recently had a still birth. Staff described the chaplaincy team as very accessible and caring.
- The trust did not have a bereavement midwife. A bereavement forum had recently begun and looked at protocols and pathways, and was attended by the chaplain, antenatal screening midwife, early pregnancy assessment clinic lead and other midwives from the unit.

Are maternity and gynaecology services responsive?

Maternity and gynaecology

Requires improvement

In order to be responsive to patients' needs, the maternity and gynaecology service requires improvement. Women had choice with regards to place of birth and there was good use of specialist midwives and community facilities to provide care closer to teenage and young mothers. While fathers could stay with partners overnight in the event of a stillbirth, there was only one room available and no other facilities for other fathers to stay. There was a single appointment process in colposcopy and women attending the early pregnancy assessment clinic had good access to services and scans, though at times this meant women had to wait several hours. Gynaecological waiting times were within national targets. The service met two-week cancer targets and also 18-week referral-to-treatment times. Emergency gynaecological surgery was generally performed in the gynaecology theatre, but in the event of out-of-hours surgery being required, patients had to be transferred to the Brunel building by ambulance. The disposal of foetal remains was handled sensitively and with care, with the hospital taking responsibility for cremation if requested. Translation and interpretation services were available and there were specialist clinics for women with specific healthcare needs. There was good follow-up of women who had experienced third- and fourth-degree perineal tears at birth.

Facilities within Quantock day assessment unit were cramped and privacy was provided by screen. This meant in the event of a need to break bad news, there was little privacy for these women.

Parking was difficult for staff and patients. Antenatal clinics often ran late, though the frequency of this was not recorded. Bed occupancy was significantly higher than the national average. The postnatal ward was described as "bursting at the seams", with occupancy in excess of 95%. As a result, women sometimes remained on the delivery suite for longer than they needed. This meant that the unit had to close on 35 occasions in the last 12 months. Cotswold ward had 15 beds, which were increased to 19 to accommodate surgical 'outliers' (non-gynaecological patients). At times women from Cotswold Ward experiencing complications in early pregnancy were provided care on the antenatal ward, further compounding the unit's high occupancy.

Service planning and delivery to meet the needs of local people

- Most routine antenatal care was carried out by community midwives based in health centres or community clinics. Antenatal clinics were held at Southmead Hospital from Monday to Friday. In addition, outreach consultant clinics were held at various locations around Bristol. This meant women did not all need to attend the main antenatal clinic at Southmead.
- Multidisciplinary clinics ran for teenage pregnancies; substance and alcohol misuse in pregnancy; and women with medical conditions such as diabetes. In addition, foetal medicine clinics were held. The teenage pregnancy midwife held clinics in the local mother and baby school. This ensured mothers could continue with their education while accessing antenatal care.
- The preferred place of birth was discussed with all women on booking with the community midwife. This was reviewed periodically throughout the pregnancy. Choices were explained and information leaflets given. These were available in several languages and information was also available on the trust's website. For women who were low risk but did not want the risk associated with transfers from a free-standing midwife-led unit, the midwife-led birthing centre at Southmead was promoted. Normal vaginal deliveries and water-birth were encouraged, but staff could readily transfer the woman to the central delivery suite in an emergency.
- Early booking ensured women had access to antenatal screening. The trust target was to have 90% of women booked for antenatal care by the time they were 12 weeks and six days pregnant. Data for 2014/15 showed rates consistently above this target. Within the antenatal clinic there was a quiet sitting room used by staff to provide counselling to women and their partners following antenatal screening.
- The trust had recently formed a bereavement group, chaired by the antenatal screening coordinator and attended by the multidisciplinary team. The group's remit was to review clinical pathways to ensure services best met women's needs. However, there was no bereavement midwife to promote review of services for women experiencing stillbirths.
- Clinics were held for women who had undergone female genital mutilation, supported by the safeguarding midwife.

Maternity and gynaecology

- Community midwifery staff ran a home birth service. During 2013/14 there were a total of 108 home births, a fall from the previous year's figure of 155. Staff we spoke with said they felt this was due to the increased options for midwife-led care available to women as a result of the opening of Cossham Birth Centre in January 2013.
- Fathers could stay with their partners if they had experienced a still birth, but there were no other overnight facilities in either maternity or on Cotswold ward.
- The Mendip Birth Centre had recently been refurbished. All other areas were well maintained, given the age and fabric of the building. We saw a family area being built at the entrance to the postnatal ward. This large room would enable women to spend time with their families away from the ward area.
- Consultant gynaecologists with specialist interest had specialist roles. We saw staff took the lead on different conditions to provide a comprehensive gynaecological service to women.
- Terminations of pregnancy were performed in conjunction with the British Pregnancy Advisory Service and carried out during dedicated times.
- Colposcopy services were provided at a 'one-stop shop'. This was subject to regular audit and complied with national targets. This process meant women were able to attend, have treatment and be discharged from the service in one appointment.
- Gynaecological waiting lists were within national guidelines. Two-week cancer targets were met, as were 18-week referral-to-treatment times. Three theatre slots were allocated each week for emergency cases within elective lists. These were subject to audit. We saw how the allocation of three emergency slots a week did not affect waiting lists and few women had to wait for surgery.

Meeting people's individual needs

- The disposal of foetal remains was handled sensitively and with care. Women who had experienced a miscarriage could bring in the remains for cremation, led by the hospital chaplain if they wished.
- Women with reduced foetal movements were seen on Quantock day assessment unit. In the event of no foetal heartbeat being detected, staff were required to walk the woman over to the antenatal clinic for a confirmation scan before accessing the bereavement suite on the central delivery suite. This meant bad news would sometimes be discussed in a bay behind a curtain. Staff were understanding and sensitive to this and, while handling this as best they could, felt facilities did not support these women's needs.
- Information was available regarding the maternity services on the trust's website. This could be easily translated into a variety of languages. Information was also available through the two support group websites, Birth Centre Bristol and Maternity Voices.
- Translation and interpretation services were available through a telephone interpretation line. Staff were aware how to access this and there was information on the wall in the office to advise staff of the process. Information leaflets were available on the trust website in a variety of different languages to suit the local population mix. For example, women who were experiencing a miscarriage could access an information leaflet in five different languages.
- Specialist antenatal clinics were run for women with other health needs, such as epilepsy and diabetes, as well as substance misuse. In addition, the trust held a female genital mutilation clinic every two weeks.
- Women who had experienced a third- or fourth-degree perineal tear were followed up by telephone at three months. Only those who required additional input were then seen within the gynaecology service. Physiotherapy input was good and physiotherapy clinics were held in the community.
- The teenage pregnancy midwife provided care and support in a number of settings, including schools, the home and community settings. They worked closely with social services and the other specialist midwives to ensure women's needs were met.
- Noticeboards on wards displayed 'You said, we did' notices. We saw one that described how excessive heat during the summer had been addressed with the purchase of fans.
- Before the move to the Brunel building, patients had access to televisions, but in the new building these were no longer in operation. Within the Brunel building free wifi was provided to inpatients, but this did not extend to the maternity and gynaecology unit.
- Meals were provided in a cook-chilled format. Following the opening of the Brunel building and subsequent changes to the way facilities operated, staff reported issues with meals. The new heated meal trolley did not fit in the kitchens on the wards. Instead these were plugged in outside of the kitchen. Staff told us meals

were variable, although plentiful. At times there was insufficient of each choice provided to allow women to have their chosen meal. Staff held regular meetings with managers from the catering department to raise their concerns.

Access and flow

- Without exception, patients and staff reported parking facilities as being difficult. One woman described it as "awful", and another "an absolute nightmare". Women spoke of being late for appointments because of trying find a parking space. One woman said "I dread coming here because of the parking." This was echoed by a report published by Healthwatch, which raised concerns about access, parking and parking costs.
- The Early Pregnancy Assessment Centre was run by an advanced nurse practitioner and was open five days a week from 8.30am to 5pm. Access was 'walk in' after a referral letter, but staff said they did not ever turn anyone away. Morning sessions were for new referrals and each morning staff saw between 10 and 36 patients. The patient pathway was clearly defined. The trust employed two sonographers to undertake the early pregnancy scans and medical access was available from the gynaecological outpatient department or on-call gynaecologist if required. Because of the numbers of women attending, waiting times for scans could vary considerably. However, staff said they felt that an introduction of an appointment system would reduce their flexibility and the numbers of women who could be seen during each session. This would result in some women not being seen for two to three days. Staff were undertaking an audit of attendees to gather their opinions on whether they should continue as a 'walk-in' service or change to allocated appointment times. If there were more than 20 new referrals, staff triaged them and saw some in the afternoons, which were usually set aside for follow-up appointments.
- Out of hours, early pregnancy services were supported by a cross-city working approach. A neighbouring trust performed the service for three out of four weekends, with Southmead Hospital taking all city-wide referrals on one weekend out of four. This was run on Cotswold ward and was supported by a sonographer who could undertake a total of six scans. Women were then seen by a junior doctor and decisions made about their ongoing care needs. Staff within the Early Pregnancy Assessment Centre reviewed the notes of those attending at weekends to ensure weekend decisions were appropriate.
- ·There were routine ultrasound scanning clinics for dating and growth. These were mainly staffed by midwife sonographers.
- ·Women were booked for birth in the community by community midwives. At this point, risk assessments were undertaken and women were referred for consultant-led care if required. There was a clear policy identifying who should be referred, that is, in the event of a multiple pregnancy or raised Body Mass Index above 35 at booking. Women identified as suitable for delivery under midwife-led care had their options discussed and could elect to deliver in either the stand-alone midwife-led unit at Cossham Hospital or in the Southmead midwife-led unit. Other than for dating and anomaly scanning, only those women requiring consultant-led care attended the hospital for antenatal care. This meant care was delivered in places more conveniently located for the women.
- Antenatal clinic often ran late. The frequency of late-running clinics was not monitored and staff did not complete incidents when this happened. Women described long waits to be seen. During the inspection we saw the clinic was running one hour late, despite being a reduced clinic because the consultant was away (clinic cover was being provided by the registrar and junior doctor). One woman said she had waited one and a half hours, while another said they had waited 45 minutes and were still waiting.
- Women attended Quantock day assessment unit if they contacted the unit with concerns and were not in established labour. From here, women were either seen and discharged, admitted antenatally, or triaged to be admitted to the midwife-led unit or central delivery suite only when necessarily. This reduced unnecessary admissions to the central delivery suite.
- Bed occupancy for the maternity services (excluding the delivery suite) in the first quarter of 2014 was 78.6%. This was significantly higher than the England national average of 58.6%. We saw incident reports of delays in transfer to the central delivery suite because of lack of capacity. Staff told us this occurred because there was no room to transfer women on the postnatal ward once they had safely given birth. The postnatal ward was full in excess of 95% of the time and was described by one

staff member as "busting at the seams". As a result, women sometimes remained on the delivery suite for longer than they needed. Occupancy on wards of over 85% is shown to increase the risk of poor care.

- The service was only funded to run three elective caesarean section lists each week. There was a dedicated staff member who booked theatre slots and managed the flow through the elective theatre. However, because of demand, the service always ran an additional two unfunded lists each week, in order to provide elective caesarean section lists Monday to Friday. Women were triaged by a consultant to identify those women who were higher risk. In conjunction with a dedicated booking clerk, they were allocated a theatre slot on the funded days. Lower risk women were allocated slots on the unfunded days.
- At times of increased need, staff were able to refer to the Emergency Staffing Escalation Policy. This showed staff could be provided from the community or Cossham Birth Centre, if they were available. However, there were times when capacity was exceeded, and there were insufficient midwives to provide safe care. At these times the maternity service 'closed', in accordance with their escalation policy. We saw this had occurred on 35 occasions in the last 12 months.
- Cotswold ward had 15 beds. These were able to be increased to 19 beds during times of need. Staff told us this only occurred if additional staff could be found. Since the opening of the Brunel building, staff described a large increase in patients from other surgical specialities on Cotswold ward. Before the move to the new building, there were usually no more than two or three patients from other surgical specialities on the ward. Figures for the month of October 2014 showed there had been a total of 64, many of whom were there at weekends. Staff described the need to manage these carefully in order to prevent cancellation of major gynaecological operations scheduled to come in for surgery on the Monday.At times women in the early stages of pregnancy with hyperemesis were cared for on Quantock ante natal ward. During our inspection we identified three such women for whom there was no bed on Cotswold ward because of surgical outliers occupying beds on the ward. This caused staff issues because the services ran different computer systems, which maternity staff were unfamiliar with.
- Wards stocked regularly dispensed medicines in packs to take home. This helped to facilitate a quicker discharge rather than having to wait for medicines to be dispensed.

Learning from complaints and concerns

- Patients and their partners were encouraged to provide feedback on their experiences. Complaints and concerns raised were addressed, when possible, at the time they were raised.
- Most complaints within the Early Pregnancy Assessment Centre related to the waiting times, so staff were looking at the possibility of an appointment-based system. The other main area of complaint within the Early Pregnancy Assessment Centre was the environment of the waiting room, which had been refurbished as a result.
- Complaints were reviewed and responded to in line with trust policy. Women were often invited in to discuss concerns and discuss outcomes.
- We saw that when complaints had arisen, action had been taken. For example, we saw changes to information leaflets to ensure women were fully informed of their choices.

Are maternity and gynaecology services well-led?

Good

Maternity and gynaecology services were well-led. Whist there were issues within the service, these had been identified. There was a vision and a strategy, though most staff were not aware of it. There was an awareness of a vision for improved facilities, but not a general awareness of the vision for care. The service had a well-defined and functioning governance structure that oversaw activity, performance, quality, safety and audit. These fed into the trust's governance processes and there was strong representation of the service at trust level. Action plans devised as a result of incidents, complaints, audits or case reviews were monitored and there was clear evidence of actions taken and learning having occurred. Leaders were visible and participated in the day-to-day running of the service. There was a cohesive approach between medical and midwifery staff. There was a clear culture of openness and learning and a strong focus on research, with national and international engagement and promotion of the

research undertaken and the outcomes delivered. Staff spoke of dedication and teamwork, which was evident during the inspection. There was good public and staff engagement, with strong input from the maternity services liaison committee. The trust had also recently featured on a television documentary charting the role of midwives and following women in labour. There were opportunities for professional development and as a result there was succession planning across all services.

Vision and strategy for this service

- The vision and strategy was described as "being to maintain and improve safety and to increase the number of environments in which to birth, and to increase the opportunity for home births". The matron in charge of the central delivery suite described their vision as "promoting normality in the heart of complexity". However, these visions were not widely publicised and while some midwives spoke of the desire to make birth centres the delivery place of choice for all low-risk women, this was not known by all midwives. Some midwives felt there were individuals who did not publicise midwife-led care options enough.
- Staff were aware of the vision to create an improved environment. Most staff we spoke with were aware that business cases and proposals were being developed and discussions were underway to review the future of the building.

Governance, risk management and quality measurement

- The maternity service had a well-defined governance structure. Service-wide meetings were held that oversaw activity, performance, quality, safety, audit and risk. Gynaecological meetings were also held, and every six weeks there was an Early Pregnancy Assessment Centre meeting that discussed guidelines, scans, information and was an opportunity for case discussion, risk issues and incidents. All these meetings fed into an overarching Women's and Children's Governance meeting, which in turn fed into the trust-wide governance committee, on which the directorate visionreccr had strong representation.
- The maternity service employed midwives to support risk, audit and professional development. All of these were seen to work closely with the wider multidisciplinary team.
- Areas had risk registers and there was a service-wide risk register. This had nine risks detailed and included the risk of staffing levels and concerns since the opening of the Brunel building. Most, with the exception of a lack of dedicated obstetric cover on delivery suite, had clear actions to be taken and time frames for action to have occurred.
- Audit programmes were actively monitored and patient outcomes recorded and reported nationally. These were reviewed at audit meetings where audits were presented and actions monitored.
- Consultant obstetricians met every Friday morning as a consultant body to discuss issues. Cases were discussed, issues raised and learning identified and shared.

Leadership of service

- Matrons, the head of nursing and director of midwifery were all highly visible and described as supportive and approachable. They undertook clinical shifts and attended ward handovers and safety briefings as well as antenatal clinics. Throughout the inspection we saw they had a good knowledge of activity and clinical issues within the unit.
- Following an incident on one of the wards during the inspection, senior staff remained into the evening to provide support to staff.
- Medical and midwifery staff worked cohesively. Midwifery and obstetric leads worked well together in the promotion of the service. The lead for the birth centre was seen to be a very strong leader, with a vision for normal midwifery and midwife-led care as the norm.

Culture within the service

- We spoke with the senior management team as well as lead clinicians and other consultants. There was a clear culture of learning, research and safe clinical outcomes for the maternity unit.
- Staff were encouraged to participate in audit and research, to report concerns and to identify risks. Learning from incidents, complaints and compliments was encouraged and seen through the use of posters and newsletters throughout the unit. Staff spoke of an open culture and were able to describe changes in practice as a result of incidents and complaints Staff involved in incidents received support through their supervisor of midwives as well as the senior midwife and matron for that area.

- Staff were aware of the whistle-blowing policy and were encouraged to raise any concerns they might have. They told us they would have confidence in raising concerns and speaking out.
- Staff of all grades spoke of dedication and teamwork, and were described as being "committed to the service user". There was a good culture of teamwork present in all areas, from training to guideline review. One staff member told us teamwork is "our approach to everything". Another said "teamworking here works".
- Staff were seen supporting each other, but staff also spoke of a reliance on good will.
- Staff held a review in March each year – similar in style to a Christmas show – put on by staff from all grades and disciplines. This had sketches, impersonations and light-hearted teasing of other staff. Staff described this positively. In addition, staff had just taken part in a 'bake off', where staff baked cakes that were then judged by the hospital chaplain. This had the effect of promoting camaraderie and cohesiveness.

Public and staff engagement

- Birth Centre Bristol is a campaign group established to promote the establishment of birth centres within the city of Bristol. The service worked with them to promote the Mendip midwife-led unit and an option for low-risk women.
- Known as 'Maternity Voices' and meeting four times a year, a cross-Bristol Midwifery Services Liaison Committee (MSLC) was found to be highly functional and well-established. The purpose of an MSLC is to contribute to the improvement of maternity care and facilities for parents and babies. Supported by the clinical commissioning group and the three local NHS trusts, this group had a website that provided information and gave women and their families the opportunity to provide additional feedback on their experiences. We reviewed the quarterly report from this group and saw how outcomes were compared across other trusts within the clinical commissioning group.
- There were approximately 30 volunteers within the maternity service. Many of them were looking for experience before being accepted to undertake midwifery training. All had to apply, have an interview and were subject to Disclosure and Baring Service checks. They were given shifts and undertook tasks supporting midwifery care assistants and the receptionist. In addition, they undertook tours of the maternity unit for women and their partners. Feedback was received and reviewed by the coordinator. We saw comments such as "really useful", and "nice to be able to see everything … the girls explained the rooms well".

Innovation, improvement and sustainability

- There was no 'materials management' or 'stock control' system. Staff ordered stock as required. Stock control systems ensure that shelves are appropriately stocked. If there is too much stock, money is tied up. We saw large amounts of stock items, some of which we were told would take a considerable time to use.
- There was good succession planning evident within the Early Pregnancy Assessment Centre. Every three months a midwife or nurse from Cotswold ward rotated onto the centre to ensure a body of staff with specialist knowledge and skills. This enabled them to support junior doctors in practice. In order to maintain these skills, staff continued to undertake one morning session each month. Staff were in discussion about whether the service could open fully seven days a week.
- Referral into the Early Pregnancy Assessment Centre was accepted from any healthcare practitioner, including school nurses and the prison service, supporting early access for groups who were at times hard to reach.
- The matron with lead responsibility for the birth centre was actively promoting the service (and that of Cossham Birth Centre) across the wider community. This involved publicity for the centre on the local Somali radio, at International Women's Day and attendance at women's groups in the local area. In addition, they were pursuing the development of a protocol to widen the criteria for women to be suitable to deliver in the Mendip (alongside) Birth Centre.
- The trust ran a community midwifery band-six development programme for midwives with a minimum of two years post-qualifying experience to provide the opportunity and support to develop their management skills in preparation for band-seven roles.
- The trust had a speciality maternity training steering group comprising matrons, risk management midwife, obstetric risk lead, anaesthetist, neonatologist, audit midwife and practice development midwife. The role of this group was to look at themes, risks, incidents, complaints and learning and to use them to influence and plan the following year's training course.

Maternity and gynaecology

- The director of midwifery had been in post since 1998. They were seconded to NHS England for two days a week to work as clinical director for the Maternity, Children's and Young Person's Strategic Clinical Network (South West). Part of this role involved the development of shared dashboards, which was being implemented at Southmead. During their absence, the directorate head of nursing and deputy director of midwifery was acting up into their role.
- Medical and midwifery staff were encouraged to actively participate in research programmes and health partnerships. For example, we heard how a grant had been provided by the Tropical Health Education Trust to provide training and support with dashboards in Zimbabwe and research was about to begin into medication to prevent postpartum haemorrhages, a major cause of morbidity in pregnancy.
- The trust maternity services had recently featured on a television documentary charting the role of midwives and following women in labour.

Services for children and young people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Inpatient services for children in the Bristol and South Gloucestershire areas were provided by Bristol's Children's Hospital, which is part of the University Hospitals Bristol NHS Foundation Trust.

Southmead Hospital had a neonatal intensive care unit (NICU), which complemented the trust's obstetric services. The NICU had 34 cots, including 11 intensive care cots (care for babies with the most complex problems who required constant supervision and monitoring), five high-dependency cots (for babies who needed constant monitoring) and 18 special care cots (caring for babies who could not reasonably be looked after at home). The NICU is part of the South West Neonatal Network. During our inspection two inspectors spent the day on the unit and spoke with 12 staff and nine parents of babies being cared for on the unit.

Summary of findings

Staff were caring and compassionate and worked in partnership with parents to provider family-centred care. Care was evidence-based and in line with national good practice. Systems were in place for incident reporting and investigation. Incidents were reported and investigated. Where lessons had been learnt, these were fed back to staff. The unit was clean, there had been no recent issues of cross infection and the staff had achieved 100% in the hand hygiene audits. Medicines were stored appropriately. A double-checking system had been started to reduce the number of medication errors. Medication errors had reduced as a result. The NICU had robust safeguarding processes in place and a clear process of referral for staff when concerns were identified. Nursing staffing was funded to establishment, but was not able to meet the standards set by the British Association of Perinatal Medicine. The parents were extremely complimentary about the staff and the care their babies received. No complaints had been received since before September 2013, but systems were in place if a complaint was received. The NICU had good governance arrangements in place. Staff were aware of these arrangements and how this linked to wider trust committees. The unit was well-led through its ward sisters and head of nursing.

Services for children and young people

Are services for children and young people safe?

Good

The NICU provided safe care to babies. Policies and procedures such as incident reporting, infection control and medicines management were in place to promote safety and staff adhered to them. When incidents occurred, the unit had robust processes in place to investigate and if necessary learn lessons to make sure the incidents were not repeated. Staffing had been a concern within the NICU, and the unit had successfully recruited additional staff to complete their establishment. However, the unit was still unable to make sure there was one-to-one care in intensive care. A business case had been submitted for additional staffing.

Incidents

- Staff completed incident forms when necessary and we saw evidence from staff and minutes of meetings to confirm they did this.
- We saw examples showing that when incidents had occurred, a root cause analysis was completed that looked at what happened, contributing factors, lessons that had been learnt and recommendations, where appropriate. These reports were comprehensive and distributed to the appropriate multi-professionals and governance committees. When lessons had been learnt, an action plan was produced. These detailed the actions to be taken, by whom and by when. Progress against the action plans was reviewed in the clinical governance meetings.
- Incidents were discussed at the NICU clinical governance meetings, which included feedback, parents' comments and future action. One example examined communication with parents and the need to be considerate and sensitive to both parents. Additional training needs were identified and a specialist nurse was brought in from the women's hospital in Bristol to provide additional specialist training to senior nursing staff.

Safety thermometer

- The NHS Safety Thermometer information was provided by the trust before our inspection. It showed that between October 2013 and April 2014 there were no incidences of pressure ulcers or catheter-associated urinary tract infections. The NHS Safety Thermometer results were shared with the clinical and managerial teams.
- Each shift started with a safety briefing, which covered any areas that staff needed to be particular aware about, including the needs of the babies on the unit, staffing issues and safety concerns.

Cleanliness, infection control and hygiene

- The NICU was visibly clean. Parents told us they felt the ward was clean and were reassured that the cleaners were on the ward a lot of the time.
- We observed staff using personal protective equipment such as aprons and gloves appropriately. Hand wash sinks and hand gel were also readily available. All staff we observed adhered to hand hygiene guidance. This included washing their hands and using hand gel when entering or leaving the unit and between babies, and that they were bare below the elbow. This demonstrated staff were adhering to the trust's infection control policy.
- The monthly neonatal highlight reports for infection control detailed risk issues, progress against action plans and future tasks to be actioned. The reports showed that the NICU was achieving 100% in their recent hand hygiene audits.
- Staff were able to tell us about an historic infection control issue that had taken place. They were able to confirm what measures were taken to reduce cross infection to other babies. These measures included double-bagging linen, ensuring visitors wore protective personal equipment and having the unit deep-cleaned. This demonstrated that staff were aware of previous incidents and the measures necessary to prevent future incidents.
- There was evidence of risk management. A lot of building work was taking place around the unit. The unit had been checked for Aspergillus and was shown as clear. A closed window policy when the air conditioner had been fitted in parent areas of the unit was implemented to help prevent the unit being contaminated by building dust.
- To reduce infection risks to the babies, sterile water was used for the hygiene needs of babies in the intensive care and high-dependency cots.
- Cleaning and decontamination processes were robust. These included cleaning of hand wash stations, daily

cleaning of cot and incubator surfaces, weekly decontamination of cots and incubators and weekly changing of respiratory tubing linked to ventilators/ CPAP (Continuous Positive Airways Pressure ventilation).

- One staff member took on the role of link practitioner for infection control. They provided support and guidance for staff and assisted with training regarding infection-control issues. They also completed regular hand hygiene audits and reported the results to the trust audit department.

Environment and equipment

- Equipment used by staff was complete and fit for purpose. The unit had a system in place to promote safety. All of the equipment checked had stickers confirming when they had been checked and where necessary calibrated by the relevant technician and in line with the manufacturer's instructions.
- Resuscitation equipment was checked and we saw this had been documented. However, this was not every day. We found some days when the equipment had not been checked.

Medicines

- All medicines used within the NICU were stored securely in locked cabinets within rooms that only staff had access to. This was in line with guidance issued from the Royal Pharmaceutical Society.
- When medicines need to be stored in a fridge, the temperatures of the fridge had been checked daily to make sure the medicines were being stored at the correct temperature.
- Medication management was audited monthly. This detailed expenditure, the top medicines that were prescribed, and any new evidence updates. The audits also detailed any questions for staff to consider on appropriate prescribing for certain medicines.
- The unit had introduced 'double-checking' to reduce the number of medication errors. This required two qualified nurses to check all medication to be administered at the baby's cot, including the dosage and route of administration.
- The unit received and acted on safety alerts. These were documented on the medicine management reports. An example of this was a contraindication in prescribing two particular medicines and issues that staff needed to be aware of.
- Staff told us that they completed incident forms for all medication errors. We saw confirmation of this when we checked the forms. The errors had been in relation to missed doses. Staff were aware of the reasons and had put measures in place to reduce these incidents. We saw that medication errors had reduced from 15 during August to seven during September 2014.

Records

- We looked at the records for eight babies and found the records to be accurate and reflected the babies' care needs. All entries were dated and signed by the appropriate healthcare professional.
- The unit had a system in place to ensure filing within individual patient notes was kept up to date. This was particularly important for babies who were patients in the unit for a long period of time.
- Discharge information was sent electronically to GPs and health visitors. These records were comprehensive and contained details of the child, health problems and the procedures and investigations they had undergone.

Consent

- Staff told us that consent was sought from parents for any intervention that staff needed to perform on their children. This consent ranged from parents signing formal consent forms for procedures through to staff asking parents' permission to perform care at the cot side.
- The consent forms we reviewed had all been signed and dated appropriately. Procedures had been explained together with the benefits and risks.
- Parents confirmed that staff explained procedures and answered their questions before consent was given or signed. Parents also told us they were kept well informed by staff.

Safeguarding

- The NICU had safeguarding processes in place and a clear process of referral for staff when concerns were identified.
- The majority of staff had received training in safeguarding children and plans were in place for those who still needed to complete it.
- Staff were aware of the safeguarding policies and of their own responsibilities surrounding safeguarding issues. Any concerns were flagged by the neonatal staff

to the community teams such as health visitors and GPs. The maternity team, including midwives, also notified the neonatal team when concerns had been raised during the pregnancy or family history.
- Security was good within the unit. Entry was controlled by the ward staff so that they were aware of who was coming and going from the unit and why.

Mandatory training

- We saw evidence that showed the majority of staff had completed all the mandatory training expected by the trust and the NICU. This included resuscitation skills and infection control. If staff had not completed the training, plans were in place to make sure this was completed at the earliest opportunity.
- A practice development nurse was in place to deliver in-house training and there is a plan to deliver Qualification in Speciality training locally when the nurse has completed the required teacher training."

Management of deteriorating patients

- The staff within the NICU had safety briefings twice a day before handover. This briefing included any issue that affected the unit, such as infection control and staffing levels, but also any particular concerns about the condition of each baby.
- The unit had systems in place to help staff identify deteriorating babies and escalate concerns to a doctor or advanced neonatal nurse practitioner.

Nursing staffing

- The off duty for nursing staff showed that each shift should have 13 or 14 staff. We noted that these numbers were achieved during the day, but sometimes dropped to 11 staff overnight. When staff numbers dropped, the unit had systems in place to obtain additional staff from the trust's in-house nurse bank or through agencies. The British Association of Perinatal Medicine published various standards for staffing levels within a neonatal unit. These standards state all neonatal intensive care units should have nurse-to-patient ratios of 1:1 for intensive care, 1:2 for high-dependency care and 1:4 for special care. The unit was funded for 13 or 14 staff on each shift. This allowed 1:2 ratio of staff to babies in intensive care and the high-dependency unit and 1:4 in special care. Therefore it met the standards for high-dependency and special care, but not for intensive care.
- We asked the senior managers for the NICU about the staffing levels. We were told that following a successful recruitment campaign, the unit was now up to their establishment. However, the increase in new staff had affected the skill-mix, resulting in an imbalance between experienced staff and new staff. Plans had been put in place to make sure the new staff were trained as quickly as possible. Staff told us that this had increased their stress levels, but acknowledged it was a short-term problem and would resolve once the new staff had received training and settled into their new role.
- We were also told that a business case had been submitted to the trust to allow for additional staff to meet the British Association of Perinatal Medicine requirements of 1:1 nursing in intensive care.
- The lack of staffing to care for babies on a ratio of 1:1 in intensive care had been added to the directorate risk register.
- Parents told us they felt the staffing levels were ok and that their babies were safe and well looked after. The nursing staff assessed the dependency of each baby, which informed the number of nurses required to deliver care.
- The nursing staff we spoke with told us how proud they were to work on the unit and that they had a high level of job satisfaction.

Medical staffing

- The British Association of Perinatal Medicine's framework for practice sets out a suggested minimum staffing for medical staff. The standards for out-of-hours care should include two doctors (one junior and one senior) or two advanced neonatal nurse practitioners or a combination of the two. A consultant should also be available through on-call arrangements. The NICU had 10 consultants, eight middle-grade doctors and seven junior doctors on its rota. In addition, eight advanced neonatal nurse practitioners were also employed by the unit. This meant they were able to fulfil the recommendations from the British Association of Perinatal Medicine.
- Staffing rotas were in place to make sure the unit was covered at all times by both junior and senior staff. While this reduced over the weekend, additional staff including consultants could be called on. One junior doctor told us that this had been their best placement, and felt fully involved in what was happening on the unit.

- We saw evidence of good links with the medical deanery. The medical staff also told us that they found this very supportive and responded to their needs. Some of the medical staff rotated between the unit and the NICU at the women's hospital in central Bristol.

Major incident awareness and training

- The trust had a major incident policy, and certain staff within the NICU had been specifically training in major incident awareness and responsibilities.
- Staff within NICU were included in specific trust-wide training when it was appropriate, such as in the use and wearing of specialised infectious disease masks.

Are services for children and young people effective?

Good

The NICU was providing good, effective care for babies admitted to the unit. Policies and guidelines were evidence-based. Staff were well trained and worked in partnership with the parents to achieve the best possible outcomes for each baby.

Evidence-based care and treatment

- We looked at a range of policies and guidelines for clinical practice within the NICU. These had been developed by clinical staff, discussed with the neonatal policy group and ratified by the NICU clinical governance group. They were evidence-based and the references were detailed in each policy and followed national good practice, when available. Monitoring arrangements were also detailed in each policy.
- Guidelines were available to all staff on the hospital's internal intranet system; staff were able to access these as necessary. Hard copies of some guidelines were available on the unit for ease of access.
- The NICU has been accredited as 'Baby Friendly'. This meant the unit had to achieve specific standards, have policies and process in place to support those standards, make sure their staff were fully trained in the areas appropriate to the NICU, and listen and act on the experiences of parents and value parents as partners in their babies' care.

Pain relief

- We observed that staff used a combination of methods to care for babies who may be in pain. This included the use of medicines but also the use of comfort as a means of pain control. As an example, the use of a pacifier before and during a procedure had been shown to be an effective self-comforting action and a good way to reduce pain and stress without medicines.
- Information had been produced to inform parents of the options for pain control. Staff also discussed options directly with parents, depending on the needs of each baby. When parents felt able, they were encouraged to be with their baby during any procedure so they could cuddle or feed them.
- Pain-relief medication was administered when a baby needed it.

Nutrition and hydration

- Monitoring charts for nutrition and hydration were completed appropriately by the nursing staff.
- Mothers were encouraged to breast feed where they wanted to and when possible given their babies' condition. When mothers wanted to breast feed but were unable to, facilities were available to allow them to express milk and to store it appropriately. This allowed staff and parents to feed the expressed breast milk to their babies through feeding tubes.
- Specialist help was available from dieticians and feeding support advisors. Parents told us that they found this help to be invaluable. When mothers did not want to breast feed, the unit had a range of specialist baby milks available for each baby.

Patient outcomes

- Information supplied to us before our visit confirmed the NICU achieved good outcomes for babies. All babies had their postnatal checks performed by the medical staff between the 15th and 20th day after birth.

Competent staff

- Junior staff were supervised by more experienced staff. This had caused problems recently with the increase in new staff. Training and induction plans were in place. Staff realised that this was a short-term problem until new staff gained the training and experience necessary.
- Weekly training was in place for medical staff. This included dedicated junior doctor teaching, a journal club to discuss relevant research and articles relevant to neonates. A grand round, which is a meeting with

multi-professional staff attending to discuss the babies on the unit, care and treatment and any new relevant research took place. An x-ray meeting took place each week. The medical staff we spoke to all told us that there was a good package of teaching available to them.

- Doctors and nurses completed simulation training together when necessary. In addition, training was open to all professional groups and demonstrated a multidisciplinary approach to training.
- Staff were trained to use the wide variety of equipment used within the NICU. When new pieces of equipment were brought in, staff were trained before using it.
- Staff received regular appraisals and if appraisals had not been completed, plans were made to complete them.

Facilities

- At the time of the inspection the unit was being redecorated. Risk assessments had been completed.
- Parents had their own coffee room where they could prepare their own food. They had access to a private enclosed garden.
- A play room was available for any siblings, although parents were required to supervise their children. Different accommodation was available for parents. There were four single rooms and a double room for use by parents who do not live in Bristol. There were three dedicated double bedrooms on the unit for parents to use before being discharged with their baby. Parents were able to care for their baby knowing that staff were close by if necessary.
- Separate accommodation was proposed that will include a living area for parents staying for long periods with their baby who are not resident in the Bristol area. This will mean siblings could stay as well if necessary.
- Recliner chairs were available on the unit to allow parents to have skin contact with their babies.

Multidisciplinary working

- The NICU worked closely with colleagues at the women's hospital in central Bristol and also with the neonatal transfer team. This meant staff followed shared protocols for the transfer of neonates to other hospitals. Additional links had been created with local hospices to support staff and parents with end of life care and facilitated post bereavement follow-up.
- Babies could have their eye checks carried out by the optometrist on Mondays and further treatment could be provided as necessary, including laser treatment.
- Grand rounds took place on the unit every week. These rounds included medical and nursing staff and also included other specialist staff as necessary such as dieticians, health visitors and midwives.
- A good example of the multidisciplinary working was evidenced in the discharge procedure from the unit, which included input from the health visitor, consultants, GPs, community neonatal nurses and the parents. Health visitors and community nurses were introduced to the parents before discharge. We noted that a dietician was also available to advise and support the family. Parents had time to ask questions on the care their baby might need once discharged home.

Seven-day services

- Medical and nursing staff were available on the unit 24 hours a day, seven days a week. This was confirmed by the staffing duty rotas. This included consultant cover.
- The unit had access to out-of-hours pharmacy support so that medication changes could be made when necessary.

Are services for children and young people caring?

Good

Staff in the NICU were caring and compassionate. Staff worked with parents to provide family-centred care for each baby admitted to the unit. Parents were encouraged to be involved as much as they wanted to be in their babies' care. The parents we spoke with were all very complimentary about the staff and the unit.

Compassionate care

- We spoke with eight parents during our visit to the NICU, who told us that overall they had an excellent experience, their babies were well looked after and that the staff were excellent. Comments we received included "the staff are outstanding in caring for me and my baby".

Services for children and young people

- We witnessed excellent interactions between staff and parents and their baby. The staff took time to explain what was happening at each stage of care and involved the parents in as much of their baby's care as they wanted.
- Discharges were arranged as soon as the baby was clinically well enough. A community neonatal team were also in place to support parents with their baby at home. A number of initiatives had been introduced that demonstrated compassionate care.
- Staff acknowledged parking was difficult for parents. A new initiative had been established by the NICU support group. They had purchased their own car with a driver to support parents who had trouble getting to the unit. They would arrange to pick parents up and return them home again.
- Another new initiative included privacy aprons, which allowed mothers to express breast milk at their baby's side, rather than having to go into a separate room. This maintained the privacy and dignity of mothers while they were with their baby.
- Staff were proud of the care they provided on the unit and told us that they would have no hesitation in having their own babies looked after on NICU. We observed very passionate staff who were enthusiastic about their job, their unit and the care they provided to parents and babies.

Patient understanding and involvement

- The parents told us how the staff had been excellent in explaining things to them. We observed this first hand during our visit. Parents were involved in as much of their baby's care as they wanted. Staff encouraged them if necessary.

Emotional support

- Staff provided initial emotional support for parents. Other staff were available, depending on the needs of the family. This included counselling for parents, available on the ward and in the community.
- The chaplaincy service was involved if parents asked for this; other religious and community leaders were available when requested.

Are services for children and young people responsive?

Good

The NICU was responsive to meeting the needs of local mothers giving birth to babies who may require additional care following birth. Good links were in place with other neonatal units locally and across the South West of England and South Wales.

Service planning and delivery to meet the needs of local people

- The NICU provided services for the local communities of Bristol and South Gloucestershire. When the unit had admitted the maximum number of babies, escalations plans were in place to transfer additional babies to other local units.
- The NICU had appropriate facilities to meet the needs of the babies and parents being admitted and, as detailed above, had appropriate accommodation for parents who needed to stay.

Access and flow

- Escalation plans were in place when the NICU became full. Arrangements were in place with other specialist units that could take babies from Bristol. Protocols were in place with local ambulance companies to transfer babies safely to other hospitals.
- Transition arrangements were in place. There were cots on the postnatal ward that babies could be discharged to while still being cared for by postnatal staff on the ward with support from the neonatal nurses.

Meeting people's individual needs

- We saw how the staff encouraged the parents to participate in as much of their baby's care as possible. Staff tried to follow the wishes of the parents, such as if parents wanted to hold or feed their baby. When the prognosis for a baby was not positive, the parents' wishes were followed with regards to end of life care. Staff could make keepsakes with the parents. Additional support was available from the Jessie May Trust, a local specialist charity for terminally ill children.

Learning from complaints and concerns

- The staff told us that they would try and resolve any concerns parents had at the time they were raised. Staff were confident that they had the skills to deal with any concerns raised and where to find additional support if necessary.

- Staff were aware of the trust's complaint process and were able to signpost parents to this process when necessary. We were informed that no complaints had been received about the NICU since before September 2013.
- We saw evidence in the monthly reports that complaint information (when received) was reported each month.
- The NICU also reported the number of compliments it had received each month.
- Information leaflets and posters were displayed informing parents and other visitors on how to give their feedback or make a complaint.

Are services for children and young people well-led?

Good

The NICU had strong leadership at both local and directorate level. We saw robust governance processes in place and staff were aware of how their local meetings fed through into the overall trust governance processes. Ward sisters and the head of nursing were very visible on the unit. Staff told us how proud they were to work on the NICU and of the care they provided to babies and their parents.

Vision and strategy for this service

- The philosophy of family-centred care within the NICU was evident during our inspection. The staff worked hard to make sure they were providing family-centred care. This meant that parents and siblings were fully involved, as much as they wanted to be, in the care of their baby.
- The staff were aware of the overall trust vision to provide 'exceptional healthcare, personally delivered care'.

Governance, risk management and quality measurement

- Governance arrangements were in place. Staff explained how each meeting linked to wider committees and why. For instance, the NICU policy group fed directly into the NICU governance committee, which in turn linked with the directorate and trust-wide governance and risk management committees. Other committees linked to the directorate management team and the overall trust management team.
- Clinical team meetings were held monthly. Minutes of these meetings showed they were attended by the head of nursing, consultants, nursing staff and the clinical governance lead. The minutes showed a range of issues were discussed in relation to the NICU and actions noted, for example. The minutes showed where action had been taken for specific concerns such as one monitor was out of action because of a lost cable. A new one was purchased to get the monitor back into service. Additional monitors were available as necessary as a back-up in these circumstances. New staff were discussed, as was the financial position of the department budget.
- The NICU clinical governance meetings were attended by nursing and medical staff and discussed issues such as findings from route cause analysis, safeguarding, clinical risk and any updates staff needed to be aware of. As an example, it had been observed by staff that gentamicin levels for one baby were incorrect. This highlighted that midwives had not taken the blood tests at the specified time. The midwives were contacted to make sure blood samples were taken at the correct time.
- The unit had systems in place for policy development and approval .It was a trust requirement that audit was an intrinsic part of any policy, so every policy must have an author, review date and an audit date that feeds into the audit plan. For fast track, the medical and nursing chair of the policy group would review urgent policies and make recommendations for sign-off by the governance chair.
- We looked at the risk register for the NICU. This detailed the issue and the resulting consequences, together with any controls that might be necessary and an action plan for resolution of the risk.

Leadership of service

- We observed good relationships between clinical staff and NICU managerial staff and the managers within the women's and children's services directorate. Staff confirmed these relationships were good and felt their immediate managers and directorate managers were very supportive to them as individuals and to the NICU as a whole.
- At the time of our inspection, the NICU was without a matron, which left a gap in managerial and professional support between the ward sisters and the head of nursing. Arrangements had been made to cover the responsibilities of the matron in the short term.

- The NICU held its own clinical team meetings. We looked at minutes from these meetings. The minutes confirmed a range of issues were regularly discussed, such as staffing, administration issues, updates from the regional networks, issues that need to be cascaded to staff and any particular items that needed discussion and decision. Medical, nursing and administration staff were able to attend this regular meeting.
- The staff did tell us that they felt detached from the trust as a whole, but added they understood the focus of the trust was the opening of the new hospital building.

Culture within the service

- We found the culture within the NICU to be open and transparent. The staff showed this in their communication and interactions with parents.
- The NICU had a reporting culture. Staff told us they had no hesitation in reporting incidents and following trust policy.
- The primary culture within the NICU was family-centred. Parents were involved in the care of their baby as much as they wanted to be. Staff told us that building the relationship with parents was as important as the care the babies received.
- Staff told us of how proud they were to work on the NICU and that they would be happy to have their own children looked after on the unit.

Public and staff engagement

- We saw evidence that parents and staff were involved with any changes to the NICU; these included recent refurbishment and also how the unit responded to continued building work on the main hospital site.
- At senior nurse meetings there was an opportunity to bring up problems. Staff felt the trust listened to them now, but previously the new building took priority.

Innovation, improvement and sustainability

- Staff told us that financial pressures within the trust may prevent them from recruiting additional staff to meet the British Association of Perinatal Medicine standards in full.
- We saw evidence that staff were continually working in partnership with parents to improve the care provided to their babies. The ward sisters, head of nursing and directorate management team had plans for the future of the NICU.
- The focus at the time of our inspection was the refurbishment of the unit while maintaining the safety of the babies being cared for.

End of life care

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

Information about the service

End of life care was delivered when required by the specialist palliative care team and ward staff throughout the hospital. The specialist palliative care team consisted of 1.6 whole time equivalent consultants, five specialist nurses and an end of life care facilitator (whole-time equivalent 5.5), an occupational therapist and a chaplain. The specialist palliative care team gave support and guidance to ward staff for those patients who required support for symptom management or had complex care needs. Support was also provided to relatives of patients who were nearing the end of their life. The team was available from 8.30am to 5pm Monday to Friday, and out-of-hours support could be accessed by medical staff through the local hospice if required. We visited ten wards and other departments, including the Intensive Care Unit (ITU), the Emergency Department (ED), the chaplaincy, mortuary and the Bereavement Services. We spoke with 33 staff members about end of life care. We reviewed 13 care records and spoke with five relatives and three patients. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

The specialist palliative care team were passionate about ensuring patients at the end of their life received high-quality, compassionate care. All staff understood their responsibilities to report incidents, but the specialist palliative care team omitted to report some incidents because of their concern for ward staff. This may have put patients at risk of unsafe care. The specialist palliative care team responded promptly to referrals and requests from colleagues to provide guidance and support for patients who were at the end of their life or required symptom management for complex medical conditions. However, the specialist palliative care team felt symptom management and psychological care needs were not always being met out of hours because they were not able to offer a seven-day service. Patients identified as being in the last days and hours of their life received care that was planned for in advance. Multidisciplinary team meetings were conducted to ensure the needs of patients they were supporting were being met. Improvements were required to identify patients who were potentially in the last year of life to enable early discussions and plans for future care. Throughout the trust, all staff we spoke with valued the support, expertise and responsiveness of the specialist palliative care team.

End of life care

Are end of life care services safe?

Requires Improvement

The specialist palliative care team consistently coordinated and planned safe care for patients. However, they were not regularly reporting medication administration incidents (because of concerns about ward staff). Medication and equipment were available to support patients who were near the end of their life. Staff understood their responsibilities to protect patients from the risk of abuse.

Incidents

- There had been no Never Events in the specialist palliative care service (serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented).
- Staff throughout the trust understood their responsibilities to raise concerns, to record safety incidents and near misses. However, the specialist palliative care team had noticed multiple clinical incidents relating to delays and omissions in medication administration on the wards. Not all of these had been reported as incidents because the specialist palliative care team felt the ward nurses were under significant pressure and "doing the best they could". The specialist palliative care team remedied any omissions or delays themselves to ensure patients received their required medication. However, this meant that investigations into incidents that could have led to improvements in practice had not been instigated.
- The last incident reported that related to end of life care was in July 2014. The incident had been reported by staff who worked in the emergency department. The incident had been investigated and discussed at the daily safety meeting held in the emergency department to ensure all staff were aware of the policies and procedures to be followed.

Equipment

- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers should be withdrawn by 2015 (these are devices for administering medicine). The specialist palliative care team had been responsible for training and producing guidelines for staff throughout the trust to use an alternative syringe pump. Records were kept of staff attendance on the course and some individual ward staff were given further training to enable them to train colleagues. We saw in the records that an appropriate number of staff had been trained.

Medicines

- Anticipatory medicines were prescribed for patients who had been identified as requiring end of life care. These medicines were prescribed in advance to enable staff to meet any changes in the patients' condition promptly.
- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for end of life care. We saw that medication had been prescribed in-line with the trust's guidelines.

Records

- Records were stored securely in trolleys on the wards to protect patient information, but were accessible to staff if required.
- The specialist palliative care team told us that obtaining sufficient information about a patient's medical history was difficult. They found it "almost impossible" to obtain notes when patients were admitted through the acute assessment unit (AAU). They told us the information was usually in the form of temporary notes and the content was disorganised. Some information was held electronically, but often this record was incomplete. The specialist palliative care team told us that complete patients notes were vital to aid accurate assessment of the patient's condition.
- We reviewed nine records of patients who had been reviewed by the palliative care team for symptom management or end of life care. Documentation was clear and legible. When required, end of life care plans were in place and end of life assessment tools were used.
- A new unified Bristol Do Not Attempt Cardio Pulmonary Resuscitation Records (DNACPR) form had been produced, which was valid across all adult care settings in Bristol, North Somerset and South Gloucestershire. An audit to assess the correct completion of these forms was conducted in April 2014. The results of the audit showed some forms were not being completed in line with trust policy. For example, 35% of forms had not been countersigned by a GP or hospital consultant, as was the trust's policy. Recommendations were made

End of life care

and an ongoing action plan produced to include regular audit of the DNACPR forms, to begin in September 2014. We were not sent any further information to enable us to assess how the trust had progressed with their action plan.

- We found there were inconsistencies in completion of DNACPR forms across the hospital. We sampled 26 records for patients who staff said had a DNACPR order, to check they had been completed correctly. We found 10 had been completed in line with General Medical Council guidance and hospital policy and 16 had not.

Safeguarding

- The specialist palliative care team informed us safeguarding training was mandatory. Records confirmed all of the palliative care team staff had undertaken the training.
- All staff throughout the hospital were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults and children from abuse.

Mandatory training

- We saw records that confirmed the specialist palliative care team were up to date with all the trust's required mandatory training. This included infection control and health and safety training.

Assessing and responding to patient risk.

- Ward staff were able to access advice and support for deteriorating patients from the specialist palliative care team. Out of hours (evenings and weekends), further advice could be sought from doctors from the local hospice.
- We looked at 13 patient records. When there was an identified risk involved in caring for a person, this risk was assessed and a plan put in place to ensure the risk was safely managed.
- Patients who were in their last days or hours of life had their care recorded on the trust's Caring for Patients at End of Life Care Plan, which is a structured document designed to prompt staff to ensure that all aspects of good end of life care are addressed and that an individualised plan of care and all discussions are clearly documented."

Nursing staffing and Medical staffing

- The specialist palliative care team comprised 1.6 whole time equivalent consultants. One consultant worked for three days a week and the other consultant for four days a week. Specialist medical registrars worked on a rotational basis. The team included five nurses, an end of life care facilitator, an occupational therapist and a chaplain.
- The team felt they were understaffed given their increase in workload and size of the hospital. The specialist palliative care team stated in their annual report for April 2013–March 2014 that they had experienced a year-on-year increase for referrals. Advertisements had been placed for a specialist nurse, but the team had been unable to fill the vacancy. To address this, the team were advertising for a lower grade nurse as a development post.
- Referrals for patients who required support during end of life care were made electronically to the specialist palliative care team from clinicians throughout the trust.
- The specialist palliative care team had daily morning briefings to update on changes in patients' condition, assess new referrals and allocate work for the day.

Major incident awareness and training

- The specialist palliative care team had not been involved in any major incident training.
- Mortuary staff did not have any additional facilities in the event that the mortuary became full.
- The mortuary staff we spoke with were unaware of the major incident plan for the mortuary in the event that the mortuary became full. This meant mortuary staff were unacquainted with the process to follow in the event of a major incident.

Are end of life care services effective?

Requires Improvement

The specialist palliative care team was highly regarded by all of the staff we spoke with throughout the trust. Clinicians and nursing staff told us the team responded promptly to referrals and were accessible and effective in supporting patients with end of life care needs. End of life link nurses had been appointed to each ward to ensure new information relating end of life care was shared with ward staff. Patients who had been identified as being in their last days or hours of life did not always receive care in line with national guidance. Patients who may have been in their last year of life because of long-term health conditions were not always recognised by staff. Staff had been

End of life care

identified as requiring further training in order to provide optimal end of life care. However, ward staff were unable to access further training because of clinical pressures on wards. Death certificates were not consistently completed in a timely manner.

Evidence-based care and treatment

- The specialist palliative care team told us care was based on guidance from National Institute for Health and Care Excellence (NICE) defining standards for clinical best practice in end of life care. NICE quality standard 13 (2011) states families and carers of people who have died receive timely verification and certification of the death. The staff in the Bereavement Office told us they aimed to provide a timely service to the bereaved.
- The specialist palliative care team told us that the trust did not achieve one of the Priorities for Care as set out by the Leadership Alliance (established following the review of the Liverpool Care Pathway for the dying patient) because within current resource allocation they are unable to offer a seven day service. As part of the action plan to meet the recommendations of the National Care of the Dying Audit for Hospitals 2015, the specialist palliative care team aimed to develop a seven-day service. However, a date for action was not available because additional funds needed to be found.
- The specialist palliative care team had taken action in response to the 2013 review of the Liverpool Care Pathway. A care plan had been developed to facilitate staff to document end of life care. In the notes we viewed we saw the plan was not used consistently across the trust and some staff were unaware of its existence. The palliative care team acknowledged they had not been able to deliver effective training about the care plan to all members of staff because of the clinical demand on their service. The care plan was developed
- The trust achieved the seven key organisational performance indicators in the National Care of the Dying Audit 2012/13. These included KPI 1: Access to information regarding death and dying. Five out of ten of the clinical indicators were below the national average. These included KPI 4: Assessment of the spiritual needs of the patient and their nominated relatives or friends. The specialist palliative care team had produced an action plan to address areas that required improvement; this was to be re-audited in March 2015 to ensure improvements had been made.
- The specialist palliative care team had produced end of life guidance for staff. This took the form of a box file, which was available on the wards we visited. The file contained information about the end of life care plan, assessment tools and bereavement information. Staff told us the information was useful when supporting patients at the end of their life.

Pain relief

- We spoke with three relatives of patients receiving end of life care. They told us staff responded promptly to requests for pain relief.
- Pain assessment tools were used to assess patients' level of pain. Nursing staff we spoke with were clear about how to assess for changes to a patients condition and what medication would be required.
- Pain-relief medication was available to patients at all times. Staff had received training from the specialist palliative care team to enable them to administer medication using a syringe driver (a machine that allows medication to be delivered continuously under the skin to enable effective symptom control when medicines given by other routes are inappropriate or no longer effective). Staff told us they had an adequate supply of syringe drivers and medicine stocks on wards.
- The specialist palliative care team told us they had access to a TENS machine (transcutaneous electrical nerve stimulation), which could be used to help ease pain in some patients.
- The specialist palliative care team produced guidance for medical staff for appropriate prescribing of pain relief.

Nutrition and hydration

- Patients' nutritional and hydration needs were assessed on a daily basis by ward staff and the specialist palliative care team. They used an assessment tool that was fit for purpose.
- Patients were referred to a specialist dietician if required, to ensure they had sufficient nutrition and hydration; this was included as part of their end of life care plan.
- Patients identified as being in the last hours or days of life had their nutritional and hydration needs evaluated on a daily basis by the specialist palliative care team. Records showed appropriate actions had been taken and discussions with relatives and patients recorded.

End of life care

Patient outcomes

- Patients in the last days of life could be referred to the specialist palliative care team. Their care needs were assessed and staff used the end of life plan and tools developed by the specialist palliative care team to ensure they received effective care.
- We reviewed 13 care records and saw that four patients who may have been in their last months or year of life because of long-term or complex health conditions had not been identified. These patients may have benefited from early care planning and discussions about their wishes for future care. The specialist palliative care team told us that patients in their last year of life were not consistently identified throughout the trust.
- The target for assessing a patient when they were referred to the specialist palliative care team was 48 hours. The team were 100% compliant with this target and if the referral was received within working hours had exceeded this target to be 100% compliant in assessing a patient within 24 hours of referral.

Competent staff

- All staff in the specialist palliative care team had regular appraisals. Clinical supervision was provided for nurses by a clinical psychologist, either in a group or individually. Staff were able to request supervision when required, but the sessions were usually available monthly.
- Donations from relatives and patients were allocated to a 'trust fund', which was used to pay for further training in, for example, advanced symptom control, nurse prescribing and teaching. The Macmillan service had previously helped fund training courses.
- All wards had palliative care link nurses. The role of the link nurse was to act as a resource for ward staff and to champion end of life care in their clinical setting. Link nurses attended regular quarterly meetings with the specialist palliative care team and subsequently updated ward staff.
- The palliative care team provided a three-day training course for registered nurses that incorporated the recommendations of the National End of Life Care Strategy (2008) and the National End of Life Core Care Competencies (2009). The aim of the course was to enhance knowledge, skills and attitudes of trained staff. However, we were told that although courses were fully booked, few people were able to attend because of ward staffing pressures.
- The end of life strategy group had identified for the past year that ward staff lacked skills to deliver optimal end of life care. In the last report for September 2014, this risk had escalated from being a moderate risk to a significant risk of the trust not reaching objectives in this area. The trust board was approached to reconsider the role of mandatory training for staff providing end of life care.
- The specialist palliative care team delivered regular training for student nurses, junior doctors and specialist registrars.

Facilities

- The specialist palliative care team told us they were based outside of the main part of the hospital, in an office shared with administration staff. They needed to have frequent confidential discussions, which they found difficult in a shared office, and they were situated far away from the patients and staff they supported. They felt they would be best placed in the main hospital, with a designated office that provided confidentiality and promoted more effective team working.

Multidisciplinary working

- The team held a weekly multidisciplinary team meeting to discuss patients care, which was attended by all members of the specialist palliative care team.
- The specialist palliative care team endeavoured to discharge people rapidly if they wished to be cared for at home or in a community setting. They worked closely with the community palliative care team and district nurses to facilitate an effective discharge. The team's target for discharging patients was 24–48 hours from initial request. However, the specialist palliative care team told us the discharge could take longer if there was a delay in organising care packages.
- Members of the specialist palliative care team attended seven cancer site specific weekly MDTs to ensure that all disciplines attending the MDT can agree the most appropriate treatment plan for patients and to facilitate appropriate referral for patients with specialist palliative care needs. This was in accordance with NICE guidelines and cancer peer review standards.
- GPs were informed when a patient was discharged. The palliative care team told us they often called GPs directly, which enabled the team to ensure prompt continuation of the patient's care.

End of life care

- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.**
- Ward staff and the palliative care team were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were aware of the processes to follow if they thought a patient lacked capacity to make decisions about their care.
- The majority of records showed that the patients' next of kin had been involved in making decisions when their relative lacked mental capacity to make decisions for themselves. We looked at the care records for two patients receiving end of life care who lacked capacity to make decisions about their care. It was unclear how decisions had been made for these patients. We bought this to the attention of staff working on the wards concerned.

Seven-day services

- Inpatients had access to specialist palliative care input from 8.30am to 5pm Monday to Friday. NICE's quality standard 13 on end of life care for adults (2011), statement 10, states that "service providers ensure that systems are in place to provide timely specialist palliative care at any time of the day or night for people approaching the end of life who may benefit from specialist input". The trust was not meeting this quality standard because specialist cover was not available at the weekends. Out-of-hours cover was supplied by ward staff and doctors. A local hospice provided a 24-hour advice service, which medical staff could access for telephone support with symptom management.
- We saw in care records that patients had been assessed by the palliative care team and medication and symptom management guidance documented to support staff to care for patients at evenings and weekends.

Access to information

- When patients were discharged to another service, a referral form was completed that documented all relevant information about the patient.
- An end of life care plan and assessment tools were used when the patient had been identified as being in their last days or hours of life. This assisted ward staff to identify and care for patients appropriately at the end of their life.
- An information sheet that explained end of life care was given to the relatives of patients who had been identified as being in their last days and hours of life.

Are end of life care services caring?

Good

The specialist palliative care team were passionate about providing people who were at the end of their lives with compassionate and sensitive care, often working above their contracted hours to ensure patients' needs were met. Emotional and psychological support was available for patients and their relatives. Patients were provided with compassionate care on the majority of the wards, with the exception of 27b (a respiratory medical ward) where staff told us there were times when they felt they were so short staffed they were regrettably unable to meet all of the care needs for someone at the end of their life.

Compassionate care

- Relatives described the care as "very good" on the wards we visited.
- During our inspection we observed privacy and dignity being maintained. For example, staff knocked and waited for permission to enter side rooms and blinds were closed when personal care was being provided.
- Staff in the Bereavement Office told us the policy was for the deceased person's possessions to remain on the ward until collected by relatives. Staff said some bereaved relatives did not want to return to the ward their relative died in. If this was the case, they ensured the belongings were in the Bereavement Offices when the relatives arrived.
- Mortuary staff monitored the condition of deceased patients on arrival at the mortuary. The mortuary staff told us most of the time deceased patients had been cared for in adherence with hospital policy. If they had any concerns, they addressed them with senior staff on wards immediately.
- Mortuary staff offered regular training to hospital porters to ensure deceased patients were treated with respect and dignity when being transferred to the mortuary.
- Staff on ward 27b (a respiratory medical ward) told us they tried to ensure patients receiving end of life care and their relatives were comfortable. However, because of the clinical needs of other patients on the ward, staff said they were unable to spend much time with end of life patients and relatives. Staff told us that unfortunately there had been occasions when patients had died alone.

End of life care

- Staff in the ED contacted bereaved relatives and friends two weeks after the patient's death to ascertain if they had further questions or queries. Relatives were invited to return to the ED to discuss any outstanding concerns with a nurse. The staff in the ED sent a card to bereaved relatives and friends on the first anniversary of the patient's death.

Understanding and involvement of patients and those close to them

- We reviewed 13 care records and saw documentation written by ward staff and the specialist palliative care team in nine records, which detailed discussions with the patients and their relatives. The recordings detailed information and discussions about medication, prognosis and family concerns. In the remaining four records, the patients had not been identified as being in the last year or months of life, although ward staff stated they had long-term complex medical conditions and their prognosis was poor. The patients had not been referred to the specialist palliative care team and it was not evident that any discussions about their future wishes for care had taken place.
- Relatives told us they felt involved and informed with decisions made about care and treatment.
- The National Care of the Dying Audit 2012/13 showed that communication by health professionals with both the patient and their relatives regarding recognition that the patient was dying was better at Southmead Hospital than the England average.

Emotional support

- Patients and relatives were able to access emotional support through the specialist palliative care team, clinical psychologists, chaplaincy and Macmillan service. An ex-specialist palliative care nurse worked as a volunteer for the chaplaincy.
- The specialist palliative care service provided emotional support for ward staff. The team described a patient with very complex end of life care needs who had recently died. The team felt the ward staff needed support in caring for the patient. The team remained on the ward (working over their contracted hours) to ensure the needs of the patient and staff were met.
- Assessments were made to determine whether patients receiving end of life care required support with their mental health needs, for example if they had anxiety or depression. Referrals were made to the mental health liaison team and treatment started if required.
- The chaplaincy had three chaplains who provided a service seven days a week, 365 days a year. The lead chaplain worked within North Bristol NHS Trust and another trust within Bristol. He felt that because of the reduction of staff in the chaplaincy, they were unable to offer the service they would like to offer. We were told spiritual needs were not always assessed; however, nurses did contact them to attend dying patients if required. They had good working relationships with other faiths to ensure the spiritual needs of patients were met.

Are end of life care services responsive?

Requires Improvement

Staff throughout the service consistently told us the team were highly responsive to requests for support and guidance. Patients referred to the specialist palliative care team were seen within 24 hours of referral, if made within working hours. Specialist palliative care was not available to patients out of hours. The discharge process was not always effective for patients requiring a fast-track discharge. Staff throughout the trust reported difficulties and delays in discharge for patients who wished to be cared for in the community.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team was referred 1,247 patients between April 2013 and March 2014. Referrals had increased for patients with a non-cancer diagnosis from previous years. For example, the referral for patients with heart failure had increased by 39% on the previous year. This showed staff recognised the value of input from the specialist palliative care team for conditions other than cancer.
- All of the wards we visited had single rooms to accommodate patients and their visitors.
- Relatives told us visiting restrictions had been lifted, which enabled them to spend unlimited time with their family member in privacy.
- Before the move to the new hospital in May 2014, the specialist palliative care team had a unit with designated beds for end of life patients with complex needs. The specialist palliative care team and staff throughout the hospital felt that some patients with

complex needs could have had their needs more effectively met on the unit. Staff told us this was because patients were looked after by specialist nurses who were able to respond to changes in symptoms more rapidly than staff on a general ward.
- The target for assessing a patient when they were referred to the specialist palliative care team was 48 hours. The team were 100% compliant with this target and if the referral was received within working hours had exceeded this target to be 100% compliant in assessing a patient within 24 hours of referral.

Meeting people's individual needs

- The specialist palliative care team told us they were concerned about out of hours care for people at the end of their life, who had complex needs because of the other pressures on clinical and nursing staff. They felt symptom management and psychological care needs of patients were not always being met out of hours.
- We did not see any patients who did not speak English, but ward staff told us translation services were available throughout the hospital. The specialist palliative care team told us they were able to access support from the learning disability support nurse if required.
- Patients' spiritual and religious needs were not consistently identified. Patients may not have had support from their preferred spiritual advisors in their last days and hours of life.
- National Care of the Dying Audit found assessment of the spiritual needs of the patient and their nominated relatives or friends to be lower than the England average.
- A quiet room was available in the ED. The room was used for the breaking of bad news and was available for relatives and friends of the deceased to use. Refreshment facilities were available, and they were able to see their deceased relative and use other facilities without entering the ED.
- Staff in the bereavement service office told us most clinical areas responded quickly to requests for completion of documentation after a patient had died. However, they often breached the five day deadline for completion of death certificates if the patient died in the intensive therapy unit (ITU). This was because clinical staff in the ITU did not see completion of the certificates as a priority. A senior staff member in ITU confirmed they did not consistently complete death certificates in a timely manner.
- On most of the wards we visited people had access to drinks when required. Across the trust staff told us that dispensing hot food could be problematic due to the size of the wards which meant food often became cold. Staff on ward 27b told us that at times they were not always able to support patients appropriately with their nutritional needs. This was due to staff shortages and the high dependency of patients. We raised this concern with senior members of the trust.

Learning from complaints and concerns

- The specialist palliative care team conducted an audit of all complaints between 2012 and 2013 to identify complaints relating to end of life care. During this period, 4.17% of all complaints related to end of life care. The audit report summarised two main themes, staff attitudes and relatives not understanding care or being given enough information. Themes were to be fed back to the trust board to ensure they were aware of the identified issues, with a plan to address staffing levels and training requirements. At the time of our inspection we could not be assured that the complaints had been raised at trust board level or an action plan produced to address concerns.

Access and flow

- The specialist palliative care team attended the daily board round in the AAU to identify patients requiring end of life care. This facilitated early care planning to ensure the needs of the patient and their relatives were met.
- Staff throughout the trust knew how to make a referral to the specialist palliative care team and reported the team usually responded the same day.
- Systems were in place to help the rapid discharge of people to their preferred place of care. The specialist palliative care team coordinated rapid discharges for patients nearing the end of their life. Their aim was to discharge patients to their preferred place of care within 24 hours, but this was not always possible because of the availability of community beds and time taken by the local authority to confirm care packages.
- Ward staff told us they did not always have the time to discharge patients rapidly.
- Mortuary staff told us they did not have any additional facilities in the event that the mortuary became full.
- Staff told us the mortuary had significantly reduced in size, from approximately 80 cold storage areas to 54 and they were often trying to discharge deceased patients to

the care of funeral directors in order to be able to take further deceased patients. We were told another infant fridge was due to arrive shortly and negotiations were underway with local funeral directors to care for deceased patients when the mortuary become full.

Are end of life care services well-led?

Requires Improvement

We found strong, positive leadership within the specialist palliative care team. All of the ward staff we spoke with found the specialist palliative care team to be approachable and supportive and valued the expertise of the team. Governance systems were in place to monitor the effectiveness and quality of care provision. The Specialist Palliative Care team and the End of Life Care Strategy Group have felt frustrated that end of life care has been seen as a low priority by the trust which has impeded developments in end of life care.

Vision and strategy for this service

- Members of the specialist palliative care team attended a regional group, which worked together to enhance end of life care across the local area.
- The specialist care team had a vision for their service. They had submitted a business plan for another consultant and were recruiting for a specialist nurse to enable them to meet their vision for the future.
- The director of nursing represented end of life care at board level to ensure end of life care was highlighted at trust board level.

Governance, risk management and quality measurement

- The End of Life Care Strategy Group met quarterly to discuss and act on clinical governance issues. We were told the trust board member rarely attended the strategy meetings. This was confirmed in minutes we saw. We saw there had been two meetings held in 2014. The board member had not attended either of them. Work plans and strategy were communicated to the Board Quality Committee on a quarterly basis.
- Issues for concern had been identified. This included that ward staff lacked skills to deliver 'optimal end of life care' and that there was a high dropout of staff attending training. The group also identified meeting the CQUIN for 2014/15 (the Commissioning for Quality and Innovation framework, set up to encourage providers to share and continually improve how care is delivered and lead to overall improvement in healthcare) was going to be a significant challenge as it related to engaging staff and changing practice. Plans had been developed, but not yet implemented to support best practice and the board were being asked to consider making end of life training mandatory.
- The specialist palliative care team could not be assured that patients were able to die in their preferred place because no audits of this had taken place since 2011.

Leadership of service

- The consultant and lead nurse were clearly dedicated to providing high-quality end of life care.
- All of the staff we spoke with throughout the hospital knew who the senior members of the team were, and described them as visible and supportive.

Culture within the service

- The specialist palliative care team were committed to delivering excellent end of life care throughout the trust.
- All the ward staff spoke positively about the specialist palliative care team. Staff thought they were well-led, highly skilled and passionate about their work.
- The specialist palliative care team felt they were not listened to or supported by the board, which had an impact on their ability to deliver care. The team told us the board member responsible for end of life care did not often attend their meetings. The team felt undervalued by the trust board and felt they were low priority within the trust overall.

Public and staff engagement

- The specialist palliative care team contributed to a regional initiative supporting hard-to-reach groups, such as work with homeless people, prisons and patients with HIV.
- Members of the team gave occasional talks within the community about end of life care. They were unable to run a previously successful cancer open day because of time constraints.
- The specialist palliative care team conducted a staff satisfaction survey from January to March 2014 and had 35 responses to the 90 questionnaires distributed. Overwhelmingly, staff from all grades valued the input from the specialist palliative care team.

End of life care

Innovation, improvement and sustainability

- The specialist palliative care team felt they were "fire-fighting" and were unable to proactively plan their day-to-day work because of clinical pressures. They felt the current situation was not sustainable.
- The team felt that by expanding their service to provide cover 24 hours a day, seven days a week, they could develop their team further and provide better care for end of life patients. Senior staff felt frustrated because they wanted to do "so much more", but funds were not available for further development.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

The North Bristol NHS Trust provided an outpatient service of approximately 700,187 first and follow-up appointments over the previous 12 months. Approximately 388,219 of these had been provided at the 'old' Southmead site. In May 2014 a new site had opened at Southmead, the Brunel building, and most of the services previously provided at Southmead Hospital and Frenchay Hospital were now provided in this new building. Therefore the majority of outpatient clinics were now located in the main hospital building (the Brunel building) and in other locations on the Southmead site. During our inspection we visited the outpatients service for dermatology, urology, physiotherapy, orthopaedics, cardiology, respiratory, radiology, geriatric medicine and phlebotomy. We spoke with 36 staff, including the outpatients management team, receptionists, booking staff, nursing staff, healthcare assistants, consultants and therapists. We spoke with 28 patients. We looked at the patient environment and observed waiting areas and clinics in operation. The diagnostic imaging department provided a large range of diagnostic services on behalf of GPs and other medical units within the trust. The facilities included general x-ray, MRI scanning, CT scanning, ultrasound, nuclear medicine and angiography. This department carries out over 350,000 examinations a year and employs approximately 250 staff over four sites.

Summary of findings

The atrium of the Brunel building, the outpatient waiting areas and the clinics were clean, comfortable and well maintained. The new building had opened in May 2014. We found that a safe environment was maintained. There were problems in the accessing and availability of medical records for patients attending clinics. There was a trust-wide action in place to address these problems, which were ongoing at the time of our inspection visit. Patients were very positive about the quality of clinical treatment and the professionalism of all the staff. Compassionate care was provided. Staff and volunteers interacted with patients in a friendly manner and treated patients and visitors with dignity and respect. There were shortfalls in the displaying of information for patients. This included information about treatments and conditions, help and support groups and also about how to report complaints. There was also limited information displayed about waiting times in clinics. There was a backlog of unreported images and actions had been instigated to address this and the reporting of images had been prioritised to ensure those that were more urgent were reported on first. However, the risk register lacked details of the actions, the timescales and who had overall responsibility for this. There was also a large backlog of appointment requests, which the trust was addressing. Action had been taken to ensure patients most at risk were prioritised. Not all the services were meeting the national referral-to-treatment targets. There had been problems with appointment booking

Outpatients and diagnostic imaging

since the opening of the new centralised call centre. There were some difficulties for patients booking appointments at times and also for some specialities with the booking of urgent appointments. An action plan was in place to address these issues. This included staff recruitment and training. Since opening, the hospital has been developing a centralised outpatients service with a new management structure that covered the majority but not all the services being run as outpatient services. There was clear leadership and risk assessments and action plans were in place to address the identified issues.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found that a safe environment was maintained with the required safety checks being completed and recorded. All staff had been trained in incident reporting and mandatory training was being appropriately monitored. We saw that regular infection audits were carried out and there were nominated staff to lead on infection control. Staff had completed safeguarding training and were aware of the procedure to follow if they needed to raise a concern. There was a backlog of unreported and actions had been instigated to address this and the reporting of images had been prioritised to ensure those that were more urgent were reported on first. However, the risk register lacked details of the actions, the timescales and who had overall responsibility for this. We found there were problems across the majority of clinics with the frequency of missing patient notes. There were also shortfalls in the storing of notes securely. There was a trust-wide action plan in place to address these problems. Overall we have judged that improvements are required.

Incidents

- There had been no reported serious incidents in the outpatients service since the new hospital opened in May 2014.
- Staff we spoke with were clear about the process for reporting incidents. However, several staff we spoke with told us they received little or no feedback after submitting an incident form.
- All staff we spoke with in the diagnostic imaging department understood their responsibilities to raise concerns and to record safety incidents, concerns and near-misses. All staff we spoke with felt confident that they could discuss incidents with their direct line manager and that concerns were listened to and acted on.
- The diagnostic imaging department was involved in a Never Event when an image was misinterpreted during a surgical procedure. An action plan was created as a result and radiography staff informed of what was being put in place and information was placed on walls in clinical areas. When asked, all staff could confidently

describe the incident, explain what actions had been put in place and how they have changed their practice as a result. Audits were being carried out to continually monitor this area of practice.

Cleanliness, infection control and hygiene

- There was a manager based at the hospital who supervised the cleaning staff. We were told that all cleaning staff completed an induction that included training on moving and handling, fire safety and COSHH (Control of Substances Hazardous to Health). The supervisor liaised with the facilities manager for the hospital and was aware of the process for reporting any incidents or concerns.
- We saw the main waiting areas for all of the outpatient clinics that were located in the main concourse of the Brunel building. Off these areas were sub-waiting areas for the respective clinics. All of these areas appeared clean and hygienic, as were the treatment and consulting rooms we saw. Patients we spoke with told us they thought the hospital was always clean and expressed no concerns about the risk of infection.
- All staff we spoke with had completed infection control training. We observed that reception staff and clinical staff observed the 'bare below the elbow' policy.
- We saw that nursing staff completed and recorded a monthly check titled Clinical Equipment Cleaning and Decontamination, and there was a checklist for a Matrons Walk Round that was also completed monthly.
- Toilet facilities were located throughout the outpatients area and these were clearly signposted. We looked at a sample of these and saw they were regularly cleaned and that this was recorded.
- There was limited information displayed about hand washing in the main clinic waiting areas. Some of the reception desks had gel-dispensers available and some did not.
- The staff in the diagnostic imaging department understood their responsibilities in relation to infection control and hygiene. They undertook hand hygiene audits and knew who the audit lead was. We were told that a monthly email was sent to the staff showing the results of these audits.
- All clinical areas observed in diagnostic imaging had a tool for recording when the x-ray machines had been cleaned. This was completed daily by the radiographers. During our inspection we observed that on one machine the cleaning chart had not been completed on 6 November 2014.
- We observed that all staff in diagnostic imaging were bare below the elbow and knew where to find the uniform policy on the intranet.

Environment and equipment

- The clinic waiting areas we visited were well maintained and provided a reasonably comfortable area for patients. There was sufficient seating.
- Each of the waiting areas had their own resuscitation trolley, known as a crash cart. We looked at a sample of the checking charts for these and saw that regular checks were being completed. Staff who completed these checks confirmed they had completed the required training.
- The diagnostic imaging department was well maintained and designed to improve the pathway for patients. In emergency department diagnostic imaging there was a CT scanner next to the resuscitation room to minimise transfer time between departments.
- We observed that doors into the department that should remain locked and have controlled access by use of a card were freely opening at both ends of emergency department -ray. People could walk into an x-ray room without being noticed by a member of staff and potentially be exposed to harmful radiation.
- In plain film x-ray, two machines were in one room with a partition wall between them. We observed that conversations with patients could be overheard from one area to the next and that privacy and dignity could be compromised.

Medicines

- The majority of the clinics we visited did not store medication, but when this was required it was done securely with the correct recording completed. Procedures were in place for storing controlled drugs, if this was required.
- Patients we spoke with told us they received appropriate information about the medication they were prescribed and that changes in medication were explained to them.

Records

- In all of the clinics in the Brunel building we were told there were regular problems with missing patient notes.

Staff told us of patients not being seen by clinicians because of missing notes and that temporary notes were put in place on a regular basis. We were told that incident forms were sometimes completed when this happened, but not always because of its frequency. Some patients could have more than one set of temporary notes in circulation.

- There were problems with the storage of records in the hospital, with the main records department being located on another site. There were plans to implement an electronic records system in the new hospital and we were told there was limited storage in clinic area and offices for notes. These were contributing factors to the problem of notes being missing for clinics.
- We also saw sets of notes that were stored insecurely and notes were not always left in lockable containers. For example, in the urology department we were told that a security door had been broken for several weeks before it was mended.
- A Patients Records Committee had been set up and there was a trust patient records review and action plan in place to address the identified issues. This included steps to improve the tracking of records, the delivery of records to clinics and the training of staff. Regular auditing against the plan was being undertaken by the managers. This plan was being overseen by the records committee with support from operational management. The issue was on the trust risk register.
- An audit of medical records in October 2014 showed that one of the main areas of risk for medical records related to the security of records within the Brunel building. Swipe access to areas not working in administration areas and vigilance regarding locking the notes trolleys and of records in reception areas were noted as areas for improvement.
- There was an off-site 'records library' that had been in place for six years. The library was well organised by a location shelf and staff were able to identify where most records were. However, there was not enough storage for all records on shelves and some were piled up around the edges of the warehouse next to shelving. This posed an issue for staff in assigning a storage area within the library. We reviewed the tracking system for two sets of notes that were stored on the floor. One had been identified as having been removed from the shelving, with no onward point. The second had been recorded as in the shelving directly adjacent to their location on the floor.
- Records were individually barcoded so that they could be tracked and traced through their pathway in the trust. This electronic system relied on staff manually tracking records at each point, i.e. leaving the library; being received in the onsite records hub; being received in outpatients and being received by medical secretaries in the administration offices.
- There were issues with this tracking system and although staff in all areas tried to ensure that records were tracked, there were times that this did not occur and records went 'missing' because they were not tracked, following outpatient clinics, for example. An audit of medical records in October 2014 showed that 81% of records were appropriately tracked throughout their pathway.
- We were told that one of the challenges in managing records within outpatients was the removal of administrative support in the department after the move to the Brunel building.
- Records for outpatients clinics and theatre bookings were 'pulled' a week in advance and sent to the Brunel building records store. When records were 'missing', the medical records team made every effort to find them and only made up a temporary record on the day before the outpatient appointment. We were told this temporary record would include the referral letter and information from the medical secretary would be sought in order to provide information for that appointment.
- The medical records team had identified areas where they could support outpatients departments in the absence of administrative staff. This included checking off records against clinic lists and putting records in appointment order. We saw this happening in practice.
- There was a project ongoing to improve the availability of medical records within outpatients and to reduce the number of missing records. Action plans were in place to support this and a medical records dashboard had been developed, although not formally implemented at the time of our inspection. These action plans linked in with the outpatients' action plan to improve referral flow.
- Although actions were ongoing at the time of our inspection, we saw a clear focus on improvement with the Notes Flow Working Group meeting during our inspection and a clear set of recommendations being

developed and circulating in the week following our inspection. These included clear flow processes for all records on the outpatient and inpatient pathways and clear actions to be taken over a three-month period.
- There were actions in place in the week after our inspection to review notes in administrative areas to ensure they were all tracked and to return notes that were no longer required to the off-site library.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Patients we spoke with told us that the clinical staff asked for consent before starting any examination or procedure. We observed staff asking for consent.

Safeguarding

- All the staff we spoke with told us they had completed safeguarding training, which was part of the required mandatory training for the trust. Nursing staff and reception staff we spoke with were aware of the process to follow if they needed to report a concern.

Mandatory training

- Healthcare assistants, reception staff and nursing staff we spoke with told us they were up to date with their mandatory training. The matron in the outpatients department explained how they audited the mandatory training every month to ensure that training was completed.
- The staff in diagnostic and imaging we spoke with were up to date with their mandatory training and told us it was easy to book for training updates on the intranet. Staff were trained in safeguarding adults and children, basic life support, fire, infection control and manual handling.
- However, two radiographers said that they were given very little time to attend mandatory training because of the staffing pressures of the department, although they were able to attend clinical governance days because these were built into the rota.

Assessing and responding to patient risk

- When asked, all staff we spoke with knew who their radiation protection advisor and supervisor was for each clinical area. They also felt confident to discuss concerns or issues with their line manager. Staff knew where the local rules were for each area and where copies of the ionizing radiation (medical exposures) regulations (IR(ME)R) 2000 could be found.
- The senior management staff in the diagnostic imaging department told us there were not enough radiologists to report on the backlog of plain film images that had been taken. When we asked for more information, they said the number of unreported images was in the thousands and that a locum radiologist had been employed to report on these images, and some of the workload had been outsourced to a radiology reporting company. The reporting of images had been prioritised to ensure those that were more urgent were reported on first.
- This issue was on the risk register, but no details had been filled about the actions taken, who had overall responsibility or what the target date was to resolve the situation. We received information after the inspection that estimated that within the last year 4,642 images that needed radiology reporting were currently not reported on. The trust did not know how many of these x-rays had been reported on in the patient notes.
- Staff were present in all the waiting areas for clinics and able to notice patients who appeared unwell and needed assistance. However, from some of the reception desks in the main atrium, where patients waited before being called through to the clinic, there was a limited view of some of the waiting areas. Staff we spoke with told us if required the staff member would escalate the situation and arrange for a doctor to see the patient.

Staffing

- Each service was supported by reception staff, doctors, nursing staff and healthcare support workers.
- The radiographers said that during busy times and out of hours they “felt stretched” to deliver the services required, particularly in emergency department x-ray between 4pm and 8pm. We were told that at this time there was demand from emergency patients, inpatients and outpatients from clinics delayed in other parts of the hospital. They said that although they had seven radiographers on duty during these times, they often had only three members of staff available because others were on wards or in theatres. Staff said that during this time they would prefer to have a senior staff member available for support, but this was often not possible. One senior member of staff said the band-five radiographers would benefit from having additional supervision and support.

Outpatients and diagnostic imaging

- We observed that while we were in emergency department x-ray there were no senior radiographers in the department. Staff were also concerned that none of the senior management team are on-site after 5pm.
- Radiographers said that out-of-hours patients were often left outside x-ray without an escort. During busy times, the radiographers did not have time to attend to these patients and that sometimes they were not given a call bell.
- We spoke to three team leaders, who said that managing the rota was difficult because they sometimes struggled to provide adequate cover for vacant shifts. They felt that because of staff turnover they did not have the required skill mix to provide certain services effectively; six of 18 staff had recently left. They all said that a lack of administration support with the rotas meant that they spent a lot of their time constructing the rota rather than performing their main duties.
- The management team in diagnostic imaging told us they had a low sickness rate of 4% and historically had a low staff turnover rate of between 7 and 8% (below the trust average). They told us that this had now gone up by 5% because of a loss of staff not able to travel or move to the new building. Developing the new team had presented some challenges.

Are outpatient and diagnostic imaging services effective?

We report on effectiveness for outpatients, but we are not currently confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in outpatients departments. We observed that patients were receiving effective care and treatment. Patients were provided with sufficient information about their treatments and the opportunity to discuss any concerns. While a lot of written information was available for patients, there was limited documentation displayed on the walls in the waiting and clinic areas. Staff were positive about the effectiveness of the multidisciplinary working across the outpatients service.

Evidence-based care and treatment

- We were told that guidelines, such as NICE guidelines, were followed when appropriate. The outpatient's matron received NICE and Medicines and Healthcare Products Regulatory Agency MRHA alerts from their manager and then cascaded this information through band-six and band-seven nursing staff. There was an information folder at each clinic gate for use by all staff. Staff were aware of how to access policies and procedures online. Nursing staff told us how new practice guidance could also be cascaded through the specialist area they were working in.
- The diagnostic imaging department had integrated diagnostic reference levels into their practices as required by the ionizing radiation (medical exposures) regulations (IR(ME)R) 2000. The equipment in the department regulated these levels. Staff were aware of why diagnostic reference levels were essential to their practice.

Patient outcomes

- Patients we spoke with were positive about the clinics and the staff they were seeing. Patients told us they were satisfied with the professional approach of the staff. One patient we spoke with told us "I think they are great, if it was not for them I'd be dead by now, it's been a marvellous experience for me". Another patient told us how they felt reassured by the information the nursing staff had given them, which had included some written leaflets about their condition. There was limited information displayed in the clinics about anything associated with the speciality such as treatments or support groups, though we saw that several clinics had literature available for patients. Staff we spoke with told us there were currently restrictions on the use of the walls for displaying information in the new building.
- We observed that none of the clinics had any safety metrics publicly displayed about the performance of the department.

Competent staff

- Many clinics were run by a clinical nurse specialist, including care of the elderly, dermatology, pain management and cardiology. There were nurse protocols and competences in place and nursing staff we spoke with, who ran these clinics, were positive about the training they had been supported to complete. Patients who attended these clinics were very positive about the nursing staff.
- Staff working in the physiotherapy department told us about staff training that was tailored to meet the specific needs of the therapists. Nursing staff we spoke with were positive about some of the specialist training they were supported to undertake.

Outpatients and diagnostic imaging

- For any new or agency nursing staff there was an orientation sheet that was completed by the nurse in charge before they took responsibility for a clinic area.
- In diagnostic imaging areas policies and protocols for the use of machines were in each clinical area and acted as a reference guide. All staff underwent local training in the use of each machine. Staff had a refresher on a yearly basis and signed a log to say they understood and were comfortable working on that machine.
- Staff said they found it difficult to undertake continuing professional development. One radiographer said they had to work in their own time in specific modalities in order to gain experience.

Multidisciplinary working

- We saw evidence of positive multidisciplinary working in a variety of clinics. For example, in the pain management clinic registered nurses ran clinics that could incorporate input from physiotherapy, psychology and occupational therapy. Patients could also receive acupuncture and intrathecal buscopan treatment, which was a new treatment for pain management.
- Nursing staff and healthcare assistants we spoke with in other clinics, such as dermatology and renal, told us teamwork and multidisciplinary working was effective and professional.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with said that they completed consent forms before treatment, when this had been appropriate. We were told that clinicians asked for consent before starting any examination and explained the procedure that was to take place.
- We observed that radiographers discussed with the patient the process involved and asked them what area was to be scanned, gaining assumed consent. In MRI we observed that a questionnaire was filled in and the radiographer obtained informed consent from the patients before taking them into the scanning room.
- Radiographers said they had the confidence to challenge referrals from other parts of the hospital. They said a common issue was the wording used on a request card.

Are outpatient and diagnostic imaging services caring?

Good

We found that the outpatient department services provided at Southmead Hospital were focused on the patients. We observed staff and volunteers interacting with patients with a caring and friendly approach. We observed staff and volunteers throughout the department treated patients, their relatives and visitors in a respectful manner.

Compassionate care

- During our visit we spoke with 28 patients and all said they found the staff were caring and respectful. Throughout our visit we observed staff and volunteers interacting in a caring and considerate manner with patients. We saw that patients were treated politely and respectfully when asking for directions or information about clinics. We saw that the volunteers, known as move makers, were proactive in providing assistance to patients in the main atrium of the Brunel building.
- In general we found that patient confidentiality was respected. There were a large number of private rooms available in the clinic areas. Patients we spoke with told us that conversations with clinical staff were conducted in private.
- We spoke with three patients waiting in the reception of diagnostic imaging. They were all positive about the care they had received at the hospital from the staff. They said the move makers were an asset to the service and enabled them to find the department quickly.
- The majority of staff we observed provided compassionate patient-centred care. When observing an x-ray, the radiographer explained the procedure, asked if they had any questions and explained what they were doing at all times.
- The reception staff engaged well with the patients and carers, and adapted the level of support accordingly. During one interaction the receptionist specifically told the patient where to sit, to make it easier for her to find the correct x-ray room when her name was called.
- We observed one incident of poor care when being shown around the department. A member of the management team was discussing the cannulation process and pulled the curtain back on a patient and pointed at her cannula without talking to the patient beforehand or asking her consent.

Outpatients and diagnostic imaging

Patient understanding and involvement

- The majority of patients we spoke with told us they felt involved in their care and were fully consulted about their treatment options. While clinics often had a wide range of leaflets displayed for patients to take that gave information about conditions and treatments, information was not on general display because of the restrictions on using the walls in the Brunel building.
- Patients told us how they were able to ask questions during their consultations and also by speaking with nursing staff running the clinics. We were told that the nursing staff were patient and listened to the concerns that were raised.

Emotional support

- Information was available, though not displayed, about various support networks or groups that patients could access.
- There was a multi-faith area that was provided and clearly signposted for patients and visitors.
- Staff explained how they would ensure that the patient was in a suitably private area or room before discussing any distressing news. We were told that it was always possible to locate a suitable room for these conversations.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Some services were experiencing difficulties in booking urgent appointments and patients had difficulty in getting through to the booking call centre. An action plan had been implemented to address the efficiency of the booking system, which included staff recruitment, training and clarifying the booking process for urgent appointments across the different specialities. There was a large backlog (49,000) of appointment requests, although actions had been put in place to address this and the number having decreased by 20,000 in the previous three months. Action had been taken to ensure patients most at risk were prioritised. Some clinics offered direct access to patients and also extended opening in the evenings. Some services were struggling to meet the demand on their capacity and were not meeting the 18-week referral-to-treatment target. We saw that some clinics did not run on time and that patients were not always kept informed of any delays There was an inconsistency in how well patients were kept informed of waiting times in individual clinics. There was limited information displayed for patients about the trust complaints and advice service. There was no information displayed about the availability of chaperoning for patients. Overall we judged that improvement was required.

Service planning and delivery to meet the needs of local people

- Several clinics had arrangements to respond directly to patient needs. For example, we were told how an urgent referral could be made by a GP to the orthopaedic clinic, with an extra appointment slot being provided if required. The nursing staff in the urology clinic described how a patient with suspected malignancy would follow a specific pathway involving a one-stop clinic within two weeks. Patients were also sent a leaflet explaining the process. The department had also introduced a process for responding to the need for urgent lithotripsy (a technique for treating stones in the kidney and ureter that does not require surgery) within 24 hours by ensuring that an emergency appointment slot for this service was kept open.
- While some patients' appointments had been cancelled because a lack of medical notes, the outpatients matron told us that no actual clinics had been cancelled since the new hospital had opened.
- We spoke with several patients who had more than one appointment on the same day. While for some there was a considerable gap between their appointments, we were told that their experience of booking appointments had greatly improved over previous months. Two people we spoke with explained how previously their appointments had been a week apart, but now were always on the same day. Some patients told us that letters confirming appointments were not always prompt in arriving, but also told us that this had improved in the past two months.
- Some of the clinical staff were critical of the booking of appointments and said there had been problems since the move to the new site and the creation of a new booking centralised centre. Staff told us that some clinics had reduced capacity for urgent referrals and the patient pathway was difficult to organise if someone needed several tests on the same day. This was difficult for patients who may have travelled considerable

distances to attend the clinic. Some staff in the clinics told us they worked closely with the booking centre to resolve issues and that the situation had improved over the previous three months.

- The trust currently had an off-site appointment booking centre. It had been planned for this new centralised service to open four months before the new main hospital, but this had not been possible and it had opened simultaneously. The call centre also received a high proportion of calls that should have been directed to other departments. We saw that staff were working under pressure to meet the high number of callers and process appointments. The managers of the outpatients acknowledged the difficulties and we saw there was an action plan in place to address the identified issues. A process was ongoing to increase staffing numbers, including recruiting additional team leaders. Work was also being done by the managers to ensure staff throughout the various hospital departments were using the booking system consistently.
- The trust had an identified problem with a large backlog in its 'appointment request' queue. At the time of our visit the list stood at 49,000, having been reduced by 20,000 in the previous three months. The reasons for the size of the list had been identified and there was an action plan in place to reduce it. This included appointing designated staff to work on validating the backlog of patient requests. This issue was identified on the trust risk register and the action plan aimed to resolve the issue within the next three months.
- Patients and staff we spoke with consistently mentioned the problems of parking. We heard about the stress of driving around looking for somewhere to park and then missing appointments, of patients phoning to say they could not park and were therefore returning home, and patients parking illegally, anxious to attend a clinic.
- Staff we spoke with explained how parking could be a problem because staff were not allocated a parking permit. The trust had plans to provide more parking as the rest of the Southmead site was developed, though this would not be for another two years.

Access and flow

- The trust was not meeting the national target time for the 18-week referral-to-treatment times for outpatient services. The data showed that the trust had operated between 97% and 94% over the previous 12 months. Clinics with high average waits for first appointments included spinal surgery, pain management, clinical immunology and allergy, and neurology.
- Individual departments managed and monitored their performance in relation to these targets.
- The department was not always meeting the two-week target for urgent cancer referrals, when people should be seen by a specialist within two weeks of a GP referral. The data showed that over the previous 12 months between 94% and 96% of patients were seen within two weeks. Over the same period between 90% and 96% of patients were waiting less than 31 days from diagnosis to their first definitive treatment.
- We found that patient waiting times varied in the different clinics, from a few minutes to over an hour. Information about waiting times was not displayed for patients, though we were told this facility was available on the television screens that were located outside the main clinic waiting areas in the central building. Some reception staff and nursing staff told us they would inform patients if clinics were running late. However, several patients we spoke with expressed frustration at the lack of information about waiting times.
- The individual clinics did not display any information about the efficiency of the service, for example the current figures on referral-to-treatment times, did-not-attend rates or staff training completion.
- The trust had introduced a text reminder system for appointments that had reduced the did-not-attend rate in recent months to 5.5%. The manager of outpatients told us there were issues around the recording of 'did-not-attends', which when addressed would further reduce this figure.
- We were told by the management team in diagnostic imaging that a high percentage of patients breached the six-week waiting time for diagnostic procedures between May and August. The risks were identified and an action plan produced. The data we received showed that 99% of scans were completed within six weeks of referral in September. The management team said this would not have been achieved without the dedication and flexibility of the staff.
- We spoke with patients who said they received information from the diagnostic imaging department in a timely manner with instructions on how to get to the department. They had a contact phone number if they had any questions.

- We spoke with one patient who had been called to attend for a procedure as part of a cancellation list. He said that when he had attended the diagnostic imaging department in the past, he had never had to wait.

Meeting people's individual needs

- Patients we spoke with told us they were allocated enough time with staff when they attended their appointments. We were told that clinicians were informed about their medical histories, but two patients we spoke with commented that the consultant had told them they did not have a full set of notes available.
- In the entrance to the building there were electronic checking-in stations for outpatients. Patients were required to check themselves in and then go to a main waiting area for a group of clinics. A television screen in the main waiting area displayed the names of patients to call them to a sub-waiting area, where they would wait to see a clinician. When we observed the checking-in stations, we saw that most patients required help to use them from the volunteers.
- Clinics were located off the main hallway, called the atrium, through entrances called 'gates'. Patients we spoke with said they found the numbering system hard to follow and we saw that the volunteers working in the atrium area often provided directions. Staff and patients we spoke with were critical of the lack of signs in certain areas, particularly when several clinics were running from the same sub-waiting area.
- Some nursing staff running clinics told us they provided chaperones if either the patient or the consultant requested this, but no information was displayed about this facility. One consultant we spoke with said they were concerned about the lack of training around chaperoning responsibilities. At the gastroenterology clinic a consultant told us that they were concerned that nursing staff were not always available to chaperone. They felt that part of this problem was nursing staff being required to undertake administrative tasks previously done by reception staff. We were told that the lack of chaperones could lead to some procedures not being undertaken as an outpatient appointment and a patient having to be admitted as a day case or an inpatient.
- Some clinical staff we spoke with were critical of the room configurations in the clinics, which could contribute to delays in clinics. For example, in the orthopaedic clinic a consultant had the use of only one room, meaning they could not dictate notes until patients had dressed and left, causing a delay for the next patient. In the urology clinic area the facilities for patients to discreetly provide urine samples were poor. Staff told us patients could be embarrassed having to walk through the main clinic area carrying samples.
- We were told that sometimes there was insufficient seating in the sub-waiting areas when several clinics were running simultaneously. Staff also said they thought the seating could be unsuitable for some elderly patients or those with mobility problems.
- Staff working in the orthopaedic clinic were concerned there was no specific stretcher provision for back trauma or surgery follow-up patients because they may be unable to stand for long periods.
- Other clinical staff were very positive about the new working environment. Staff in the physiotherapy clinic described their new facilities as "superb", and said it provided all the facilities and equipment required to meet the needs of patients.
- We spoke with several staff who had completed dementia training run by the trust, which they all described as excellent. However, staff felt that that there was a need to develop some clearer procedures and guidelines to meet the needs of patients who have dementia.
- Throughout the waiting areas in the Brunel building there was little information being displayed for patients. We saw that information leaflets were available on some of the desks and also the specialities had various stocks of leaflets that they could give to patients. However, general information about support or advice groups, information about complaints or chaperoning was not displayed. The managers of the outpatients department told us there were restrictions on displaying posters in the new building, but that they thought this was time limited.
- Several patients we spoke with said they would appreciate greater information about the waiting times in the clinics. We saw limited information displayed about whether clinics were running on time or if there was an extended waiting time for patients. Staff told us there was the capacity to display this information on the television screens in the waiting areas, but this was not being done regularly by the majority of the clinics.
- Patients also told us that problems with parking when they visited the hospital added to the stress of visiting for an appointment.

- Translator services were available for patients, both in person and using telephone loudspeaker. We were told that this should be booked through the GP when the appointment was arranged. There was no information displayed in the outpatient areas advertising the translator services that were available.
- We observed that the volunteers working in the atrium were proactive, and were helpful and respectful towards patients. Several patients we spoke with commented on the help and support that was provided.
- Within the atrium area there was also a mother and baby changing area, three cafes and also a multi-faith area, which had several single rooms for use by visitors.
- Staff said that during busy clinic days patients could be waiting for a long time to get their scan. They said that sometimes patients could be waiting between one and three hours for their x-ray.
- Imaging support workers were employed to meet the patient in the waiting room and prepare them for their scans or procedures. They managed the flow of patients and ensured that patients were cared for when they were waiting. We spoke with an imaging support worker who said they supported the radiographers when specific patient issues presented. One task they explained was to act as a chaperone, though they had not received any information or training on this.

Learning from complaints and concerns

- The trust had a complaints and advice service but we observed that there was limited promotion of this service in the outpatients areas. Information leaflets were available but patients were required to ask for these from reception staff. Patients we spoke with told us they would be prepared to make a complaint but were unaware of the formal process to follow. Patients told us that the reception staff responded politely and sympathetically when they had expressed their concerns.
- Some patients we spoke with told us they had complained about parking and appointment booking problems informally to the staff, but there was no recording of these concerns.
- The trust's annual report showed there had been five formal complaints made about the outpatients service in the previous 12 months.

Are outpatient and diagnostic imaging services well-led?

Good

Visible and clear leadership was being provided by the management of the outpatients team to the services that were being directly managed within the new department. Staff were clear about the management structure and the lines of accountability. Staff were kept informed of the development of the outpatients department and felt the managers of the service were approachable, responsible and listened to staff. There were systems in place to identify and manage risks, and action plans were in place to address the key issues and challenges the department faced.

Vision and strategy for this service

- We met with the outpatients manager, the service manager and the matron. They were able to explain clear objectives for the development of the department. The management team had clear priorities in relation to the action plans for improving the appointment booking systems and the access and availability of patient records.
- Regular meetings were held that supported the work being done in the department. There was a monthly outpatients board meeting with representatives from every department and weekly outpatient management meetings.
- The managers felt that the management of a centralised department was still being developed and that they felt well supported by the trust management.

Governance, risk management and quality measurement

- Monthly governance meetings covering the whole of the department were held and there were also individual governance meetings for each speciality.
- There was risk register in place for the outpatient department and this was regularly monitored and updated by the manager. We saw that action plans were in place to address the issues on the register. These had clear deadlines and nominated individuals responsible for tasks. However in the risk register for diagnostic imaging services not all risks had sufficient detail , for example the backlog in reporting on plain film images.

Outpatients and diagnostic imaging

- The service manager and the matron for outpatients had offices that were located in the centre of the main outpatient area. They kept in regular contact with the staff in the various clinics and also conducted walk-arounds and checks that were recorded.
- We observed the risk register for diagnostic imaging. This was managed by the service management team and was regularly discussed in team meetings.
- X-ray team leaders were expected to manage and formulate actions from incident forms but told us they thought they were insufficiently trained to do this.

Leadership of service

- Not all of the outpatient clinics came under the management of the central outpatients management team, for example urology and physiotherapy were line managed from within their relevant directorates. The new structure had come into place when the new hospital had opened. The staff we spoke with who were under the main outpatients team were positive about the management and leadership. Staff were confident about approaching the outpatients matron, service manager or overall manager about issues, or for support. Staff told us they felt very positive about having an overall outpatients management team.
- The managers of the various specialities we visited said they were well supported by the managers of the outpatients department and also at directorate level. We were told that information was communicated effectively. Staff told us they were kept informed of trust developments and were aware of the challenges that the organisation faced.
- Staff we spoke with who were managed outside of the outpatients structure were positive about their managers and the communication and leadership in place. Staff in the plastics, urology and dermatology clinics told us they were well supported by management and had regular appraisals completed.
- Diagnostic imaging managers felt information from the board could pass them by and they felt disconnected from the executive leadership within the organisation. Some managers told us they felt undervalued. Several staff said they felt that the senior management in the department were not visible enough but were well supported by their direct team leaders.

Culture within the service

- Nursing, healthcare and reception staff we spoke with told us they thought that a good teamwork ethos was being developed in the department. We were told that staff were supportive toward each other and that the managers were approachable and responsive.
- Several staff told us there had been problems since the new department had been opened, which had caused stress for staff when dealing with patients who were unhappy with cancelled appointments, parking problems and the Brunel building layout. However, we were also told that staff could see that work was being done to address issues. Staff also commented that they felt proud to work in the new building and be part of a new department that was being developed and was innovative in the delivery of service.
- All staff said they enjoyed working in the diagnostic department and felt that since the move into the new building they had bonded as a group. Before the move, staff were worried about how well the two teams (from Frenchay and Southmead hospitals) would merge onto one site, but any concerns had since been addressed.

Public and staff engagement

- We were told that every four weeks there was a staff meeting in the diagnostic imaging department where staff were updated on upcoming events, audits, appraisals, mandatory training and also to celebrate the achievements of the department. Minutes were taken and emailed to all staff. All staff we spoke with were aware of these.
- We saw a copy of the newsletter the staff had produced to called 'Outpatient Times', which shared news and information for staff about the department.

Innovation, improvement and sustainability

- The staff in the diagnostic imaging department had created a journal club to encourage innovative ideas and suggest improvements to the service. We were given evidence where radiographers discussed an article on nasogastric tube insertion. From this, nine recommendations were made to the management team to improve the service. We were told that the management team had not yet responded to the recommendations.

Outstanding practice and areas for improvement

Outstanding practice

- The emergency department's performance in relation to stroke treatment was excellent.
- Clinical staff in the emergency department were compassionate and caring; they showed passion, resilience and determination to provide high standards of care in the face of significant challenges.
- Staff in the emergency department worked well as a team. The senior team were strong, highly respected leaders, who motivated and supported their staff.
- There was a high level of dedication among the senior management team in critical care to their staff, patients and one another.
- The emergency department had designed a quiet room, for relatives and friends of the deceased patient. The room was sensitively decorated and had the capacity for up to 12 people. Hot and cold refreshments and a telephone were available for relatives to use. Access to toilet facilities and the viewing room was designed so that the bereaved did not have to enter the emergency department.
- The specialist palliative care team were passionate and committed to providing a high-quality service to patients at Southmead Hospital. The team was highly regarded throughout the trust and were praised for their knowledge, skills and support by everyone we spoke with.
- The participation in research and improvement in clinical outcomes as a result of obstetric skills training.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Improve its performance in relation to the time patients wait to be assessed and the time they remain in the emergency department.
- Improve patient flow through the hospital to ensure that patients arriving at the emergency department by ambulance do not have to queue outside the department because there is no capacity to accommodate them in clinical areas of the emergency zone.
- Work with healthcare partners to ensure people with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained staff to meet their needs.
- Ensure that the seated assessment area is used appropriately for the short-term assessment, diagnosis and treatment of patients who are not expected to be admitted. If patients require a lengthy or overnight stay, they must be accommodated in an appropriately equipped ward that provides same-sex accommodation to ensure their dignity is protected.
- Ensure that nurse staffing levels in the emergency department are urgently reviewed and aligned to match current patient demand, flow and acuity.
- Ensure that temporary staff employed in the emergency department receive appropriate induction to ensure their familiarisation with the department and their competence in the role.
- Enable and facilitate emergency department staff to undertake mandatory and essential clinical training and professional training and development.
- Take action to support emergency department staff, including senior staff, to ensure their psychological wellbeing.
- Ensure there are enough staff with the rights skills and experience to provide safe and quality care to patients at all times.
- Ensure there is capacity in the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and wellbeing. This includes a robust hospital-wide system of bed management.

Outstanding practice and areas for improvement

- Ensure it acts in full accordance with the law as it relates to the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.
- Ensure staff meet the targets for statutory and mandatory training.
- Ensure that more than 50% of the nursing staff in critical care have attained their post-registration qualification in critical care nursing.
- Ensure that equipment required for surgical procedures is available in sufficient quantities so all patients operations can go ahead as planned.
- Ensure all surgical equipment and materials are cleaned and sterile and ready for use.
- Ensure that all medicines are stored safely and appropriately and records relating to administration are accurate.
- Ensure that all incidents are reported and investigated, and that feedback is provided to staff. The specialist palliative care team did not consistently report medication errors.
- Take action to address the problem of the backlog of unreported images.
- Continue to take action on, and monitor, the patient appointment request backlog.

Action the hospital SHOULD take to improve

- Continue to participate in local and national audits to benchmark practice and ensure continuous improvement in patient experience and outcomes in the emergency department. In particular, staff should take steps to improve pain management.
- Ensure that refrigerators used to store medicines at controlled low temperatures in the emergency department are regularly checked in accordance with the trust's medicines policy. This is to ensure that medicines are fit for use.
- Ensure that appropriate records are maintained for the disposal of controlled drugs in the emergency department, in accordance with the trust's medicines policy. This will reduce the risk of misuse of these medicines.
- Ensure that appropriate records are maintained in the emergency department in respect of emergency medicines and that the medicines trolley is sealed to show that it has not been used. This will ensure that appropriate emergency medicines are always available when needed.
- Ensure that resuscitation equipment in the emergency department is appropriately sited and regularly checked.
- Review and amend the standing operating procedure for the emergency zone and the standing operating procedure for triage in the emergency zone to accurately reflect current practice.
- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include customer service training for receptionists, the provision of TVs, appropriate reading material and information about waiting times.
- Ensure that concerns about nurse staffing levels are appropriately documented on the emergency department risk register and escalated for consideration at the directorate and/or trust level, as appropriate.
- Keep under review the emergency department staff skill mix and training to ensure staff are competent to care for children.
- Improve the provision and take up of training for emergency department staff in dementia care, supported by departmental champions and the development of a pathway for dementia care. This is so that the needs of patients with dementia are identified and appropriately met.
- Ensure that the reception staff in the emergency department are receptive to patients arriving and observe those that are waiting to be seen.
- Improve access to cleaning materials on Percy Phillips ward for the cleaning of patient baths.

Outstanding practice and areas for improvement

- Improve access and flow through the maternity service to ensure capacity meets demand.
- Ensure that medical records are available for patient appointments, mortality and morbidity reviews and data recording, and that they are stored securely so that patient confidentially is maintained.
- Ensure that patients are kept informed of the waiting times in clinics.
- Display safety metrics and quality performance information in the clinic waiting areas.
- Ensure that chaperoning is available and that patients are aware of this service.
- Ensure that information about reporting complaints is clearly displayed and available to patients and visitors to the hospital.
- Continue to develop and improve the centralised booking system with increased staffing and training. This should include reducing the backlog of appointment requests referrals.
- Ensure that information for the benefit of patients, such as translator and interpreter services and chaperoning, is available and visible.
- Review the incidents they are reporting to ensure they represent a full and accurate reflection of the events within the service.
- Improve feedback to staff about incidents they have reported and demonstrate learning and improvements from remedial actions.
- Improve the quality of safety thermometer and patient outcome data and how it collects this data in the critical care unit to ensure the service is able to innovate and improve.
- Ensure staff meet the targets for annual appraisals and performance reviews.
- Ensure that monitor alarms in the critical care unit can be heard or seen at all times.
- Ensure that the critical service develops a set of standard operating procedures to ensure consistency of clinical approach to patients.
- Ensure that the critical care service investigates ways to develop the emotional support offered to patients, their relatives and friends.
- Ensure that the critical care service produces a booklet for patients, their relatives and friends about staying on and visiting the unit.
- Make sure that all wards have the correct consent form in place for staff to use when caring for patients who lack capacity to consent to treatment and surgery.
- Consider improving early identification of patients who could be in the last year or months of their life.
- Ensure all staff are trained to enable optimal end of life care to be delivered.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing** **The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity.** **There were not always sufficient numbers of suitably qualified, skilled and experienced staff in theatres, critical care, emergency department, medicine, surgery and maternity services.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** **The provider must take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of:** **(a) the carrying out of an assessment of the needs of the service user; and** **(b) the planning and delivery of care and, where appropriate, treatment in such a way as to:** **(i) meet the service user's individual needs,** **(ii) ensure the welfare and safety of the service user.**

This section is primarily information for the provider

Compliance actions

There were insufficient beds to move patients from critical care when they no longer required that intensity of care.

In the children and adolescent mental health service there was a lack of robust, documented, accurate individual risk assessments.

Patients in the emergency department waited too long for a mental health assessment.

The discharge of medical and surgical patients was not always planned effectively, delaying their discharge when they were fit to be discharged.

Medical and surgical patients were not always cared for in the most appropriate wards for their needs. Reviews were not always undertaken in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider did not have suitable arrangements in place to protect patients against the risk of control or restraint being unlawful or excessive. Deprivation of Liberty Safeguards in critical care were not in accordance with the provisions of the Mental Capacity Act 2005. In medicine not all staff were aware of which patients had a Deprivation of Liberty Safeguard in place.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Compliance actions

The provider did not have suitable arrangements in place to ensure that staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients safely and to an appropriate standard by the receipt of appropriate training.

Mandatory training was not being consistently undertaken across the trust.

Less than 50% of nursing staff in critical care had a post-registration qualification in critical care.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment**

The provider had failed to ensure that equipment was available in sufficient quantities to ensure the safety of service users and meet their assessed needs.

The trust had not ensured that all equipment required for surgical operations was available and ready for use.

Equipment at the head injury treatment unit at Frenchay was not serviced appropriately, and taps were not flushed effectively.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines**

This section is primarily information for the provider

Compliance actions

The trust had failed to protect services users against the risks associated with the unsafe management of medicines in relation to the appropriate arrangements for the safekeeping of medicines used for the purposes of the regulated activity.

Medicines were not always stored securely in the medirooms and surgical wards.

Medication was found in some areas to be out of date.

Administration of medication was not consistently recorded accurately.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services 1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. The emergency zone provides the regulated activity of the treatment of disease, disorder or injury in the following co-located departments. We inspected the following departments and found beaches of Regulation 9 in all of these co-located areas which are as follows: · Emergency Department (ED) which provides emergency care and treatment to adults with serious or life threatening emergencies.(The department has facilities to treat children, although most paediatric care is provided at Bristol Children's Hospital and this is where ambulance borne patients would attend). · The Minor Injuries Unit (MIU) which provides care and treatment for adults and children with illnesses or injuries that are not life threatening but still need prompt attention.

This section is primarily information for the provider

Enforcement actions

· The Seated Assessment Area (SAA) which provides urgent assessment, diagnostic investigations, observation or treatment for adults who do not require a bed for assessment/treatment and who are not expected to require an overnight stay. This area is also known as Ambulatory Emergency Care (AEC).

There were restrictions, due to the capacity of the emergency zone, on the ability of the provider to provide prompt assessment of patients, diagnosis, care and treatment. Patients waited too long in the emergency zone and were sometimes accommodated inappropriately in the Seated assessment Area which was not designed or equipped to accommodate patients for extended and/or overnight stays. This meant the provider had not taken proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment.

The provider confirmed in an email to the Care Quality Commission dated 20 November 2014 that the ED declared a status of 'red' or 'black escalation' on 13 out of 14 days from 20 October 2014 to 2 November 2014. According to the definitions outlined in the trust's Full Capacity and Emergency Department Escalation Policy (June 2014) this meant that the department was "regularly unable to function as normal" and was "verging on unsafe for periods of time" or deemed "dangerous for a sustained period of time (more than two hours) and where normal care was not possible".

The enforcement action we took:

Warning notice served 16 December 2014